

Qualitative Content Analysis of What Constitutes Effectual Group/Support Therapy
for Individuals Diagnosed with Schizophrenia/Psychosis Spectrum Illnesses:

Client's Perspective

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Abstract

The purpose of this qualitative content analysis is to demonstrate that individuals diagnosed with a schizophrenia spectrum illness know and understand what the need from individual and group therapy in order to achieve therapeutic success and mental wellness. Additionally, clients know how to collaborate, know what it feels like to be empowered and have the know-how to inform mental-health professionals on the constituents of what would create successful group therapy rather than the expert/mental health professional telling them what they think they need. This study focused on client messages embedded in the various text, audio, and video resources. After an exhaustive search for content, this study utilized 10 resources exclusive to a schizophrenia spectrum illness. The ten resources were examined and themed as determined by the author of this study.

Results indicate the most valued theme for effective group or individual (one-on-one) therapy is that the client and mental health professional relationship fosters autonomy. Eight out of the 10 data resources analyzed revealed autonomy as highly valued. Three of the data resources appreciated active versus passive listening skills on the part of the mental health professional, upholding or fostering dignity, and establishing trust.

In order to truly adopt a therapeutic stance in a group setting, a counsellor might benefit from recognizing that the client is the expert on their own existence. Furthermore, carefully thought-out group therapy for those living with schizophrenia spectrum illness is needed within communities. Because of the stigma associated with mental illness, the societal wedge is growing between cohorts of those diagnosed with a schizophrenia spectrum illness and the remaining majority of the collective considered as functioning “normally.”

TABLE OF CONTENTS

1. INTRODUCTION.....	4
Epistemic Issues.....	4
Epistemological Viewpoint Informing Analysis.....	8
2. LITERATURE REVIEW.....	16
3. METHOD—QUALITATIVE STUDY PROCEDURE.....	24
Description of Qualitative Design.....	24
The Researcher’s Role.....	27
Data Sample.....	28
Data Collection and Data Interpretation.....	30
Ethical Considerations & Limitations Analysis.....	32
4. RESULTS.....	34
Research Data Containing Client Perspectives of what Constitutes Helpful and Unhelpful Individual Therapeutic Practice.....	38
Research Data Containing Client Perspectives of what Constitutes Helpful and Unhelpful Combined Individual and Group Therapeutic Practice.....	52
Research Data Containing Client Perspectives of what Constitutes Helpful and Unhelpful Group Therapeutic Practice.....	68
DISCUSSION.....	80
5. REFERENCES	85
6. Appendix A—DSM-5 (2013) Criteria for Schizophrenia and Related Schizophrenia Spectrum Illnesses.....	90
7. Appendix B—ICD-10 Criteria for Schizophrenia and Related Disorders.....	92
8. Appendix C—Coursey, Keller, & Farrell (1995)—Characteristics of Therapy That Can Improve the Therapeutic Experience.....	97
9. Appendix D—Mackler (2014)—Documentary Information on What Clients Need to Improve The Therapeutic Experience.....	103
10. Appendix E—Mead & Copeland (2000)—What is Needed from the Therapeutic Profession to Recover from Schizophrenia.....	106
11. Appendix F—McLean (2003)—What is Helpful in Therapy.....	110
12. Appendix G—Goodliffe, Hayward, Brown, Turton and Dannahy (2010)—Helpful Advice to Improve Quality of Life for Those Who Hear Voices.....	115

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Introduction

Epistemic Issues: Concerns

*“No one—not the dying, not the outcast, not the mighty—transcends
the need for human contact.” (Yalom & Leszcz, 2005, p. 24)*

According to the World Health Organization (2013) and the Schizophrenia Society of Canada (2013), people who have been diagnosed with schizophrenia need care and social support from both family and community. However, many people with schizophrenia are not receiving the social support or care they need to function in society. As a result, people with schizophrenia do not belong to a cohesive social unit which is partly due to illness-associated stigma. Corrigan (2006) notes that the negative phenomena resulting from the stigmatization of individuals with schizophrenia, such as discrimination, prejudice, and stereotyping, will more often than not result in a total disconnect from social relationships. In his autobiography, Burke (1996) reveals that the most devastating aspect of his experience with schizophrenia was how he became isolated from his friends, family, and the rest of society. One reason why social exclusion and isolation take hold of a person diagnosed with schizophrenia is that the person who is diagnosed with the illness takes on the persona depicted by their macro and micro social systems. In other words, they often become the illness and dominant discourse of what the general population and they themselves think people with mental illness should be. Mead and Copeland (2000) believe

People have gotten used to their identities and roles as ill, victims, fragile, dependent and even as unhappy. Long ago, we learned to “accept” our illnesses, give over control to others and tolerate the way of life dictated by professional and governmental sectors of society. Think of how many people live like this who do not have diagnosed mental illnesses (p. 321).

More importantly, stigma is of concern to social scientists largely because of the egregious effects it has on almost all levels of society. Stigma represents a social injustice that deprives people of their humanity, leads to violence, and results in individuals being robbed of opportunities that are rightfully theirs (Corrigan, 2006, p. 6).

In order for a reduction to occur in associated stigma, Topor, Borg, DiGirolamo, and Davidson (2009) believe a shift needs to occur in relation to how the present mental health system views patients diagnosed with schizophrenia. Topor et al. (2009) conclude that the majority of mental health professionals currently believe recovery takes place at the individual level, all the while excluding the social aspects of recovery. They believe that the social aspects of recovery include relationships with friends, family members, and professionals; having a place to call home; and having sufficient funds and/or paid employment to minimize the stress of financial situations. To elaborate, it is important not only for the person who is experiencing schizophrenia to foster friendships but also for society to find a means of nurturing friendships among this cohort. There are some societal programs that focus on the fostering of relationships for those diagnosed with schizophrenia—for example, the Windhorse Community Program in Boulder, Colorado, and Forward House Community Society in Parksville, British Columbia. Programs such as these are few and far between, under funded and do not have the space to meet the demand.

Furthermore, Topor et al. (2009) believe the social support of friendships, whereby experiences can be shared and compared, are invaluable; they function as an external support resource and reassure the person they are not alone. In regards to fostering social aspects of recovery, Topor et al. believe that family plays a large role in the person's well-being. The mere existence of family bonds and supports goes a long way in aiding a person's well-being. For people experiencing schizophrenia, the relationship with their health professional or professional team helps create balance and stability within both the micro and macro social systems. Topor et al. (2009) believe the alliance between the person experiencing schizophrenia and the mental health professional goes a long way, as does the equality and respect between the parties involved. Next, the social aspect of having a home and lifestyle and the means to support these is crucial to the physical and mental health of a person diagnosed with schizophrenia. The structure and stability of having a home affords a sense of accomplishment and belonging. Borg, Sells, Topor, Mezzina, Martin, and Davidson (2005) state

Participants describe the various ways in which having a home had help their recovery:

home was a place to grow and find hope and confidence through dealing successfully with daily tasks; home was a safe place for developing coping strategies as well as for having fun and enjoying hobbies (as cited in Topor et al., 2009, p. 93).

They go on to say that failing to recognize the value of the collective in the recovery process is a significant oversight. Topor et al. (2009), have been attempting to broaden the scope of their therapeutic practice to include social factors in hopes of fostering healthier community/client relationships.

One social factor whose impact must be acknowledged is the reduction in in-patient beds in psychiatric care facilities throughout North America. In some cases, psychiatric care facilities,

such as the Riverview psychiatric hospital in Port Coquitlam, British Columbia, have been closed completely. People with schizophrenia have been forced to integrate into the community—willingly or otherwise and without the life skills they need to integrate successfully. In addition to being forcibly placed back into mainstream society, people with schizophrenia-related illnesses have not always been treated with the dignity and respect they deserve during this process. Therefore, in the opinion of Topor et al. (2009), society needs to foster and nurture community, not segregate the sick even further. Topor et al. (2009) believe mental health institutions should shift their thinking to include community-based programs when helping those diagnosed with schizophrenia, which would include not only individual therapy but also group/support therapy.

According to O'Brien (1975), we can learn from past successes with effective therapeutic intervention. O'Brien (1975) notes that, since the earliest recorded successful group therapy session, conducted by Edward Lazell in 1921 with individuals diagnosed with schizophrenia, group therapy has constituted a significant proportion of effective therapeutic practice. Not only is group therapy cost-effective and efficient in its use of session time, it also meets a human need of belonging, one that has the capacity to enhance quality of life. What better way to reintegrate those who experience seclusion due to mental health difficulties than to first foster relationships with like-minded individuals who have had similar experiences? More importantly, Pitt and Killbride (2006) believe,

service users [individuals diagnosed with a mental illness] should be recognized as experts in their own experiences and it should be acknowledged that they have a valuable contribution to make to services. It is only through such involvement that services will

be developed in such a way as to genuinely meet the needs of service users and successfully promote their recovery (p. 23).

The Canadian Psychiatric Association and the Schizophrenia Society of Canada (2008) concur with Pitt and Killbride (2006) and endorse client (that is, people diagnosed with schizophrenia) participation in recovery. Specifically, “persons living with schizophrenia need to be closely involved in their rehabilitation, not just to stabilize their symptoms, but also to regain their ability to function in society and improve their quality of life” (Pitt & Killbride, 2006, p. 23). Although the Canadian Psychiatric Association and the Schizophrenia Society of Canada do not reject the notion of mental health professionals as experts and specialists in the mental health requirements of people with schizophrenia, they are beginning to implement strategies that focus on the positive effects of client collaboration and the benefits of client empowerment.

Epistemological Viewpoint Informing Analysis

The following section on epistemological viewpoints will conceptualize the importance of client-based collaboration for improved quality of life and social inclusion. Empowering individuals diagnosed with schizophrenia in their treatment plan can foster client autonomy and improve quality of life. Enhanced quality of life and the positive effects of social inclusion will be demonstrated by the professional opinions of two relevant studies depicting client needs in the context of well-being. With the greatest respect for the research process and the respect of the invested researchers of the following studies, I would like to note here that the studies are not reporting directly from the client’s perspective. Although theoretically collaborative, the studies’ results rely on the perceptions of the professional researchers and their meaning-making. In

other words, there are no first-person reports by the clients diagnosed with schizophrenia or schizophrenia-spectrum illness on what constitutes effective therapy.

The first of the two studies was conducted by Bechdorf, Knost, Nelson, Schneider, Veith, Yung, and Pukrop (2010). They investigated the similarities and differences between a Cognitive-Behavioural Therapy (CBT) group and a control group of psychoeducation group therapy. They wanted to determine how these therapies helped or hindered patients diagnosed with schizophrenia or schizoaffective disorder in relation to their quality of life. Participants for this study were adults aged 18–64 years who did not meet the criteria for existing alcohol or drug dependence, organic brain disorder, learning disability, or deafness (Bechdorf et al., 2010). Participants were randomly allocated to either CBT group therapy or psychoeducation group therapy in addition to their regular treatment protocols. Regular treatment protocols included antipsychotic treatment or individual therapy (Bechdorf et al., 2010). The CBT and psychoeducation groups consisted of eight group members per session, each session lasted 60–90 minutes and the eight sessions of psychoeducation and sixteen sessions of CBT continued for eight weeks (Bechdorf et al., 2010). The researchers assessed and measured the following quality of life components: physical health, vitality, socialization, affect, material, spare time, and problems in general. According to Bechdorf et al. (2010), at baseline, there was no difference between the CBT and psychoeducation group therapy participants and no notable difference between groups for the quality of life measures at the six-month follow-up analysis. However, the 24-month research condition follow-up on participants revealed there were fewer re-hospitalization incidents among the CBT group therapy participants compared to the psychoeducation group therapy participants (Bechdorf et al., 2010). Overall, the researchers found that patients in both groups improved on quality of life test scores demonstrating clinical

relevance. However, Bechdolf et al. (2010) have expressed regret at not using an additional control that would “rule out that [quality of life] of the patients would have improved independently from the psychological intervention” (p. 149).

Roder, Mueller, and Schmidt (2011) also conducted an equally large study, this one on the effectiveness of Integrated Psychological Therapy (IPT). According to Roder et al. (2011), IPT is an effective cognitive-behavioural group therapy program for people with schizophrenia. They believe that IPT has a specific focus on neurocognitive, social cognitive, and social skills and problem-solving techniques. The meta-analytic research by Roder et al. (2011) took 30 years and included 36 independent studies, which collected data from both inpatient and outpatient facilities, with a combined 1,601 patients from 12 countries. This study reports that the average treatment period was 16.4 weeks, with an average of three group therapy sessions per week and a dropout rate of 14.6%. Additionally, Roder et al. (2011) found significant improvements in participants’ neurocognition, social cognition, psychosocial functioning, general psychopathology, negative symptoms, and positive symptoms, with social cognition showing the greatest improvement via IPT. It also should be noted that IPT had “longer lasting effects at follow-up and is more successful in generalizing therapy effects” (Roder et al., 2011, p. 75).

The studies discussed above are impressive by many standards by way of mentioning the positive outcomes of CBT, psychoeducation and IPT, but neither of them mentions at any time the perspective of the patients as people as opposed to statistical outcomes. More importantly, if therapeutic interventions like CBT and IPT are so effective, why are “[m]ore than 50% of persons with schizophrenia ... not receiving appropriate care” (World Health Organization, 2013)? What ingredients are missing to create this 50%? The answer could be that the voices

and expertise acquired through first-hand experience of persons living with schizophrenia or schizophrenia spectrum illnesses are missing from the research into what is needed, and possibly desired, in individual or group therapy. Additionally, the literature does not inform the reader of how the participants perceived the group therapies. Overall, the responses from participants were reduced to a numerical value, with no acknowledgement of the rich information embedded in participants' experiential narratives in a qualitative study.

E. Fuller Torrey is considered an expert in the field of schizophrenia and the associated group treatment options. He believes group work is very important for people experiencing schizophrenia because they will discover that their illness is not unique, that others have had and are having similar experiences (Torrey, 2006, p. 167). In his view, group work fosters a sense of belonging and purpose for people who are suffering from schizophrenia (and other severe mental illnesses). When asked about her experience of group participation, one woman commented that "joining a user-controlled group transformed her own sense of self into a person who has something to offer others" (Topor et al., 2009, p. 90).

Overall, there is no shortage of literature on what professionals think patients need in therapy. According to Topor et al. (2009),

this perspective prevents psychiatry from putting into practice the measures for patient co-determination, which are becoming increasingly prevalent in other fields of medicine. In these other fields, an effort is being made to incorporate the patient's values and points of view when determining treatment; in psychiatry, it is supposedly the patient's power of reasoning that is impaired and therefore what the patient says cannot be taken as face value but must be interpreted by professional helpers (p. 96).

This point of view might be considered counterproductive, even damaging, for people diagnosed

with schizophrenia or schizophrenia spectrum illness because the patient's perspective is discounted. Like Toper et al. (2009) I concur that the valuable therapeutic component of the client's voice is not counted as a contributing factor in client well-being. Therefore, I conducted a qualitative content analysis research study that demonstrates that the patient living with schizophrenia or schizophrenia spectrum illness knows what they need in group/support therapy in order for there to be a better chance of therapeutic success, collaboration, and experiential empowerment.

One such study demonstrating the power of collaboration was conducted by Sajatovic, Davies, Bauer, McBride, Hays, Safavi, and Jenkins (2005). They found that patients diagnosed with bipolar illness adhered to therapeutic treatment when there was collaboration between client and counsellor/psychiatrist and not just an expert (counsellor/psychiatrist) saying what they think should happen vis-à-vis the client's well-being. Effective therapy is a joint effort by both mental health professional and client. Furthermore, the researchers utilized a structured group psychotherapy, which included "collaborative definitions of problems, joint goal setting, and planning" (Sajatovic et al., 2005, p. 273). They also asked the following question of all their participants: "What do you think the ingredients are for an effective client-provider relationship?" (Sajatovic et al., p. 274). The results of their study indicated there are 12 key ingredients for a positive mental health outcome and the following information is taken directly from Sajatovic et al (2005):

- Patient-centered qualities
 1. Take medications regularly
 2. Attend designated counselling appointments
 3. Openly share information

4. Client assertiveness (example, phone help hotline if needed)
- Provider-centered qualities
 5. Providers need to pay special attention and caution to the effects of medications the clients are consuming.
 6. The counsellor needs to understand and take seriously that the client knows and understands their own bodies and wellbeing when taking medications.
 7. The provider needs to consider other therapies, not just medications.
 8. Patients want a “humanness” quality in their health care provider.
 9. Counsellor needs to be a good listener..
 - Interactional qualities
 10. Interaction with health care providers is critical, especially in times when bipolar symptoms seem out of control. The health care provider needs to be a grounding force.
 11. Trust between client and counsellor is paramount.
 12. The interaction needs to be one of flexibility. Flexible with time, especially when symptoms are at their worst and the counsellor needs to allow for enough time for the client to be heard. (pp. 274–275)

Overall, Sajatovic et al. (2005) demonstrate that both the client and the counsellor need to take an active role in maintaining the client’s health and well-being. They further believe that adherence to medication and various other forms of therapy “is not simply a ‘patient problem’ but a component of the patient-provider relationship” (Sajatovic et al., 2005, p. 275). Even though the Sajatovic et al. (2005) study was conducted with patients experiencing bipolar illness, I believe there will be parallel attributes and needs in people diagnosed with a schizophrenia

spectrum illness.

My research will demonstrate through the experience of people living with schizophrenia or schizophrenia spectrum illnesses that such clients have the valuable insight that mental health professionals need to conduct potentially effective group/support therapy. For the sake of brevity, the specific identifying term of schizophrenia spectrum illness will be used as an umbrella term for schizophrenia spectrum and other psychotic illnesses in accordance with the American Psychiatric Association (2013) definitions, that is, as having the key features of “delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms” (p. 87). Negative symptoms can be defined as “diminished emotional expression, avolition, anhedonia, alogia, and asociality” (American Psychiatric Association, 2013, p. 88). Illnesses included in the schizophrenia and other psychotic illness spectrum include schizotypal (personality) disorder, delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, unspecified catatonia, other specified schizophrenia spectrum and other psychotic disorder, unspecified schizophrenia spectrum and other psychotic disorder (American Psychiatric Association, 2013). (For a complete diagnostic outline on the illnesses of schizophrenia and schizoaffective disorder, see Appendix A and Appendix B.) This proposed content analysis research did not include the later seven diagnoses under the schizophrenia spectrum umbrella: substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, unspecified catatonia,

other specified schizophrenia spectrum and other psychotic disorder, unspecified schizophrenia spectrum and other psychotic disorder. They were not included because of the complexity involved in identifying them and the connected research. For the purpose of this study in providing client-led insight into effective versus non-effective therapy, the terms *effective*, *effectual*, *good*, *helpful*, and/or *successful*, and their antonyms, are a few examples of words used in an attempt to describe the phenomenon on what the client perceived as producing a favourable or not favourable impression towards their therapy. Also, I must mention that my perception upon reading and listening to written or spoken text was based and bias on moving someone forward, positively influencing a static outcome, or producing a favourable outcome (Webster's New World Dictionary, 1983) and their opposites influences the outcome of this thesis. In addition, the descriptors listed above, which inform the results section of this study, will also act as an information baseline to be built upon and to report the client's meaning-making regarding effective or non-effective individual or group therapy. When determining whether or not what someone says is describing effective versus non-effective therapy, it is important that I remove my biases and preconceived ideas and listen carefully and objectively to the individual reporting because all recovery from therapy, benefit from therapy, ineffective outcome towards the therapeutic experience and so on, is qualified by the client using the therapy.

