

**THE STORY UNDER THE STORY: NARRATIVE THERAPY WITH INDIVIDUALS IN
A RELATIONSHIP WITH PSYCHOSIS**

by

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Abstract

The current treatment for the phenomena of psychosis is predominantly bio-medical in spite of other documented causes such as abuse, trauma and substance use. This type of approach is too narrow and fails to be inclusive of social, relational and socio-economic domains of reality. There has been recent momentum within the Mental Health Commission of Canada, and at various macro levels, to include approaches that are collaborative, respectful and supportive of a person-centered path to wellness and wellbeing.

Based on a social constructivist approach rooted in a critical psychiatry perspective this study explored the observations and experiences of five service providers, counsellors and social workers, in regard to how narrative therapy contributes to well-being for individuals who have a story that includes the phenomena identified as psychosis. Their experiences were captured through qualitative semi-structured interviews. The themes that emerged through the interviews were impacts and dangers, personal agency, nuanced meanings and narrative therapy as a conduit. These themes identify the work that is being done in this area and the viewpoints of social workers and counselors who utilize a social constructivist lens. These themes also provide direction as to the emerging practice of narrative therapy in this area of interest. Implications for social work practice, policy and research are discussed which provide a promising future for narrative therapy and working with the phenomena of psychosis.

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Introduction

The medical model is missing the mark in terms of how it engages with the understanding of psychosis (Casey & Long, 2003 in France & Uhlin, 2006), and consequently how individuals are treated within the mental health system as a broad client group. The current treatment for the phenomena of psychosis is predominantly biomedical in spite of the broad range of documented causations which include abuse, trauma, (Kilcommons & Morrison, 2005 in Green, 2006) interpersonal stress, (Green, 2006) substance use or a biological brain disease. According to Double (2002) “the use of diagnosis based in biological explanations of experience eliminates the possible significance of the meaning of distress, and obscures its social and psychological origins” (cited in Thomas, 2013 para.18)

Even the concept of causation itself is a medical construct and recommended to be used with a cautionary note. According to the National Institute of Mental Health (2017), the medical term “psychosis” refers to a condition in which “there is some loss of contact with reality” (para.1) where the individual may experience perceptual disturbances i.e. “delusions (false beliefs) and hallucinations (seeing and hearing things that others do not see or hear)” (para.1).

The overarching experiences of individuals within the mental health system are those of oppression, stigma and lack of personal control (Kidd, Kenny & McKinstry, 2015). Deinstitutionalization, originally intended as a civil right, empowerment based movement, has resulted in social control methods, case management models and increased use of psychotropic medications. While current psychiatric treatment has been helpful for some people it does not account for nor provide lasting change due to its lack of intrinsic focus on each person’s unique needs and their social context. There has been extensive literature on the harms and increased

vulnerabilities that medications can cause (Schooler, Goldberg, Booth & Cole, 1967; Leff 1992; Gur et al., 1998; Harrow, 2007 in Mehl- Madrona, Jul & Mainguy, 2014). Importantly there are ongoing criticisms from the client group regarding the ill effects of psychotropic medications and how it is not improving their lives (Williams, 2012). There has been an over reliance on biomedical intervention to the detriment of other therapeutic models. Biomedical treatments are too narrow and fail to be inclusive of social, relational and socio-economic domains of reality.

There has been recent momentum at international, national, regional and local levels towards improving current mental health systems, signifying a move away from the medical model of illness toward inclusive recovery based approaches. This entails services that are client focused, collaborative, respectful and that support individuals to “determine their own path to mental health and wellbeing” (Mental Health Commission of Canada, 2015, p.4) which may or may not include use of medications or a combination approach.

As a result of this shift there is a long-awaited need for research in alternative and additional treatment modalities with individuals who are in a relationship with psychosis. For the purpose of an audience of various readers, the phrase ‘in a relationship with psychosis’ would be medically termed Psychosis not otherwise specified, Schizoaffective or a Schizophrenia diagnosis (American Psychiatric Association, 2013). Frequent allies with psychosis have been noted to include trauma and/or a relationship with drugs. Research in this area would be beneficial to both service providers as well as the individuals we work with. Contrary to medical models operating within a modernist epistemology which focuses on “reductionism”, “linear causality” and “neutral objectivity” (Van Niekerk, 2005, p.53), social constructivist approaches are concerned with opening up the possibilities through therapeutic engagement. According to Anderson (1997), “reality including our experiences, our descriptions and our explanations of

reality, is a product of a social dialogue-exchange and interaction and represents an agreement between people” (p. 202). In this sense, the benefit in using social constructivist or therapeutic engagement is that it allows individuals to step out of the confines of their experiences and out of the experience of internal state psychologies to intentional relational understandings (Madigan, 2017). The benefit to service providers is potentially feeling more effective in our work, having stronger relationships with those we work with and a greater understanding of how to support others.

The aim of this research is to explore the current work that is being done by counsellors, therapists, and social workers in the area of narrative informed practices. The specific research question is, “How does narrative therapy contribute to well-being for individuals in a relationship with psychosis?” A Social constructivist and critical psychiatry perspective were used in this research study. Both mental/theoretical models will be expanded on throughout the paper. This study looks specifically at exploring and identifying the ways that narrative therapy can contribute to well-being for individuals in a relationship with psychosis through service providers’ experience with the aforementioned individuals. In the context of this study well-being and its measurements are defined as a coherent sense of self (Lysaker & Lysaker, 2001 in Green, 2006), with self-agency and the ability for meaning making in self narratives. The context of the measurements evolved from the initial description of personal agency (Seikula, Alkare & Aaltonen, 2001a in France & Uhlin, 2006), and personal narratives (Biggs & Hinton Bayre, 2008). The rationale for the researchers shift in language and perspective comes from narrative therapists who would position that a self-identity opens up the possibilities of who the self is; juxtaposing westernized notions of a core self with notions of a dialogical self. To elaborate further we turn to Bakhtin’s (1891) concept of a polyphony which situates self as multiplicity of

voices and positions both within the internal and external worlds. Anderson (1997) would reiterate that this dialogical self has a foundation upon which the self is constructed and that the various positions and voices do not emerge independent of each other.

This research does not only address individualized concepts of well-being, but includes the cultural and social contexts. This includes a focus on social responsibility, social hierarchies, social exclusion and the cultural context into which psychosis is defined, understood, and experienced. This study is concerned with the meaning making and its connections with well-being that results in a narrative focused relationship between client and clinician. This study was limited to focusing on service providers experiences.

Literature Review

There is growing literature concerning the narrative therapy model of intervention, and its utility when working with individuals who have experienced trauma, are dealing with addictions and are impacted by psychosis or disordered thinking. Importantly these aforementioned factors frequently exist in relationship with each other which may include one or all of these factors. There have been a large number of professional disciplines interested in narrative therapy ranging from clinical social workers to medical doctors. Recent literature related to addiction, psychosis, trauma, recovery and narrative approaches will be reviewed. Additionally, the limitations of different theories of knowledge will be explored which will include an exploration of the tensions between positivist (modernist) and social constructivist (postmodernist) theories of knowledge.

The relationship with psychosis

There are a number of reasons for experiences of psychosis such as “trauma, drugs, [the presence of a thought disorder] (American Psychiatric Association, 2013), spiritual journeying

without a map” (Mehl-Madrona, Jul, & Mainguy, 2014, p. 59). Spiritual journeying is the shamanic practice within Indigenous contexts which involve journeying away from the physical world to the spiritual and imaginative world (Gucciardi, n.d.). Mehl- Madrona, Jul & Mainguy (2014) argue that a developmental trauma hypothesis has been more successful than a brain disease theory to demonstrate the correlational effects on the nervous system. They argue that “schizophrenia is not a brain disease but a state of brain function” (p. 65). Similarly, Walker (2006) posits from a mind behavior biology standpoint that mind and behavior impact the biology. In his article Walker (2006) delineates how psychotherapies are capable of altering the biological construct which in turn alters the mind and behavior resulting in an iterative process. The result of the interpersonal processing is the ability to create new neural pathways and enhanced responsiveness resulting in increased harmony in one’s environment and with self (Mehl-Madrona, Jul, & Mainguy, 2014). Drawing from cognitive behavioral therapy (CBT) for psychosis and narrative therapy, authors Jakes & Rhodes (2009) posit their understanding of psychosis as social, historical and psychological processes. This means that societal context, personal experiences including positive and negative emotional states contribute to the complexities and interconnectedness of thoughts, ideas and imagination (Jakes & Rhodes, 2009). These descriptions move away from the explanation that the diagnostic label schizophrenia is incurable and progressive, and instead argues for a relational and hopeful understanding of the experience of psychosis which is one of the medically documented symptoms of schizophrenia. Importantly, from a medical viewpoint schizophrenia may cause psychosis but it isn’t the only cause of psychosis. This writer would like to offer and remind the reader of the possibility of including descriptors that move way from theories of causation and instead include complex webs of relations of understanding which derive from a social constructivist approach. These

aforementioned descriptions by the authors also relay to the reader that a social constructivist approach would take into account their explanations and more. The possibilities are not confined to a single way of understanding psychosis. Social constructivists operating within postmodern epistemologies are concerned with moving towards a social consciousness of multiple systems and multiple perspectives (Gonzalez, Biever & Gardner, 1994 in Van Niekerk, 2005 p. 59). How this theory links to a narrative model of therapy intervention presents itself in the following examples: from a social constructivist approach, it is the therapeutic conversation that lends itself to the creation of reality. Narrative therapists are concerned with both the dominant metanarratives (Parry & Doan, 1994) known as discourses and the subordinate narratives that go unacknowledged unless paying specific attention to these sub narratives or sub plots. In narrative therapy this process is known as double listening - a process where change can occur through the deconstruction of the dominant narrative and its assertions to truth while simultaneously listening to the non-dominant narrative and where initiatives occurred which contradict or criticize the metanarrative (White, 2003). The intent is a re-authoring where, if the individual client is interested, the subplots are explored and built upon. By expanding on and thickening the alternative narratives it allows for depictions in contradictions, gaps, strengths, alternative meanings and places for resistance and growth (Brown, 2011). The imperative is looking at the contradictions, continuities and discontinuities in constructing a helpful and coherent narrative that lends itself to self-agency and self-identity (Anderson, 1997, p. 221). For marginalized populations, such as the population this study is concerned with, narrative therapy is both useful and relevant. Referring to Anderson's (1997) acknowledgement of a dialogical self and consistent with the context of this study, narrative therapy has the ability to give meaning to the various positions and voices. According to Hermans and colleagues "the voices function like

