

Talking about hearing voices: A Narrative Analysis of experience

Thesis submitted in partial fulfilment for the requirements of the
Doctorate in Clinical Psychology

by

Laura O'Halloran

Department of Psychology

University of Leicester

November 2013

“The process of allowing stories to be told could become both therapeutic and empowering for the person in the throes of their difficulties.”

(Kilty, 2000, p2)

Statement of Originality

I confirm that this is an original piece of work. The literature review and research report contained within this thesis have not been submitted for any other degree or to any other institution.

Thesis Abstract

Talking about hearing voices: A Narrative Analysis of experience

By Laura O'Halloran

People who hear voices can find the experience distressing. Largely speaking voice hearing is viewed by society, and some mental health professionals, as being a symptom of mental illness. In this way the experience of voice hearing is more often than not seen as being biological in nature which can preclude other possible explanations.

A systematic literature review carried out in this study found that the most researched psychological intervention for use in schizophrenic spectrum disorders found was CBTp. The effectiveness of CBTp varied across studies but overall positive outcomes were reported. These included a reduction in relapse, improvement in social functioning and a reduction in symptoms. The evidence for the impact CBTp has on voice hearing as a specific symptom is less well established. The majority of trials place voice hearing within the wider category of positive symptoms. The majority of other interventions reviewed were found to be less effective than CBTp. There are some promising, albeit very limited, results to show that self-help groups have a positive impact for people who hear voices.

This research project aimed to find out from voice hearers what their experiences are when it comes to talking about their voices. In total eight unstructured interviews were carried out with individuals from mental health services. Interviews were transcribed and analysed using Narrative Analysis.

Results showed that some people want to talk about their voice hearing but, at times, a number of factors prevent this. These factors are external barriers, such as from services, and internal barriers, such as personal readiness to talk. In addition to this it seems that how people view themselves in their own story leads them to either being stuck within their difficulties or free to move on. Finally resources available to the individual, whether real or perceived, also impact on how able they are to manage their voice hearing. Clinical implications using the results in this study are discussed.

Acknowledgements

I would like to begin by thanking all of the people who took part in this research project. Without you all it would not have been possible. I would like to thank my research supervisor Dr. Jon Crossley for all of his support and words of encouragement. I would like to thank my husband Benedict and our dog Ted as they have kept me grounded in times of stress and self-doubt. I would also like to say thank you to the rest of my family and friends who have been a great support to me in writing this thesis.

Word counts

(All word counts are excluding abstracts, tabulated information or diagrams).

Part one

Literature Review: 7, 718

Part Two

Research Report: 14, 641

Part Three

Critical Appraisal: 3,808

Entire thesis word count: 26,167

Total word count: 26, 562

(Not including mandatory appendices)

Contents

Part one: Literature Review..... 11-56

Abstract

1. Introduction.....	11
2. Method.....	26
3. Results.....	39
4. Discussion.....	51
5. Limitations of Review.....	54
6. Conclusion.....	55
7. Suggestions for Future Research.....	55

References

Part two: Research Report 71-153

Abstract

1. Introduction.....	72
2. Method.....	82
3. Results.....	98
4. Shared and unshared stories.....	135
5. Discussion.....	137

References

Part three: Critical Appraisal..... 163-177

1. In the beginning.....	164
2. Ethics and Research Development.....	165
3. Literature Review.....	165
4. Recruitment.....	165
5. Interviewing.....	166
6. Transcribing.....	168
7. Analysis.....	169
8. The write up.....	173
9. Limitations.....	174
10. Dissemination	175
11. Summary.....	176

References

Appendices

A Record of database search and key words used

B Summary of quality assessment outcomes using the SIGN checklist

C Basic data extraction form

D Ethics and Research and Development letters of approval

E Information Sheet for Participants

F Study consent form

G Bracketing Interview

H Micro and macro analysis for each participant

I Guidelines for targeted journal (for literature review)

J Epistemological position of main researcher

K Chronology of research process

List of Tables, Figures and Boxes

Table 1: Details of articles used in literature review

Table 2: Synthesis of first and second order concepts into third order interpretations

Table 3: Inclusion and exclusion criteria

Table 4: Details of study sample

Table 5: James Gee's components of macro analysis (with examples)

Table 6: Participants story parts

Figure 1: A diagram to show systematic review process

Figure 2: Recruitment process of study

Figure 3: The process of carrying out the micro and macro analysis

Box 1: Three core narratives (Frank, 2010)

Box 2: Interview excerpt to demonstrate micro analysis

Box 3: Emerson and Frosh's levels of narrative interpretation

Box 4: Bracketing interview considerations

Boxes 5-11: Participants positions

Box 12: Shared stories from study

Box 13: OARS: Motivational Interviewing Principles

Literature Review Abstract

What evidence is there for the effectiveness of psychological interventions for voice hearing?