Additionally, because information regarding client-voiced testimony of those who have been diagnosed with schizophrenia or a schizophrenia illness is limited, this study will draw upon client definitions or descriptions of effective or non-effective therapy components adapted from other non-schizophrenia or schizophrenia spectrum illness studies reporting effective versus non-effective therapeutic components. For instance, the literature review of this study uses first-hand accounts from people who have experienced bipolar illness and depression-related illnesses

to create a schematic of what is helpful towards effective group therapy for schizophrenia and schizophrenia spectrum illnesses.

Literature Review

Qualitative literature resources reporting first-hand accounts by individuals utilizing group therapy were difficult to locate within the available databases. Reports supporting this thesis topic were not only limited in quantity but their publication dates also varied greatly, with some dating back to 1975 and 1993. However, this study also includes current literature and video recordings dated as recently as 2015. One recent study that demonstrated a favourable and effective outcome regarding group treatment was conducted by Goodman and Santangelo (2011). Although this body of research did not include individuals diagnosed with schizophrenia spectrum disorder, it does offer valuable insight into what clients diagnosed with another pervasive and serious illness—postpartum depression—need from group treatment. According to Goodman and Santangelo (2011), postpartum depression can be defined as an individual experiencing “depressed mood, anxiety, compulsive thoughts, loss of control, feelings of inadequacy, inability to cope, irrational fears, fatigue and despair” (p. 277). The researchers report that one of the main appeals of a group-based treatment plan is that some women might not be able to afford individual counselling, and group treatment is a less expensive option. Goodman and Santangelo’s (2011) research involved an exhaustive search of the literature representing support groups for women experiencing postpartum depression. They found that 10 out of the 11 studies demonstrated that postpartum depression symptoms were alleviated or reduced with group treatment, “suggesting that group treatment is effective in reducing postpartum depressive symptoms” (Goodman and Santangelo, 2011, p. 290). They also found the specific therapeutic delivery methods of CBT, social support, and interpersonal therapy had

similar effects. In other words, the type of therapeutic intervention did not alter the outcome of group treatment—the collective nature of the interaction was the common variable in alleviating postpartum depression (Goodman and Santangelo, 2011, p. 290).

Kadam, Croft, McLeod, and Hutchinson (2001) also conducted a study focusing on depression, but instead of postpartum depression, their focus was on clinical depression. In regards to the treatment of anxiety and depression for those living with clinical depression, Kadam et al. (2001) report that in a very broad manner, the pattern in which therapeutic effectiveness has been reported has been primarily through the opinions of many doctors and their subsequent drug therapy treatments. However, in all the opinions and reports one thing was consistently missing—the patient's perspective. Through a qualitative study, Kadam et al. (2001) examined depression and anxiety by using the experiences and opinions of 27 participants who all had first-hand understanding of what it was like to live with the illness. In light of this information, Kadam et al. (2001) then designed a research study that centred on

patients' perspectives regarding their illness and their expectations about how the primary healthcare team might meet their needs. Both individual interviews and focus groups were used to provide detailed information of experiences to obtain a collective picture of the provision of primary care services. (p. 375)

In addition, their research entailed both individual interviews and patients' collective discussion about what they need in order to get the best possible care from mental health and general health care establishments. Kadam et al. (2001) utilized data from a sample size of 27 participants. Their method consisted of two focus groups containing nine participants in each group and 18 individual interviews. The individual interviews included questions such as

if you can think of an occasion when you have felt “stressed,” please tell the “story” of what happened, what led up to the problem, what you felt during this time and who or what was involved? The word “stress” could mean feelings of tension, wound up, anxious or mood which was low, tearful, or depressed ... In an ideal world what sort of help should be available? Are there any new ways of coping with problems that you have heard about and might want to try out, particularly in relation to the type of problem you described...? (Kadam et al., 2001, p. 376).

For the focus group questions, the researchers explained that “we are here to discuss what sort of services, a general practice could provide for you, if you suffered from stress. The word stress could mean feelings of tension, wound up, anxious or mood which was low, tearful, or depressed” (Kadam et al., 2001, p. 376).

Furthermore, the research results of the Kadam et al. (2001) study showed that participants disclosed many treatment protocols that had worked for them in the past and continued to be helpful at the time of this study. Participants also informed the researchers about the treatments by describing and voicing their opinions about what is not working in the health care system or for their personal well-being. A particular skepticism about drug therapy was expressed by a majority of the participants, and a percentage of participants voiced a preference for counselling and complementary therapies (therapies other than pharmaceuticals).

From the participant testimony, Kadam et al. (2001) extracted three common themes. One, participants identified with the struggles “to control unwelcome and intrusive thoughts and feelings” (Kadam et al., 2001, p. 377); two, participants reported “living in a hostile and threatening world” (p. 377); and three, participants had “searching for sources of help” (p. 377) as a common interest. Another interesting finding the researchers stumbled upon was that

participants “were clear that the challenge in their everyday life was not that of dealing with the cause of their problem, but of coping with the thoughts and emotions associated with it” (p. 377). In addition, people who experience anxiety and depression will often report that they search out methods of distraction to temporarily take their frame of mind and reference away from the anxiety and depression. For instance, Kadam et al. found “reading, music, housework, and watching television” (p. 378) were common means of distraction. “These methods were not seen as solutions but as forms of respite” (p. 387). However, Kadam et al. (2001) express an opinion demonstrated by the data that “there was nevertheless a strong sense that people in general were not sympathetic to their difficulties” (p. 378). Additional information brought forth by the Kadam et al. (2001) study is that participants felt a tremendous sense of shame and embarrassment about their anxiety and depression and they “describe their problem as ‘trivial’ in the eyes of other people” (p. 378). When it came to inquiring about sources of help, Kadam et al. (2001) observed and documented,

What was very striking was that most of these people had been active in searching out different forms of therapy. Apart from GP referrals to counselling, clinical psychology, hypnotherapy, and psychiatry, many of them had on their own initiative made use of a range of therapies: acupuncture, relaxation tapes, self-help books, exercise, self-help groups, reflexology, aromatherapy, and analytic psychotherapy. (p. 378)

Their research identified three main categories pertinent to this study on effectual group therapy: “(a) someone to talk to, (b) issues around access [to help], and (c) attitudes to medication” (Kadam et al., 2001, p. 378). When asked to elaborate, participants reported they had low expectations that their doctors would do more than just issue pharmaceuticals. Several informants, particularly in the focus groups, observed that there was a lack of conversation and

welcoming of tough topics in therapeutic environments, such as psychological problems and daily difficulties related to the illness.

Furthermore, only two participants had ever received counselling, which prompts the question: Why? According to the participants and researchers, the main components of a helping relationship, regardless of whether it is in a group environment or between two individuals, is there needs to be more direct access to helping programs and mental health professionals could have more awareness of which programs are available in the community. More importantly, Kadam et al. (2001) stress that professionals in the helping field should keep in mind that patients welcome help in the form of a therapeutic bond and this is a “valued part of the patient’s perception” (p, 379).

In sum, Kadam et al. (2001) believe “these views contrast with the current professional emphasis in anxiety and depression management, and need to be considered if there is going to be an improvement in the care of these patients” (p. 376). In their final recommendations, Kadam et al. (2001) strongly encourage counsellor-to-client education to better educate patients on drug therapies and inform them about the available coping skill techniques that they could use to ease their situations.

The next study to be discussed was both broader in scope and specific to what components of therapy aid in the recovery process for someone who has been diagnosed as experiencing psychosis. In 2006, researchers Pitt and Killbride conducted research in which they applied a user-led testimony. When questioning people who have recovered from psychosis, they used open-ended dialogue and incorporated characteristics unique to the person being interviewed that not only helped the person recover from psychosis, but also uncovered common themes within the individual testimonies. Pitt and Killbride (2006) had the goal of improving

services in the United Kingdom by laying out the needs of service users via data gleaned from the testimonials. The researchers interviewed seven people—two women and five men—who had all experienced psychosis in the form of hallucinations and delusions. They asked open-ended questions about what recovery meant to the interviewees, and asked questions about, for example, what was helpful and what hindered their progress. After collecting the data via audio recording, Pitt and Killbride (2006) carefully extracted three common but subjective themes and six less prominent themes from the common themes that coincidentally ran through the verbatim phenomenological analysis. The three common themes and six smaller themes Pitt and Killbride (2006) teased out are as follows:

1. Rebuilding self:
 - a. Understanding the self,
 - b. Empowerment.
2. Rebuilding life:
 - a. Active participation in life,
 - b. Rebuilding social support.
3. Hope for a better future:
 - a. A process of change, desire for change (p. 21).

According to Pitt and Killbride (2006), their research findings indicate that recovery is not a static concept but a fluid concept that entails a “process rather than an endpoint or cure” (p. 20). Moreover, they report the beliefs of their participants that mental health services can take away an individual’s sense of empowerment. When speaking on the issue of empowerment, participants specifically relayed the message to the researchers: empowerment includes seeking knowledge, taking control, developing self-esteem, and becoming more assertive. Furthermore,

the issues centred on the lack of empowerment can be changed to empowerment through the sharing of experiences with other service users. One of Pitt and Killbride's (2006) research participants commented that "the most positive has been finding the hearing voices group is talking to other voice hearers and realising that the sort of diagnostic process and the medical model isn't the only way of looking at things" (Pitt and Killbride, 2006, p. 21). According to Pitt and Killbride (2006), this testimonial reflects a smaller but no less significant theme of sharing experiences and the validation of experiences.

Another valuable insight gained from the Pitt and Killbride (2006) research was that "I go out and do training and we kick start the hearing voices groups in various towns and that sometimes you have a group to talk to, a group of CPNs or social workers" (p. 21). This participant statement reiterates that some people believe group work is important when sharing similar experiences around psychosis. It further illustrates the importance of people having a purpose in life—something to strive for that gives meaning to life.

In addition to the importance of people having a purpose in life Pitt and Killbride (2006) also determined the following for the category of hope for a better future, specifically through a lens of "social process, a process from social exclusion to social inclusion" (p. 21). One interviewee commented that "basically it is proof to me that I am returning to society rather than being in some sort of exile, whether self-imposed or from outside" (Pitt and Killbride, 2006, p. 21). Overall, Pitt and Killbride (2006) believe recovery from psychosis does not always have to occur within the confines of the mental health system; it can occur in external programs created by the very people experiencing the problem. However, in contrast to these positive reports by users of the various support options, there is a plea from Pitt and Killbride (2006) "for more self-help groups, particularly in relation to psychosis to provide people with the opportunity to

discuss their experiences and share coping strategies. These groups could be facilitated, at least in the first instance, by mental healthcare professionals” (p. 22).

In another study, Australian researchers Halperin, Nathan, Drummond, and Castle (2000) conducted a small controlled pilot study looking at the effects of a group-based Cognitive-Behavioural Therapy (CBT) for individuals who had been diagnosed with schizophrenia and social anxiety problems. According to Halperin et al. (2000), CBT is a long-standing and proven effective therapy in the treatment of schizophrenia symptoms. The researchers recruited 16 participants (13 male and three female) who met all the research, assessment, and data collection requirements. The participants were allocated to one of two groups, the waitlist group who received treatment as usual and the actual treatment group. Individuals in both treatment groups continued to take their antipsychotic medications and also maintained regular visits with their assigned psychiatrists or community case managers. In the actual treatment group, all participants attended the CBT group-therapy sessions, which comprised psychosocial, psychoeducation, “exposure situations, cognitive restructuring, and homework assignments between sessions” (Halperin et al., 2000, p. 810). Sessions were held weekly for eight weeks and each session lasted for two hours.

Results from this controlled pilot study suggest CBT group-based treatment for social anxiety is an effective strategy for increasing quality of life for people who have been diagnosed with schizophrenia. Intriguingly, the researchers found more of an improvement with the patients’ symptoms of depression than with anxiety characteristics. Halperin et al. (2000) achieved statistical significance with their study, but they question whether their results occurred because of the supportive group environment, because of how the participants were empowered, or because the participants had extended quality time with mental health professionals versus the

use of individual CBT treatment protocols. Overall, Halperin et al. (2000) were pleased with the increased quality of life scores found with all treatment group members (n=7) compared to zero improvement in the control group (n=9). Conclusions from this study open channels for further inquiry about the social inclusion aspect of quality of life that can be obtained by group therapy, empowerment, and collaboration.

Methods—Qualitative Study Procedure

Description of Qualitative Design

In order to venture into the realm of what constitutes effective group/support therapy as determined by individuals living with the illness of schizophrenia or a spectrum related illness, this qualitative study will inform the reader of how I arrived at client-driven results. The following qualitative design involved content analysis methodology focused on the essence of the positive and negative experiences of users of individual therapy and group therapy in order to produce a schematic on what constitutes effectual group therapy. The aim of this qualitative inquiry is to “describe the lived experiences of individuals about a phenomenon as described by participants” (Creswell, 2014, p. 14). This qualitative study espoused a rhetorical analysis approach, specifically focusing on client messages embedded in the various text, audio, and video resources. Written or spoken evidence from people who experience a schizophrenia spectrum illness were taken from concrete descriptions, and so as a researcher, I had the task of recognizing whether comments made were in regards to effective or ineffective individual or group therapy components. Quoted material was derived from journal articles, Web-based articles published on credible online journals such as the *Schizophrenia Bulletin*. Quoted materials were also used from books (autobiography), audio books (autobiography) downloaded

from iTunes, eBooks (autobiography) downloaded from iTunes, and video watched via YouTube. Overall, testimony and descriptions of effective and non-effective therapy components for individuals diagnosed with schizophrenia or a schizophrenia spectrum illness in either an individual or group-based therapeutic setting yielded 10 solid resources. Overall, the 10 resources found in the result section of this thesis consisted of five journal articles, one book, two eBooks, and two YouTube videos.

The next step, in accordance with recommendations made by Krippendorff (2013), was to tease out themes and sort through various communications on “what works and what doesn’t” (p. 22) in regards to effectual group therapy for clients experiencing a schizophrenia spectrum illness or other psychotic illness. Testing for the accuracy of diagnostic categories was beyond the scope of this particular research endeavour, therefore individual diagnoses were considered to be true and taken at face value. More importantly, the schizophrenia or schizophrenia related illnesses were not expressed through the voice of the actual autobiographies of people diagnosed and for this reason I account for the biases and diagnosis methods of the researchers and mental health professionals who originally handed out schizophrenia and schizophrenia related illnesses. To assimilate the data, I first used data from individual therapy sessions and separated out what people defined as helpful/effective versus unhelpful/ineffective qualities of the therapeutic encounters. Several data resources depicted both individual and group therapeutic qualities towards effective versus ineffective therapy which entailed sifting through information in order to determine if therapeutic characteristics were linked to individual therapy or group therapy. The coding and decoding ended with analyzing data from exclusively group therapy information.

Results derived from individual therapeutic help (client and mental health professional only) proved the most fruitful. The studies of McLean (2003), Mackler (2014), Goodliffe et al.

(2010), Coursey et al. (1995), and Mead and Copeland bore the most data. Spiro (2006), Mackler (2014), and Hanley et al. (2015) proved to have the least data that were applicable for this particular research analysis. All the other data resources depicted in Table 14 had median results. Although by many research standards data such as the Spiro (2006) autobiography would have been excluded because of sparse information, in this particular study, any piece of information helped. In addition, it is my belief that any voice—no matter how big or small—conveys a message that some will find helpful.

Using an inductive approach developed by Elo and Kyngäs (2007), my research method included three phases: preparing, organizing, and reporting the analyzing process and results. The preparation phase, carried out in accordance with Elo and Kyngäs's (2007) criteria, entailed selecting journal articles, books, eBooks, video, and audio-recorded data relevant towards this thesis. The preparatory phase was followed by an initial organization of the data (although data analysis was ongoing and continued until the very end of this research endeavour). Krippendorff (2013) states that a "content analysis design may include iterative loops—the repetition of particular processes until a certain quality is achieved" (p. 86). Quality was achieved when it had come to my attention that I had exhausted all communication pertinent to the research purpose.

The organization phase of the data was very detailed. Krippendorff (2013) recommends that research entail a well-organized method with the following research characteristics: a) open coding, b) coding sheets, c) grouping of the data, d) categorization instead of concept development, which aided this research in the abstraction process. After the organization phase, a reporting and analysis process followed. The results phase included the development of a data model or categorical map, which presented the effective and ineffective qualities of individual

and group therapy as determined by client opinions and perceptions.

The Researcher's Role

As the researcher, I attempted to set aside all preconceptions about the topic being investigated in this research endeavour with the exception of my belief that the client/patient is the expert on what they need from mental health care providers and the various governing mental health care systems. Even though I have had extensive teaching in various fields of mental health—for example, clinical counselling, neuropsychology, classic behaviouralism, policy formation, ethics, and best practices for patient care—I was cognizant that my perceptions of others' behaviours, dominant discourse, and knowledge are mine and mine alone. For example, what I might think is successful movement in a therapeutic alliance with a client might be perceived as a setback by the client. However, I did not rule out the possibility of a collective concept arising from the written communication among individuals diagnosed with a schizophrenia spectrum illness. People with schizophrenia experience a world with which I do not have first-hand experience. Most of my understanding of a diagnosis of a schizophrenia spectrum illness derives from the dominant discourse embedded within past and current literature, as well as secondary experience in working with individuals diagnosed with schizophrenia or some form of psychosis.

Additionally, as the researcher, I believe I live a life of privilege and will always be cognizant that I experience privilege and life differently because I am a white, middle-class, female of European Canadian decent who has not been diagnosed with a severe mental illness. I have not had to deal with stereotyping, discrimination, or prejudicial behaviours like those often experienced by people with psychosis at the hands of those sectors of society who consider themselves superior to those who suffer from schizophrenia. Understanding my privilege is

important when working with a vulnerable and disenfranchised population, according to France, Rodriguez, and Hett (2004), because ethically it is my responsibility “to move beyond a Eurocentric position and empower all ... clients” (p. 8).

Moreover, the empowerment of individuals is brought to the fore partially by means of written or vocalized experiences from first-hand accounts and then the gathered information is then relayed to those I might encounter or those who read this thesis. In essence, I am leaving a voice for those who live a life experiencing a schizophrenia spectrum illness that can be heard and understood from the people who shared their experiences on what works and does not work in either individual or group therapy. Regardless of my positive and compassionate outlook towards those who have been diagnosed with a schizophrenia spectrum disorder, I am still part of the collective that has for the most part kept this sector of the population suppressed and oppressed because they do not meet expectations of what is considered to be “normal” in today’s society.

I have also had extensive training and experience in working with people diagnosed with severe mental illness. For instance, for 10 years (2002–2012) I worked at Forward House Community Society (the governing body is Vancouver Island Health Authority) with individuals living with and experiencing mental health difficulties. Furthermore, I am currently counselling individuals who have been diagnosed with, for example, schizophrenia, depression, and bipolar disorder. A family member has a diagnosis of schizophrenia and so I recognize a personal attachment to the diagnosis of schizophrenia as a bias.

Data Sample

The literature review for this qualitative study included studies conducted with other major mental illnesses of bipolar and depression in addition to schizophrenia spectrum illness, as

defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) (2013). The reason for this broader analysis of literature is because of the scarcity of information on what constitutes effective individual or group therapy gathered from first-hand testimony from clients who have been diagnosed with having a schizophrenia spectrum illness. However, to uphold the integrity of this qualitative research endeavour and to provide consistency and a categorical map, the primary body of research will only use communication from a client/patient perspective. Additionally, the client/patient perspectives utilized will be from people who have been diagnosed with a schizophrenia spectrum illness as defined by the DSM-5 (2013) (see Appendix A) and the World Health Organization's ICD-10 (1993) (see Appendix B).