interacting characters and each character has a story to tell about experiences resulting in a complex narratively structured self” (cited in Anderson, 1997, p. 220). This does not result in fragmentation but results in a self-moving back and forth between several positions (Hermans et al. cited in Anderson, 1997, p. 221). “The self is not a single entity, one voice or one position but a multiplicity of each” (Bakhtin, 1981 in Anderson, 1997, p.225). “Each character or author could be for example, another character, a conscience, one’s inner thoughts or an imagined other in dialogue” (Bakhtin in Anderson, 1997, p.225) existing simultaneously through continuities and discontinuities and possibly in harmony with one and other. However, this would need to be determined through how the narrative emerges and through the perspectives of the narrators. The concept of fragmentation in this case is a value judgement akin to a medical approach and denies the complexity of who people are. Expressions of the self through different dimensions does not signify fragmentation but could signify a difficulty with integration with the multiple dimensions of self. These “stories” and trajectories evolve through peoples lives and through intra and inter dialogues and relationships with themselves and others. The process of narrative therapy augments and reinforces these stories and likely changes the hierarchy of importance and significance of the persons view of themselves while creating a foundation for the stronger self.

Illness narratives

Various articles within the literature had different levels of agreement with the biomedical illness narrative. Marlowe’s (2009) study consisted of a discussion on various forms of narrative practice through psychotherapy and its implications for individuals. However, the reference of the study was predominantly medical focusing on diagnostic language and

concerned with symptoms. Although Marlowe (2009) addresses the recovery movement she does this from a medical lens. According to Walker (2006), while the recovery movement has moved us in a trajectory of strength, service users and service providers are “still bound by the balls and chains of diagnostic language” (para. 58); language which is concerned with defining an objective reality. “The recovery model as it currently exists is an incomplete transformation of the mental health profession” (Walker, 2006, para. 88). The way the model has been taken up is not in its original form or its original intent. The original intent of the model was as an individualized approach through equal partnership where the client is able to take a “leading role” and where service providers “move away from paternalistic approaches that presume to know what is best for a person, and instead involve the person in identifying what they want to achieve” (Kidd, Kenny & McKinstry, 2015, p.45). The intent with the model is to see people through their strengths and possibilities as opposed to deficits and problems and through a sociocultural as opposed to a biomedical framework. “Consumer advocates argue that recovery as a paradigm has been co-opted into the individual bio medical frame, while the social determinants of health, structural disadvantage and social exclusion have been downplayed” (Morrow, 2011 in Kidd, Kenny & McKinstry, 2015 p.39). It is the above-mentioned operations of language and power that social constructivists, narrative therapists and anti-oppressive social workers are concerned with.

Roe and Davidson (2005) highlight how it can be either the illness or the illness narrative that disrupts a person’s understanding of themselves. Walker (2006) argues that within medical and psychological paradigms it is the illness narrative with its medical vocabularies and absolute truths as opposed to perspectives which contribute to the disruption. This results in individuals feeling locked in an understanding of themselves or their world that is incongruent. According to

Davidson and Roe (2005) while these meanings are established through social understandings they get adopted at an individualized level resulting in negative social and personal effects. To add to their description Prasko et al. (2015) highlights that “narratives are shaped by detailed cultural and often context specific cognitive schemas [...] which mediate an understanding of the world” (p. 136). Roe and Davidson (2005) point out that these cognitive schemas are in place to explain current realities and specifically to also explain one’s engagement with their level of acceptance of having a psychotic “illness”. Roe and Davidson (2005) critique descriptive psychiatry because of its assertion “that people accept their diagnostic label with the good intention of improving adherence and outcome” (p. 90). The paradox with this understanding of schizophrenia is that you have to accept the illness to move forward in life. This need for acceptance of having a diagnosis by medical professionals creates its own list of “iatrogenic problems; problems created in our efforts at helping” (Walker, 2006 para. 60). From a social constructivist framework, the researcher would highlight how it is the need of other modernist frameworks to accept fact as objective truth that contributes to the in-congruency that individuals experience instead of allowing for multiple truths and perspectives to exist simultaneously. Following from this theory a postmodern perspective would also agree that any perspective which purports to have the monopoly of truth and that dismisses other knowledges would not carry equal validity in its assertions. It is the agreement upon shared meanings where these knowledges are established (Anderson, 1997).

Narrative approaches or narratives of psychosis

Many articles reviewed recognized the importance of not dismantling an individual’s belief system concerning experiences of ‘psychosis’, ‘delusions’, or ‘hallucinations’. Mehl-Madrona, Jul, & Mainguy (2014) suggest that the value of narrative therapy comes from the

ability for relational understanding, co-constructions of one's experiences and the ability to give peoples' voices and visions full existential validation rather than being considered a meaningless experience. As noted by Rhodes and Jakes, "When individuals are experiencing psychosis, there is [...] an alteration of the experience of self, self with others, and self in the world, which is a persistent and profound concern for the individual" (Rhodes & Jakes, 2009 in Mehl-Madrona, Jul, & Mainguy, 2014, p. 65). Although psychosis disrupts one's experience of reality it also contains realistic themes in its content that connect to the individual's narrative (Garett, 2016). Bar-am (2015) suggests a concept of "magical realism" (p. 20) as a "listening space" (p. 20) to push the boundaries of what is termed to be 'reality' and 'legitimate knowledge'. This author suggests a tremendous ability for a reconceptualization of psychosis, stating that it involves a combination of "fantastical events interwoven into everyday life" (p. 20). Tying into these previous mentioned models of psychological processes and realistic themes, Garrett (2016) invites the reader to consider how psychosis is a construct of "persistent logical reasoning", "unconscious phantasies", and "attempts to integrate them into real world experiences" (p. 36). The difficulty arises through the "[breakdown] of biological substrates that maintain boundaries between thoughts, feelings and perceptions" (Garrett, 2016, p. 37) allowing the stage for a play which has both a protagonist (the self) and antagonist, (the expressions of the anomalous experience or unresolved psychic pains and/or defenses against that psychic pain) (Garrett, 2016). He offers the reader an explanation that places "psychosis as a meaningful expression of unbearable psychological pain in the aftermath of adverse life events" (Garrett, 2016, p. 35). He suggests that as clinicians if we saw these connections between "ordinary mental life" and expressions of psychosis i.e. 'delusions' or 'hallucinations' we may more readily be able to understand the anomalous subjective experience relating to the individual's mental processes and

narrative.

In another example, White (2007) recommends to externalize the problem by taking an investigative stance, to build an expose of the problem and to uncover the mechanisms of power through giving meaning to the motivations and strategies that the voices are using. White's theory is that in exposing the mechanisms of power and invisibility of them it moves [power] from a place of being impenetrable to being able to provide alternative meanings and an alternative stance. In this example, even within the realm of medical understandings narrative therapy contributes to changed accounts and alternative narratives and meanings. "A successful revision of a person's relationship to the voices invariably has a significantly positive effect on the person's quality of life and reduces the vulnerability to psychotic episodes" (White, 2007, p. 29). Importantly, various relationships can exist to the voices. While some relationships may be distressing others may be supportive.

France and Uhlin (2006) pose the following questions: "What dimensions of narrative must or are most likely to change during recovery; and do narrative based therapies have the potential to significantly improve outcomes in psychosis?" (p. 56). The France and Uhlin (2006) study identified that when individuals are moving towards recovery and away from acute illness, the shape of the narrative changes. Although there may still be psychosis present "the content of the narrative would contain increased personal agency, increased coherence in its organization and added complexity and subtlety" (p. 62). What these observations suggest is that narrative therapy has the ability to monitor changes and improvements and improve overall outcomes. The reader is also left with some important questions concerning the topic of psychosis, such as "what might we ask about context; what might privilege the client's personal agency within his or her context and what might psychosis teach us about being, identity and relationships"? (Bar-

am, 2015, p.18). A recent study notes that with narrative and dialogical approaches “over 60 % of patients had resolution of symptoms without any medication and over 20 % required only low dose medication” (Mehl-Madrona, Jul, & Mainguy, 2014, p. 69). This study included 51 participants with a psychosis diagnosis on the spectrum inclusive of schizophrenia, schizoaffective disorder, bipolar with psychotic features, psychosis NOS and Substance induced psychosis. Participants were required to remain for a period of 6 months for the data to be included in the findings. Follow up ranged from 2 – 12 years. Importantly in the data the percentages resolving without medications ranged from 50 % to 90 % with individuals who had received a diagnosis of schizoaffective, psychosis NOS or bi polar with psychotic features in the 90th percentile and individuals who had received a diagnosis of substance induced psychosis and schizophrenia in the 50th percentile.

In another study, there were similar results – the Soteria project. This project developed by Loren Mosher which was consistent with RD Laing’s perspective was focused on the theory of supportive, interpersonal, phenomenological and humane environments facilitating healing. The Soteria house was a service “delivered in the context of a 24-hour small, homelike, quiet, supportive, protective, and tolerant social environment” (Mehl-Madrona, Jul, & Mainguy, 2014, p. 62). Mosher’s aim was to develop over time, “a shared experience of the meaningfulness of the client’s individual social context- current and historical” (p.62). He juxtaposed this approach with standard psychiatric treatment. Findings again highlighted that the alternative approach was just as effective if not better than traditional pharmacological psychiatric treatment. There were a number of projects and studies replicated and modified after this one (Mehl-Madrona, Jul, & Mainguy, 2014). The literature speaks to the importance of other therapeutic modalities having equal if not more value in resolution of symptoms for the individuals in the study.

