Published in final edited form as:

Int J Group Psychother. 2011 October ; 61(4): 576–595. doi:10.1521/ijgp.2011.61.4.576.

Narrative Enhancement and Cognitive Therapy: A New Group-Based Treatment for Internalized Stigma among Persons with Severe Mental Illness

Philip T. Yanos, Ph.D.[Associate Professor],

Department of Psychology, John Jay College of Criminal Justice, City University of New York

David Roe, Ph.D.[Chair], and

Department of Community Mental Health, Faculty of Social Welfare and Health Sciences,
University of Haifa

Paul H. Lysaker, Ph.D.[Psychologist]

Roudebush VA Medical Center, Indiana University School of Medicine, Dept of Psychiatry

Abstract

Internalized stigma has been suggested to play a major role in negative changes in identity in severe mental illness. Evidence suggests that roughly one-third of people with severe mental illness show elevated internalized stigma and that it is linked to compromised outcomes in both subjective and objective aspects of recovery. Despite substantial evidence for the impact of internalized stigma, few efforts have been made to develop professionally-led treatment to address this issue. In this article, we discuss our development of a new, group-based approach to the treatment of internalized stigma which we have termed “narrative enhancement and cognitive therapy” (NECT). We describe the treatment approach and offer an illustration of it by way of a case vignette.

While it has been long recognized that the experience of mental illness, along with its label and social consequences, influences identity (Estroff, 1989; Goffman, 1961), only recently have research efforts begun to identify the specific mechanisms involved in this process. One factor which has been suggested to play a major role in negative changes in identity in severe mental illness is internalized stigma. Internalized stigma, or self-stigma, refers to the process by which a person with severe mental illness adopts stigmatizing views (e.g., dangerousness, incompetence) widely held by the general public. Consequently, self-stigma restricts and limits previously held or hoped for identities (e.g., self as student, self as worker, self as parent). Evidence suggests that roughly one-third of people with severe mental illness show elevated internalized stigma (Ritsher & Phelan, 2004; Lysaker, Roe, & Yanos, 2007) and that internalized stigma is linked to both subjective and objective aspects of recovery, including hopelessness (McCay & Seeman, 1998; Lysaker, Roe, & Yanos, 2007; Yanos et al., 2008), diminished self-esteem (Watson, Corrigan, Larson, & Sells, 2007; Corrigan, Watson, & Barr, 2006; Yanos et al., 2008), and impoverished social relationships (Lysaker, Roe, & Yanos, 2007).

Previously, we argued that ignoring internalized stigma in comprehensive treatment programs for people with severe mental illness may leave difficult roadblocks to recovery

untouched (Yanos, Roe, & Lysaker, In Press). However, despite substantial evidence for the impact of internalized stigma on recovery outcomes in this population, few efforts have been made to develop professionally-led treatment to address this issue. In this article, we will review the strengths and weaknesses of previous attempts to address self-stigma and discuss our development of a new, group-based approach to its treatment which we have termed “narrative enhancement and cognitive therapy” (NECT).

Previous Treatments for Self-Stigma

To date, we are aware of only four different programs that have sought to address self-stigma among persons with severe mental illness. Wiczynski (2000) developed and carried out a psychoeducational stigma management group in an inpatient setting attended by 27 participants. While the participants reported the group was helpful, there were no significant increases in participant self-efficacy or knowledge, perhaps because the brief number of sessions. Concurrently, Link and colleagues (Link et al., 2001; Link et al., 2002) developed a primarily educational intervention which sought to provide information sufficient to reduce agreement with views endorsing the community’s devaluation and discrimination against people with mental illness. The approach helped share important information about stigma but offered little room for persons to support one another in the change process. Participation in this program was not found to be linked with changes in perceptions of stigma, stigma management strategies, or related outcomes such as self-esteem. Findings from these two studies suggest that purely educational interventions are not likely to be successful in altering self-stigma.