Additionally, data was also obtained from relevant sampling of client testimony only and not from mental health care provider communications, such as communication from counsellors, physicians, psychiatrists, or psychologists. Overall, I made inferences from bodies of text gathered from journal articles, books, eBooks, magazine articles, and public domain video and audio recordings. I did not use Internet blogs or Internet discussion forums due to the ethical challenges associated with such communications, including an inability to honour participant confidentiality and to meet informed consent and refusal requirements.

In accordance with recommendations by Krippendorff (2013), I did “acknowledge working within hermeneutic circles in which their own socially or culturally conditioned understandings constitutively participate” (p. 23). Utilizing an approach that is considered “interactive-hermeneutic, a description that speaks to the process of engaging in systematic interpretation of text” (Krippendorff, 2103, p. 23). Systematic interpretation began with identifying broad concepts such as, what is helpful in therapy and then deduced the broad concept into more specific effective or ineffective characteristics in which users of the therapy found helpful or not

helpful. It must also be taken into consideration by mental health professionals that the many cultures and subcultures of the world can have very different dominant discourse on what constitutes not only a schizophrenia diagnosis but also the treatment and recovery processes. For the purposes of this study, a predominantly Western philosophy as explained in the DSM-5 (2013) and ICD-10 (1993) diagnostic manuals will be applied in the context of schizophrenia spectrum illnesses.

Data Analysis, Data Collection, and Interpretation

In accordance with criteria laid out by Elo and Kyngäs (2007), my aim when recording and collecting data that support my research question was to “attain a condensed and broad description of the phenomenon, and the outcome of the analysis ... categories describing phenomenon ... to build a categorical map” (p. 108) of what therapeutic components constitute effective therapy. When analyzing the data, I followed recommendations by Creswell (1998, p. 52) to proceed with a methodological reduction and begin with the statements and themes. Next the research followed a series of steps as follows: First, divide the statements (horizontalization); second, sort through clusters of meaning and link the textural descriptions; finally, compile structural descriptions of the data (Creswell, 1998). To be even more specific, I followed the recommendation of Elo and Kyngäs (2007) and utilized an inductive process with three phases of data analysis. The first phase was the preparation phase, which included selecting the units of analysis, followed by making sense of the data (Elo & Kyngäs, 2007). The units of analysis were first chosen by using the search engines of Google Scholar and City University of Seattle’s Library database. Search phrases on both Google Scholar and City University of Seattle’s Library database were as follows:

1. What do schizophrenia patients need from therapists?

2. Qualitative analysis on group therapy.
3. Content analysis on group therapy for the treatment of schizophrenia.
4. What do people diagnosed with schizophrenia want out of group therapy?
5. What qualities do people diagnosed with schizophrenia find helpful from their therapist?
6. Group therapy and schizophrenia.
7. Schizophrenia and recovery.
8. Schizophrenia and treatment outcomes.
9. Schizophrenia and effective treatments.
10. What not to do for people with schizophrenia in a therapeutic setting.
11. Bad therapy and schizophrenia.
12. Group therapy and bipolar illness.
13. Group therapy for depression.

The next phase was organizing the data, which included “open coding, coding sheets, grouping, categorization and abstraction” (Elo & Kyngäs, 2007, p. 110). Open coding was achieved by reading books, journal articles, and eBooks and extracting any word, phrase, paragraph, or chapter that included descriptions of individual or group therapy that was considered either effective or non-effective as experienced by a person diagnosed with a schizophrenia spectrum disorder. For video and audio data, the same process was utilized, except that number markers were used instead of my physically highlighting and labelling text. In accordance with Khandkar (2009), my aim was to comprehend and clearly defined representations via line-by-line coding. Line-by-line coding lends strength to the rich contextual data surrounding a message or concept. However, labels and coding were dependent on what the

participant said. For instance, if the participant said, the doctor failed to uphold my dignity, this would then be coded under the theme of dignity. Additionally, labels and coding occurred on a less obvious level, such as when a person said, I felt as though the doctor thought I was stupid because he was talking to me like I was a child, this again would be labeled and coded under the theme dignity.

The final stage was the reporting and analyzing process combined with the results of the textual communication (Elo & Kyngäs, 2007). This is where I built the categorical map or system of what constitutes effectual group therapy for people diagnosed with a schizophrenia spectrum illness.

Ethical Considerations and Potential Limitations in the Analysis

I was working with a vulnerable population and so took extra precautions to ensure their safety and privacy. I followed the ethical guidelines of the British Columbia Association of Clinical Counsellors Code of Ethical Conduct (BCACC), paying specific attention to the ethical criteria of the following fundamental ethical principles:

- *Principle I: Respect for the Dignity of All Persons and Peoples*
- *Principle II: Responsible Caring*
- *Principle III: Integrity in Relationships*
- *Principle IV: Responsibility to Society* (BCACC, 2008, p. 3).

Krippendorff (2013) writes in some detail on the ethics surrounding content analyses research. He clearly states, “researchers conducting content analyses of institutionalized texts—which most mass communications are—have to observe whether communications constitute new patterns, strengthen what has been said before through repetition, or weaken a pattern by omission or attention to alternatives” (p. 75). That is, a researcher assumes a tremendous responsibility when transcribing testimony, and acknowledgement of this responsibility underpinned this research endeavour. There are different standards, criteria, and ethics governing

what information is available in texts and stories and how the information is formed. For example, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders-5* (2013) is governed primarily by a biomedical model of illness detection and its panel of writers and editors are primarily physicians who have not experienced a schizophrenia spectrum illness first-hand. Contrast this with an autobiography written by a person who is living with the illness of schizophrenia and who believes their symptoms are caused by God being upset with them. In this context, it is important to consider and incorporate the ethics, criteria, and respect standards and practices according to the person's religion. Dominant discourse cannot be overlooked or discounted when data have been chosen and assimilated for research purposes. Human beings are unique individuals, they come with their own unique perceptions about the world and this will always influence how information is perceived. For example, two people can both be looking at a paint colour on a wall and one person might see blue while the other sees green. One person experiencing schizophrenia might find the people within a visual hallucination (seeing people who are not seen by a third party) discomfoting, whereas another might find them comforting because they never have to be alone in the world and they have utilized different coping skills and embraced a unique and different perception.

Additionally, because this content analysis research examined literature content of reported experience that is by nature secondary experience, there is no way of determining the authenticity of what people with a schizophrenia spectrum or other mental illness experienced. To elaborate, although the researchers and authors of the literature I examined were reporting experience gathered from people with relevant illnesses, I have no way of verifying if text had been altered in any way or if experiences were mutually understood by participants and researchers. Every research study has inherent methodological limitations and this study is no

different. With every study used to form a result within this study, I acknowledge and accept the associated limitations and interpretations of the researchers before me.

Results

In order to demonstrate the components of what constitutes effective therapy for those living with a diagnosis of either schizophrenia or schizophrenia spectrum illness, the results section presented here will scaffold the data, beginning with individual, client-based testimony on both the helpful and the unhelpful components of one-on-one therapeutic help. It will then examine data sources that embody both effective and ineffective individual and group components. The final section will cover testimony from individuals regarding the effective and ineffective nature of group therapy according to their experience.

I used 11 resources for their data as they pertain to this thesis topic. The 11 resources have been utilized for their data on effective and ineffective individual and group therapy components. They are, in order of use:

1. Coursey, Keller, & Farrell (1995)
2. Longden (2013)
3. Mackler (2014)
4. Mackler (2014)
5. Mead & Copeland (2000)
6. McLean (2003)
7. Morgan (2013)
8. Sigman & Hassan (2006)
9. Spiro (2006)
10. Goodliffe, Hayward, Brown, Turton, & Dannahy (2010)

11. Hanley (2015)

For the sake of clarity, the themes chosen for this research analysis have been determined by the data resources themselves. I did not create the themes I am about to discuss in my role as researcher; they were determined by participants/clients/persons all diagnosed with schizophrenia or schizophrenia spectrum illness and are as follows.

1. **Active/passive listening** and the associated synonymous and contrasting terms and descriptions—tentative listening, listening carefully, listening, doctor cared what I said, empathic listener passive listening, was not listening, doctor did not care what I had to say will be recognized.
2. **Autonomy**—With this term not only were associated terms utilized like independence, self-sufficiency and self-government, they also refer to how the individual felt, what perceptions of circumstance they adopted as their own. Specifically, there had to be some kind of gain towards self. Not to be confused with the term *dignity* (see below).
3. **Client Successes of the Past**—Client(s) clearly stated what therapeutic factor had worked in the past or continued to improve their symptoms. Synonymous terms such as accomplishments and achievements were used.
4. **Communication**—Specifically, how the mental health professional communicates messages, statements, and meaning to the client. For example, “The doctor did more talking than I did.”
5. **Compassion/Indifference**—For defining compassion, synonymous terms such as concern, kindness, tentative to my story, consideration for situation will be recognized. For defining indifference, comments such as doctor did not seem to care, ushered me out of the office as quickly as possible, lack of compassion will be recognized.

6. **Dignity**—This term is used in reference to some aspect of character being deduced or amplified by a third party (mental health professional in this context). A reduction or increase in perceived self-worth as a result of a mental health professional's actions and spoken words. For example, the doctor spoke over me to my mother while they were discussing my case, they did not even acknowledge my presence in the room, I felt as though I was not being respected or included in the discussion about me. Synonymous terms such as self-respect, respect, disrespectful, and pride will be recognized.
7. **Identity**—With this term, the individual facing a schizophrenia spectrum illness had to experience an occurrence to their identity. For example, letting go of a past identity to embrace a new identity or maintaining two identities simultaneously. Overall, there had to be a recognizable shift in identity by the person experiencing a schizophrenia spectrum illness.
8. **Insight Toward Symptoms**—This term refers to an acquisition of new awareness, understanding, or perception of individuality or mental illness on behalf of the client.
9. **Isolation Prevention**—This term encompasses ways in which clients either recognized a behaviour or thought that kept them isolated or a behaviour or thought that moved them through and out of isolation. For example, attending group therapy prevents the isolation that often accompanies schizophrenia.
10. **Medication Awareness**—Any comment in relation to medication that either the mental health professional or other group members would find helpful in the individual or group setting. For example, in many cases medication can place a person in a foggy state of mind, which leads to limited group interaction.
11. **Mental Health Professional's Demeanour**—This theme will be identified from the way

the mental health professional behaved when interacting with a client/patient who experienced schizophrenia or a schizophrenia spectrum illness. Other words associated with demeanour are conduct, character, manner, and behaviour.

12. **Mental Health Professional's Knowledge**—This term is in relation to how the client perceives the knowledge base of the mental health professional. For example, “the doctor did not seem to know anything about my mental illness.”
13. **Prognosis Details Said by the Mental Health Professional**—This term is limited to the verbal correspondence or communication of the mental health professional that was either helpful/effective or unhelpful/ineffective according to the client.
14. **Psycheducation**—Any education shared by a mental health worker or other client that the client either benefitted from or did not find useful.
15. **Shared Meaning**—This term refers to an exclusive exchange of meaning between two clients attending the same group therapy. For example, one client no longer felt alone once they realized another person in the group had gone through the same situation.
16. **Support Group (External)**—Support group in this case means any group other than the group mentioned in the study. For example, Alcoholics Anonymous (AA) was suggested by clients as being important to their ongoing recovery not only for substance mis-use issues but also for their mental illness.
17. **Trust**—Trust had to have been fostered either between client and mental health professional or between client and client. The word *trust* had to be used within the client's sentence.

In relation to the definition of mental health care professional(s) in the following body of data, the definition encompasses a plethora of titles and defining labels. Titles and

labels of mental health professionals included, but were not limited to, clinical social worker, psychiatrist, psychologist, general practising doctor (GP), and clinical counsellor. It should be noted that the credentials and legitimacy of the mental health professional titles could not be verified and are taken on trust.

Research Data Containing Client Perspectives of what Constitutes Helpful and Unhelpful

Individual Therapeutic Practice

Resource 1: Coursey, Keller, & Farrell. (1995). Individual

Psychotherapy and Persons with Serious Mental Illness: The Client's Perspective.

The article by Coursey, Keller, and Farrell (1995) was the first resource analyzed for its data content applicable to this thesis. Coursey et al. (1995) investigated effective individual psychotherapy through the client perspective in order to determine the therapeutic components best suited for the needs of mental health clients. They believed that an ideal way to design a mental health treatment protocol would be by first including the perspectives of its users and their attitudes towards appropriate mental health care. More importantly, Coursey et al. (1995) state, "When the dialogue fails to include the perspectives of all concerned, the discourse is naturally skewed toward the views of those who are included" (p. 283). Since 1995, and currently, the mental health profession as a whole does not take seriously the viewpoint of a person who is using mental health services or experiencing the illness first-hand when it comes to investigating what they might need from therapeutic interaction. Coursey et al. (1995) cite many reasons for this disconnect in the literature, several of which resemble assumptions among mental health professionals. First, people who are experiencing psychosis or other symptoms of severe mental illness, such as deep depression, are not able to formulate responses that are not vague in nature. Vagueness affords limited structuring on what entails effective therapy.

Second, clients will claim the least taxing therapeutic encounters as effective so the effort on their part is minimized. Third, clients of mental health services will report inaccurate results if it means the therapist and other mental health staff will see them in a more favourable light. For example, a client will give positive feedback about their mental health helper so as to not compromise future encounters when they feel vulnerable. In addition, Coursey et al. (1995) report, many clients do not want to jeopardize their medications, hospital stays, or extended services, etc. Fourth, there is a belief among mental health professionals that people with severe mental illness are simply unreliable. Lastly, Coursey et al. (1995) state that “cognitive impairments in areas such as attention, memory, reading ability, and sustained effort; intrusive symptoms; and medication may undermine the client’s ability to comprehend and complete extensive questionnaires” (p. 285). Coursey et al. (1995) clearly relay the message: The client’s incomplete responses are not at fault when considering what constitutes effective therapy. The problem often lies in how researchers design their questions; they are frequently too broad in scope and therefore foster large interpretative results or skewed global responses. Another problem is the use of psychological jargon in questions. Language is better understood when it is centered on the client’s nomenclature. Furthermore, Coursey et al. (1995) suggest that researchers acknowledge that people who are experiencing mental health difficulties find it beneficial if the therapist or mental health worker compassionately confronts the issues that often hinder quality of life when experiencing mental health difficulties. Overall, Coursey et al. (1995) believe individuals who experience mental health difficulties in a severe form are reliable informants who can “provide a detailed account of their perspectives on individual psychotherapy” (p. 285). The following is important information that has been gathered from Coursey et al. (1995) on what clients say they need from mental health professionals and

characteristics that can improve the therapeutic experience. It is important to mention, however, that the participants in the Coursey et al. (1995) study were not strangers to therapy. The participants surveyed in this research study attended psychotherapy sessions at intervals ranging between one month and 24 years.

Within the Coursey et al. (1995) study, client testimony emphasized the importance of the following thematic results, which are pertinent to the outcome of this thesis: active and/or passive listening; autonomy; communication; compassion and/or indifference; insight into symptoms; medication awareness; the mental health professional's demeanour; the mental health professional's knowledge, and trust. Following are a few examples of information arising from the Coursey et al. (1995) survey (for a full list and discussion, see Appendix C and Table 1).

Examples of selected applicable themes: Active/passive listening, autonomy, compassion/indifference, mental health professional's knowledge, and trust.

One participant in the study noted that they value the active listening skills of their mental health professional. For example, the person made a comment in reference to their doctor and the value of "Someone who listens empathetically" (p. 294).

With reference to the subject of autonomy, one participant in the Coursey et al. (1995) study explained how their therapist gave "advice in a way where if I don't see what he's talking about, usually I tell him why and ... he's accepting of that. If I tell him I can do this, I really believe I can do this, he'll give me credit for that too" (p. 294). In addition, on the subject of autonomy, the same participant recalls a moment with another mental health professional:

The other psychologist I had in the hospital, if I told him I could do something, he'd say, "I'm not really sure you can do that" to the point to where it was discouraging sometimes, because a lot of things that I told him that I wanted to do or things that I

thought were very small steps ... and it seems that he put a limit on what kind of progress I could do. The majority of people that he dealt with will probably never be productive in society and will probably be limited. This therapist that I have now thoroughly believes that I can live my own life within a very short period of time. (p. 294)

In regards to compassion, one person reported,

Sometimes I was just downright ornery and stubborn, but they came across, they made me feel like, "Look, here's my hand—take it—I'll help you." ... It was like these people are here to help you ... and are also here to show you that they care and try to get you to start caring again— about yourself (p. 288).

However, mental health professionals can also hinder therapeutic progress and thwart clients' quality of life. For instance, one client reported, "My former doctor hurt me in a way—he would always focus on my bad qualities."

The next most common response from the participants was that they appreciate a therapist who understands their illness "someone who will motivate me," (p. 292), "an advice giver," (p. 292), "an unbiased a listener," and "a problem solver" (p. 292).

When it comes to trust and confidentiality, most of the participants in the study (54%) reported that their therapist had indeed kept to the confidentiality agreement. However, 35% of the participants felt some unease around the therapist keeping confidentiality and 11% believe that their therapist was not careful about confidentiality: "42% of the clients reported having had a therapist that sometimes failed to keep confidentiality private, and of those, over half reported being either very upset at 45% or so upset that they left therapy 10%" (Coursey et al., 1995, p. 293).

Overall, the Coursey et al. (1995) study suggests that people who are diagnosed with a mental illness are more than capable of not only designing study questions for research but also having the insight to answer them. They are “reliable reporters of their needs, wishes, and experiences” (p. 294). In addition, it seems the therapists who are helping individuals through life difficulties could enhance therapeutic efficacy if they were to engage in autonomous, client-centred communication (Coursey et al., 1995).

Table 1

Coursey, Keller, and Farrell (1995, p. 286-294): *Helpful and Unhelpful Individual Therapeutic Components: Client’s Perspective*

Theme	Example
Active Listening	<ul style="list-style-type: none"> • Helpful: “A unbiased a listener.” • Helpful: “Someone who listens empathetically.” • Unhelpful: “The bad ones wouldn’t listen. They’d listen to my mother though.”
Autonomy	<ul style="list-style-type: none"> • Helpful: Gave “advice in a way where if I don’t see what he’s talking about, usually I tell him why and ... he’s accepting of that.” • Helpful: “If I tell him I can do this, I really believe I can do this, he’ll give me credit for that too.” • Unhelpful: “I’m not really sure you can do that” to the point to where it was discouraging sometimes.” • Unhelpful: “It seems that he put a limit on what kind of progress I could do.”
Client Success of the Past	-----
Communication	<ul style="list-style-type: none"> • Unhelpful: “He did a lot of talking. I think he did more talking than me and I’m a talker.”
Compassion/Indifference	<ul style="list-style-type: none"> • Helpful: “It was like these people are here to help you... and are also here to show you that they care and try to get you to start caring again– about yourself.” • Helpful: “She gives me a warm feeling, a warm caring feeling.” • Unhelpful: “My former doctor hurt me in a way—he would always focus on my bad qualities.” • Unhelpful: “And I got the feeling sometimes that he wasn’t very compassionate.”
Dignity	-----

Identity	-----
Insight	<ul style="list-style-type: none"> • Unhelpful: “[The doctor] really never put himself in your place and said, ‘Now I wonder, if I was in her place, what would I do?’”
Isolation Prevention	-----
Medication Awareness	<ul style="list-style-type: none"> • Helpful: 80% conveyed their regular physicians did “a good job helping me with my medication needs.”
Mental Health Professional’s Demeanor	<ul style="list-style-type: none"> • Helpful: 70.5% of people surveyed said friendliness was the most important therapist characteristic. • Helpful: “He’s very professional about the doctor-patient relationship, we often take a few minutes to just joke around.”
Mental Health Professional’s Knowledge	<ul style="list-style-type: none"> • Helpful: “Someone who will motivate me.” • Helpful: “An advice giver.” • Helpful: “A problem solver.” • Helpful: “Someone who teaches me how to handle my problems.” • Helpful: “Someone who tells me things I need to hear even if I don’t like it.”
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	-----
Shared Meaning	-----
Support Group (External)	-----
Trauma	-----
Trust	<ul style="list-style-type: none"> • Helpful & Unhelpful: Changing from a familiar therapist to a new one; 23.2% said it took three months to adjust. • Helpful & Unhelpful: 12.7% said it took a good six months before they felt comfortable. • Helpful & Unhelpful: 42% of the participants needed only one month to feel comfortable. • Helpful & Unhelpful: 22% of participants reported they need at least one year to adjust to a new therapist. • Helpful & Unhelpful: 54% reported that their therapist had kept to the confidentiality agreement. • Helpful & Unhelpful: 35% of the participants felt some lack of certainty about the therapist keeping to the confidentiality agreement. • Helpful & Unhelpful: 11% of participants believe their therapist was not careful about confidentiality. • Helpful & Unhelpful: “42% of the clients reported having had a therapist that sometimes failed to keep confidence private.”