Trauma psychosis and narrative therapy

Williams (2012) indicates that psychosis can signify connections between experiences of trauma and the window of tolerance. He suggests that the experience of ‘psychosis’ could be an intentional yet unconscious operation of the psyche to increase the window of tolerance for the psyche to absorb whatever is occurring in consensual reality that is difficult to tolerate. “The window of tolerance is increased by destabilizing and loosening the cognitive structures in the psyche” (Williams, 2012, p. 180). Briere and Scott (2015) note that “psychotic symptoms (typically hallucination, delusions, tangential or loosened mental associations, and some instances of catatonic behavior follow exposure to overwhelmingly traumatic events” (p.49). Moreover, psychotic symptoms have been documented among survivors of physical or sexual assaults (Burns, Jhazbhay, Esterhuizen, & Emsley, 2011; Kilcommons, Morrison, Knight & Lobban, 2008 in Briere & Scott, 2015, p. 49) and childhood abuse (Alemany et al., 2011; Saha et al., 2011). Notably the presence of childhood trauma is associated with more severe and varied psychotic symptoms [...] (Alvarez et al., 2011; Ramsay, Flanagan, Gantt, Broussard, & Compton, 2011; A. Thompson et al., 2010; Vogel et al., 2001 in Briere & Scott, 2015, p.49). It would follow from these description that “psychosis may be the manifestation of a natural coping healing growth oriented process initiated by the psyche” (Williams, 2012 p. 66).

Importantly and consistent with the discussion on the relationship with psychosis and trauma there is the imperative of how individuals are treated within mental health systems and how this treatment can be worse than the anomalous experience itself. Kidd, Kenny, and McKinstry (2015) acknowledge that structural violence and individual and collective discrimination is a reality for many individuals accessing the mental health systems or find themselves implicated in it involuntarily. Many of the first-person accounts in Williams (2012)

research conveyed that the psychiatric support was not helpful and in many cases worsened the person's experience. "People diagnosed with psychotic disorders are often treated in a manner that is disempowering, frightening and sometime even ... violent" (Williams, 2012, p. 53).

Williams further points out that "this particular combination of experiences is very likely to lead to trauma (Williams et al., 1999, p. 1729 in Williams, 2012, p. 52). In addition, the application of the medical model paradigm and "contributing factors associated with this paradigm such as stigma, hopelessness and trauma are likely to collude with and reinforce the distressing associated with psychosis" (p.54). In a couple of the cases the isolation, lack of hope, and general treatment contributed to suicidality. Notably the literature speaks to the importance of compassion and conveying a sense of hope for "genuine recovery to really be possible" (Williams, 2012, p. 206).

This brings us to the developing literature concerning post-traumatic growth and some of the mediating factors. This concept termed by Tedeschi and Calhoun coined in the mid-nineties has significance relevance to the context of this study. The facets of post-traumatic growth include: appreciation of life; relating to others; new found possibilities; personal strength and spiritual change (Tedeschi & Calhoun 1996; Tedeschi & Calhoun 2004 in Mazor, Gelkopf & Mueser, 2016, para.1). In Williams (2012) phenomenological study the implications of the findings signified that medical treatments received by the individuals interrupted a natural healing process and even prolonged the psychosis in a couple of the examples. The other implication from the study was that as a result of the psychosis and the recovery process, which occurred away from a purely medical orientation, "participants underwent a profound and primarily positive transformation in regard to wellbeing" (p. 214). The findings point to the mediating factors of "meaning making", coping self-efficacy, and the importance of providing

space for people to just talk about their experiences with the support of a professional through a “loving eye” (Mazor, Gelkopf & Mueser, 2016). Furthermore, this study also concluded that the psychosis itself and the reflections from the psychosis contributed to deeper insights and experiences that contributed to significant meaning and purpose in one’s life (Williams, 2012). Many of the participants in Williams study went on to be advocates and supporters of people who have anomalous experiences of psychosis. In another study Mazor, Gelkopf & Mueser (2016) focused on post-traumatic growth and psychosis. One hundred and twenty-one participants were interviewed. The criteria included adults 19 or over “who have had experiences of psychosis corroborated by their clinicians and the positive and negative syndrome scale (PANSS)” (para 6). The implications from this study noted that the ability for post-traumatic growth was contingent upon the ability to engage in a meaning making process regardless of high levels of symptoms. The conclusion from this study was that “mental health rehabilitation needed to broaden its perspective of recovery to post traumatic growth and to develop interventions that promote meaning making” (para. 25) . The implications from this study suggest that narrative therapy as a model of intervention supports and facilitates the mediating factors of coping self- efficacy through agency; meaning making and being a listening partisan through the concept termed by Marilyn Frye- as the “loving eye”. These findings and implications will contribute to the formulation of research questions

This last section will address the work of narrative therapy with trauma, which as noted above is often relevant to those in a relationship with psychosis. Beaudoin (2005) endorses there are multiple processes occurring concerning trauma experiences and responses. Usually individuals will either minimize or will not recognize their personal agency. Contributing factors that add to the difficulty of recognizing their personal actions is the oppression they have

experienced and or diversion from the oppression they have experienced. A trauma informed, narrative approach serves to acknowledge that sometimes responses to traumas and violence may not only contain physical responses but may involve emotional and mental processes (Beaudoin, 2005). Consistent with Wade's (1997) work of language of response rather than effect, the purpose of the narrative is to examine how these responses contributed to personal survival and preservation. A trauma-informed approach helps individuals to "reframe their responses as attempts to cope with what they have been through" (BC Provincial Mental health and Substance Use Planning Council, 2013, p.17). The purpose of the narrative approach is to identify and build on the stories of agency and strength (Beaudoin, 2005). It is important to note in this article and consistent with trauma informed practice in general, that the specific trauma does not need to be revisited to do trauma work (BC Provincial Mental health and Substance Use Planning Council, 2013). In closing for this section, it is important to note that psychosis, trauma, and narrative therapy is a valuable area for research exploration.

Gaps in the literature

This researcher was drawn to Garrett's (2016) inquiry surrounding why the rationale existed for psychotherapy with non-psychotic expressions such as depressions and anxiety but that psychotic expressions are mainly addressed through medications? This researcher is also left with the question and the gaps in the literature concerning narrative therapy as a therapeutic approach related to trauma and psychosis. Garrett (2016) discusses psychotherapies and the minimal focus related to psychosis and trauma but he does not specifically mention narrative therapy as one of those psychotherapies even though he describes psychosis as expressions of mental processes through a story line and a plot i.e. a narrative. Additionally, Williams (2012) and Mazor, Gelkopf & Mueser (2016) also acknowledge the importance of meaning making but

do not name narrative therapy as one of those interventions. Following from this line of discussion, recovery is mentioned numerous times in the literature concerning a transformation of current mental health systems signifying the importance of incorporating a more human rights social justice orientation however the literature concerning recovery also lacks identification of viable intervention's that support this movement.

The current literature does not speak to whether healing from trauma would improve the relationship with psychosis. Many times, individuals who have been diagnosed with psychotic symptoms also have narratives which are intertwined with themes of trauma, abuse and distress. If one is able to create a coherent narrative that addresses the trauma from a far proximity would we see reductions in psychotic symptoms and indications of distress? Would healing from trauma reduce the psychosis and increase the continuity of the narrative across time, and contribute to agency? Or would the ability to increase the continuity of the narrative contribute to self-agency and healing from trauma? As we have noted from multiple authors many speak about the expressions of psychosis through a narrative with protagonists and antagonists, a story line and a plot. The literature that this author reviewed is consistent with the hypothesis of the research that narrative therapy is a viable intervention for the professional who provides services for those clients who are presenting with symptoms that include psychosis. Narrative therapy's capacity extends beyond psychotherapy and object relations (Garett, 2016) to explore multiple realms and dimensions of consciousness and possibilities.

The literature review identified a significant gap in terms of methodology and first-person research therefore the researcher thought it was important to include in the findings any first-person research to center those voices, experiences and realities. There was overwhelming evidence that the methodology does not normally include a phenomenological study of psychosis

however when these studies are attained they provide valuable information as demonstrated by Williams (2012) research.

This last-mentioned gap in the literature concerned the limited number of Canadian studies concerning psychosis, narrative therapy, and recovery. Most of the research occurred in countries such as Australia, New Zealand, Britain, Israel, and Finland in addition to the United States. Canadian studies are required. Consistent with this identified gap is also Canada's limitations in terms of a national mental health strategy developed and adopted though established policies. As Casey (2008) points out Canada is behind in terms of a commitment to recovery oriented services in comparison to other international countries. The Mental Health Commission of Canada came out with a strategic plan in 2017. A commitment is required at various jurisdictional levels to operationalize the strategy, to incur a transformation of mental health services and narrative therapy is one intervention that can support this strategy.

Theoretical Framework

This research study centers on a social constructivist framework rooted in a critical psychiatry perspective. Narrative therapy is one model of intervention that has developed out of Social Constructivism. While medical models are concerned with defining an objective reality, social constructivist frameworks are concerned with understanding how these realities are created, acknowledgment that there are multiple realities and acknowledgement that it is the construction of the conversation that lends itself to the creation of reality which informs the contributions towards agency. Critical psychiatry, congruent with a social constructivist framework, rejects the medical model in psychiatry in favor of a social model of understanding psychosis. According to Thomas & Moncrieff (n.d.) the main elements of critical psychiatry are

its skepticisms with neuroscience, its “ethical perspective on psychiatric knowledge and practice” and its political viewpoints of mental health issues characterized by deep inequalities in society and the medicalization of distress and experience (para, 3). Proponents of critical psychiatry would argue that psychiatry through government legislation has “shifted the balance away from care to control” and has sacrificed the “basic human values of respect for the persons beliefs and preferences for coercion and expert knowledge” (Thomas & Moncrieff n.d. para 2). This is operationalized in the name of community care and government legislation. In current systems “the dominant voice, the culturally designated professional voice, usually speaks and decodes for marginal populations” (Anderson, 1997, p.71).