More recently, two more therapeutic interventions were developed and discussed. A study of a group-based intervention for young adults with first episode schizophrenia focusing on teaching skills to reduce “engulfment,” a process of acceptance of the patient role as the primary definition of self, found promising findings with regard to improving self-conceptions at 3-month follow-up (McCay et al., 2006). Although the study used a small sample, brief follow-up period, and did not employ random assignment, it supports the view that interventions can have an impact on internalized stigma. Finally, Knight et al. (2006) developed and implemented a more comprehensive group treatment for perceived stigma, geared to help people with severe mental illness be more informed and educated about their illness and better cope with it. This seven session intervention relied on cognitive behavioral techniques, emphasizing an empowering and supportive discussion of stigma related issues. Findings based on 21 participants revealed an increase in levels of self-esteem and decrease in depression, positive and negative symptoms and general psychopathology.

Findings from the above studies suggest the limitations of education interventions to combat stigma, but support the potential promise of group-based interventions that move beyond education and focus on changes in how persons actively think about themselves and their lives.

Theoretical Background for the Present Intervention

In light of the strengths and weaknesses of the above, we sought to develop an intervention that would include not only educational materials about stigma, but also techniques aimed at enhancing the cognitive skills necessary for changing one’s identity. We sought to help persons to not only recognize and discard stigma but also to be better able to recognize and correct dysfunctional cognitions which might impede the development of a new sense of self and positive identity. To that end, we turned to two major theoretical areas and related literatures: cognitive restructuring, and narrative models of the processes involved in positive identity development.

First, *cognitive restructuring* (Beck, 1970) refers to the process of learning to challenge one's own inaccurate and/or maladaptive beliefs and then to replace them with more accurate and adaptive ones. Cognitive restructuring is a core element of most cognitive behavioral therapies (CBT) and specifically is accomplished by persons coming to be aware of their sometimes most automatic thoughts and then learning to challenge them by examining the evidence that supports and does not support them.

Cognitive restructuring is relevant to reducing internalized stigma for several reasons. First, self-stigma can be conceptualized as involving person's coming to develop and hold onto inaccurate and maladaptive belief such as "I am incompetent to manage my own life," "I am a danger to others," or "my emotions are not to be trusted." Second, CBT has been successfully modified by a range of researchers and clinicians to address maladaptive cognitions among persons with severe mental illness. Controlled studies have further showed that persons with severe mental illness will accept CBT and that CBT leads to reduction in symptoms and improvements in function relative to treatments as usual (Drury et al, 1996; Haddock et al., 1998; Sensky et al., 2000). We reasoned that a group intervention could be developed which would help persons to recognize self-stigma as a matter involving the acceptance of dysfunction beliefs which could be challenged and replaced. Indeed, this is consistent with a range of theoretical discussions (Corrigan & Calabrese, 2005) and case studies (Holmes & River, 1998).

The second literature we drew upon in designing our intervention study concerns *narrative* and positive identity both among persons with and without severe mental illness. There is a considerable amount of work that suggests that a person's experience of his or her identity is not a matter merely of a set of particular beliefs about oneself, but is fundamentally experienced as a series of meaningful events arranged in a storied manner (Gallagher, 2000; Lysaker, Clements, Placak-Hallberg, Knipschure, & Wright, 2002; Polkinghorne, 1995). Personal identity is inextricably bound within the stories we tell about ourselves both to others and the stories which we cherish and review with ourselves in private moments (Bruner, 1987). For example, one set of particular beliefs (e.g., "I am a talented musician with a devotion to certain humanitarian ideals but also someone who struggles to be assertive and who lacks personal discipline") could have totally different meanings dependent upon its storied context (McAdams, 2001).

Literature on narrative and identity is relevant for an intervention targeting self-stigma for several reasons. To begin, it self-stigma is not merely a matter of inaccurate beliefs but also infects the stories one tells about oneself. To accept, for instance, that one is dangerous would seem necessarily to have an enormous range of consequences for how one might tell or not tell one's life narrative. Consistent with observations by Davidson (2003) and others (Lysaker, Lysaker & Lysaker, 2001) accepting that one was incompetent or dangerous might lead one to conclude that there was no real future to one's story, that one's story was one of failure, or even that one was not worthy of having story be told about one's life. As a corollary of this, to decrease self-stigma and construct a positive identity, a person may need to come to tell a new story about his or her life. In other words, in addition to correct beliefs, a new narrative may have to be evolved.