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 2: Longden (2013). Helpful and Unhelpful Individual Therapy**Components: The Client's Perspective.**

The author of the second data source to be analyzed for applicable content for this thesis, Eleanor Longden, gave a TED Talk (2013) on what it is like to live with persistent and unwelcomed voices in her mind. She recounts not only what it was like to seek help for her first experience with mental illness but also her first encounter with a psychiatrist after succumbing to the persistent voices in her head. In hopes of acquiring help from a campus doctor, she welcomed his initial surprised curiosity because she “was desperate for interest and help” (Longden, 2013, t. 3:09).

Examples of selected applicable themes: Active/passive listening, autonomy, compassion/indifference, prognosis details said by mental health professional, psychoeducation.

Longden explains how she was then referred to another psychiatrist who had a negative and twisted view of how she actually reported her voices. The doctor's view of her voices stemmed from the fact that whatever she said, even if she was not conveying the messages of the voices in her head, he would distort what she said through his own interpretation. In order to illustrate the severity of the breakdown in communication between her and her doctor, Longden comments on how the psychiatrist received everything she said as “latent insanity.” One such example of the “latent insanity” was when she was communicating to her psychiatrist how she was part of the campus “TV station that broadcasted news bulletins around the campus and during the appointment that was running very late, I said, ‘Sorry, doctor, I have to go. I am reading the news at 6.’ I saw on my medical records that ‘Eleanor has delusions that she is a television news broadcaster’” (Longden, 2013, t. 4:20). Not only was her original statement of

circumstance lost in translation but it was also completely discarded as Longden’s version of truth and reality. Her acting psychiatrist at the time even went as far as say to her “Eleanor, you would be better off with cancer because cancer is easier to cure than schizophrenia. “I have been diagnosed, drugged, and discarded”” (Longden, 2013, t. 5:55).

Longden (2013) later worked with a doctor who believed recovery from schizophrenia was possible. She reiterated what he told her and her family: “Don’t give up hope. I believe Eleanor can get through this” (t. 7:02). In closing her TED Talk, she left the audience members with the following message: “An important question in psychiatry should not be what is wrong with you but rather what’s happened to you?” (Longden, 2013, t. 10:55).

Table 2

Longden (2013): *Helpful and Unhelpful Individual Therapy Components: Client’s Perspective*

Theme	Example
Active/Passive Listening	Unhelpful: Psychiatrist inaccurately listened to client explanation of needing to air news broadcast.
Autonomy	Unhelpful: Psychiatrist inaccurately processed the client explanation of needing to air news broadcast.
Compassion/Indifference	Unhelpful: “Eleanor, you would be better off with cancer because cancer is easier to cure than schizophrenia.”
Prognosis Details Said by Mental Health Professional	Unhelpful: “Eleanor, you would be better off with cancer because cancer is easier to cure than schizophrenia.”
Psychoeducation	Helpful: “An important question in psychiatry should not be what is wrong with you but rather what’s happened to you?”

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 3: Mackler, D. (2014). *Helpful and Unhelpful Individual Therapy*

Components: The Client’s Perspective.

New York City therapist Daniel Mackler (2014) published a candid documentary video titled *Take these Broken Wings: Recovery from Schizophrenia without Medication* which covers issues related to recovering from schizophrenia without the use of medications. More

specifically, it asked people who experience schizophrenia about what characteristics they find most useful in their helpers and mental health professionals to aid them in making their journey out of mental illness positive and effective. In the documentary, Mackler (2014) interviews myriad clinical professionals who specialize in schizophrenia treatment. Some of the specialists interviewed were well-known names such as Peter Breggin, Danielle Krafo, and Robert Whitaker. Mackler (2014) also interviewed two women, Catherine Penney and Joanne Greenberg, who generously let the public into their private lives and clarified what it means to experience schizophrenia from a recovery standpoint. The following information gathered from Mackler's (2014) documentary will incorporate testimony about both the helpful and the unhelpful components of one-on-one therapy. Knowledge was extracted from Penny's personal experience followed by Greenberg's familiarity with living life with a diagnosis of schizophrenia, as illustrated in a few examples below. (For a detailed list of effective and ineffective qualities of therapy used in this thesis, see Table 3 and Appendix D.)

Catherine Penney worked as a psychiatric nurse in California for over 30 years following her recovery from schizophrenia (Mackler, 2014). Penney describes several helpful and unhelpful characteristics themes of the mental health profession (see also Table 3). In addition to Penney candidly exploring the therapeutic relationship and the healing of schizophrenia symptoms, Joanne Greenberg offered a personal insight into what it is like living with schizophrenia and the characteristics of the helping profession that aided her on her wellness journey. Born in 1932 in Brooklyn, New York (Mackler, 2014, t. 6:46), Greenberg explained (as cited in Mackler, 2014, t. 6:46) that she received intense therapy from Dr. Frieda Fromm-Reichmann in 1948 and recovered from schizophrenia in the year 1958. Greenberg is the author of *I Never Promised You a Rose Garden*, one of 16 books she has published since she achieved

recovery from schizophrenia. The following information is applicable to helping those who suffer from schizophrenia either on an individual basis or in a group therapy format.

Examples of selected applicable themes: Autonomy, dignity and isolation prevention.

The first themes to be briefly discussed are autonomy and dignity. For both Penney and Greenberg, autonomy was an important aspect of their recovery. For instance, in Mackler's (2014) documentary, Greenberg emphasized how unhealthy it is for the doctor to talk over her to others as if she were not in the room. Not only is talking over a person contrary to the promotion of autonomy, it could also be seen as an incursion on their dignity. Another example of how autonomy is important in the recovery process was described by Penney: "I started to feel like somebody when her therapist would listen and talk about it" (Mackler, t. 39:46). In addition, she states, "The therapist and myself had an 'I, Thou' relationship. ... I was a human being. It wasn't [an] 'I, Thou' versus 'I, It' relationship" (Mackler, t. 40:16).

Whereas Penney talked about autonomy and dignity, Greenberg talked about the manner in which she and her therapist interacted with each other, which in turn fostered autonomy and dignity. Greenberg comments (as cited in Mackler, 2014, t. 39:50), "she never stripped me without my consent. ... She knew the difference between problems and symptoms, the difference between being creative and being crazy." In other words, Greenberg's therapist did not infuse the interaction with negative judgments about Greenberg's character and recognized strength in what Greenberg would consider weaknesses. The mere act of the therapist asking for Greenberg's permission before getting into the sensitive territory of the illness and about life's situations fostered autonomy and upheld dignity.

The next issue pertinent to this thesis is that isolation is another factor that can hinder progress in a person's recovery. It is to fuse anti-isolation solutions in the therapeutic

relationship as Penney (as cited in Mackler, 2014) stipulates, “the best thing my therapist said to me was, ‘Catherine, it is not good to isolate yourself’” (t. 46:00). She goes on to say, “the more I stayed in the room with the four other talkative women, the more and more the stuff in my head became less and I started becoming interested in the topics they were talking about” (Mackler, t. 46:39). According to Penney, “the greatest gift is wanting to be with people ... Really loving the contact with people ... Seeing the sacred in each one of us” (as cited in Mackler, 2014, t. 1:03:09–1:04:10).

Greenberg concurs with Penney on the importance of preventing isolation not only in life but also in therapeutic environments. Greenberg emphasizes the importance of acquiring friends with similar mental health issues in the hospital, and notes that she is still in contact with friends she made while in the hospital.

(For an overall perspective on the helpful and unhelpful qualities of therapy as reported by Penney and Greenberg, see Table 3 and Appendix D.)

Table 3

Mackler (April, 2014): Helpful and Unhelpful Individual Therapy Components: Client’s Perspective

Theme	Example
Active Listening	<ul style="list-style-type: none"> • Helpful: “She started to feel like somebody when her therapist would listen and talk about it.” • Helpful: “She kept saying take me along, take me along.”
Autonomy	<ul style="list-style-type: none"> • Unhelpful: Don’t talk about me like I’m not there or here. • Helpful: “She started to feel like somebody when her therapist would listen and talk about it.” • Helpful: “The therapist and myself had an ‘I, Thou’ relationship. ... I was a human being. It wasn’t [an] ‘I, Thou’ versus ‘I It’ relationship.” • Helpful: “Give yourself time.” • Helpful: “She never stripped me without my consent.”
Client Success of the Past	<ul style="list-style-type: none"> • Helpful: It’s important that the therapist plant a seed to

	<p>address what is under the delusion.</p> <ul style="list-style-type: none"> • Unhelpful: “What doesn’t help is dressing up the illness.” • Helpful: “Convalescence takes a hell of a long time”
Communication	<ul style="list-style-type: none"> • Unhelpful: Don’t talk about me like I’m not there or here. • Helpful: “Talk about curiosities around human existence.” • Helpful: “Talk about normal day-to-day things”. • Helpful: “She kept saying take me along, take me along.”
Compassion/Indifference	<ul style="list-style-type: none"> • Helpful: Self-compassion, “give yourself time.”
Dignity	<ul style="list-style-type: none"> • Unhelpful: Don’t talk about me like I’m not there or here. • Helpful: “She started to feel like somebody when her therapist would listen and talk about it.” • Helpful: “The therapist and myself had an ‘I, Thou’ relationship. ... I was a human being. It wasn’t [an] ‘I, Thou’ versus ‘I, It’ relationship” • Helpful: “Give yourself time.”
Identity	<ul style="list-style-type: none"> • Helpful: Understand that we are acquiring and assimilating a new identity.
Insight into Illness and Symptoms	-----
Isolation Prevention	<ul style="list-style-type: none"> • Unhelpful: It is not good to isolate yourself. • Helpful: Talking to people lessened the talk and stuff in my head. • Helpful: Friends are helpful and needed.
Medication Awareness	-----
Mental Health Professional’s Demeanour	-----
Mental Health Professional’s Knowledge	<ul style="list-style-type: none"> • Helpful: The therapist needs to have patience because healing and recovery could take a while. • Helpful: It’s important that the therapist plant a seed to address what is under the delusion • Helpful: “Challenge the psychosis” • Helpful: “Schizophrenia saved me from real-world trauma.” • Helpful: Often mental health helpers have not had the experience of mental illness and they need to be taught about it. • Helpful: Mental health helpers need to love the health and strength in the person. • Helpful: Know the “difference between problems and symptoms, the difference between being creative and being crazy.”
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	-----
Shared Meaning	-----

Support Group (External)	-----
Trauma	<ul style="list-style-type: none"> • Helpful: “Schizophrenia saved me from real-world trauma.”
Trust	<ul style="list-style-type: none"> • Helpful: Trust needs to be fostered. • Helpful: “She never stripped me without my consent.”

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 4: Mackler, D. (2014). *Helpful and Unhelpful Individual Therapy*

Components: The Client’s Perspective.

Mackler again investigates psychosis through the lens of his camera in his documentary titled *Healing Homes: Recovery from Psychosis without Medication*, released on April 8, 2014. Healing Homes is a Swedish program in which people who are experiencing psychosis are placed in a home, on a farm, with a caring family. The clients work on the farm, become part of the family, receive consistent mental health support, and get to raise their children in a loving and supportive environment. The family-care staff watches over the family and client and supports them every step of the way. The program also includes psychiatrists and other healthcare workers at hospitals. While Mackler (2014) was filming in Sweden, he met a young woman who gave a candid description of what it was like to be in this particular program.

Examples of selected applicable themes: Medication awareness, mental health professional’s demeanor.

The woman in the film, name unknown, made two comments that stand out in this video clip. First, she commented, “It’s not about the medication, it’s about the people” (Mackler, 2014, t. 9:56). In many cases, mental health professionals will be focused on administering medication for various symptoms while dismissing the person they are treating as a participant in their own well-being and environment. Second, she commented, “If the [therapist] does not have love

[they] cannot help people” (Mackler, 2014, t. 10:46). Due to the minimal information in this data resource, the information gathered will only be placed in Table 4 below.

Table 4

Mackler (April 2014): Helpful and Unhelpful Individual Therapy Components: Client’s Perspective

Theme	Example
Active Listening	-----
Autonomy	-----
Client Successes of the Past	-----
Communication	-----
Compassion/Indifference	-----
Dignity	-----
Identity	-----
Insight	-----
Isolation Prevention	-----
Medication Awareness	Helpful: “It’s not about the medication, it’s about the people.”
Mental Health Professional’s Demeanor	Unhelpful: “If the [therapist] does not have love [they] cannot help people.”
Mental Health Professional’s Knowledge	-----
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	-----
Shared Meaning	-----
Support Group (External)	-----
Trust	-----

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Research Data Containing Client Perspectives of what Constitutes Helpful and Unhelpful Combined Individual and Group Therapeutic Practice

Resource 5: Mead and Copeland (2000): Helpful and Unhelpful Individual and Group Therapy Components: The Client's Perspective.

In 2000, Shery Mead and her sister Mary Ellen Copeland published an article titled *What Recovery Means to Us: Consumers' Perspectives*. Mead was diagnosed with schizophrenia as an adolescent and was hospitalized in psychiatric units many times over the course of her life. Copeland, in attempts to understand and help her sister in her illness and recovery journey, would later become a psychotherapist and professor specializing in mental illness at Virginia State University. Although Copeland was not diagnosed with schizophrenia, she was still affected by mental illness with a diagnosis of manic depression. Alongside her sister, Copeland was determined that the characteristics of their severe mental illnesses would not define who they were. In other words, they were much more than their mental illnesses. According to the personal account of Mead and Copeland (2000), their severe mental illnesses did not mean that they did not have dreams and goals. As well, through their experience they had early awareness that they “are in charge of [their] own lives and can go forward and do whatever it is [they] want to do” (Mead and Copeland, 2000, p. 316).

Examples of selected applicable themes: Autonomy, mental health professional's knowledge and prognosis.

Through Mead's experience of schizophrenia, and through the experience of many other individuals living with a diagnosis of schizophrenia, the sisters compiled qualitative data on what is needed from the therapeutic profession and from loved ones in order to heal and recover from schizophrenia symptoms (Mead and Copeland, 2000). In accordance with upholding individual

autonomy, it is important to advocate for people to make their own choices about crisis and treatment plans, medication, and medication side effects; informed consent; having access to personal records, relationships, and spiritual practices and upholding “dignity, respect, and compassion” (Mead and Copeland, 2000, p. 319). Mead and Copeland (2000) say that “we need to be fully supported in taking the steps toward re-creating our own sense of self and be challenged to continue to grow” (p. 321). Additionally, “we need a caring environment without feeling the need to be taken care of” (Mead and Copeland, 2000, p. 317). When in a helping alliance with a person who has schizophrenia, it is important to keep in mind that the majority of individuals believe that “it is not up to the provider to determine when a person is ready to make progress—it is up to the person” (Mead and Copeland, 2000, p. 322). More importantly, we understand that “we want to be respected by healthcare professionals for having these fears and for sometimes choosing not to use medications that are compromising the quality of our lives” (Mead and Copeland, 2000, p. 324).

Overall, Mead and Copeland state (2000),

It must be recognized that risk is inherent in the experience of life. It is up to us to make choices about how we will live our lives; it is not up to the healthcare professionals to protect us from the real world. We need healthcare professionals to believe that we are capable of taking risks and to support us as we take them. (p. 325)

They add that we should “recognize strengths and even the smallest bit of progress without being paternalistic ...[and] accept that a person’s life path is up to them” (Mead and Copeland, 2000, p. 327).

In addition to understanding the apparent risks that go with a diagnosis of schizophrenia or related schizophrenia spectrum illnesses, and respecting client autonomy, Mead and Copeland

(2000) believe mental health professionals can become involved in not only the client's growth but also their own growth during the process of helping. They put forth the following recommendations with a view to fostering growth in the mental health professional and increasing their knowledge base:

How much of our own discomfort are we willing to sit with while someone is trying out new choices? (Mead and Copeland, 2000, p. 320)

How are our boundaries continuously being redefined as we struggle to deepen each individual relationship? (Mead and Copeland, 2000, p. 320)

What are the assumptions we have about this person, by virtue of his/her diagnoses, history, and lifestyle? "... how can we put aside our assumptions and predictions in order to before we present to the situation and open to the possibility for the other person to do the same? (Mead and Copeland, 2000, p. 320)

What are the barriers that might prevent both of us from stretching and growing? (Mead and Copeland, 2000, p. 320)

Mead and Copeland (2000) go on to say:

A truly supportive therapeutic relationship begins with honesty and a willingness to take a critical look at assumptions learned during training. Clinical support, in a recovery environment, means at the same time that clinicians attempt to take care of a person, they also hold the person accountable for his or her behaviour and believe in the ability to change. ... As part of our support system, healthcare professionals need to continue to examine their own roadblocks to change, understand where they get "stuck" and dependent, and look at their own less-than-healthy ways of coping. Healthcare professionals need to relate to us that they have their own struggles and own that change is

hard for all. They need to look at our willingness to “recover” and not perpetuate the myth that there is a big difference between themselves and people they work with. (p. 320)

Finally, in regard to the theme of how mental health professionals communicate prognosis details, Mead and Copeland (2000) state, “we don’t need dire predictions about the course of our symptoms— Something that no one else, regardless of their credentials, can never know” (p. 317). “Focus on how the person feels, what the person is experiencing, and what the person wants rather than on a diagnosis, labeling, and predictions about the course of the person’s life” (p. 327).

Mead and Copeland (2000) also believe support groups can be a healing factor in the treatment of schizophrenia symptoms and indeed beneficial for mental health. In addition, when a person is in a support group environment, “people in the relationship[s] strive to use the relation[s] to become fuller, richer human beings ... [And] support works best when both people are willing to grow and change” (p. 319).

Table 5

Mead and Copeland (2000): Helpful and Unhelpful Individual and Group Therapy Components: Client’s Perspective.