The relevance to this study in using a social constructivist and critical psychiatry perspective is that it challenges and provides an alternative framework to current psychiatry through a more palatable and accurate explanation and approach. A social constructivist approach takes into consideration that it is the binary constructs of normal and abnormal which create the boundaries of what we call treatment. These binary constructs contribute to the distressing outcomes of experiences through stigma, lack of compassion and forced treatment, which result in increased traumas and quite possibly increased psychotic phenomena. Reading *Foucault for Social Work* the authors bring attention to how disciplines and dividing practices serve to create these stratified classifications between normal and abnormal which also impact on the individual themselves in surveillance of themselves (Chambon, Irving & Epstein, 1999). According to Chambon, Irving and Epstein (1999), “dividing practices lie at the heart of techniques of power by establishing partitions and categories and are implemented through procedures that distinguish, separate and categorize populations” (p. 273). A social constructivist framework refutes these ideas of categorizations and binaries, and challenges ideas

of normativity. Social constructivists are concerned with the limitations of modernism and the use of language and are “especially interested in the normative narratives or grand narratives which are formed by and in turn influence people, and against which people measure themselves” (Van Niekerk, 2005 p.65).

Critical psychiatry explains the limits to the generalizations of psychiatry and anti-psychiatry and places a good understanding of the balance of where our focus should be. It does not completely dispose of bio-medical explanations or the use of medications but it places neuroscience secondary to social science (the scientific study of human society and social relationships). Critical psychiatrists also uphold the skeptics viewpoint that there are a lot of ambiguities in diagnosis with its broadened criteria and its ambiguity in the use and effectiveness of medications and following from that discussion, psychiatry’s connection with the pharmaceutical industry.

Relevant to this study, critical psychiatry advocates for a consultant model of care where individuals are regarded as experts of their experience through different epistemological explanations and through alliances between service providers service users and their families in a meaningful, collaborative and respectful way. Moreover, narrative therapy contradicts the medical model of a passive recipient of treatment that has symptoms that require eradication and instead places it along political lines of who’s doing the talking and who’s doing the listening? “Acts of resistance and the development of alternative ways of knowing are key to the development of social work practices that help people to overcome their marginalized status in the larger oppressive societies” (Massaquoi, 2007 p.178). Narrative therapy as a model of treatment intervention is very important in uncovering and centering different ways of knowing. It is also imperative in challenging the thin story lines (Brown, 2011) of diagnostic language and

impressions, and in challenging “medical reductionism” (reducing experience to symptoms and pathology that “deprives the person of any meaning or context to their difficulties”) which has “implications upon how individuals come to view themselves” (Green, 2006 p. 52). Narrative therapy makes room for something much more meaningful and empowering resulting in a richer understanding of one’s self and a richer contextualized story (Green, 2006).

Design & Methodology

The present research is an inductive, exploratory cross-sectional study that is being completed at a local level to add to the existing body of knowledge. The reason the researcher chose this design is because there is not a lot of research related to narrative therapy with individuals who are in a relationship with psychosis. The research is also limited in terms of narrative therapy in relation to psychosis and trauma.

Recruitment

Recruitment began once approval had been obtained from the University of the Fraser Valley’s Human Research Ethic’s Board on March 6th 2017 (Appendix A). Social workers, counsellors and therapists were invited to participate in the study through a recruitment email (Appendix B) sent to them by the researcher during the period of March 2017 and Jan 2018, explaining the study and the criteria for participation. A letter of informed consent which provided more details about the study was provided to the individual participants upon meeting with them (Appendix C). Potential participants were invited to contact the researcher if they were interested in participating in order to schedule an interview at a time and place that was convenient for them.

The sample population included social workers, therapists and clinical counselors with experience working in narrative therapy and specifically with the client population - individuals who are in relationship with psychosis. All participants had a qualification of a MSW degree, a MA in counselling psychology degree or a PhD degree. One participant was nearing the completion of her MSW degree. The sampling frame that was used was an exponential non-discriminative snowball sampling approach meaning that subjects gave multiple referrals and each referral gave more until the required sampling amount was attained. The researcher first identified some potential participants that she was aware of through her own network and then was able to identify more participants through an advanced narrative counselling workshop with professionals currently employing narrative approaches with the identified population group. Potential participants were contacted by email to invite them to participate in the study. Other potential participants were identified through asking participants if they knew other professionals who fit the criteria for the research study and who might be interested in participating in the study.

Five individuals responded to the invitation to participate in the study. Between March 2017 and January 2018, the researcher conducted individual interviews with each participant. These participants were interviewed either face to face, or by telephone, if time or convenience for the respondent did not permit a face to face interview.

Data collection and Analysis

Data was collected through semi structured interviews with participants. With their consent the researcher interviewed five individual professionals with PhD, MA, or MSW degree criterion using open-ended questions (Appendix D). Part of the researcher's methodology included a pilot interview to ensure the questions being asked were addressing the overarching

research question and were relevant to the concepts that the study is concerned with. Questions that were posed consisted of participants experiences, approaches, observations and practices with the identified population (the criterion group). These questions included discussions on recovery-oriented services, trauma, phenomenology of psychosis and meaning making. There were some overarching questions that informed the interview process, but questions were asked spontaneously in response to what information the participant was providing. The rationale was for further elaboration of a response or clarification of a response.

Interviews ranged in duration from sixty to seventy-five minutes. Two of the interviews took place at the work places of participants while the remaining three happened over the phone and one over a visible face time interaction. Each participant was provided the informed consent document (Appendix C) and were given the instruction as to consent and that they could opt out of any questions or the interview should they choose without any impact to them. When the researcher finished asking questions in the interview, participants were asked if they felt that any additional questions should be added that would be beneficial to the study. None of the participants offered additional questions. The researcher's last question of the interview specifically notes "is there anything else that you would like to tell me about psychosis trauma or anything else that you feel is relevant to the interview"? This allows for an opportunity for anything that was not addressed by the researcher to be included as meaningful data. Participants were asked if they wanted to be involved in confirmation of the thematic analysis once first analysis was completed. Each respondent with the exception of one stated that they did not need to be but if the researcher wished they would participate. This participant received the analysis of the themes and the feedback from the respondent was affirming of the themes.

The interviews were all recorded with a recording device. The researcher transcribed each interview onto the researcher's password protected computer. Each interview was given a numeric code based on the sequence date of when the interviews were completed. The transcripts for the interviews were stored on the researcher's computer for the duration of the study. A thematic analysis was conducted in order to identify the central themes that were uncovered from the interviews. Data was analyzed using emerging themes within each transcript. Dudley (2011) recommends that researchers keep a memo of their impressions while reviewing the data for later reference and for recording emerging questions which this researcher did. Through comparing and reviewing the transcripts, key themes were discovered. Themes were grouped together based on similar content and labels were created for each theme. Variations were also identified and noted within each theme. The themes which were identified addressed the intention of the study while having some association with the questions in the interview guide. However, they were not discovered based on categories of questions within the interview guide.

Ethical considerations

In order to ensure that the parameters of research met the requirements from the Human Research Ethics Board, the researcher submitted an application of the research proposal on February 17, 2017. The HREB Certificate of Approval (Appendix A) was received on March 6, 2017.

The ethical consideration included the designing of the study. The intention of the researcher was not to cause harm to an already vulnerable population through asking sensitive questions. This researcher therefore chose to interview service providers instead. The design did not include direct service user's voices. Wadsworth (2011) poses the question who is the

research for? The motivations to complete this research was primarily for the (client population); the secondary motivation was for the professionals that work within the system in order to employ supportive and meaningful approaches. The former group is not included which brings up the concern “if their realities are being represented appropriately?” (Guba & Lincoln;1982 in D’Cruz & Jones, 2004 p.74).

The second ethical consideration is that the criteria this researcher was using for the client population is contrary to the foundation of narrative practice. However, for the purpose of this study it requires some parameters i.e. diagnostic categorization. The research adhered to the research requirement for there to be diversity in the research, by including the client population to mean anyone with a psychosis diagnosis on the spectrum.

Limitations of the study

According to Dudley (2011) “limitations of a study need to be taken into account before they can be generalized to bigger populations” (p. 276). Following from the ethical considerations, the biggest limitation in this study is that client perspective is not directly included. The findings and perspective that are accessed are those of service providers. However, follow up research should include practice evaluations directly with the client population as a pilot study. There is evidence that points to the value of narrative therapy. The sampling size of five interviews is limiting. Unfortunately, it is a small therapeutic community which employs narrative traditional approaches. While developing, it is not a mainstream approach. Narrative therapy requires mentoring and supervision to be authentic and valuable. The next couple of limitations also acknowledged by Green (2006) in her study is that it is a certain type of therapy and clinician who embraces narrative approaches which are

predominantly upheld by social constructivist and postmodern philosophies. In its purest form these philosophies contradict and challenge scientific truths and medical philosophies. Coupled with this is the researchers bias and position in performing this study. Similar to Green (2006) the interest in the research derived from the researchers experience of observable limitations within the medical approach and as a result of the contradictions in both professional and personal values when working with others. It is this framework that informs the study and will pose limitations in terms of how this study will ask certain questions and will not ask others. For example, this study does not ask questions in line with the benefits of the medical model. This is also a limitation that Dudley (2011) acknowledges. In an attempt to address biases, the direction of the interviews was guided by the research participants. In addition, the researcher did not ask any questions to confirm any curiosities of potential emerging themes that could compromise the data.

Findings

Demographic Summary

Five service provider participants were interviewed for this study. There was a variation in both the number of years of experience as well as the level of engagement and current practice with narrative therapy. Some spoke about it in terms of a philosophy while others spoke about it as a model or technique. The years of experience ranged from over twenty years practicing narrative therapy to engaging in practices that were narrative informed. Each respondent had over five years' experience in narrative practices with the average being fifteen years. All had received narrative therapy training/mentorship from mentors. There was very little variation in terms of the education level. Four out of five of the respondents had a master in either

counselling or social work. One respondent has a MSW degree and Masters of Narrative Therapy degree. Another respondent has a Masters of Anthropology and a MA in counselling degree. One respondent has her Masters in Counselling. One respondent has a Masters of Social Work and is currently in the process of completing his PhD. Lastly one individual has a bachelor of social work and is in the final steps of her Masters of Social Work.