The perspective that overcoming internalized stigma may require a transformation in one's personal narrative may be a crucial point, as phenomenological observations suggest that severe mental illness often involves a profound diminishment in a person's ability to narrate his or her own life's evolving story (Gallagher, 2003; Lysaker, Wickett, Wilke & Lysaker, 2003). Many with severe mental illness may have stopped telling stories of their lives in which they are a protagonist meaningfully connected to others (Holma & Aaltonen, 1998; Young & Ensign, 1999). They may describe their lives and trials without sufficient temporal

organization and have difficulty differentiating themselves from their disorder (Roe & Ben Yishai, 1999). Constructing or developing a meaningful story of one's disorder and life that promotes recovery may be particularly difficult for persons with schizophrenia and other forms of severe mental illness.

The view that interventions geared toward narrative transformation would be an important feature in the treatment of internalized stigma is consistent with other research suggesting that addressing narrative (or story-telling) in psychotherapy is beneficial (Lysaker, Davis, Eckert, Strasburger, Hunter & Buck, 2005; Lysaker, Davis, Jones, Strasburger, & Hunter, 2007; Lysaker, Lysaker & Lysaker, 2001). It has been suggested that such a psychotherapy may help clients to tell stories about what is wrong, not wrong, about hopes, losses and what could be done (Lysaker et al., 2001; Lysaker, & Buck, 2006). To help draw out stories, therapists inquire with curiosity and respect about what is wrong and not wrong in the lives of clients. As clients begin to tell their stories, therapists actively offer reflections about clients' presence or absence as protagonist in the stories they are telling. Therapists also reflect about how clients experience them (the therapist) as an audience for their stories. Finally, therapists offer a reflection about issues not mentioned. By listening carefully to what was being said, therapists also often recognize and note what had not been said, and encourage clients to elaborate on these important dimensions of stories.

Based on these findings, we reasoned that disempowered narratives in which themes dominated by internalized stigma prevail can be gradually reframed and revised using similar techniques in a group setting so that themes of agency and potential come to experienced, shared with others and internalized as part of a more integrative experience of oneself

The Present Intervention

For the present intervention, we drew on our collective expertise in CBT, coping and narrative enhancement to develop a structured, group-based treatment. The intervention combines psychoeducation to help replace stigmatizing views about mental illness and recovery with empirical findings, cognitive restructuring geared toward teaching skills to challenge negative beliefs about the self, and elements of psychotherapy focused on enhancing one's ability to narrate one's life story. We developed a group-based intervention, as we believed that a group orientation has several notable advantages for participants to gain feedback and support from peers (Yalom, 1995), and within this context, to provide opportunities for interactions with an audience for their storytelling (Lysaker et al, 2007). We designed a manual that is geared to be "user-friendly" and could be easily implemented with reasonable fidelity by master's level clinicians. The intervention, which we called Narrative Enhancement/Cognitive Therapy (NECT), is intended to be made available to routine public-sector treatment settings that work with persons with severe mental illness, and to allow such services to offer an intervention geared specifically to decrease internalized stigma which they may have previously been unable to offer.

Treatment Manual

The manual features a guide for the practitioner aimed to help explain the rationale, tone and technique of each section, as well as hand-outs that can be used to guide group discussions. In addition, the manual includes worksheets that can be used to help group members learn and practice skills for coping with internalized stigma by identifying cognitive distortions or dysfunctional attitudes related to having a mental illness, and telling stories and providing constructive feedback to the stories of others. Below is an outline of the main sections of the manual:

Introduction

The purpose of this section of the intervention is to begin the process of assessing where the person is with regard to his or her experience of self, and in particular to the relation of self to illness (that is, their degree of internalized stigma). In order to do so, each participant engages in exercises designed to elicit a description of him/herself, and a description of the problem for which he or she is seeking help (to avoid naming it for the person). These self-conceptualizations are elicited through written group exercises (although participants have the opportunity to dictate responses in the event that they are unable to write). The expected length of the introduction segment is 1 group meeting.