Theme	Examples
Active Listening	-----
Autonomy	<ul style="list-style-type: none"> • Helpful: “We need a caring environment without feeling the need to be taken care of.” • Helpful: Medication choices. • Helpful: Informed consent. • Helpful: Crisis plans. • Helpful: Treatment plans. • Helpful: Spiritual choices. • Helpful: Life choices.
Client Successes of the	<ul style="list-style-type: none"> • Helpful: Look to the past for what has been helpful

Past	in our treatment.
Communication	-----
Compassion/Indifference	<ul style="list-style-type: none"> • Helpful: “We need assistance, encouragement, and support ...”
Dignity	<ul style="list-style-type: none"> • Helpful: Treat client as an equal. • Helpful: Promote self-worth
Identity	-----
Insight	-----
Isolation prevention	-----
Medication Awareness	-----
Mental Health Professional’s Demeanor	-----
Mental Health Professional Knowledge	<ul style="list-style-type: none"> • Helpful: Challenge dominant discourse. • Helpful: Ever-expanding knowledge acquisition about self and client. • Helpful: Examine barriers to health and well-being for self and client.
Prognosis Details Said by Mental Health Professional	<ul style="list-style-type: none"> • Unhelpful: “We don’t need dire predictions about the course of our symptoms.”
Psychoeducation	<ul style="list-style-type: none"> • Helpful: Education tailored to the individual and their uniqueness.
Shared Meaning	-----
Support Groups	<ul style="list-style-type: none"> • Helpful: Encourage and implement a variety of support groups, including peer support. • Helpful: Encourage client collaboration.
Trust	-----

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 6: McLean (2003). Helpful and Unhelpful Individual and Group Therapy

Components: The Client’s Perspective

Richard McLean (2003) wrote and published an eBook on what it is like to live with a diagnosis of schizophrenia. McLean (2003) attended both individual and group talk therapy as part of his treatment regimen to lessen the stronghold schizophrenia had on his mind, body, and soul. He notes that there are stresses in attending group therapy and gives a first-hand example of how he responded to a group therapy environment: “I seem to speak well one on one, but in

group situations I found it hard to follow conversation, and always read extra meanings aimed at me. I still sometimes feel like this. I chose to keep to myself” (p. 170). McLean (2003) made it quite clear that he found face-to-face group therapy unhelpful.

In contrast, he found individual talk therapy and online support forums to be especially crucial and helpful in his wellness journey. The following information provides some insight into what McLean (2003) found helpful and is applicable to this thesis.

Examples of selected applicable themes: Identity, external support groups, and trust.

The McLean (2003) resource was rich in informative data that was relevant to the purpose of this thesis. (For a comprehensive description of the pertinent data used in this thesis see Tables 6 and 7, and Appendix E.) Drawing from the rich information McLean (2003) shares in his autobiography on living with the illness of schizophrenia, I will briefly discuss the themes of identity, external support groups, and issues around trust. McLean (2003) has struggled with his identity in many ways for his entire life. Not only did he struggle to maintain his identity before the symptoms of schizophrenia emerged, but he also had to adapt to the new identity of someone with a severe mental illness. It did not stop at adapting his identity with schizophrenia symptoms he also had to merge the new identity with the old because there were some aspects of the schizophrenia identity he did not want to let go of and some aspects he would have to live with. The following explanation from McLean (2003) can shed light on the complex issue of changes of identity. He states, “years later I have met people who are running from treatment because their idea of being mentally ill is such a part of who they are that they don’t know any alternative. It is hard to give up the idea of who you are” (McLean, 2003, p. 102).

McLean (2003) goes on to explain the shame and guilt that can consume an individual when they require a new identity:

[D]uring the past 10 years I made a terrible mistake (twice) of thinking I was well and stopped taking my medication. I got sick again and was hospitalized. I didn't want to think that I had schizophrenia. I have to confess that I am not over the shame I feel. It's not something I can talk to people about so I feel I have a dirty little secret. It affects my relationships with women, as I can't tell them of the shame I feel. I probably seem weak but I really want to be accepted by people for what I am (which includes having schizophrenia) (p. 207).

Additionally, McLean (2003) talks about how the new identity of being someone with schizophrenia is not all centred on an entirely negative experience. He explains that, talking to a friend who also has schizophrenia, I decided it was a beneficial experience in many respects. We have learned humility, are open to a lot more ideas, and have a respect for reason. We also know how lucky we are to live in the age of medication. Our psychoses have revealed parts of us we might never otherwise have integrated. (pp. 219-220)

Lastly, McLean (2003) informs his readers, psychosis becomes the new normal

McLean (2003) is staunchly in favour of support groups for a person coping with and learning from the new normal of psychosis. He is in favour of support groups not only in the form of traditional professional mental health support groups, but also Internet support networks and support groups such as Alcoholics Anonymous for substance misuse problems. McLean (2003) emphasizes that "the Internet provides great resources, support and freedom for its users" (p. 123). He later goes on to say, "good support networks are also critical" (McLean, 2003, p. 214), especially for finding like-minded individuals who are free from alcohol or street drugs. He states that, when remodelling one's life it is more about learning to adapt to the demands

imposed by the symptoms, it is important not only to find support/group therapy environments to help with addictions, but also to attend them alcohol- and drug-free. Remaining substance-free is not only for their own sake but also for the sake of others who are seeking help.

The final theme discussed from the McLean (2003) is about the value of trust when helping someone who is experiencing schizophrenia. On the issue of trust with his psychiatrist, McLean (2003) reports,

it was a leap of faith to confide in him, I had in mind he was the enemy. In the back of my mind I thought the meeting serve two purposes: to talk to him honestly, and to show the conspirers what pain they were causing—it might make them call the whole thing off. I thought he might confide in me either way (p.188).

McLean (2003) also stresses,

I have had mistrust of my psychiatrist—this is very difficult because she/he is the one person who can help you. I started to think that he was in on the whole conspiracy against me. It was awful, because really he's a sweetie. I have also thought that my psychiatrist was recording me, or that people were listening in on our conversations. I told him that I was having these thoughts and it helps to know that he knows somehow. (p. 193)

Overall, sometimes it can take months for trust to be built, sometimes it is never built at all. McLean (2003) comments, “as the weeks passed, I started to trust that Dr. X really was trying to help” (p. 197). He leaves the reader with an important piece of information aimed at those mental health professionals designing group therapies: When designing support/group therapy for individuals suffering from schizophrenia, it is important to recognize that sometimes

it takes months before enough trust is built and the individual decides to attend the support/group therapy.

Table 6

McLean (2003): *Helpful and Unhelpful Individual Therapy Components: Client's Perspective*

Theme	Example
Active Listening	<ul style="list-style-type: none"> • Helpful: "He asked me to elaborate" about my story. • Unhelpful: "He was friendly but I got the impression that he was leading me away from the story I wanted to tell him."
Autonomy	<ul style="list-style-type: none"> • Helpful: "Stand up to your fears." • Unhelpful: "We are our own worst enemies."
Client Success of the Past	<ul style="list-style-type: none"> • Helpful: "They were mostly 'messages' from auditory hallucinations, and I put them down and diagrams to help make sense of my distorted perceptions." • Helpful: Don't "wait until a person hit hits rock-bottom before getting help."
Communication	<ul style="list-style-type: none"> • Helpful: "I don't know what to do. Please, please help." • Helpful: Be honest when telling your story to mental health professionals. • Unhelpful: "I felt as if I could not concentrate." • Unhelpful: "I felt emotionally flat, and talking about my experiences and ideas out loud made them seem ridiculous."
Compassion/Indifference	<ul style="list-style-type: none"> • Helpful: "He asked me to elaborate" about my story. • Helpful: "I told him that I was having these thoughts and it helps to know that he knows somehow."
Dignity	<ul style="list-style-type: none"> • Unhelpful: "I am not over the shame I feel." • Unhelpful: "The illness of schizophrenia "not only destroy[s] ... dignity but also life."
Identity	<ul style="list-style-type: none"> • Helpful: "It is hard to give up the idea of who you are." • Unhelpful: "I didn't want to think that I had schizophrenia." • Helpful: "My psychosis developed so gradually and affected my reason to such a degree that I didn't see it, and I didn't know anyone else who had suffered similar delusions." • Helpful: "Our psychoses have revealed parts of us we might never otherwise have integrated." • Helpful: "It hard for someone who is psychotic to engage in things that might be commonplace for others."

Insight	<ul style="list-style-type: none"> • Helpful: “It’s vital for others to show insight.” • Helpful: “Can you offer me some advice or even just a little bit of hope.” • Helpful: “Insight” and awareness are dynamic, one day they are present and the next day they are covered up.
Isolation Prevention	<ul style="list-style-type: none"> • Helpful: “I probably seem weak but I really want to be accepted by people for what I am (which includes having schizophrenia).” • Helpful: “If such things had been talked about more openly, I might not have felt so alone, and I might have recognized symptoms in myself.”
Medication Awareness	<ul style="list-style-type: none"> • Helpful: “We also know how lucky we are to live in the age of medication.” • Unhelpful: “I made a terrible mistake (twice) of thinking I was well and stopped taking my medication.” • Unhelpful: Medication alone is not offering help.
Mental Health Professional’s Demeanor	-----
Mental Health Professional’s Knowledge	<ul style="list-style-type: none"> • Unhelpful: “Doctors were not that well-versed in psychiatry.” • Helpful: “The world can speak to the psychotic person in many ways throughout analogies, metaphor or symbols.”
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	<ul style="list-style-type: none"> • Unhelpful: “I didn’t even know the difference between psychology and psychiatry at that point.” • Helpful: “Suffering could be prevented if the general public’s awareness of mental illness was greater.” • Helpful: “The world can speak to the psychotic person in many ways throughout analogies, metaphor or symbols.”
Shared Meaning	-----
Support Group (External)	<ul style="list-style-type: none"> • Helpful: “MSN Schizophrenia Web Community, a wonderful resource and support.” • Helpful: “The internet provides great resources, support and freedom for its users.” • Unhelpful: “Many people who have been diagnosed with schizophrenia in Canada are left without an acting psychiatrist due to the unavailability in the profession.”
Trust	<ul style="list-style-type: none"> • Helpful: “It took me months to get to a point where I knew I had to seek treatment, and more months before I penetrated the medical System to get the help I needed.” • Helpful: “It was a leap of faith to confide in him, I had in mind he was the enemy.” • Helpful: “As the weeks passed, I started to trust.”

	<ul style="list-style-type: none"> • Helpful: He would hurt himself but would not report it to either his parents, psychiatrist or social worker because he was afraid they would be upset with him. • Unhelpful: “I have had mis-trust of my psychiatrist—this is very difficult because she/he is the one person who can help you.”
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Note: Dashed line (-----) means there was no available data to record for that particular theme.

Table 7

McLean (2003): *Helpful and Unhelpful Group Therapy Components: Client's Perspective*

Theme	Example
Active Listening	-----
Autonomy	-----
Client Success of the Past	<ul style="list-style-type: none"> • Helpful: It is important for group to be alcohol and drug-free.
Communication	<ul style="list-style-type: none"> • Unhelpful: “I found it hard to follow conversation.... and always read extra meanings aimed at me.”
Compassion/Indifference	-----
Dignity	-----
Identity	-----
Insight	-----
Isolation Prevention, Duration	<ul style="list-style-type: none"> • Helpful: Sometimes it takes months before enough trust is built and the individual decides to attend the support/group therapy • Unhelpful: “I don't feel safe on my own but when around others I freak out.”
Medication Awareness	-----
Mental Health Professional's Demeanor	-----
Mental Health Professional's Knowledge	-----
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	-----
Shared Meaning	<ul style="list-style-type: none"> • Unhelpful: “Always read extra meanings aimed at me.”
Support Group (External)	<ul style="list-style-type: none"> • Helpful: Substance mis-use programs.
Trust	-----

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 6: Morgan (2013). Helpful and Unhelpful Individual Therapy Components: The Client's Perspective.

The next resource utilized in this thesis is an autobiography by Kristina Morgan. Morgan is a young woman who was diagnosed at a young age with schizophrenia. In her book, she shares her personal journey through her detailed journal entries. One of her first observations on the mental health profession was made at the age of 15 and concerned how mental health professionals discounted her as a human being.

Examples of selected applicable themes: Autonomy, medication awareness, trust, dignity, prognosis details and support group(s) external.

On what was to become many doctor/hospital visits brought on by psychosis and/or substance misuse, Morgan's mother took her in out of concern. According to Morgan (2013) in one situation they arrived at the doctor's office and the doctor began examining Morgan and talking directly to her mother while inadvertently ignoring the opinion, concern, or experience of Morgan. Morgan (2013) reports, "the doctor ... never asks me what is wrong" (p. 29). In addition to not being addressed personally about how she might be feeling, she says that it was not helpful that her mother and doctor talked over her as if she were not in the room. In this case, Morgan's autonomy was not acknowledged or respected by her mother or the physician caring for her (Morgan, 2013).

Morgan (2013) also talks about how terrified she was of medication. This fear stemmed from the effects that past medications had had on her mind. In Morgan's words, she had experienced "medication that would mess with my mind" (2013, p. 56). Medication has been reported on many occasions to be a significant reason why people are not truthful about the positive or the negative symptoms they are experiencing. In Morgan's case, she did not want to

fully disclose her symptoms to mental health professionals because she had found that sometimes a mind clouded with medication is a worse experience than a mind filled with hallucinations and delusions (Morgan, 2013). Ezzo Leete would concur with Morgan in that “unfortunately the side effects of antipsychotic medications can often become more disabling than the illnesses themselves” (as cited in Torrey, 2006, p. 294). Morgan (2013) candidly expresses how medication can “take your real mind away and make into something else” (p. 56). The importance of Morgan’s statements for mental health professionals might be to not mention the use of medication until absolutely necessary, and to be aware that, when in an individual or group therapy session, clients might not be giving the full story of their illness.

Morgan (2013) was also reluctant to talk with her doctor about her experience with hallucinations and delusions. She explains that, when she first met a clinical counsellor, she disclosed many aspects of her life but “mention[ed] nothing about hearing voices. I didn’t want to give it up. I thought it was really none of her damn business” (p. 118). Although people with schizophrenia are usually attending therapy for symptoms of schizophrenia—at least initially—that is not necessarily what they want to talk about. In Morgan’s case, she wanted to start the session by talking about her family. When the therapist accepted the idea of not pursuing the topic of Morgan’s symptoms, the therapy process was accepted by Morgan. In other words, the therapist followed Morgan’s lead, which in turn fostered Morgan’s autonomy (Morgan, 2013).

Furthermore, Morgan (2013) talks about her experience with psychodrama played out in one of her group therapy sessions. The short version of her narrative is that she did not appreciate what psychodrama offered her. She reports how the emotions shared with the group were just too much for her to handle, to the point where she had to leave the group therapy session halfway through. What specifically made her unable to tolerate the group psychotherapy

session was that “the staff would push the patient into reliving past horrors, like sexual abuse” (Morgan, 2013, p. 63).

Another incident Morgan found unhelpful for her well-being was when one doctor told her father she “would be in and out of institutions for the rest of [her] life” (2013, p. 64). These types of definitive statements can leave a person feeling helpless, hopeless, and discouraged about life in general. For Morgan (2013), mental health workers have the ability to remove a person’s dignity, and she openly states, “My voice is one of the things that is still mine. The hospital stole my dignity” (Morgan, 2013, p. 67). Also, when a mental health professional is in either an individual or a group therapy setting, it is not helpful to attack the family of the person who is living with schizophrenia, even subtly. On one occasion, Morgan’s father was verbally attacked by a mental health professional, and Morgan responded accordingly, she got angry and lost respect for the doctor (Morgan, 2013). “The doctor in Phoenix subtly attacked my father one too many times, insinuating that he had something to do with my emotional problems” (Morgan, 2013, p. 70). As a result, Morgan’s father was furious and they ended up attending only two therapy sessions together (Morgan, 2013).

Morgan (2013) shared in her book how sometimes she talks unintelligible and irrational at group meetings and will exhibit what many consider to be bizarre behaviour in attempting to deal with her hallucinations. For instance, in one group session, she told “the members of the group that [her] clock was talking to [her], so [she] threw it against the wall to stop it” (Morgan, 2013, p. 73). There is one more important aspect of group work that Morgan mentions in her book and that is how she was able to keep her sobriety from alcohol by belonging to the cohesive AA group at her church (Morgan, 2013). Often alcoholism goes hand-in-hand with

schizophrenia; it is one way to try to deal with an altered reality in the form of hallucinations and delusions, social exclusion, and the impact of illness-associated stigma.

Table 8

Morgan (2013): Helpful and Unhelpful Individual Therapy Components: Client's Perspective

Theme	Examples
Active Listening	-----
Autonomy	<ul style="list-style-type: none"> • Helpful: “Mention nothing about hearing voices... I don’t want to give it up.” • Helpful: I might want to talk about my family versus the symptoms. • Helpful: “My voice is one of the things that is still mine.” • Unhelpful: Discounted as a human being. • Unhelpful: “The doctor ... never asks me what is wrong.” • Unhelpful: Doctor and mother talked over her.
Client Successes of the Past	-----
Communication	-----
Compassion/Indifference	-----
Dignity	<ul style="list-style-type: none"> • Unhelpful: “The hospital stole my dignity.”
Identity	-----
Insight	-----
Isolation prevention	-----
Medications Awareness	<ul style="list-style-type: none"> • Unhelpful: A mind clouded with medication is worse than experiencing hallucinations. • Unhelpful: Medication can take your mind away.
Mental Health professional’s Demeanor	-----
Mental Health Professional’s Knowledge	-----
Prognosis Details Said by Mental Health Professional	<ul style="list-style-type: none"> • Unhelpful: Doctor said Morgan “would be in and out of institutions for the rest of her life.”
Psychoeducation	-----
Shared Meaning	-----
Support Group (External)	-----
Trust	-----

Note: Dashed line -----means there was no available data to record for that particular theme.

Table 9

Morgan (2013): Helpful and Unhelpful Group Therapeutic Components: Client's Perspective

Theme	Examples
Active Listening	-----
Autonomy	<ul style="list-style-type: none"> • Helpful: Sharing emotions was too difficult and Morgan left the session halfway through.
Client Successes of the Past	-----
Communication	-----
Compassion/Indifference	-----
Dignity	-----
Identity	-----
Insight Towards Symptoms & Illness	Helpful & Unhelpful: “[her] clock was talking to [her], so [she] threw it against the wall to stop it.”
Isolation prevention	-----
Medications Awareness	-----
Mental Health professional's Demeanor	<ul style="list-style-type: none"> • Unhelpful: “Staff would push the patient into reliving past horrors.”
Mental Health Professional's Knowledge	-----
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	-----
Shared Meaning	-----
Support Group (External)	<ul style="list-style-type: none"> • Helpful: Morgan was able to maintain her sobriety by regularly attending AA meetings.
Trust	-----

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Research Data Containing Client Perspectives of what Constitutes Helpful and Unhelpful Group Therapeutic Practice

Resource 7: Sigman and Hassan (2006). Helpful and Unhelpful Group Therapy Components: The Client's Perspective.

Sigman and Hassan (2006) investigated the benefits of long-term group therapy with individuals with schizophrenia in a seven-year longitudinal study. For their research, Sigman and Hassan (2006) recruited 66 participants who were considered to be low-functioning adults due to mental illness and who were suffering from schizophrenia, schizoaffective disorder, or bipolar illness. All participants had to have occurrences with psychotic features such as hallucinations or delusions. Mental health professionals considered most participants as not functioning at a “normal” level and most members exhibited cognitive impairment. Additionally, all participants were on pharmacotherapy in attempts to treat/control schizophrenia and/or schizoaffective and bipolar illness symptomology.