Introduction:

Voice hearing is experienced by people with a number of diagnoses but it is most commonly associated with schizophrenic spectrum disorders. There are a range of explanations for voice hearing ranging from the biological to the psychological. There are also a number of psychological interventions developed predominantly to help individuals with schizophrenia. These vary but the most widely used is Cognitive Behavioural Therapy for Psychosis (CBTp).

Method:

The current evidence base for the use of psychological interventions for voice hearing was explored. This was done using a systematic search of five databases. These were Psychinfo, ASSIA, Medline, Scopus and Web of Science. A number of inclusion and exclusion criteria were used to determine which papers would be included in this review. A total of 15 papers were included in the final review.

Results:

The most researched intervention found was CBTp. The effectiveness of CBTp varied across studies but overall positive outcomes were reported. These included a reduction in relapse, improvement in social functioning and a reduction in symptoms. The evidence for the impact CBTp has on voice hearing as a specific symptom is less well established. The majority of trials place voice hearing within the wider category of positive symptoms.

The majority of other interventions reviewed were found to be less effective than CBTp. However there are some promising, albeit very limited, results to show that self-help groups have a positive impact for people who hear voices.

Discussion:

The evidence base for using CBTp is growing and it continues to suggest positive outcomes. There are, however, a number of methodological issues to be considered within the research. These relate to masking procedures, therapist experience, frequency and number of sessions offered and the maintenance of benefits at long term follow up.

Whilst there is evidence to suggest that CBTp can produce a reduction in symptoms less is known about the impact of this on voice hearing as a specific symptom. The limited evidence available about CBTp reports changes to the frequency of voices heard but little if no change to the distress or intensity.

Literature Review

What evidence is there for the effectiveness of psychological interventions for voice hearing?

1. Introduction

Voice hearing is defined in the International Classification of Diseases - 10 (ICD – 10) as ‘Auditory hallucinations of thought echo, discussing type in third person and running commentary type’ (World Health Organisation, ICD – 10, 1994).

Voice hearing is experienced by 60% of people diagnosed with a schizophrenic spectrum disorder (Shergill *et al.*, 1998). The experience can adversely affect a person’s quality of life and self-esteem and increase the likelihood of depression, anxiety and of attempting suicide (Birchwood & Iqbal, 1998). The use of anti-psychotic medication is the most common initial treatment offered to people with a first episode of psychosis. This is due to the evidence base that exists regarding the efficacy of such medications and is recommended within NICE guidelines. (NICE, 2002). Despite these guidelines Morrison *et al.* (2012) found that recent evidence from systematic reviews and meta-analyses suggests that the efficacy and effectiveness of antipsychotics to produce clinically meaningful benefits for people with psychotic disorders has been overestimated.

It is important to note that it is not only people with a diagnosis of schizophrenic spectrum disorder that hear voices. Voice hearing can be apparent in different types of mental health difficulty and is, therefore, not exclusively associated with a diagnosis of schizophrenia. Indeed only one in six of all voice hearers meet the traditional psychiatric criteria for the diagnosis of schizophrenia (Romme *et al.* 2009).

According to NHS Choices 'hearing voices is a well recognised symptom of depression, dementia and bipolar disorder, but can also be unrelated to mental illness' (NHS Choices, 2009). It has been estimated that 10% of the population hear voices that are not there with only a small minority of hearers likely to ever receive a clinical diagnosis (Rethink, 2003).

1.2 Historical accounts of voice hearing

Historical accounts of voice hearing date back as far as the 5th century BC where Socrates claimed to be in direct relation to a *daemon* – “a voice” who warned him against certain actions (Leudar & Thomas, 2000, p50). In the 12th century Hildegard von Bingen is believed to have heard divine messages which she devoutly followed (Flanagan, 1989). In the 20th century poet Allen Ginsberg whilst having a psychotic episode heard the voice of William Blake. Ginsberg viewed this experience as the presence of Blake as his poetic muse (Shorto, 1999). Up until the 20th century history shows that voice hearing was often viewed as a source of meaning for people and a positive non-pathological experience. Yet Bentall and Slade (1988) explain that currently voice hearing, encompassed also by the term auditory hallucinations, is generally considered a clinical symptom which is often associated with a diagnosis of schizophrenia.