Psychoeducation

The purpose of this segment of the intervention is to provide participants with the current empirical knowledge about the prognosis of severe mental illness and the inaccuracy of stigmatizing views about it. Educational handouts summarizing information on the rates of recovery for severe mental illness are reviewed and discussed, as are handouts about stigma and how self-stigma develops. Common myths about mental illness are also presented and debunked using research-based findings. The material is presented in a humble manner to foster a meaningful and genuine dialogue between persons with valuable expertise of experience and updated mental health research. The goal is to help “replace” stigmatizing and inaccurate myths but not a persons’ experience or personal understanding of it. Discussion of material follows some of the principles discussed by Roe and Yanos (2006) in using psychoeducation to “inspire” persons with severe mental illness. The expected length of the psychoeducation portion of the group is 3 group meetings.

Cognitive Restructuring

This section introduces the first “active ingredient” of the treatment that we expect to impact self-conceptualizations. This section starts out by teaching the basic principles of cognitive restructuring, including: the connection between thoughts and feelings, how thoughts and feelings influence behavior, what an irrational belief is, types of irrational beliefs, how to monitor thoughts, and how to challenge irrational beliefs. The participants then engage in exercises where they attempt to identify, challenge and consider replacing inaccurate beliefs and/or dysfunctional cognitions about self, illness and self in relation to illness. There is also information on common misconceptions related to stigmatizing views of mental illness and thinking errors related to these misconceptions. Group members engage in discussions of thinking errors, as well as complete exercises designed to stimulate the use of cognitive restructuring techniques outside of the group context. Participants are encouraged to monitor situations in which cognitions about the self, illness, and self in relation to illness are elicited, and then discuss these situations in the group. The expected length of the cognitive restructuring portion of the group is 8 group meetings.

Narrative Enhancement

After the participants have completed the psychoeducation and cognitive restructuring portions of the group and have had the opportunity to develop significant group cohesiveness (Yalom, 1995), the group transitions into the narrative enhancement portion. The rationale for placing this segment last is that it is believed that participants will be more comfortable within the group and with the group facilitators and therefore more prepared to take on the task of sharing personal stories within the group. The last section focuses on the process of constructing personally useful narratives of self, illness and self in relation to illness. Participant are encouraged to write (or tell) and share stories within the group. The stories can be about past or recent events. The intervention focuses on trying to bring together previously fragmented and isolated aspects of the self by being an audience to the

story, exploring the way (content and process) one tells his or her story, responding to the participants' difficulties thinking of themselves (and being center or/and an active agent), recognizing the participants' right to have and create their own stories, and reflecting about the participants as protagonists in the stories that they tell. A further focus during this section is to discuss how the types of stories may be influenced by cognitive distortions which can in turn be inspired by popular (and erroneous) beliefs about mental illness. This component therefore attempts to integrate aspects of psychoeducation and CBT to help participants internalize change and impact not only cognitions, but also the subjective experience that accompanies (and interacts with) cognitions. Thus, the ultimate goal is to enable participants to learn and practice skills which offer opportunities to negotiate and rewrite their personal stories and experience as well as internalize the empowering role of the narrator and protagonist of these stories. The expected length of this section of the intervention is 8 weeks.

Recommended Structure of the Intervention

It is recommended that the group be conducted by 2 facilitators, which helps give more personal attention when needed, strengthens continuity, and provides the facilitators with the opportunity to discuss and process the group together and provide mutual support. The ideal size of the group is 4–8 members, not including facilitators. Each group meeting should last for an hour. Each group meeting begins with a 5–10 minute structured section in which participants are welcomed and allowed to add to the day's agenda. This “check in” time also allows participants to give a brief report of their experiences that week and call to mind any questions or concerns they may have. During this time homework may also be “turned in” to the group. Following “check in” is the didactic section which lasts roughly 40 minutes. During this period, group members together review and complete roughly 2–3 pages of manual worksheets. Group members are encouraged, but not required, to read from worksheets in order to facilitate participation in the group. Following the didactic session participants have time to process what they learned, give their comments about the usefulness of the group and offer one another support. This “processing section” lasts 10–15 minutes. During this time each group member will identify a goal (or home assignment) they would like to accomplish during the week.

Pilot Implementation

The manual was developed during 2008 and separately piloted by the three authors (together with co-facilitators) between late 2008 and early 2009 at three different settings: an Assertive Community Treatment program in New York City, a day treatment program in Indianapolis, and a University clinic in Israel. A total of 17 consumers participated in these three pilot groups. Consumers volunteered to participate in the pilot intervention and were recruited through announcements and referrals from clinical staff in the 3 settings.