The intentions of Sigman and Hassan (2006) were to carefully explain the purpose of the group in addition to their hypotheses. The group purpose was to provide structure to participants by providing “a consistent time and place each week—noon on Thursdays—where individuals suffering severe and chronic mental illness can come together to talk about whatever they choose, or to simply be together for 45 minutes” (Sigman and Hassan, 2006, p. 273). As for their hypotheses, the structures of the group in and of itself would afford participants an opportunity to increase interpersonal skills. Group meetings never had an agenda or plan in place. Part of the “no agenda” purpose was to strengthen the relationships between the individual participants who, as a result of living with a psychosis-based illness, had a propensity to isolate themselves from the rest of society. The isolation characteristic familiar to

schizophrenia was present in most of the participants. Participants and researchers on average spent a total of “308 weekly sessions from January 1999 to December 2005” (Sigman and Hassan, 2006, p. 275) together in group sessions.

Examples of selected applicable themes: Active listening, Shared meaning, and trust,

Results from the Sigman and Hassan’s (2006) study suggest there are certain characteristics that can aid effectual group therapy sessions. First, in this case, active listening was valued. In addition, group therapy afforded the participants an understanding that they do not have to endure their illness alone. More importantly, having others around to just listen is beneficial for people experiencing psychosis. “As Brett told the group recently: ‘An ear to listen is better than a person telling you what to do’” (as cited in Sigman and Hassan, 2006, p. 280).

Paul (alias), one of the research participants cited in Sigman and Hassan (2006), reports, “it helps to know others have the same issue with sisters” (p. 276). This comment demonstrates how one individual can connect with other individuals in realizing their issue is not isolated, that other people have similar experiences. Shared meaning within the group setting is beneficial for the individual, giving them a chance to view themselves as part of a larger context.

Both the researchers and participants agreed not to tape-record the sessions because that might have hindered trust and comfort within the group. In many cases when there is psychosis present, individuals can also experience paranoia. Paranoia belongs to the positive symptom of delusions in the category of psychosis and, according to Mueser and Gingerich (1994), can present to the client as someone from the outside—often an organization like the FBI or CIA—gathering information via surveillance in order to use it against the individual at a later date.

Overall, Sigman and Hassan (2006) believe that group therapy affords the attending individuals the therapeutic space to grow and develop through other people’s experiences and

social inclusion. Also, group therapy affords “the development of humor, insight, support, and engagement occurs over time and that each member, given enough time and support, can increase his or her own level of maturation and functioning” (Sigman and Hassan, 2006, p. 280).

Table 10 illustrates condensed data as it pertains to effectual group therapy as declared by the clients who utilize group therapy as a means of enhancing quality of life.

Table 10

Sigman and Hassan (2006): Effective Group Therapy Components: Client’s Perspective

Theme	Examples
Active Listening	Helpful: A person listening is better than someone telling you what to do.
Autonomy	-----
Client Successes of the Past	-----
Communication	-----
Compassion/Indifference	-----
Dignity	-----
Identity	-----
Insight	-----
Isolation prevention	• Helpful: Group therapy counteracts isolation.
Medication Awareness	-----
Mental Health Professional’s Demeanor	-----
Mental Health Professional Knowledge	-----
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	-----
Shared Meaning	• Helpful: Other people diagnosed with schizophrenia experience similar family problems.
Support Groups	-----
Trust	• Helpful: Researchers and clients agreed there would be no audio or visual recording.

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 8: Spiro-Wagner and Spiro's (2006) Helpful and Unhelpful Group Therapy Components: The Client's Perspective

Although this next section of data is short, it still holds valuable insight into what is helpful and unhelpful when someone diagnosed with schizophrenia is experiencing group therapy. Additionally, the available information of what constitutes effective versus ineffective therapy is lacking, therefore this resource lends to the evidence strengthening this thesis. In an autobiographical narrative, twins Pamela Spiro-Wagner and Caroline Spiro (2006) recount what it is like living in a reality touched by the diagnosis of schizophrenia. Spiro-Wagner was diagnosed with schizophrenia, and her twin sister experienced the illness second-hand through her. Although they do not go into too much detail about individual or group therapeutic help, they do offer valuable insight into the shared meaning that group therapy can afford (see Table 11). In their experience, attending members who often experience parallel symptoms can discuss them with each other. In addition, Spiro-Wagner and Spiro (2006) notes, members can voice and share the confusion that often accompanies communication.

Table 11

Spiro-Wagner and Spiro (2006): Effective Group Therapy Components: Client's Perspective

Theme	Example
Shared Meaning	Members can share parallel symptoms and confusion.

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Resource 9: Goodliffe, Hayward, Brown, Turton, and Dannahy (2010.) Helpful and Unhelpful Group Therapy Components: The Client's Perspective.

British researchers Goodliffe, Hayward, Brown, Turton, and Dannahy (2010) conducted a qualitative study utilizing grounded theory principles to obtain clients' perspectives on how they experienced group therapy based on person-based cognitive therapy (PBCT). The hearing of voices component was determined by the criteria in the ICD-10 classification of schizophrenia or schizoaffective disorder (see Appendix B). Additionally, participants of this study had to have been determined as having medication-resistant symptoms but receiving standard psychiatric care. Participants were not excluded if taking medication or experimenting with medication under medical guidance. After receiving an average of eight sessions of group-based PBCT, the participants were asked to attend focus groups consisting only of people who were part of their original group therapy. Each focus group discussion was on average 90 minutes in length and consisted of three to five participants per focus group. The emphasis of the focus group was to discuss five main areas, according to Goodliffe et al (2010):

1. The circumstance(s) that prompted them to join the therapy group.
2. Their expectations of therapy and how this contrasted with their actual experience.
3. Their understanding of the therapeutic process.
4. Their perspectives of the formation of relationships among group members and with the facilitators.
5. Their current well-being following therapy (p. 449).

Examples of selected applicable themes: Isolation prevention and shared meaning.

After categorically sorting the data received from the focus groups, the researchers gained the following insight from 18 participants on their experience of this particular (PBCT) group therapy as it pertains to the research question of this thesis—that is, the effective/helpful and ineffective/unhelpful components of group therapy. According to Goodliffe et al. (2010), participants reported the following in regards to sharing experiences of voices and developing group identity, coping skills, and a sense of self other than being identified only as a voice hearer. (For a comprehensive look at the results from this study, see Appendix G.) In regards to social support, one participant explained, “When I first started getting voices ... I felt so isolated because there was no one I could talk to. I didn’t know what was happening to me, and I thought I was going crazy” (Goodliffe et al., 2010, p. 450). This point has direct implications in regards to the purpose of this thesis. As with other studies examined in this thesis, shared experience and isolation avoidance are two important factors contributing to a person’s quality of life when faced with schizophrenia. The issue of social inclusion was also touched upon by another participant:

It was good because you didn’t feel isolated. Which I had been four years—I felt really isolated I had no idea of other people suffering, and it made it better for me because I would, sort of, relate to them. (Goodliffe, et al., 2010, p. 453)

In regards to shared meaning, one participant commented, “I’ve never met anyone else who is a schizophrenic. You just think they’re mad and don’t want to be associated with them anyway” (Goodliffe, et al., 2010, p. 452). Additionally, when it came to developing a group identity, it was reported by one participant that group therapy afforded her the sense that she was not alone with her illness. Normalization and validation was “what I found most helpful, was

you lot being the same as me. That's what I found most comforting" (Goodliffe, et al., 2010, p. 453). Moreover, in the realm of normalizing the illness and shared meaning about the symptoms, one person said "I'm just surprised that everyone was so normal [...] I thought if they seemed all right, they looked, you know, normal, perhaps I did as well" (Goodliffe, et al., 2010, p. 453). The final comment, which proved particularly enlightening for this thesis topic of effective group therapy, was

It wasn't until we were in the group that we started to realize that you haven't done anything bad. You know? At all of them were saying, "yeah, well, I must've done something to make me have these voices" [...]. We can't all be evil. We can't all be wrong. (Goodliffe, et al., 2010, p. 456)

Table 12

Goodliffe, Hayward, Brown, Turton and Dannahy (2010): Helpful and Unhelpful Group Therapeutic Components: Client's Perspective

Theme	Example
Active Listening	-----
Autonomy	<ul style="list-style-type: none"> • Helpful: "I wasn't expecting to be able to cope with the voice still there. I wasn't expecting to, just be in control. I was expecting to either have to voice our not have to voice." • Helpful: "I learned that ... it was still my will that overcame the voice that was extremely powerful. I still was more powerful than the voice at the end of the day." • Helpful: "It wasn't until we were in the group that we started to realize that you haven't done anything bad."
Client Success of the Past	-----
Communication	-----
Compassion/Indifference	-----
Dignity	<ul style="list-style-type: none"> • Helpful: "I am not the illness. I am a person with a certain illness."
Identity	<ul style="list-style-type: none"> • Unhelpful: "I've never met anyone else who is a schizophrenic."
Insight Towards Illness and Symptoms	<ul style="list-style-type: none"> • Helpful: "I just thought, well, anything might help, anything. Any type of therapy or psychology or talk might

	<p>help.”</p> <ul style="list-style-type: none"> • Helpful: “Coming here [group therapy] my stress went down.” • Helpful: “We can’t all be evil. We can’t all be wrong.”
Isolation Prevention	<ul style="list-style-type: none"> • Unhelpful: “When I first started getting voices ... I felt so isolated because there was no one I could talk to.” • Helpful: “It was good because you didn’t feel isolated.” • Unhelpful: “[The voices] make me lose self-esteem and self-confidence, and they even get the point sometimes when I don’t want to walk out of the front of the flats, be anywhere near any people.” • Helpful: “We went to a club, for the first time in about 10 years ... I wouldn’t have done that had I not come to this group.”
Medication Awareness	-----
Mental Health Professional’s Demeanor	-----
Mental Health Professional’s Knowledge	-----
Prognosis Details Said by Mental Health Professional	-----
Psychoeducation	<ul style="list-style-type: none"> • Helpful: “That’s why they group has been so good, because there is a bit of ... this and what you can try, or you can do, whereas before you were on your own.” • Helpful: “I found it very hard to understand why I couldn’t stop [the voices] if it was me doing them. And the groups helped me understand that, yes, it is me, but also it’s not really me, it’s my mind.”
Shared Meaning	<ul style="list-style-type: none"> • Helpful: “I had no idea of other people suffering, and it made it better for me because I would, sort of, relate to them.” • Helpful: “What I found most helpful was you lot being the same as me. That’s what I found most comforting.” • Helpful: “I’m just surprised that everyone was so normal ... I thought if they seemed all right, they looked, you know, normal, perhaps I did as well.” •
Support Group (External)	-----
Trust	<ul style="list-style-type: none"> • Helpful: “Whereas with this group you know how many there are all the time. You get to know each other as well.”

Note: Dashed line (-----) means there was no available data to record for that particular theme.

**Resource 10: Hanley (2015). Helpful and Unhelpful Group Therapy Components:
Client's Perspective**

An altered reality experienced by people diagnosed with schizophrenia is something therapists can remain aware of when in an individual or group therapeutic setting. Like Kristina Morgan, Dominic Hanley (2015) reports the difficulties that arise from attempting to keep hallucinations and delusions under control. One way to address the intrusiveness of an altered state is to have a structured, routine life. Hanley (2015) explains that

The routine of playing sport, learning, and socializing at specific times on specific days were the structures of my life. Yes, I embraced this life and did so willingly, but once these routines no longer existed, I was left behind. (p. 1)

From this testimony, it appears that the concept of routine plays a large role in maintaining stability. The stability of structure within a group or individual therapeutic session could also play a part in someone's well-being and mental health. For example, therapists could always have group sessions at the same time on the same day, ensuring that sessions are also all of the same duration.

In addition to noting the importance of routine, Hanley (2015) says that the anxiety he experienced from a plethora of things caused him great discomfort. For example, when Hanley was hospitalized, he was told he had drug-induced psychosis, which later developed into schizophrenia. This, combined with the doctors saying he might never recover, produced great anxiety in him. "The anxiety was overwhelming to the point where I had to take part in the activities in hospital just to keep my mind distracted" (Hanley, 2015, p. 3). In keeping with the theme of this thesis, the statements by Hanley (2015) coincide with the importance of socialization and activity distraction when attempting to balance what is perceived as "normal"

reality versus an altered reality. Even though Hanley (2015) was partaking in activities in a therapeutic group environment, he reports how anxious he felt about the prospect of having to talk to the other participants. This aspect of group work is important to keep in mind when one of the participants in a group or individual therapy session is not speaking. Hanley (2015) did not want to speak with other patients because he did not want to get into a detailed account of his illness until he could sort through new ways of having to exist in the world. He was held back by fear (Hanley, 2015).

Table 13

Hanley (2015): Helpful and Unhelpful Group Therapeutic Components: Client's Perspective

Theme	Example
Active Listening	
Autonomy	
Client Success of the Past	<ul style="list-style-type: none"> • Helpful: It is important to have a structured daily life. • Helpful: "Once these routines no longer existed, I was left behind." • Helpful: "I had to take part in the activities in hospital just to keep my mind distracted."
Communication	<ul style="list-style-type: none"> • Helpful: He reports how anxious he felt about the prospect of having to talk to the other participants. • Helpful: He did not want to get into a detailed account of his illness until he could sort through new ways of having to exist in the world.
Compassion	
Dignity	
Identity	
Insight Towards Symptoms	
Isolation Prevention	
Medication Awareness	
Mental Health Professional's Knowledge	
Prognosis Details Said by Mental Health Professional	Unhelpful: Doctors said he might never recover.
Psychoeducation	
Shared Meaning	
Support Group (External)	
Trust	

Note: Dashed line (-----) means there was no available data to record for that particular theme.

Overall, results indicate the most valued theme for effective group or individual (one-on-one) therapy is that the client/mental health professional relationship fosters autonomy. For instance, eight out of the 10 data resources analyzed for this thesis revealed that autonomy is valued. Three data resources valued active versus passive listening skills on the part of the mental health professional, upholding or fostering dignity, and establishing trust. All other themes were valued equally within either individual or group therapy. (For a comprehensive analysis of the data resources, see Table 14 below).

DATA SOURCE (Table 14)													
Theme ↓	Coursey et al. (1995)	Longden (2013)	Mackler (2014)	Mackler (2014)	Mead & Copeland (2000)	McLean (2003)	McLean (2003)	Morgan (2013)	Morgan (2013)	Sigman & Hassan (2006)	Spiro (2006)	Goodliffe et al. (2010)	Hanley (2015)
Active/Passive Listening	X	X	X	----	----	X	----	----	----	X	----	----	----
Autonomy	X	X	X	----	X	X	----	X	X	----	----	X	X
Client Success of the Past	----	----	X	----	X	X	X	----	----	----	----	----	X
Communication	X	----	X	----	----	X	X	----	----	----	----	----	----
Compassion/ Indifference	X	X	X	----	X	X	----	----	----	----	----	----	----
Dignity	----	----	X	----	X	X	----	X	----	----	----	X	----
Identity	----	----	X	----	----	X	----	----	----	----	----	X	----
Insight Towards Symptoms	X	----	----	----	----	X	----	----	X	----	----	X	----
Isolation Prevention	----	----	X	----	----	X	X	----	----	X	----	X	----
Medication Awareness	X	----	----	X	----	X	----	X	----	----	----	----	----
Mental Health Professional's Demeanor	X	----	----	X	----	----	----	----	X	----	----	----	X
Mental Health Professional's Knowledge	X	----	X	----	X	X	----	----	----	----	----	----	----
Prognosis Details Said by Mental Health Professional	----	X	----	----	X	----	----	X	----	----	----	----	----
Psychoeducation	----	X	----	----	X	X	----	----	----	----	----	X	----
Shared Meaning	----	----	----	----	----	----	X	----	----	X	X	X	----
Support Group (External)	----	----	----	----	X	X	X	----	X	----	----	----	----
Trust	X	----	X	----	----	X	----	----	----	X	----	X	----

Legend

- Data from Individual Therapy
- Data from Combined Individual and Group Therapy
- Data from Group Therapy
- X Theme Present in Data Source
- No Available Data

Discussion

This qualitative examination of past and current data sought to establish a client perspective on what makes effectual individual and group therapy dynamics between a client and a mental health care professional (or professionals). In essence, what characteristics of therapeutic intervention(s) are helpful in the treatment of their symptoms of psychosis and their recovery? Recovery is dynamic and is defined by the person experiencing schizophrenia spectrum symptoms—not by friends, family, or mental health professionals.

The process of scaffolding the data from individual to group therapy components can begin to solidify the ideas put forth by users of mental health services with a view to gently reminding the micro and macro mental health systems of what can constitute effective versus ineffective group therapy.

In addition to defining the diagnostic criteria and mental health professional titles and labels, what constitutes the descriptive *Themes*—active/passive listening, autonomy, client successes of the past, communication, compassion /indifference, dignity, identity, insight towards symptoms, isolation, medication awareness, mental health professional's demeanor, mental health professional's knowledge, prognosis details said by mental health professional, psychoeducation, shared meaning, support group (external), and trust—had to be clarified in order to understand more clearly the perspective from which this analysis was being drawn.

Themes were deduced according the testimony expressed by the clients within the independent studies. From the very beginning of this content analysis there were no preconceived ideas about what themes or concepts would be found threaded throughout the data. Themes only came into being if the data resources clearly stated there was either a therapeutic benefit or some aspect of therapy was shown to be ineffective in regards to a desired client

outcome. Again, participants in the various studies had to clearly indicate the concept. For example, “I had gained insight towards my mental illness,” or “the doctor did not communicate effectively, or “the hospital failed to uphold my dignity.” Although the aim is to draw themes from the literature, there is no way of verifying if meaning is perceived the same or differently. What one person may perceive as a close relationship might be perceived as something completely different by another individual. It is at this point where my personal synthesis, biases, and perception come into play. Additionally, it must be mentioned that once a theme was established this affected all following theme searches in the data. For instance, once a client, person, or research participant defined the theme of active listening through personal narrative, I could not merely dismiss this acquisition of new information and therefore sought this theme in other analyzed bodies of data.

More importantly, and rather unfortunately, the descriptive terms and themes are without context, which gives additional perception and description to interpretation of the words utilized to describe the phenomenon as experienced by the clients/participants. The context in this situation went from a general broad narrative to the specific. Although the rich backdrop of people’s testimony is missing, words such as *autonomy*, *dignity*, *active listening*, and *trust* can speak volumes in and of themselves. Isolated words are powerful, and like a photograph can tell a story simply and without distraction. Krippendorff (2013) believes deductive inference, such as the process used to inform this analysis, is logical in its own right. Through careful examination, and in essence seeing different perspectives through the same lens, I was able to cohesively and comfortably derive at the common themes utilized in this analysis, which in turn supported this thesis.

Results isolated common themes (see Table 14). All the studies analyzed for what

individuals diagnosed with schizophrenia or a related schizophrenia spectrum illness found helpful/effective in therapy revealed the importance of autonomy. An environment or interaction fostering autonomy was the most client-valued concept in both individual and group therapy, as illustrated by the following participant statement: “My voice is one of the things that is still mine” (Morgan, 2013, p. 67). Of the 10 data resources used for this analysis, eight found autonomy to be important for well-being and effective therapeutic intervention.

Active listening, client successes of the past, compassion, and the preservation of dignity were all also considered important factors in both individual and group therapy encounters (see Table 14), following autonomy. Closely following on these characteristics of /helpful/effective therapy, are communication, client insight towards their illness or symptoms, awareness about medication, mental health professional’s demeanour and knowledge, psychoeducation, shared meaning between clients, and external support groups such as Alcoholics Anonymous.