As noted in the previous paragraph in terms of theoretical orientation four respondents identified with social constructivist theories of knowledge. Each participant practices narrative therapy currently with one individual highlighting that her current practice consisted of the narrative therapy strategies of meaning making and externalization and another highlighting that she cannot say she is a purist anymore because she also needs to work within the government system and medical orientation which are contradictory to narrative therapies philosophies. However, her guiding philosophies are person as the expert and person defining their own experience. One of the other respondents also discussed how he uses a hybrid approach of narrative therapy and other modalities such as mindfulness. He provided some valuable insight referencing a statement by Korzybski (1931) that “the map is not the territory”, meaning clinicians need to be careful not to get caught up in the commodification of narrative therapy and it being “the end all be all modality”. He pointedly acknowledged that narrative therapy is in service of the greater project of creating relationships and meaningful connections with people-the therapeutic alliance. Every respondent provided a strong social justice orientation.

Interview data were analyzed using thematic analysis to identify the key themes.

Themes

Four themes were identified: impacts and dangers, personal agency, nuanced meanings and narrative therapy as a conduit.

Impacts and Dangers

One of the themes that emerged was the impacts and dangers for individuals in a relationship with psychosis being caught up in the mental health system and namely the medical model. All of the participants spoke about how the mental health system operates from a liability and risk discourse as opposed to a healing discourse and how this affects both the individuals they are working with as well as themselves as service providers. Respondent three spoke about its “direct link with separation and pretty severe othering”. She stated “there’s this sense of other when you deny a person basic dignity and rights and that’s what happens when that diagnosis flips on them, the liability discourse pipes up and dignity goes right out the window”. Respondent four contributed to this point by highlighting “that there tends to be a need to eliminate experiences of voices and beliefs” [associated with psychosis] “at all costs- at the cost to a person’s freedom”. Some examples that were provided included people being forced to take medications or forcing people to go to hospital. Consequently, there was an acknowledgment from participants that societal expectations and beliefs are the driving force in how individuals are treated within the mental health system. Although situations are not black and white and there is sometimes the necessity to intervene overall the viewpoint was that “taking away freedom is overused and that maybe professionals exert a little bit too much control over people’s experiences because our culture has an intolerance to seeing the world differently”. The need for intervention came down to a question of human suffering Is the person suffering with

the experience. In the interviews participants shared about the hope that social norms would encompass a greater acceptance and understanding of difference without judgement.

Continuing from the above impacts it was addressed that a person's knowledges and individual identities are discounted within the medical model as a result of receiving a diagnosis such as schizophrenia or psychosis. Respondent one demonstrated his frustration with the lack of validation of a person's knowledge system due to having experiences of psychosis:

You throw out that word anosognosia - lack of insight. I mean by the very nature the person with an illness like schizophrenia we belittle their opinion because they don't have insight it's a symptom of the illness. So, we slam down their opinion right from the beginning right from our diagnosis. As soon as that person has the label and you see that in early psychosis intervention, you see it it's like a line is drawn in the sand immediately with that diagnosis.

Following from the discussion on validation of knowledge there was also a further exploration of validation or lack of concerning identity. Respondent three shared that the intention and purposes of narrative therapy is not to discredit someone as having a full identity with a diagnosis and to realize that as individuals we have multiple versions of ourselves which may or may not include agreement with a diagnosis.

There was also an acknowledgement that decontextualizing peoples struggles and locating the problem inside the person had harmful effects which contributed to individuals showing up disproportionately to others with a positive identity story in the various systems such as the criminal justice, mental health and child welfare systems. The following quote demonstrates by respondent four how decontextualizing and blame supports a negative identity conclusion:

Because of all the stigma associated with mental health and addiction, a lot of folks have deeply rooted stories of shame and personal failure and inadequacy. With enough repetition, sometimes people start telling themselves those stories and start to make meaning of who they are, and start creating what we would call a problem identity as a failed person or as a psychotic person.

This was referred to by respondent three as the panopticon effect. “If you’re someone whose experiencing being mistrusted or being feared you’re going to engage in that because that’s what you’re told repetitively”. Paradoxically, and to provide a slightly different observation respondent one shared the inaccuracies surrounding statistics about the dangerousness and risk discourse that “these are folks far more likely to be a victim of a violent incident than a perpetrator”. The overall impressions from respondents based on the previous contributions was that as a society we need to provide a much more compassionate approach instead of a fear based and judgmental approach.

There was a general consensus concerning the drawbacks in the mental health system contributing to burnout of service providers. A subtheme to impacts and dangers is the capacity of narrative therapy to help ameliorate this impact. One of the methods that Respondent five used was a narrative process of meaning making:

If you engage in a process of meaning making with other human beings you get energy from that you don’t get depleted because other people aren’t depleting. Anyone that’s been around would say it’s not the people it’s the systems were working in that are depleting. Were fatigued because of the requirements of the system or how we feel constrained by the system.

Respondent two spoke about how the “problem based perspective can be very draining and debilitating and feel like you’re not making a difference” she suggested narrative therapies capabilities “provide an opportunity to disrupt the medical language and formulation of problems”. It involves a shift in perspective in how we see and work with others. The following account was shared by respondent five after coming to a realization of the stressors and expectation in the system that contributed to anxiety in her work:

I remember becoming very anxious in my work and then listening to Michael White speak with such clarity and in contrast to those dominant views about how trauma was being discussed and about how mental illness was being discussed. It just takes a very different position that was revolutionary. It was a really strong turning point to realize I didn’t need to be the expert and all the concerns that I had were born out of the models, the traditional models that I had been taught and they weren’t necessarily about me.

This theme denotes that the difficulties and the impacts that arise are not from the individuals that they work with rather from the system requirements, the focus of risk discourse and aversion and the professional as expert position.

Agency

Another theme that arose from the interviews was agency. The concept of agency as it is applied to these findings is a focus on actions, redistribution of power and ownership of narratives. In the analysis of the data, there was a common thread with the theme agency and subtheme of person defining their experience and the meaning making that results. All participants talked about the importance of individuals being able to define their own experience and not having words and meanings imposed on them. Respondent five provided an account of how this process occurs:

You're still always talking with them about what those words mean and what the words are that they would use to describe their experiences and a lot of people that I work with still would say they don't identify with those labels. So, for me it's still about using language that is relevant for them, using their words and getting them to describe and define their own experiences and talking about the meaning of those things.

Respondent three shared:

I definitely borrow from Michael Whites language where I just want people to tell me their version of the story, essentially with psychiatric stuff because I think that they don't really get to do that often. And I think that the meaning they give me that can get made from that is that they actually can have some agency in how they're talked about even if it's just with me. And, I think that agency opens up the relationship in a way that can be really important for when the person is in crisis.

The notion in this quote was the acknowledgement that the trust and space afforded to the individual would likely result in supportive and helpful relationships in the future.

The data also spoke to how the psychiatric model of care can deter and deflect people from seeing personal agency and change. Respondent one felt that it was important to do an expose of the challenges with psychiatry. He posed the question "What else has been going on that been overshadowed by the power of psychiatry and the power that comes from those words?" He shared an example of how people's successes and triumphs can go unacknowledged if the service provider or team is not attuned to asking or looking for them:

No one knew about the actions and no one knew the strength and the meaning behind the actions. So, that's important to me is figuring out what's the story under the story and

then trying to see is that a preferred story? Is that something that the person you're working with wants to think? Is that something that could lead to re authoring down the road?

Respondent four also shared his views of how psychiatry hinders personal agency. "I think that the medical perspective is more about getting rid of it at all costs and I think there's not a lot of respecting personal agency in that sometimes the voices are actually helpful for people".

Similarly, respondent one said "I've heard folks say that they don't want to lose the voices".

Respondent four restated that:

My preference is to definitely always to air on the side of respecting the persons agency and choice wherever I can. Sometimes with an anthropological lens in a more traditional society maybe some of these folks would be honored as shamans and as people that have insights, but our agenda is to limit the experience completely.

Respondent one also shared:

At the heart of narrative, you're deconstructing what psychosis is and how it's labeled and how it is defined and what the person is actually experiencing. Some of it may be pieces that are working, a part of their identity that they want to keep. ...if our goal is to take it away how is that therapeutic?

The following quote provides one context to the above statements and the connection between voices and trauma. Respondent four shared how the voices were an outlet for traumatic experiences. The participants belief was that agency was present because there was "choice fullness and that people could choose how they were relating to the voices or were choosing how they were relating to the traumatic memories of flashbacks or somatic symptoms".

While there was also discussion around the importance of individuals defining their experience, there was also acknowledgement that choice is an unnegotiable element when it comes to narrative therapy because it facilitates opportunities for personal agency and connecting with meanings that are helpful for the individual. The following are two accounts from different respondents regarding their thoughts on this element:

Sometimes clients want to stay with the story they had before and for some clients that's comfortable and that's the story they want to thicken is that dominant story of the medicalized problem and that has to be ok too.

For some people, it's a helpful framework to make sense of their experience and sometimes people like to take on this identity as a way to create community with people with shared experience.

The aforementioned data speaks to the importance of the individual choosing their meaning and connection with their narrative. Respondent four acknowledged how he is constantly pointing out all these different choice points and supporting the individual's agency in making those choices.

Respondent two spoke about the difficulty of the person having or being given voice in a psychiatric assessment process. She shared in the interview that clients have very little input as to how the story is written down afterwards. Respondent three in her discussions provided an example of her own work within a community agency how one can support the persons agency.

I'll say, and you own this paper my opinions and I'll rip it up if at the end you feel that you gave too much and we can add on if you feel you gave too little. And, if it's not

relevant then we can have a chat about that too. So, I'll just sort of take away this idea that people have to give me information for starters because of my job of where I sit in the room.

The acknowledgement from her was the importance of redressing the power in the relationship.

In the proceeding sentence respondent one shared:

I tell them, I like to take notes and it's not my interpretation its pieces of what they're saying. And so, that actual written documentation to have control of it, to have a client know that this is not my words that are going in there and this is not my judgement of what they are saying. This is me trying to follow their story and document their story. I think that adds so much strength and power.