A focus of the pilot implementation was to help refine the manual but also to determine the “tolerability” of the group. In all three locations, we found the consumers who participated in the group to be thoroughly engaged in the group. Attendance was generally good, and although in some instances consumers found that the group material elicited strong emotions, consumers showed no signs of being unduly upset by the group material. Clients in all three settings reported being helped by the group and some appeared to have made important changes as a result. The below case vignette illustrates some of the types of changes that we observed in group participants. The vignette is a composite of several group participants created to illustrate some of the central components of NECT.

Case Vignette

Peter is a 33 year old male who lives alone and works part-time in a supportive employment program. He began experiencing serious psychiatric symptoms in his early 20s for which he was hospitalized three times, and has been treated through outpatient and rehabilitation services for the prior 10 years. He reported having been diagnosed over the years by different psychiatrists as having schizoaffective and bipolar disorder. He heard about the pilot intervention from his case manager and was interested in participating.

At first he appeared quiet and cautious. He said he felt both drawn as well as threatened by the topic of self-stigma because he believed that part of his problem is that he thinks too much. During the first few sessions he said very little while following the group with an intense look. He participated only when referred to directly, and appeared quite anxious. When reviewing the psychoeducational material, he seemed notably drawn to the tone and information but was also hesitant, as though concerned that he might annoy anyone. Gradually, however, he began to share personal stories which generated feelings of injustice and pain. In one incident, he told the rest of the group that his brother no longer allows his kids visit him alone since he first "got sick." On another occasion, he shared an incident during which he volunteered to give a blood donation but was rejected by the nurse when she heard he used psychiatric medication claiming his "blood was no good." As the group proceeded, Peter appeared less and less concerned about others' opinions, which manifest itself both within the group as well as in events outside the group which he shared with the group members. For example, he expressed his disapproval towards a mental health provider who spoke disrespectfully to a person who was receiving treatment at the same outpatient clinic he was receiving services from. He appeared a little less shy and slightly more assertive, and shared with the group his fear of feeling anger which he was afraid would lead to losing control and getting into trouble. The cognitive restructuring section was a helpful opportunity for him to practice strategies to identify thoughts that accompanied these feelings. This helped him distinguish between situations in which he concluded that his anger was justified and resulted from an annoying or insulting incident, and situations in which he was overly "reading into" a situation. These tools helped him feel a little less threatened by his own feelings and he frequently negotiated this topic in group, moving towards a conscious decision that he chose to avoid confrontation. For example, he came to the group one day and reported a frustrating experience that very same morning but was proud this did not get him "set off."

During the last sessions, as part of the narration exercises, Peter shared stories about his post hospitalization period emphasizing his passivity and attributing any forms of his activity to "miracles." Hesitantly, he listened to his peers reflect the active role he played which must have at least "helped" make these miracles happen. This appeared to have an impact on him, and he gradually began to tell stories with elements of greater agency. A few weeks before the group ended, he shared how he applied for and successfully obtained competitive employment. He related a story about how he did this saying that he realized that "having a mental illness does not limit you from pursuing your goals." The accomplishment of obtaining competitive employment appeared to significantly improve his self-esteem.

At the last session he described himself "being in physical and spiritual struggle for survival and that he hopes for the best." He described the reason for seeking services as a result of "a struggle which required help and attention." When one of the group participants commented that this is "a fate he has to accept" Peter rejected this, saying "this is not fate but something that requires faith in myself."

We believe that the case of Peter demonstrates how involvement in the group helped engage participants' self-conceptualizations, provide them with skills for changing them, and ultimately impact outcomes outside of the treatment context

Discussion and Future Plans

In this article we have described a new intervention we have developed to reduce internalized stigma, our pilot efforts to implement it and a brief vignette to help illustrate the process by which it might effect change. This pilot implementation in three sites was suggestive of its potential benefit. Providing a group of consumers with the opportunity to discuss, explore the often emotionally charged and personally relevant topic of "who am I?" appeared to be a meaningful and welcome task. A safe environment which enabled support, sharing and tools while encouraging a genuine dialogue and the development of personal exploratory models appeared to be a good context for helping the participants to develop their a sense of agency.