Lastly, the least relevant qualities for effective therapy were revealed to be preserving identity or shifts in identity of the client, prognosis details, and finally, trust issues. It must be noted that just because the characteristics are listed from most relevant to least relevant does not mean that they are not important to people who experience schizophrenia or a schizophrenia spectrum illness. To elaborate, if questions in the independent studies, the videos, etc., do not address the topics included in this piece of research as themes, they will not be brought into conscious awareness. For instance, if questions were raised about what the doctor said about the prognosis of the illness, the response might be different than the one reported in this content analysis. For example, if someone was diagnosed with diabetes, the doctor might look at all the different lifestyle options and how changing them might not only increase the person’s physical health but their overall quality of life, even possible recovery. The same response does not tend

to follow a diagnosis of schizophrenia. One of the theories as to why it is considered to have a negative prognosis is because mental health professionals and scientists are still attempting to understand the illness and the possible treatments. There are many life issues circulating around an illness at any given time and to touch on them all would take an extended period of time that goes beyond the scope of the data resources used for this report and beyond the scope of this report itself. Again, what has been reported within the text of this report remains crucial to the well-being of people diagnosed with schizophrenia and a schizophrenia spectrum illness. Any piece of insight or information can help another. It also plays the crucial role of guiding mental health professional through a world they do not experience first-hand.

To conclude, in order to curtail the negative outcomes of illness and societal-based stigma, it is helpful to first empower vulnerable populations, in this case people who have been diagnosed with a mental illness of schizophrenia or schizophrenia related illnesses. Schizophrenia is sometimes classified as the cancer of mental illness (Longden, 2013), so this is a good place to begin the client/person empowerment journey: a wellness journey embarking on collective recovery that nurtures and implements a client perspective. Healthy, autonomous human beings make for a healthy, diverse community. When we see ourselves as being part of a bigger whole, we see ourselves as not existing without others. As human beings, we compare, sympathize, hypothesize, and rationalize about human and worldly phenomena. This is no different for people who have experienced schizophrenia or schizophrenia spectrum illness. As this analysis of literature demonstrates, people can view themselves as being part of the much larger concept or context. They can be active participants in their wellness and contributing members of society and it can happen within a therapeutic group setting.

The intention of this study is to present counsellors with client testimonials so that they

may utilize this information in their practice. It is my belief that in order to truly adopt a therapeutic stance in a group setting, a counsellor might benefit from recognizing that the client is the expert on their own existence. Furthermore, carefully thought-out group therapy for those living with schizophrenia spectrum illness is greatly needed within communities. Because of the stigma associated with mental illness, the societal wedge is growing between cohorts of those diagnosed with a schizophrenia spectrum illness and the remaining majority of the collective considered as functioning “normally.” Also, what better way to develop a group therapy than to draw upon the experience of those who would potentially utilize the service? According to Topor et al. (2009), people experiencing mental health difficulties “are not just a collection of symptoms, failings and shortcomings; they are individuals who have acquired a wealth of experience and knowledge about their condition and what could help to improve it or make it worse” (p. 97).

The proposed content analysis research is only the first instalment in a series of research endeavours. My long-term aim is to develop a model of group therapy designed by individuals diagnosed with a schizophrenia spectrum illness. In my role as researcher, I have no vested interest beyond helping to improve the quality of life for people living with a schizophrenia spectrum illness.

“There is no single deed or thought that lies fully outside the experience of other people.”

(Yalom & Leszcz, 2005, p. 6)

References

- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*, (5th ed.). Arlington, Virginia: Author.
- Bechdolf, A., Knost, B., Nelson, B., Schneider, N., Veith, V., Yung, A.R., & Pukrop, R. (2010). Randomized comparison of group cognitive behaviour therapy and group psychoeducation in acute patients with schizophrenia: Effects on subjective quality of life. *Australian and New Zealand Journal of Psychiatry*, *44*, 144-150.
- British Columbia Association of Clinical Counsellors. (2008). *Code of ethical conduct: Using the code of ethical conduct and practice standards: Explanation of principles*. Retrieved from <http://bc-counsellors.org/wp-content/uploads/2011/02/2011-11-22BCACCCodeGuidelinesApprovedOct161.pdf>
- Burke, R. D. (1996). *When the music's over: My journey into schizophrenia*. New York, New York: Plume/Penguin.
- Canadian Psychiatric Association & Schizophrenia Society of Canada (2007). *The Journey to Recovery: A consumer and family guide to assessment and treatment*. Retrieved from <http://www.schizophrenia.ca/docs/RoadtoRecoverySchzioph-web.pdf>
- Corrigan, P. (2006). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.
- Coursey, R. D., Keller, A. B., & Farrell, E. W. (1995). Individual psychotherapy and persons with serious mental illness: The clients' perspective. *Schizophrenia Bulletin*, *21*(2). Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/21/2/283.long>
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods*

- approaches* (4th ed.). Thousand Oaks, California: Sage.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, California: Sage.
- Elo, S., & Kyngäs. (2007). The qualitative content analysis process. *Journal of advanced nursing*, 62(1) 107-115. doi: 10.1111/j.1365-2648.2007.04569.x
- France, M. H., Rodriguez, M. D. C., & Hett, G. G. (2004). *Diversity, culture and counselling: A Canadian perspective*. Calgary, Alberta: Detselig Enterprises LTD.
- Goodliffe, L., Hayward, M., Brown, D., Turton, W., & Dannahy, L. (2010). Group person-based cognitive therapy for distressing voices: Views from the hearers. *Society for Psychotherapy Research*, 20(4). doi 10.1080/10503301003671305.
- Goodman, J. H., & Santangelo, G. (2011). Group treatment for postpartum depression: A systematic review. *Archives Women's Mental Health*, 14, 277-293. doi: 10.1007/s00737-011-0225-3
- Halperin, S., Nathan, P., Drummond, P., & Castle, D. (2000). A cognitive-behavioural, group-based intervention for social anxiety in schizophrenia. *Australian and New Zealand journal of psychiatry*, 34, 809-813.
- Hanley, D. (2015). First person account: The journey. *Schizophrenia Bulletin*. doi: 10.1093/schbul/sbu145
- Kadam, U. T., Croft, P., McLeod, J., & Hutchinson, M. (2001). A qualitative study of patients' views on anxiety and depression. *British Journal of General Practice*, 51, 375-380.
- Khandkar, S. H. (2009). Open coding. Retrieved from <http://pages.cpsc.ucalgary.ca/~saul/wiki/uploads/CPSC681/open-coding.pdf>
- Krippendorff, K. (2013). *Content analysis: An introduction to its methodology* (3rd ed.).

Thousand Oaks, California: Sage.

Longden, E. (2013, February). The voices in my head. [Video File]. Retrieved from http://www.ted.com/talks/eleanor_longden_the_voices_in_my_head?language=en#t-644973

Mackler, D. (Director). (April 08, 2014). Healing homes: recovery from psychosis without medication. Retrieved from <https://www.youtube.com/watch?v=JV4NTEp8S2Q>

Mackler, D. (Director). (April 08, 2014). Take these broken wings: Recovery from schizophrenia without medication [Video File]. Retrieved from <https://www.youtube.com/watch?v=EPfKc-TknWU>

McLean, R. (2003). *Recovered not cured: A journey through schizophrenia*. Crows Nest, Australia: Allen & Unwin.

Mead, S. (2010). Intentional peer support: A personal retrospective [online commentary]. Retrieved from <http://www.intentionalpeersupport.org/about-us/>

Mead, S., & Copeland, M. E. (2000). What recovery means to us. *Community Mental Health Journal*, 36(3), 315-328.

Morgan, K. (2013). *Mind without a home: A memoir of schizophrenia*. Center City, Minnesota: Hazelden

Mueser, K. T., & Gingerich, S. (1994). Coping with schizophrenia: A guide for families. Oakland, California: New Harbinger Publications, INC.

O'Brien, C. P. (1975). Group therapy for schizophrenia: a practical approach. *Schizophrenia Bulletin* (13).

Pitt, L., & Killbride, M. (2006). Researching recovery from psychosis. *Mental Health Practice*, 9(7).

- Roder, V., Mueller, D. R., & Schmidt, S. J. (2011). Effectiveness of integrated psychological therapy (IPT) for schizophrenia patients: A research update. *Schizophrenia Bulletin*, 37(2), S71-S79. doi: 10.1093/schbul/sbr072
- Sajatovic, M., Davies, M., Bauer, M. S., Bride, L., Hays, R. W., Safavi, R., & Jenkins, J. (2005). Attitudes regarding the collaborative practice model and treatment adherence among individuals with bipolar disorder. *Comprehensive Psychiatry*, 46, 272-277. doi: 10.1016/j.comppsy.2004.10.007
- Schizophrenia Society of Canada. (2013). Education: Learn more about schizophrenia. Retrieved from http://www.schizophrenia.ca/learn_more_about_schizophrenia.php
- Sigman, M., & Hassan, S. (2006). Benefits of long-term group therapy to individuals suffering schizophrenia: A prospective 7-year study. *Bulletin of the Menninger clinic*, 70(4).
- Topor, A., Borg, M., DiGirolamo, S., & Davidson, L. (2009). Not just an individual journey: Social aspects of recovery. *International Journal of Psychiatry*, 57. doi: 10.1177/0020764009345062
- Torrey, E. F. (2006). *The indispensable guide to today's most misunderstood illness: Surviving schizophrenia: A manual for families, patients, and providers* (5th ed.). New York, New York: HarperCollins.
- Wagner-Spiro, P., & Spiro, C. S. (2006). *Divided Minds: Twin sisters and their journey through schizophrenia*. New York, New York: St. Martin's Press.
- World Health Organization (2013). Programs and projects: Mental health: Schizophrenia: What is schizophrenia? Retrieved from http://www.who.int/mental_health/management/schizophrenia/en/
- World Health Organization (1993). The ICD-10 classification of mental and behavioural

disorders: Diagnostic criteria for research. Retrieved from
<http://www.who.int/classifications/icd/en/GRNBOOK.pdf>

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, New York: Basic Books

Appendix A

The following diagnostic criteria have been directly quoted from the *Diagnostic Statistical Manual Fifth Edition* (2013).

SCHIZOPHRENIA DIAGNOSIS

- A. Two (or more) of the following, each present for a significant portion of time during a one-month period (or less, if successfully treated). At least one of these must be (1), (2), or (3):
1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g., frequent derailment or incoherence).
 4. Grossly disorganized behaviour.
 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, the level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to it.
- C. Signs of the disturbance persist for at least six months. This period must include at least one month of symptoms (or less, if successfully treated) that meet criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred

concurrently with the active phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if delusions or hallucinations, in addition to other required symptoms of schizophrenia, are also present for at least one month (or less, if successfully treated).

SHIZOAFFECTIVE DIAGNOSIS

- A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.
- B. Delusions or hallucinations for two or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
- C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.
- D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Appendix B

The following diagnostic criterion are from the World Health Organization (ICD-10) description of schizophrenia, schizotypal, and delusional disorders.

CODE F20 SCHIZOPHRENIA

This overall category includes the common varieties of schizophrenia, together with some less common varieties and closely related disorders.

G1. Be there at least one of the syndromes, symptoms and signs listed below under (1), or at least two of the symptoms and signs listed under (2), should be present for most of the time during an episode of psychotic illness lasting for at least one month (or at sometime during most of the days stop it).

- (1) At least one of the following:
 - a) Thought echo, thought insertion or withdrawal, or thought broadcasting.
 - b) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception.
 - c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him/her between themselves, or other types of hallucinatory voices coming from some part of the body.
 - d) Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world).

- (2) Or at least two of the following:
- e) Persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.
 - f) Neologism, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.
 - g) Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.
 - h) “Negative” symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or neuroleptic medication).

Note: subtypes of schizophrenia such as paranoid, hebephrenic, catatonic, undifferentiated, Post-schizophrenic depression, residual, simple, and other unspecified is not posted in this section.

All of the subtypes of schizophrenia just mention require an initial diagnosis of general schizophrenia. Excluded from this schizophrenia criterion is organic brain disease, or alcohol or drug related psychosis and intoxication.

CODE F21 SCHIZOTYPAL DISORDER

- A. The subject must have manifested, over a period of at least two years, at least four of the following, either continuously or repeatedly:

- 1) Inappropriate or constricted affect, subject appears cold and aloof;
- 2) Behaviour or appearance which is odd, eccentric or peculiar;
- 3) Poor rapport with others and a tendency to social withdrawal;
- 4) Odd beliefs or magical thinking influencing behaviour and inconsistent with subcultural norms;;
- 5) Suspiciousness or paranoid ideas;
- 6) Ruminations without inner resistance, often with dysmorphophobic, sexual or aggressive contents;
- 7) Unusual perceptual experiences including somatosensory (bodily) or other illusions, depersonalization or derealization;
- 8) Vague, circumstantial, metaphorical, over elaborate or often stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence;
- 9) Locational transient quasi – psychotic episodes with intense illusions, auditory or other hallucinations and delusion-like ideas, usually occurring without external provocation.

B. The subject must never have met the criteria for any disorder and schizophrenia.

CODE F22 PERSISTENT DELUSIONAL DISORDERS

- A. The presence of a delusion or a set of related delusions other than those listed as typical schizophrenic. The commonest examples are persecutory, grandiose, hypochondriacal, jealous or erotic delusions.
- B. Delusion(s) in A must be present for at least three months.

- C. The general criteria for schizophrenia are not fulfilled.
- D. Persistent hallucinations in any modality must not be present (but transitory or occasional auditory hallucinations that are not in the third person are giving a running commentary, maybe present).
- E. Depressive symptoms (or even a depressive episode) may be present and intermittently, provided that the delusions persist at times when there is no disturbance of mood.
- F. Most commonly used exclusion criteria: it must be no evidence of primary or secondary brain disease, or a psychotic disorder due to psychoactive substance.

Note: delusional subtypes will not be listed here but they include the following: persecutory, litigious, self-referential, grandiose, hypochondriacal, jealous or erotomanic.

CODE F25 SCHIZOAFFECTIVE DISORDERS

Note: this diagnoses depends upon an approximate “balance” between the number, severity and duration of the schizophrenic and affective symptoms. The disorder meets the criteria of one of the affective disorders listed in the ICD– 10 of moderate or severe degree, as specified for each subtype. Also, symptoms from at least one of the symptom groups listed below, clearly present for most of the time during a period of at least two weeks (these groups are almost the same as for schizophrenia).

1. Thought echo, thought insertion or withdrawal, thought broadcasting
2. Delusions of control, influence or capacity, clearly referred to body or limb movements or specific thoughts, actions or sensations.

3. Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves; or other types of hallucinatory voices coming from some part of the body.
4. Persistent delusions of other kinds that are culturally inappropriate and completely impossible, but not nearly grandiose or persecutory, for example has visited o other worlds; can control the clouds by breathing in and out; can communicate with plants or animals without speaking and so on.
5. Grossly irrelevant or incoherent speech, or frequent use of neologisms.
6. The Internet but frequent appearance of some forms of catatonic behaviour, such as posturing, waxy flexibility and negativism.

Note: the most common exclusion criteria are: The disorder is not attributable to organic brain disease, Or to psychoactive substance– related intoxication, dependence or withdrawal also, not included in this description is the subtypes of schizoaffective disorder and they are as follows: manic, depressive, mixed, and unspecified.

Appendix C

Coursey, Keller, & Farrell (1995)—Characteristics of Therapy that Can Improve the
Therapeutic Experience

The following information has been gathered from Coursey, Keller, & Farrell (1995) and from what clients say they need from mental health professionals and what characteristics can improve the therapeutic experience.

Helpful and Unhelpful Characteristics of Individual Therapy

- 93% of 191 participants of this study we're taking medications and out of the 93% participants 80% conveyed their regular physicians did "a good job helping me with my medication needs."
- "Sometimes I was just downright ornery and stubborn, but they came across, they made me feel like, 'Look, here's my hand— take it— I'll help you.'" "It was like these people are here to help you... and are also here to show you that they care and try to get you to start caring again— about yourself."
- A large part of the therapeutic exchange is dependent on the duration of the individual therapy session. Coursey et al. (2015) determined through their data that the opinion on the time of the desired session is mixed, in other words opinions varied greatly. For instance, 57.2% of the 191 participants preferred 30 minutes sessions and 42.8% preferred 50 minutes or longer sessions. Additionally, 61.3% of people preferred to have therapeutic session about once a month versus 32.7% who preferred weekly sessions. Interestingly, 84% of people with a diagnosis of schizophrenia preferred therapeutic session shorter in time and frequency when compared to other individuals within Coursey et al. (1995) study.

- “My former doctor hurt me in away – he would always focus on my bad qualities. I listen to him and I learned from him, but he didn’t help me much for myself.”
- “He did a lot of talking. I think he did more talking than me and I’m a talker. And I got the feeling sometimes that he wasn’t very compassionate.”
- “I’d get the feeling that I was just another number on the wall. I just got the impression that he really didn’t care—it was just another job.”
- “He really never put himself in your place and said, ‘Now I wonder, if I wasn’t her place, what would I do.’”
- “The bad ones wouldn’t listen. They’d listen to my mother though.”
- A very high percentage of those who had seen a therapist reported that they believed their therapist had learned quite a bit (51.1%) or a little (21.7%) from them.... Nevertheless, over a quarter of the sample said they did not know whether their therapist had learned anything from them.

Additionally, the following issues were taken from the 191 persons diagnosed with severe mental illness as being the most important topics to discuss with the therapist during a session (Coursey et al., 1995, p. 291):

- Illness-intensified life issues
 - Independence
 - Developing self-esteem
 - Achievement and hope
 - Relationships
 - Feelings (depression, anxiety, and anger)
- Adverse secondary consequences

- Lack of work
- Poverty
- Stigma
- Self-management of the disorder (handling relapse, hospitalization, side effects of medication).
- Coming to terms with the disability
 - Grieving the loss
 - Understanding the disorder
 - Discovering a new identity
 - Seeking alternative values
- Specific schizophrenia symptoms (staying focused, knowing what's real, feeling terror).
- Normal developmental issues
 - Dealing with sexual relationships
 - Dealing with a troubled past
 - Dealing with family

Coursey et al. discuss additional qualities the 191 participants preferred in their therapists:

- The number one quality chosen by the participants was friendliness (70.5%). Two elaborate, participants made comments such as; “she was like a good friend... She is still a good friend... I still go over and talk to her once in a while even though it's not on my plan anymore.” Additionally, comments were made like, “she gives me a warm feeling, a warm caring feeling... They are like my leaning post... He's very professional about the doctor – patient relationship, but we often take a few minutes to just joke around.”

- The next most common response from the participants was they appreciate the therapist understand their illness, “someone who will motivate me”... “an advice giver”... “and unbiased a listener” and “A problem solver.”
- “Someone who teaches me how to handle my problems.”
- “Someone who tells me things I need to hear even if I don’t like it.”
- “Someone who listens empathetically.”
- Prefer “a medical doctor.”
- “Flexibility of the therapist in allowing them to adjust the length of their sessions” was not a major concern.
- “[Session] flexibility would be helpful in an emergency.”
- Many of the participants expressed a preference “for a therapist of the same age or older.”
- It in regards to therapist disclosure most of the participants didn’t mind deal occasional self-disclosure and about half said it did just didn’t matter and “14.4% preferred that the therapist not talk about him or herself.”
- “46.8% of participants said that they would not prefer therapist who had a mental illness.”
- When it came to gender preference of the therapist just under half said that it did not matter however, within that other 50% more women than men preferred a same-sex therapist.
- In relation to changing from a familiar therapist to a new one 23.2% said it took three months to adjust, 12.7% said it took a good six months before they felt comfortable, and 42% of the participants needed only one month to feel comfortable and an astonishing

22% of participants reported they need at least one year or longer to adjust to a new therapist (p. 293).