The previous paragraph speaks to the importance of ownership of one's story, words and experience within a narrative framework.

To provide a different context to the conversations regarding personal agency respondent one and five also provided examples how the phenomena of psychosis could detract someone from their own personal agency, however not indefinitely:

It steals that ability that a person used to have to see the bigger picture and they're almost pummeled into a tunnel so that these beliefs become all-encompassing and powerful. It ebbs and flows there's always windows where things kind of subsist a little even without medications.

Respondent five shared about the disconnect from "reality" and the possibility that the questions posed do not always go in these transformative directions especially when a person is acutely unwell:

We're not all going to have a Michael White interview. We're not going to make beautiful meaning in one conversation and revolutionize a person's relationship with that experience. But, I like to think that those questions are different and potentially useful to that person even if in reflection later. Because, if the medical model hasn't "fixed" them then surely, we've got to try something else.

The participants perspective was that the overall outcomes of service users being provided the opportunity to have agency was that it was positive for both service providers and service users. "I think some of the narrative tools helps to reconstitute their relationship with those lived experiences and there was some agency in that and it was kind of dignifying and empowering".

In contrast to standard psychiatric models the following quote by respondent four addressed how personal agency, choice and possibilities contributes to positive outcomes:

I find rather than narrowing things down to a solution it's really good at opening up possibilities and holding multiple possibilities. And, if the person is really invested in the possibilities they choose, you are more likely to have a good outcome because they are invested in them rather than being imposed on by professionals.

The overall context of this theme noted that providing choice and opening up the possibilities was far more inspiring on everyone involved with far better outcomes than imposing meanings and conclusions onto people. There was a concern from respondent one that "if the folks we are working with aren't driving the process if the system is, you're never going to get the results that springboard people into these new stories you just won't". This quote speaks to the danger of the system really holding people back if the people they're working with are not included in an integral and meaningful way.

Nuanced Meanings

Another theme that arose in the interviews was nuanced meanings. There were different methods and examples regarding how this theme showed up in the data by four of the five participants. Some of these examples included unpacking the nod, having nuanced conversations, looking for the subtleties, listening for meaning and therapeutic letter writing. Respondent three talked about “unpacking the nod and to be in a process of constant meaning making”. She highlighted how there is a tendency for professionals to agree with statements without unpacking what it really means. The following is an account of that example:

Steven Madigan wrote about unpacking the nod. Which is when everyone’s sitting around and go Bill’s schizophrenic oh yeah totally and everyone might be agreeing on something different and no one says anything because they all think they’re agreeing on the same thing. So, I will often say to the medical team, tell it to me like I’m five. What does that mean when you someone is this? How does that show up for them? Investigating how people came to that knowledge as practitioners because I think sometimes too that people get misdiagnosed really easy. I’ll ask can you give me an example of how you came to that conclusion and is there other possible alternatives as to why they are behaving that way?

Revisiting the previous *agency* theme respondent four highlighted how opening up the possibilities created a much more nuanced discussion and expanded the subplots and various themes in a person’s narrative:

It's about me getting alongside and having a conversation about what they want to do with or about this experience i.e. do you want to continue with it, eliminate it, renegotiate it, engage at some times and not in other contexts it's a much more nuanced conversation.

Instead of a black and white description or the good bad narrative this discussion is concerned with the possibilities and the subtleties that make a difference.

Respondent one shared his impressions how the art of Therapeutic Letter Writing and writing things down captures subtleties and meaning:

With psychosis, it's interesting because I think it allows a person to connect things that maybe they were having a hard time connecting before, to see the ties of the story and the fragments of the story and maybe be able to put them together in a different way. It's actually better when they've found a new meaning in what they've said before. That's the other piece, sometimes a person will let something slip or it's a word or a couple of words and you see this often with psychosis, that when you've written it out and you see the words that's are actually there. Sometimes they see a way, I would say this but there is also this, and then look a little bit later and there is this, and this relates to this and it's not the same as the other story that was about problems. It was about solutions or it was about something that was good and that's kind of cool when it's written out because you know there's no judgement there.

The message that he was conveying was twofold; by using the actual words of the individual it was avoiding people feeling judged. In addition, being able to connect with the words allowed the individual to connect with other parts of their story that maybe they had not connected with before.

The other element of nuanced conversations is that the subtleties and the minute aspects carry a lot of weight and meaning. The following is an example:

With psychosis, so often with delusions there's a kernel in there that not only has meaning, I think the other people around them would say oh that comes because Johnny used to do this. It didn't come from nowhere it came from somewhere. It was about a hope and a dream at some point and now it's become something different in his mind.

The other very strong notion regarding the qualitative data concerning nuanced meanings was the imperative and connection with listening. The examples given concerned the narrative practice of double listening and the practice of listening rather than questioning:

What meaning is behind that, like what's their understanding what's their meaning? And even sometimes you're double listening You're hearing the dominant story that they're telling but you're also hearing those little threads that's there's that back-story underneath. If you're really listening and you really want to know you can start hearing it and start flushing it out. Narrative forces a practitioner if they're doing it right to listen for that and those threads that you start with and then you start naming or sewing or whatever you want to call it to work with the person and let's figure out what else is there.

Similarly, respondent five shared that narrative involves going with what you've been taught psychosis is and actually taking it to a human being and not just observing:

I think that's the thing with the medical model we're just so taught to observe, and you're taught to question as well, but with narrative you do more listening than you do talking, and that's the part where they're saying a whole bunch of words that don't really string

together in the way that I would make sense but if you listen long enough you connect a theme.

She noted that although words were not conveyed in a linear form there was still meaning and intention attached to it. Similarly, as the quote above the examples highlight the importance of focused, active and intentional listening to generate meaning.

Narrative Therapy as a Conduit

The final theme was narrative therapy as a conduit which for the context of this study implies a translator and conductor between the individual and the medical model through utilizing other recognized practices which will be elaborated on throughout this section. Each participant within the study provided valuable contributions towards this theme. One of the examples provided by all five respondents was the ability for narrative therapy to act as a translator between clients and the medical model and through the therapeutic alliance. The following paragraphs will provide examples from slightly different perspectives of this theme and how it was navigated.

It's like a core thing opening up space or holding space for people to make their own meaning and being curious about that using narrative and bridging this gap. Because, the medical model hasn't really connected with the person so I'm kind of that conductor in between the two worlds and I guess meaning making and asking those questions is the whole crux of it and offering people a space where they can use their own words.

To add to the above quote respondent one shared:

You're looking at non-medicalized ways of viewing it and looking at uniqueness. Your goal isn't to take away the symptoms so much as to look for those unique meanings, what

the phenomena is and about how the same symptoms can look different in different cultural settings and even that information can be powerful in itself.

Respondent two shared a more medicalized view that “helping people talk about what’s important to them really helped them eventually be able to ease into more mainstream goals like the medical system might have for them. Conversely the following example highlighted some of the challenges in our current healthcare system of accepting different knowledges:

There’s so much need to challenge ways of knowing and accepting other knowledge’s and for me that’s like an ongoing process that you need to be committed to and you need to have the space and safety to do that. So, I think that more often than not and this has been me as well in healthcare systems even the good therapists are forced to do narrative light.

To add to the above contribution respondent four shared how as clinicians we can practice some “resistance” and “stealth narrative” and “dress it up in more acceptable language”:

One card I have to play in more mainstream settings in this context anyways is that the best research we have is that the active ingredient for client change is the therapeutic alliance. What I often pitch is that narrative for people is a really effective way for building a stronger therapeutic alliance especially in the context of mental health and addiction where there is so much “resistance” and where narrative is particularly good at getting them around resistance because of its collaborative nature.

Respondent four discussed some of the mechanisms of the therapeutic alliance and the challenges within the current healthcare systems. The following sections will outline how narrative therapy fosters the therapeutic alliance and leverages practices that are trending in our

field and will operationalize the core competencies of recovery oriented and trauma informed practice by connecting these core competencies with narrative therapy.

Each respondent noted that narrative therapy was “consistent” with true recovery-oriented models; that “attitudes with clinicians is more strengths-based and hopeful as opposed to seeing people in the context of their problems”; that “narrative therapy provides a more person-centered language philosophy as opposed to using labelling terms” and “rather than looking to completely resolve mental health symptoms narrative therapy helps a person to create meaning”.

Respondent four put it this way:

It’s very aligned and as the notion of mental health recovery becomes more mainstream this is one way that narrative is a great way to operationalize recovery but [recovery] is principle based and it doesn’t really tell you how to enact it or how to do it on the ground. So, I find that I talk about narrative as a way to operationalize mental health recovery and practice.

Respondent one outlined the example below as it came up in his responses:

First off who defines recovery? Well it’s the person who’s going to recover and so narrative starts from that idea. It removes the expert in the clinician and it places the client as the expert and it really is driven by them for what recovery is, how we’re going to get there and how were going to measure it. It’s strength-based and it’s focused on that idea that there will be recovery. The curiosity of narrative says were going towards recovery and what is this going to look like for you?

Similarly, respondent five shared that “you’re just naturally building relationships with people and then you’re asking about their goals and their hopes and dreams and how they are going to get there and what knowledge’s they have and that’s recovery oriented practice”.

She shared her views on the consistency between recovery oriented practice, other core competencies and narrative therapy:

I’ve worked in mental health, homelessness and substance use like those three things and so when you’re doing that you’re automatically doing trauma stuff, harm reduction or [Motivational Interviewing] MI stuff and recovery stuff and all those other buzz words that you get. In terms of the future of incorporating it I think there is a good future because narrative will fit so well with that.

Transitioning into the section of trauma-informed practice and following from the sub theme of leveraging practices, all respondents shared the strong connection with narrative therapy. There was acknowledgement by four out of the five respondents that the frequency of trauma was high with most citing one hundred percent for individuals who were in a relationship with psychosis. Respondent three summed up this position saying “I’ve never seen anyone who is experiencing psychosis that hasn’t had experiences of trauma. In my work, it’s a hundred percent.” The following quote by respondent one seems to highlight narrative therapy’s connections with trauma informed practice:

Narrative doesn’t make a person have to go back to it and relive it like some other therapies do. It works in a way that is trauma informed but it doesn’t force a person to relive it. What it does is provide space for the person to be and to have been hurt and to find space for themselves to heal in their own way.