Given the demonstrated tolerability of the NECT intervention, our plans are to assess the effectiveness of the intervention in a randomized controlled trial study, and ultimately to attempt to disseminate the intervention in routine treatment settings where it can benefit a large number of persons with severe mental illness.

Acknowledgments

This work was supported by National Institute of Mental Health grant R34-MH082161 to the authors.

References

- Adler JM, Skalina LM, McAdams DP. The narrative reconstruction of psychotherapy and psychological health. *Psychotherapy Research*. 2008; 18:719–734. [PubMed: 18815950]
- Beck A. Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy*. 1970; 1:184–200.
- Bruner JS. Life as narrative. *Social Research*. 1987; 54:11–32.
- Corrigan, PW.; Calabrese, JD. Strategies for assessing and diminishing self-stigma. In: Corrigan, PW., editor. *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association; 2005. p. 239-256.
- Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. *Clinical Psychology: Science & Practice*. 2002; 9:35–53.
- Corrigan PW, Watson AC, Barr L. The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*. 2006; 25:875–884.
- Davidson, L. *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: University Press; 2003.
- Drury V, Birchwood M, Cochrane R, MacMillian F. Cognitive therapy and recovery from acute psychosis: A controlled trial. *British Journal of Psychiatry*. 1996; 169:593–601. [PubMed: 8932888]
- Estroff SE. Self, identity, and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin*. 1989; 15:189–196. [PubMed: 2665052]
- Gallagher, S. Self-narrative in schizophrenia. In: Kircher, T.; David, A., editors. *The self in neuroscience and psychiatry*. New York: Cambridge University Press; 2003. p. 336-357.
- Goffman, E. *Asylums; essays on the social situation of mental patients and other inmates*. Garden City, NY: Anchor Books; 1961.
- Haddock G, Tarrier N, Spaulding W, et al. Individual cognitive behavior therapy in the treatment of hallucinations and delusions. *Clinical Psychology Review*. 1998; 7:821–838.
- Holma J, Aaltonen J. Narrative understanding in acute psychosis. *Contemporary Family Therapy: An International Journal*. 1998; 20:253–263.