- Most of the participants in the study were not bothered when this therapist was away on vacation for more than a week.
- When it comes to the issue confidentiality most of the participants in the study 54% reported that therapist had indeed kept up the confidentiality agreement. However, 35% of the participants felt some disease around the therapist keeping confidentiality and 11% believe that their therapist was not careful about confidentiality. “42% of the clients reported having had a therapist that sometimes failed to keep confidentiality private, and of those, over half reported being either very upset at 45% or so upset that they left therapy 10%.”
- With reference to the subject of autonomy, one participant of the Coursey et al. study explained how his therapist gave “advice in a way where if I don’t see what he’s talking about, usually I tell him why and... he’s accepting of that. If I tell him I can do this, I really believe I can do this, he’ll give me credit for that too.” Also in regard to the subject of autonomy the same participant recalls a moment with another mental health professional. He replies, “The other psychologist I had in the hospital, if I told him I could do something, he’d say, “I’m not really sure you can do that” to the point to where it was discouraging sometimes, because a lot of things that I told him that I wanted to do or things that I thought were very small steps... and it seems that he put a limit on what kind of progress I could do. The majority of people that he dealt with will probably never be productive in society and will probably be limited. This therapist that I have now

thoroughly believes that I can live my own life within a very short period of time” (p. 294).

- “Large percentages of clients in both samples reported positive life changes from psychotherapy, endorsed similar views of illness and treatment, and selected friendliness as the most desired quality in a therapist” (p. 294).

Appendix D

Mackler (2014)—Documentary Information on what
Clients Need to Improve the Therapeutic Experience

The following information has been compiled from Mackler (2014) and from what clients say they need from mental health professionals, along with characteristics that can improve the therapeutic experience.

Helpful and Unhelpful Characteristics of Individual Therapy

Catherine Penney is first of the two women interviewed for Mackler's documentary. She describes the following helpful and unhelpful attributes of the mental health profession.

- Don't talk about me like I'm not there or here.
- Trust needs to be fostered.
- The therapist needs to have patients because healing and recovery could take a while.
- It's important that the therapist plant a seed, to address what is under the delusion, "appeal to the part of me that is healthy.... There is always a healthy part no matter how small" (32:16).
- "Challenge the psychosis" (34:44).
- When the patient tells the therapist you have some aspect of their life wrong, for example, believing there is a bad mother-daughter relationship when it is actually good, the therapist needs to listen and talk about it. Penney (39:46) reports, "she started to feel like somebody when her therapist would listen and talk about it."
- "The therapist and myself had an 'I, Thou' relationship ... I was a human being. It wasn't 'I, Thou' versus [an] 'I, It' relationship" (40:16).

- Penney (46:00): “The best thing my therapist said to me was, Cathy it is not good to isolate yourself.”
- “The more I stayed in the room with the four other talkative women, the more and more the stuff in my head became less and I started becoming interested in the topics they were talking about” (46:39).
- The therapist can “talk about curiosities around human existence. Talk about boyfriends and process, the new feelings that come along with the stages of recovery” (47:09).
- Penney clearly states, “Give yourself time. I held onto this like a life raft because I was starting to feel suicidal” (52:13)
- Understand that we are acquiring and assimilating a new identity. Just as it was new and scary taking on the identity of schizophrenia, it is just a scary letting go of the old ways of being and letting the new ways flourish (52:25)
- According to Penney, “the greatest gift is wanting to be with people [1:03:09] ... Really loving the contact with people [1:04:01] ... Seeing the sacred in each one of us [1:04:10].

The following are recommendations and insight provided by Joanne Greenberg, the other woman in the documentary, in regards to helpful and unhelpful characteristics of therapeutic interaction.

- What people need to know is that schizophrenia saved me from real-world trauma (6:46).
- What doesn't help is dressing up the illness, for example, she's just creative or she's just different (6:46).
- When Greenberg was asked by Mackler, “Could you describe the best qualities that your therapist had that helped you?” she replied, “Courage, humor, the whole thing that set up the rest of my life, we were miners [such as coal-miners], I had the map and she [Dr.

Frieda Fromm-Reichmann] had the light ... We were minors together and she kept saying take me along, take me along” (27:50).

- Greenberg also explains how Fromm-Reichmann would say that she has never had a mental illness and it is Greenberg’s job to tell her all about it (28:48).
- Love the health in the person.
- Love the strength in the person; loving the health and the strength are the weapons needed to heal (32:42).
- Greenberg comments (39:50), “She never stripped me without my consent ... She knew the difference between problems and symptoms, the difference between being creative and being crazy.”
- “Convalescence takes a hell of a long time” (46:52).
- Greenberg met friends in the hospital. She is still in contact with them up today (1:06:30).
- Greenberg comments that it takes hard work to recover from schizophrenia (1:07:34).

Appendix E

Mead & Copeland (2000)—What Is Needed from the Therapeutic Profession to
Help Recover from Schizophrenia

Through Mead's experience of schizophrenia and the experience of many other individuals who live with a diagnosis of schizophrenia, Mead and Copeland compiled qualitative data on what is needed from the therapeutic profession and from loved ones in order to heal and recover from schizophrenia symptoms. Mead and Copeland (2000) state:

- “We don't need dire predictions about the course of our symptoms— Something that no one else, regardless of their credentials, can never know” (p. 317).
- “We need assistance, encouragement, and support as we work to relieve the symptoms and get on with our lives” (p. 317).
- “We need a caring environment without feeling the need to be taken care of” (p. 317).
- When the symptoms are really bad we need our mental health professionals to guide us and take small steps into helping us out of the distressing situation.
- Education is a necessary element of them recovery process. It is helpful if the mental health professional can guide us to relevant resources that fit our needs. Not every person is the same so resources will be dependent on the individual's experience.
- In accordance with upholding individual autonomy, it is important to advocate for people in making their own choices on crisis and treatment plans, medication and medication side effects, informed consent, having access to personal records, relationships and spiritual practices, and upholding “dignity, respect, and compassion” (p. 319).
- “We need to be fully supported in taking the steps toward re-creating our own sense of self and be challenged to continue to grow” (p. 321).

- “It is not up to the provider to determine when a person is ready to make progress, it is up to the person” (p. 322).
- “In self-help recovery groups, people who experience symptoms are working together to redefine the meaning of these symptoms, and to discover skills, strategies, and techniques that have worked for them in the past and that could be helpful in the future” (p. 323).
- “When people who have shared similar experiences get together, they begin to talk about their concerns about medication and alternatives that could be helpful. They build up a kind of group empowerment that begins to challenge the notion of medications as the only way to address her symptoms” (p. 324)
- “We want to be respected by healthcare professionals for having these fears and for sometimes choosing not to use medications that are compromising the quality of our lives” (p. 324).
- “It must be recognized that risk is inherent in the experience of life. It is up to us to make choices about how we will live our lives; it is not up to the health care professionals to protect us from the real world. We need healthcare professionals to believe that we are capable of taking risks and to support us as we take them” (p. 325).
- It is important to define wellness and illness individually.
- “If the symptoms should become that severe, people may have developed their own personal crisis plan—a comprehensive plan that would tell close supporters when they need to step in and take over responsibility for their care, and exactly what the supporters need to do to keep the situation from becoming a disaster” (p. 326).

The following are recommendations put forth by (Mead and Copeland 2000, p. 320) to foster

growth within the mental health professional:

- How much of our own discomfort are we willing to sit with well someone is trying out new choices?
- How are our boundaries continuously being redefined as we struggle to deepen each individual relationship?
- What are the assumptions we have about this person, by virtue of his/her diagnoses, history, and lifestyle? How can we put aside our assumptions and predictions in order to before we present to the situation and open to the possibility for the other person to do the same?
- What are the barriers that might prevent both of us from stretching and growing?

Mead and Copeland (2000) Guidelines For Recovery– Orientated Services (p. 327).

- Treat the person as a fully competent equal with the equal capacity to learn, change, make life decisions, and take action to create life change, no matter how severe the symptoms.
- Never scold, threaten, punish, patronize, judge or condescend to the person, while being honest about how you feel when that person threatens or condescends to you.
- Focus on how the person feels, what the person is experiencing, and what the person wants rather than on a diagnoses, labeling, and predictions about the course of the person's life.
- Share simple, safe, practical, noninvasive and inexpensive or free self-help skills and strategies that people can use on their all own or with the help of their supporters.
- When necessary, break tasks down into the smallest steps to ensure success.
- Limit the sharing of ideas and advice. One piece of advice a day or visit is plenty. Avoid making an overwhelming the person with feedback.
- Pay close attention to individual needs and preferences, excepting individual differences.

- Assure that planning and treatment is a truly collaborative process with personal choice as the bottom-line.
- Recognize strengths and even the smallest bit of progress without being paternalistic.
- Except that a person's life path is up to them.
- Ask the first step toward recovery, listen to the person, let them talk, hear what they say and what they want, making sure their goals are truly theirs and not yours– understanding that what you might see as being good for them may not be what they really want.
- Ask yourself, “Is there something going on in the individual's life which is getting in the way of change or moving toward wellness, e.g. learned helplessness?”
- Encourage and support connection with others who experience psychiatric symptoms.
- Ask yourself, “Would this person benefit being in a group led by others who have experienced psychiatric symptoms?” (p. 327).

Appendix F

McLean—Information on What Is Helpful in Therapy

The following information provides some insight into what McLean (2003) found helpful from mental health professionals and therapy and how this information is applicable towards this thesis.

- “My delusions were amplified by the fact that I was by myself, and had no support to “reality-check” with. I had no real anchor to actuality” (p.43).
- “The internet provides great resources, support and freedom for its users” (p. 123).
- “Good support networks are also critical” (p. 214).
- “Years later I have met people who are running from treatment because their idea of being mentally ill is such a part of who they are that they don’t know any alternative. It is hard to give up the idea of who you are” (p. 102).
- “People in the grip of mental illness often have to hit rock bottom before any action is taken. “It took me months to get to a point where I knew I had to seek treatment, and more months before I penetrated the medical system to get the help I needed” (p. 212).
- “He [doctor] was friendly but I got the impression that he was leading me away from the story I wanted to tell him. I took this as confirmation that the conspiracy had liaised with the doctor, that he thought I deserve to be punished. He knew damn well what was going on. The fact that he hadn’t questioned theories that even I thought [were] ridiculous proved it. I didn’t know then that a lot of doctors were not that well-versed in psychiatry—I didn’t even know the difference between psychology and psychiatry at that point. This doctor saw a person who was a little odd maybe, but generally well mannered, and he sent me on my way. I felt confused. I had had enough feedback to make me think there

really was something wrong with my mind, but underneath was unshakable conviction that there really was something fast and threatening out there. I chose to put the whole episode to the back of my mind. Stuff doctors” (pp. 168–169).

- “At this point my life, I felt as if I could not concentrate. I was sensitive to every nuance of social hierarchy, and talking to people was hard work. My thirst for social contact had been extinguished. My pleasure and enjoyment was always tainted by suspicion of ulterior motives” (p. 62).
- “Dr. X turned to face me. ‘What brings you here?’ He asked. In tense situations, I sometimes resort to terseness. In response to his question, I replied, ‘I’m fucked.’ It was a huge effort, but strangely a relief to say it. He asked me to elaborate. I thought, ‘It’s now or never,’ and told him of the things I’ve been going through, and a stark and retrospective way. I felt emotionally flat, and talking about my experiences and ideas out loud made them seem ridiculous. It was a leap of faith to confide in him, I had in mind he was the enemy. In the back of my mind I thought the meeting serve two purposes: to talk to him honestly, and to show the conspirers what pain they were causing—it might make them call the whole thing off. I thought he might confide in me either way” (p.188).
- “During the past 10 years I made a terrible mistake (twice) of thinking I was well and stopped taking my medication. I got sick again and was hospitalized. I didn’t want to think that I had schizophrenia. I have to confess that I am not over the shame I feel. It’s not something I can talk to people about so I feel I have a dirty little secret. It affects my relationships with women, as I can’t tell them of the shame I feel. I probably seem weak but I really want to be accepted by people for what I am (which includes having schizophrenia)” (p. 207).

- “Of course, friends can’t do much if you don’t tell them what’s going on. Apart from the occasional ‘reality check,’ I didn’t confide much in my friends or my parents, partly because I didn’t really believe I was sick. My psychosis developed so gradually and affected my reason to such a degree that I didn’t see it, and I didn’t know anyone else who had suffered similar delusions. Once I realized, and was open about it, I came across plenty of examples: neighbors, relatives, friends, and friends of friends. If such things had been talked about more openly, I might not have felt so alone, and I might have recognized symptoms in myself” (p.214).
- “Talking to a friend who also has schizophrenia, I decided it was a beneficial experience in many respects. We have learned humility, are open to a lot more ideas, and have a respect for reason. We also know how lucky we are to live in the age of medication. Our psychoses have revealed parts of us we might never otherwise have integrated” (pp. 219–220).
- “This illness is a battle and anyone with it is a fighter with the potential of recovery. The problem is we are our own worst enemies. You have got to stand up to your fears to overcome them” (p. 202).
- “The great tragedy of psychosis is that (by definition) it precludes awareness that something is going wrong—which means it’s vital for others to show insight. I often wonder how much suffering could be prevented if the general public’s awareness of mental illness was greater” (p. 212).
- “They were mostly ‘messages’ from auditory hallucinations, and I put them down and diagrams to help make sense of my distorted perceptions” (p. 66).

- In regards to a support/group therapy environment it is important for it to be alcohol and drug-free.
- “I have had mistrust of my psychiatrist—this is very difficult because she/he is the one person who can help you. I started to think that he was in on the whole conspiracy against me. It was awful, because really he’s a sweetie. I have also thought that my psychiatrist was recording me, or that people were listening in on our conversations. I told him that I was having these thoughts and it helps to know that he knows somehow” (p. 193).
- “As the weeks passed, I started to trust that Dr. X really was trying to help” (p. 197).
- “[The illness of schizophrenia] not only destroy[s].... Dignity but also [his] life. I don’t know what to do. Please, please help” (p. 206).
- “I was once intelligent and full of life but have been reduced to live a life that’s not worth living. I can’t stand it. I don’t feel safe on my own but when around others I freak out. I can’t eat, sleep or even think. Does anyone understand what I’m saying? Please, if anyone else there does can you offer me some advice or even just a little bit of hope, something that I can hang onto until my doctor figures out a way to help if there’s a way to help” (p. 208). According to McLean (2003), when someone is considering designing support/group therapy for individuals suffering from schizophrenia it is important to recognize that sometimes it takes months before enough trust is built and the individual decides to attend the support/group therapy. Also, McLean believes it is important to not “wait until a person hit hits rock-bottom before getting help” (p. 208).
- McLean emphasizes that prescribing medication alone is not offering help.
- “These kinds of wayward connections are classic symptoms of schizophrenia. And make it hard for someone who is psychotic to engage in things that might be commonplace for

others. For example, I found it uncomfortable at this stage to listen to the radio or watch television. After a spell of radio or TV I would sometimes go and lay down, out of mental exhaustion and anguish” (p. 56).

- One thing to keep in mind when creating a support/group therapy is that many people who have been diagnosed with schizophrenia in Canada are left without an acting psychiatrist due a shortage of professionals. According to McLean (2003), “I have excellent insurance but cannot find a site doctor who is taking new patients” (p. 80).
- McLean comments, that there are moments in time when he would hurt himself but would not report it to his parents, psychiatrist, or social worker because he was afraid they would be upset with him.
- “‘Insight’ and awareness is dynamic, one day it is present and the next day it is covered up by beliefs such as, ‘thanks, but no thanks, I’m fine’” (p. 91).
- Psychosis becomes the new normal.
- “The world can speak to the psychotic person in many ways throughout analogies, metaphor or symbols. Not long ago I did an IQ test, with varied results: in math I got 8%, in analogies I got 95%. It makes me wonder if there is a predisposition for a delusional personality” (p. 120).

Appendix G

Helpful Advice to Improve Quality of Life for Those Who Hear Voices

According to Goodliffe, Hayward, Brown, Turton, & Dannahy (2010), participants reported the following in regards to sharing experiences of voices, developing group identity, coping skills and a sense of self other than being identified only as a voice hearer:

- In regards to social support one participant explained, “When I first started getting voices [...] I felt so isolated because there was no one I could talk to. I didn’t know what was happening to me, and I thought I was going crazy” (p. 450).
- The issue of social inclusion was also touched upon by another participant in their comment, “it was good because you didn’t feel isolated. Which I had been four years—I felt really isolated ... I had no idea of other people suffering, and it made it better for me because I would, sort of, relate to them” (p. 453).
- When it came to the voices controlling one participant and her attendance in group therapy she noted, “They allowed me to come to these groups and the reason for that was that they could laugh at me and what I was doing here ... I should be grateful to them for allowing me to come” (p. 451).
- Another participant describes how the loss of control over her voices helped her seek out any kind of therapy, which included joining group therapy: “I just thought, well, anything might help, anything. Any type of therapy or psychology or talk might help” (p. 451).
- “[The voices] make me lose self-esteem and self-confidence, and they even get the point sometimes when I don’t want to walk out of the front of the flats, be anywhere near any people” (p. 452).

- In regards to developing a concept of what constitutes psychosis/madness in a group therapy setting, one participant commented, “I’ve never met anyone else who is a schizophrenic. You just think they’re mad and don’t want to be associated with them anyway” (p. 452).
- When it came to developing a group identity, it was reported by one participant that group therapy afforded her the sense that she was not alone with her illness. “What I found most helpful, was you lot being the same as me. That’s what I found most comforting” (p. 453).
- Also in the realm of normalizing the illness and shared meaning about the symptoms, one person said, “I’m just surprised that everyone was so normal ... I thought if they seemed all right, they looked, you know, normal, perhaps I did as well” (p. 453).
- Structure and consistency of attendance in group therapy was also reported as an appealing characteristic. “Sometimes there might only be two or three of you, and other times there would be lots of you, and it’s very difficult because you don’t know how many. Whereas with this group you know how many there are all the time. You get to know each other as well” (p. 453).
- Another participant reports, “We went to a club, for the first time in about 10 years ... I wouldn’t have done that had I not come to this group” (p. 454).
- It was reported, “I wasn’t expecting to be able to cope with the voice still there. I wasn’t expecting to, just be in control. I was expecting to either have to voice or not have to voice” (p. 454).
- Group therapy afforded one individual insight into what stress can do to the mind and body: “When I’ve got a lot of stress I’ve got voices. When less stress, less voices. And

coming here [group therapy] my stress went down ... It's a worry when work is too much, too much stress I need to protect myself" (p. 454).

- Reflecting on the power of voices and how these voices can control a person with schizophrenia or schizoaffective illness, one woman commented, "I learned that ... it was still my will that overcame the voice that was extremely powerful. I still was more powerful than the voice at the end of the day" (p. 454).
- In regards to coping strategies, one participant said, "You're trying not to do what they're telling you to do, but you don't know what to do. That's why the group has been so good, because there is a bit of ... this and what you can try, or you can do, whereas before you were on your own" (p. 455).
- Developing a sense of self beyond the voices was also reported as being a valuable tool gained through group therapy. One man said, "I am not the illness. I am a person with a certain illness" (p. 455).
- Separating the voices from the self of the person hearing them was another helpful tactic obtained from attending group therapy. It was reported, "I found it very hard to understand why I couldn't stop [the voices] if it was me doing them. And the groups helped me understand that, yes, it is me, but also it's not really me, it's my mind" (p. 456).
- The last comment, which proved fruitful towards this thesis topic of effective group therapy, was that "it wasn't until we were in the group that we started to realize that you haven't done anything bad. You know? At all of them were saying, "Yeah, well, I must've done something to make me have these voices' ... We can't all be evil. We can't all be wrong" (p. 456).