He also acknowledged that if the person wants to go back through the trauma history narrative will allow them to do that as well. Similarly, respondent two shared:

I think in every brief encounter we can make a difference for people and actually you don't necessarily have to understand their whole story and problems in the past and help them unravel and make sense of everything that's happened before to help them act or do something differently now.

Conversely respondent five also shared the drawbacks of not being asked about trauma. She provided some insight into where and when trauma could be explored if that was the individuals wishes:

I'm sure a lot of people don't get asked about trauma and you know in some ways they get the message that we're not interested and so when they do get asked those questions either they've been asked too many times or it's not actually asking to talk about it. When I'm working with people for a few months that's really the time where you can be curious about that and you can sense or gauge-do they want to and shall we go there and what would that be like? And they can sense genuineness and interest in that-and even if it's just to get to the point of hearing from someone else- that was really messed up that that happened to you and do you think your life would be different if that hadn't been? Those are also painful things to ask because wow when you hear about some of the things that has happened to people's lives. That's why I would rather be asking those questions of what do you think it says about you that you're still standing after all of this has happened. These labels have come about but let's talk more about what you think it shows about you.

A strong principle within both trauma-informed practice and recovery-oriented practice is incorporating Indigenous worldviews and knowledges into our work which is another area that narrative therapy resonates very well with and came up in the interview responses by the two following individuals:

It's pretty fair to say that [narrative therapy] is more aligned with traditional Indigenous perspectives. What's not talked about enough in narrative is that people usually identify David Epston and Michael White as being the originator which is true but David in particular was influenced a lot by The Just Therapy team in New Zealand which had a lot of Maori folk on it.

It's recognized that, that way of talking to people is a very appropriate way to talk to Indigenous folks and so if I ever had to defend myself that would be the very easy thing to say but I don't feel that need.

Respondent one shared his views on the challenges or dangers of the commodification of practice specifically as it relates to narrative therapy, psychosis and trauma:

This is where narrative is supposed to go you're supposed to try with new populations. You're supposed to work collaboratively and each time it's going to look a little different. Systems healthcare systems they don't tend to want that, right? They want evidence based service and that means standardized and that means something that you can turn people through and train them like a day or two and say this person is qualified they are now trauma informed practitioners. You've done three hours of TIP training there you go. Well ok but really is it that simple? An it's not for trauma and it's not for narrative and the two are, I would say, intertwined quite a bit and when you look at psychosis and you

look at trauma those two are very much intertwined but we seldom talk about them together.

Consistent with the theme of narrative therapy as a conduit there were challenges noted by each respondent in regards to incorporating narrative therapy into currently service delivery models. Some of these challenges have been mentioned throughout the findings but what reoccurred for individuals was the subtheme of culture of the agency -specifically significant attention to the medical model as opposed to a social model, “people being attached to being experts and their professional knowledge”, and a lack of attention to power and privilege:

The challenge is that it’s asking the people who aren’t with the diagnosis to change a lot of deeply rooted preconceived notions of power and privilege and that’s tough. So, you have old doctors or you have social workers or you have nurses or you have housing workers or whoever that hold a lot of identity in being on the other side of the table. Asking them to not disregard that but to just stop acting as though that means something is really hard on people’s ego and I think the biggest challenge would not be with the persons who are experiencing psychosis I think it would be with the system

The following two individuals shared their views on the cultural shift “it doesn’t have to be so complex I think that people think that changing a medicalized view of a person is complicated and its really more just about ego checking. “it’s very simple to try a narrative approach respecting people and putting people that are receiving services first”.

All of these respondents acknowledged how and where they practice resistance in their pockets in the organizations and where it can have a ripple effect:

It requires quite a large cultural shift from everybody but I see us starting from the inside out. Frontline workers social workers nurses can just start doing it and people start seeing it and when its seen in action versus being explained in theory I know people feel more comfort around it. Just doing it and then as you're going along displaying your work and then explaining your work. (respondent three)

Similarly, respondent four was able to identify in a case conference meeting in the hospital how to invite people into your work and displaying your work with the colleagues and person receiving services:

That's one way you can resist and invite other people in to different ways of seeing the way that we use language and the way we are with people- like with our colleagues. I was talking to her in a respectful and dignifying way and trying to include her voice and focusing on her strengths and using narrative oriented language in the way that I was describing her struggles.

There was a lot of discussion on the subtheme of mentorship and clinical supervision as a means to support the work. "I supervise other social workers and they come to me because they're interested in narrative. I have that ability as well to do whatever that is with them and support them in that". Respondent three shared that "a lot of coworkers are really into the way that she practices" and come to her for direction and guidance. Respondent one shared his thoughts in regards to the importance of supervision as it relates to the population this research is concerned with:

Narrative is one of those things that you learn by doing and by someone who's more experienced in the craft helping you along the way. And especially when you're talking

about folks who are so marginalized who are dealing with psychosis, I think that you know probably we should weigh on the side that folks should receive more mentorship and training, that at least we owe that to the folks that we work with. We need to create space for the therapist to learn to use it with psychosis and to grow as therapists and receive mentorship and pass it on to others. But, they need the safe space to do it and then the clients need the safety to know that the person they are working with is not going to be case managing them and that it's going to be there for a while and all those things that create a therapeutic relationship or at least help with that

Respondent five provided her thoughts regarding the lack of space to provide treatment and where she makes her one to one work count:

Treatment isn't funded anymore for people to come longitudinally to talk with a therapist. Those kinds of things are not getting funded anymore. And then it just becomes around how can I make my work with people the most useful to them when I realize that I am probably one of the few people that they are going to see.

Respondent two also highlighted that opportunities for social workers and counsellors to practice resistance and agency exists in the active involvement and development of care plans, assessments and the curriculum that is delivered in groups or taught with clients. This example demonstrates how a social model is incorporated into practice.

Reviewing the theme narrative therapy as a conduit and reflecting on the language and the context of responses, this research theme could also be termed *resistance*; both in the sense of resistance within systems towards change but also in the sense of the resistance that the

clinicians involved in the study employ on a daily basis in their work to situate narrative as an emerging, therapeutic and valuable practice.

Discussion

The aim of this research was to explore the current work that is being done with counsellors, therapists, and social workers in the area of narrative informed practices with individuals in a relationship with psychosis. Participants involved in the research all incorporated a strong social justice lens with four out of five of the respondents being guided by a social constructivist framework in the work they did with people receiving services in substance use and mental health settings. The research question asked: How does narrative therapy contribute to well-being for individuals who are in a relationship with psychosis? The findings with the current study demonstrated alignment with the literature and evolved to situate them in a context appropriate to the research question. The themes which were identified were: *impacts and dangers, personal agency, nuanced meanings and narrative therapy as a conduit*.

The themes identified in the interviews and literature review differed in their labels but contained similarities in their content which some noted differences. The data from the *impacts and dangers* theme in the research mimicked the literature review theme of *illness narratives*. Both of these contents were covered in the literature review and the research data. There was extensive discussion in the interviews regarding the illness narrative and its impacts as well as the challenges which show up for individuals when they have a medically documented story of themselves. The majority of respondents shared their challenges and strategies with negotiating these realities and situating the persons experience and their meaning making of their experience. In the research study, responses from respondents regarding the medical model was situated outside of taken for granted knowledge or understanding that it was a go-to model. Participants

were critical of this view and were committed to placing stories in context, which is a strong principle in narrative practice. The theme from the research study *personal agency* was not a strong theme in the literature review. Many of the participants talked about personal agency in various forms. Participants spoke about the importance of being attuned to looking for agency in the folks they were working with otherwise integral parts of a story or opportunities could be missed. There were a few of how individuals initiated personal agency as well as examples of service providers having agency in employing a narrative approach in their workplace.

The theme of trauma from the literature review was not identified as a theme in and of itself in the research study. However, the discussion of trauma was identified in more than one theme similar to the literature review. Many of the participants talked about the strong relationship with psychosis and trauma with one respondent noting that they were very much intertwined but we seldom talk about them together. There was also consensus on the lack of clinical therapy related to psychosis and trauma in the literature. Moreover, narrative therapy was not addressed as one of those intervention models even though the model has demonstrated its utility with lessening distressing experiences. Trauma informed practice and narrative therapy appeared frequently in the participants responses. There were similarities in the content and acknowledgment that the trauma does not need to be revisited to do trauma work. Although the findings did not provide its own separate theme, there was acknowledgement of utilizing narrative therapy successfully in this regard with a couple of the participants. There were various means and approaches to do this such as looking towards the future in a hopeful way; exploring the relationship with voices and the agency involved in choosing this relationship as a means to move away from the trauma, as well as acknowledgement that narrative therapy allows one to work with trauma through various proximities.

Narrative approaches within the literature and the relationship with psychosis aligned with the theme narrative therapy as a conduit and nuanced meanings. Both themes recognized the variety of ways that psychosis is understood and the mechanisms through which knowledge is centered. These themes within the research also point to a true recovery model. The example comes from the practice of documentation and capturing individual's words as opposed to interpretations or clinical language. This approach satisfies the needs of both system and narrative.

The viewpoint of this research is that there is promise for narrative therapy and its application with those who provide a story that includes the phenomena identified as psychosis.

Implications for Policy, Practice and Future Research

Drawing from Dudley's (2011) framework the political context has implications to practice and policy. The focus of this study involves a significant cultural change in healthcare. According to Kidd, Kenny and McKinstry (2015) "mental health services have a role in challenging societal views of mental illness, that provide alternative approaches that are based on social justice and human rights approaches and that address both individual and systemic discrimination" (p. 45).