- Holmes EP, River LP. Individual strategies for coping with the stigma of serious mental illness. *Cognitive and Behavioral Practice*. 1998; 5:231–239.
- Knight MTD, Wykes T, Hayward P. Group treatment of perceived stigma and self-esteem in schizophrenia: A waiting list trial of efficacy. *Behavioural and Cognitive Psychotherapy*. 2006; 34:305–318.
- Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. The consequences of stigma for the self-esteem of people with mental illness. *Psychiatric Services*. 2001; 52:1621–1626. [PubMed: 11726753]
- Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. On describing and seeking to change the experience of stigma. *Psychiatric Rehabilitation Skills*. 2002; 6:201–231.
- Lysaker PH, Bond GR, Davis LW, Bryson LD, Bell MD. Enhanced Cognitive Behavioral Therapy for vocational rehabilitation in schizophrenia: Effects on hope and work. *Journal of Rehabilitation Research and Development*. 2005; 42:673–682. [PubMed: 16586193]
- Lysaker PH, Buck KD, Roe D. Psychotherapy and recovery in schizophrenia: A proposal of critical elements for an integrative psychotherapy attuned to narrative in schizophrenia. *Psychological Services*. 2007; 4:28–37.
- Lysaker PH, Buck KD, Taylor AC, Roe D. Associations of metacognition, self stigma and insight with qualities of self experience in schizophrenia. *Psychiatry Research*. 2008; 157:31–38. [PubMed: 18023881]
- Lysaker PH, Clements CA, Placak Hallberg C, Knipschure SJ, Wright DE. Insight and personal narratives of illness in schizophrenia. *Psychiatry*. 2002; 65:197–206. [PubMed: 12405078]
- Lysaker PH, Davis LD, Eckert GJ, Strasburger A, Hunter N, Buck KD. Changes in narrative structure and content in schizophrenia in long term individual psychotherapy: A single case study. *Clinical Psychology and Psychotherapy*. 2005; 12:406–416.
- Lysaker PH, Davis LW, Jones AM, Strasburger AM, Hunter NL. The interplay of relationship and technique in the long-term psychotherapy of schizophrenia: A single case study. *Counseling and Psychotherapy Research*. 2007; 7:79–85.
- Lysaker PH, Davis LW, Warman DM, Strasburger A, Beattie N. Stigma, social function and symptoms in schizophrenia and schizoaffective disorder: Association across 6 months. *Psychiatry Research*. 2007; 149:89–95. [PubMed: 17156853]
- Lysaker PH, Davis LD, Hunter NL. Effects of cognitive behavioral therapy and vocational rehabilitation on metacognition and coping in schizophrenia. *Journal of Contemporary Psychotherapy*. 2006; 36:25–30.
- Lysaker PH, Davis LD, Lightfoot J, Hunter N, Strasburger A. Association of neurocognition, anxiety, positive and negative symptoms with coping preference in schizophrenia spectrum disorders. *Schizophrenia Research*. 2005; 80:163–171. [PubMed: 16125370]
- Lysaker PH, Davis LD, Hunter NL. Neurocognitive, social and clinical correlates of two domains of hopelessness in schizophrenia. *Schizophrenia Research*. 2004; 70:277–285. [PubMed: 15329303]
- Lysaker PH, Lancaster RS, Lysaker JT. Narrative transformation as an outcome in the psychotherapy of schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice*. 2003; 76:285–299.
- Lysaker PH, Lysaker JT, Lysaker JT. Schizophrenia and the collapse of the dialogical self: Recovery, narrative and psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*. 2001; 38:252–261.
- Lysaker PH, Roe D, Yanos PT. Toward understanding the insight paradox: Internalized stigma moderates the association between insight and social functioning, hope and self-esteem among people with schizophrenia spectrum disorders. *Schizophrenia Bulletin*. 2007; 33:192–199. [PubMed: 16894025]
- Lysaker PH, Wickett AM, Wilke N, Lysaker JT. Narrative incoherence in schizophrenia: The absent agent-protagonist and the collapse of internal dialogue. *American Journal of Psychotherapy*. 2003; 57:153–166. [PubMed: 12817547]
- McAdams DP. The psychology of life stories. *Review of General Psychology*. 2001; 5:100–122.
- McCay EA, Seeman MV. A scale to measure the impact of a schizophrenic illness on an individual's self-concept. *Archives of Psychiatric Nursing*. 1998; 12:41–49. [PubMed: 9489173]

- Polkinghorne DE. Transformative narratives: From victimic to agenic life plots. *American Journal of Occupational Therapy*. 1995; 50:299–305. [PubMed: 8712249]
- Ritsher JB, Phelan JC. Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research*. 2004; 129:257–265. [PubMed: 15661319]
- Roe D, Ben-Yishai A. Exploring the relationship between the person and the disorder among individuals hospitalized for psychosis. *Psychiatry*. 1999; 62:370–380. [PubMed: 10693233]
- Roe D, Yanos PT. Psychoeducation for people with psychotic symptoms: Moving beyond education and towards inspiration. *The Behavior Therapist*. 2006; 29:53–56.
- Sensky T, Turkington D, Kingdom D, et al. A randomized controlled trial of cognitive behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*. 2000; 57:165–172. [PubMed: 10665619]
- Watson AC, Corrigan P, Larson JE, Sells M. Self-stigma in people with mental illness. *Schizophrenia Bulletin*. 2007; 33:1312–1318. [PubMed: 17255118]
- Wieczynski, DM. Dissertation Abstracts International: Section B: the Sciences and Engineering. Vol. Vol. 61. US: Univ. Microfilms International; 2000. Effects of a stigma management group for individuals with mental illnesses; p. 2786
- Yalom, ID. The theory and practice of group psychotherapy. 4th ed.. New York: Basic Books; 1995.
- Yanos PT, Roe D, Lysaker PH. The impact of illness identity on recovery from serious mental illness. *American Journal of Psychiatric Rehabilitation*. (In Press).
- Yanos PT, Roe D, Markus K, Lysaker PH. Pathways between internalized stigma and outcomes related to recovery in schizophrenia-spectrum disorders. *Psychiatric Services*. 2008; 59:1437–1442. [PubMed: 19033171]