Dudley (2011) acknowledges the importance of balancing efficiency with effectiveness, relevance and quality. In our current healthcare system, some of these get compromised at the expense of others such as efficiency over effectiveness and relevance or quality. Current healthcare systems are concerned with the least amount of funds for the biggest population served (Dudley, 2011). Unfortunately, the results of this philosophy or funds allocation is crisis management and standardization and masking problems rather than long term meaningful

wellness. However, in order to affect change, we need to be able to work within existing organizational structures.

In review of the critical psychiatry perspective and the findings, this research would propose that critical psychiatry is in line with the recovery-oriented model not necessarily in how recovery models have been received in many areas, especially in British Columbia, but critical psychiatry is in line with the original intention of the recovery model. Additionally, the following description found in Casey's (2008) article brings attention to how the findings in this current research study support an authentic recovery-oriented approach:

Critical psychiatry emphasizes “social and cultural contexts, placing ethics before technology and working to minimize the control of medical interventions” (Bracken & Thomas, 2001, p. 724). Critical psychiatry can challenge the traditional biopsychosocial approach of mental health and aims to make experiences of psychosis meaningful rather than psychopathological. The ultimate aim of the movement is to move toward collaboration. (Robert & Wolfson, 2004). As with the recovery approach critical psychiatry seeks to democratize mental health systems so that the “voices of service users and survivors... move center stage (p. 727 cited in Casey 2008, para 6)

This is a call to action for policy developers and stakeholders to recognize how narrative therapy as an emerging evidenced based practice situates critical psychiatry in the dialogue, a practice which operationalizes social justice work and supports delivery of recovery oriented services in its true form. As part of policy development there needs to be formal mechanisms in place which captures the voices of those receiving services. There also needs to be the mechanisms in place which provide the accountability as well. Traditional services in the public domain are still a very long way away from collaboration with service users and their families. We need the tools

to bridge this gap. Narrative therapy is a great starting point and one of the practices due to its ethics which embrace a not knowing stance and support true partnership with service users and their families. The ability to de- center oneself from the expert position provides significant possibilities and opportunities for transformation: with oneself as a clinician, in the therapeutic relationship as well as the outcomes for individuals.

According to one of the study respondents “There needs to be the space for it, the acknowledgement that it can work and the mechanisms which are going to allow it to work which is funding and allocating time”. Until that time occurs individuals will continue to practice Narrative Therapy in pockets and will continue to provide mentorship to those seeking support with the practice. One area where support could be received is through various bodies such as the BC Association of Clinical Counsellors or the British Columbia College of Social Workers or the Mental Health Commission of Canada. All of these organizations could support initiatives and knowledge exchange opportunities. Any place where we can strengthen our practice and strengthen our numbers as a community of practice / therapeutic community is a place where we can make a difference in people lives. It starts with one step. Dudley (2011) acknowledges practice evaluations as an opportunity to work within one’s agency towards cultural change. Importantly policy change proceeds evidence of effective interventions.

In terms of the future research, more is needed in the area of complex trauma and psychosis. There is still currently limited research in this area as it relates to narrative therapy as one of those psychotherapies. This study provided an initial place from which to start as there was acknowledgment that it has and could work.

Future research could also include a phenomenology with recipients of service who are the critical reference group. The current findings demonstrated that there are various means of

understanding and experiencing the phenomena of psychosis. A study such as this could help capture the various experiences and knowledges and could contribute to professionals understanding of psychosis and alternative approaches.

Most recent research has focused on service providers experiences. Research is needed which captures those accessing services and their experience of the model of intervention. This could involve a pilot study incorporating either a narrative group or counselling format or both which could measure the value of sessions utilizing this approach. Some places where this could be utilized could involve an Assertive Community Treatment Team or a community mental health team. A study such as this as part of a quality assurance process would require the following: standards clearly defining what this process is, what it looks like and when it's working; procedures which allow one to achieve the standards; training to ensure that the procedures work; and evaluation i.e. what are the measures for success and records of outcomes that can be applied to other jurisdictions where one is able to go back and revisit at any time. This framework is favorable given there is not significant funding required for the research as mentorship and training would have already occurred. However, strong clinical supervision is valuable for continued improvements in practice. As a final thought evidenced based practice is widely known but there is also the importance of recognizing "practice-based evidence" (Paddock, 2017) such as this study has demonstrated.

Conclusion

This research explored how narrative therapy can contribute to well-being for individuals in a relationship with psychosis through service providers experiences. The results of the study demonstrated that well- being can be achieved at various levels through the micro with the individual, the mezzo through organizational change and the macro in society as a whole. While

the medical model is perceived to be dominant, the benefits of narrative therapy are far reaching. There was overwhelming acknowledgement in the research that narrative therapy fosters the therapeutic alliance through its non-threatening, supportive, respectful and dignifying approach. A very strong identified factor for client change is the therapeutic alliance. Narrative therapy and critical psychiatry have a lot to offer in terms of psychosis, addictions and trauma. One of the ways that this is achieved is relocating problems in the broader context of people's lives signifying the possibility for hope and change.

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Appendix A

**Certificate of Human Research Ethics Board Approval**

Contact Person Elissa Black	Department Social Work	Protocol # 9635-17
Co-investigator(s) Glen Paddock		
Title of Project Narrative Practice with Psychosis; An Evidence Based Approach		
Sponsoring/Funding Agency N/A		
Institution(s) where research will be carried out University of the Fraser Valley		
Review Date: 17-Feb-17	Approval Date: 06-Mar-17	Approval Term: 06-Mar-17 - 05-Mar-18
Certification: <i>The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.</i>  _____ Michelle Riedlinger, Chair, Human Research Ethics Board <i>NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.</i> <i>If the project will go beyond the approval term noted above, an extension of approval must be requested.</i>		

Appendix B

Recruitment Letter

There has recently been a newly emerging focus regarding mental health reform (recovery approach) which has led to the importance of examining and including alternative therapeutic approaches when working with individuals with severe mental illness. I have been working with individuals with lived experience of psychosis for upwards of 10 years and have been employed in the mental health and addiction field for this time. I have been privy to the practice implications and discrepancies that arise between various discourse perspectives

Purpose/Objectives of the Study

This study will explore professionals experience utilizing narrative therapy as a therapeutic approach with individuals who live with psychosis. The service providers' perspectives will be explored through a semi structured interview process consisting of approximately 8 open ended questions. The intention of the study is to synthesize the research regarding narrative therapies possibilities as an evidence based approach. The project seeks to examine and strengthen practice with individuals with lived experience of psychosis who are being served in the mental health system. Narrative therapy is not a mainstream approach with this client population. The benefits of the study could result in improved practice consistent with trauma informed and the newly emerging recovery oriented approach. The possible use of the final report could result in sharing the findings with relevant public mental health agencies that are vested in improving practice and services. Or it could be utilized to inform a pilot study with the identified population.

Procedures involved in the Research

For this study I am conducting 5 8 1:1 semi structured interviews with research participants who agree to participate in the study. The purpose of these meetings is to gather information from professionals with respect to their experiences with narrative therapy as a therapeutic approach with the aforementioned client population. The interviews will take place at the selected meeting spot of participants. The interviews will take approximately one hour of time in which approx. 8 open ended questions concerning narrative therapy, the role of psychosis, prevalence of trauma, and questions regarding recovery oriented systems of care will be asked. The interview process will be audio taped and transcribed.

If you would like to participate in a one hour interview please respond to this email indicating your name and contact information and some preferred times that you could meet.

Sincerely,

Elissa Black RSW (student in masters of Social Work Program)
University of the Fraser Valley

.

Appendix C

Letter of informed Consent



Elissa Black

School of Social Work Masters Program
University of the Fraser Valley
33844 King Road
Abbotsford, BC V2S 7M8
[REDACTED]

Date: Feb 2, 2017

Narrative Practice with Psychosis; An Evidence Based Approach

Letter of Informed Consent for 1:1 semi structured interviews

My name is Elissa Black. I am a registered social worker currently enrolled in the MSW program at the University of the Fraser Valley. As part of my requirement for completing my MSW I am conducting a research study. There has recently been a newly emerging focus regarding recovery oriented systems of care which has led to the importance of examining and including alternative therapeutic approaches when working with individuals with severe mental illness. I have been working with individuals with lived experience of psychosis for upwards of 10 years and have been employed in the mental health and addiction field for this time and have been privy to the practice implications and discrepancies that arise between various discourse perspectives.

Purpose/Objectives of the Study

This study will explore your experience utilizing narrative therapy as a therapeutic approach with individuals who have lived experience of psychosis. Your contributions to the study will be explored through a semi structured interview process consisting of approximately 8 open ended questions. The intention of the study is to synthesize the research regarding narrative therapies possibilities as an evidence based approach when working with individuals who have lived experience of psychosis.

Procedures involved in the Research

For this study I am conducting 1:1 semi structured interviews with research participants who agree to participate in the study. The purpose of these meetings is to gather information from you with respect to your experiences with narrative therapy as a therapeutic approach with the aforementioned client population. Your interview will take place at your selected meeting spot. The interview will take approximately one hour of time in which approx. 8 open ended

Appendix D

Interview Schedule Questions

How can narrative therapy contribute to well being for individuals who experience psychosis.

1. Have you worked with clients i.e. the identified population using a narrative approach?
 Sub question: What parts of narrative therapy do you use?
 What is your back ground; what drew you to narrative therapy?
2. What are your experiences with this approach and population?
3. What have you found helpful about using narrative therapy with individuals in a relationship with psychosis?
4. What prevalence do you see with individuals who have received a diagnosis of psychosis and histories of trauma? What relationship do you see between psychosis and trauma?
5. How do you see the concept of meaning making contributing as a therapeutic approach in understanding the clients individual and social context? For both the individual themselves as well as service providers?
6. In what ways does narrative therapy contribute meaning and understanding to the phenomena of psychosis for the individual and for ourselves as service providers.
7. How do you see narrative therapy being introduced more intentionally into current service delivery models?
 Sub question: Do you see any challenges with the above idea
8. How do you see narrative therapies principles being consistent with the move towards true recovery oriented systems of care in mental health?
9. Is there anything else you would like to tell me about narrative therapy, psychosis or anything else you feel is important for the interview