1.3 Explanations of voice hearing

There are a number of explanations for why people hear voices with medical or biological and psychological being the dominant. However, there are overlaps between the various explanations of voice hearing. Within cognitive models there are biological components, for example in the variations between how the brain

processes information and experiences. Models and theories for understanding voice hearing are discussed in separate categories below but it is important to consider that there are overlaps that occur between them.

1.3.1 Medical and biological explanations

Psychiatric diagnoses

Within the sphere of psychiatry auditory hallucinations are generally considered to be a pathological symptom of illnesses such as schizophrenia (Anthony, 1993). The explanation for auditory hallucinations is that they are a result of neurological deficits or functional deficits in the brain. Much research has been and continues to be carried out into a possible genetic component in schizophrenia. According to Tiwari *et al.* (2010) investigations of schizophrenia have demonstrated that genetic factors have an important role to play in its genesis. However, Tiwari also states that although research done during the last two decades has provided several candidate genes unfortunately these have not been consistently replicated across or within a population. Understanding the genetic basis of schizophrenia therefore continues to be major challenge.

1.3.2 Psychological explanations

A variety of explanations about the causes of voice hearing from a cognitive perspective have been advanced over the last three decades. These are described here:

Activation of the Inner Speech Processing Network

An influential cognitive model of auditory verbal hallucinations (AVH) suggests that a failure to adequately monitor the production of one's own inner speech leads to

verbal thoughts being misidentified as an alien voice. In a study by Vercammen *et al.* (2010) twenty-two patients with schizophrenia and AVH underwent a 3-T functional magnetic resonance imaging scan while performing a metrical stress evaluation task (which has been shown to activate both inner speech production and perception regions). They found that strong activation of the inner speech processing network may contribute to the subjective loudness of AVH. However, a relatively increased contribution from right hemisphere language areas may be responsible for the more complex experiential characteristics such as the non- self source or how real AVH are.

Beliefs about voices

Another theory as to why people hear voices suggests it is to do with beliefs that people have about their experiences. Bentall *et al.* (1991) found that people who are paranoid or deluded tend to attribute the cause of bad events to external factors and make judgments with excessive confidence when compared to depressed control groups. For people with schizophrenia, when the initial attribution made is based on faulty information processing attempts to cope are then based on misjudgments of reality.

Chadwick and Birchwood (1994) developed a cognitive model for understanding voice hearing in which attributions about voices is central. The cognitive model suggests that a person's belief about their hallucinations is based on their interpersonal schemata which are influenced by early life experiences. Therefore if a person had adverse and threatening life experiences they will be more likely to perceive their voices (and other people) as dominant and themselves as vulnerable

and helpless. The model also suggests that those who classify their voices as malevolent will resist them whereas those who appraise their voices as benevolent tend to engage with them. The model further suggests that people who believe their voices are omniscient (all seeing) and omnipotent (all-powerful) struggle when it comes to coping with them and will have higher levels of distress. This distress is due to the person feeling powerless when it comes to challenging or escaping the voices. The feeling of being powerless is because of the person believing that the voices have the control and not them. (Chadwick & Birchwood, 1994; Haddock & Slade, 1998).

Misinterpretation of intrusions

Rachman and Silva (1978) suggest that most everyday thoughts could be defined as being intrusive, however, it is when a person has repetitive thoughts, images or impulses that are unacceptable or unwanted that they are misinterpreted as being external to them. Morrison (2001) developed a cognitive model which supports this theory about the misinterpretation of intrusions. The model suggests that auditory hallucinations occur when a person experiences an intrusion into their awareness which they then misinterpret as an external voice. Morrison (2001) explains that the person struggles to understand that an intrusion can really be a part of them if it is discrepant with their culture and beliefs. The person will therefore assume that there must be some other explanation such as it being an external voice. Morrison explains that 'it is the interpretation of these intrusions that causes the associated distress and disability'. Morrison and Baker (2000) examined and compared the frequency of cognitive intrusions experienced by psychotic patients with auditory hallucinations with psychiatric patients and non-patients. They found that patients

with auditory hallucinations not only experienced a higher frequency of intrusive thoughts than both psychiatric patients and non-patients but that they reported their intrusive thoughts as being more distressing, less controllable and unacceptable than the other two groups. This research suggests that psychiatric patients who hear voices are prone to experiencing higher levels of intrusive thoughts which they subsequently find difficult to manage.

Attribution bias

According to Bentall and Slade (1985) cognitive processes influence the way we think, interpret information and also how we perceive ourselves and our environment. They developed a Five - Factor cognitive model for understanding hallucinations which suggests that it is sensory stimulation from the environment that triggers hallucinations. They proposed that individuals with hallucinations use different judgment criteria from non-voice hearers when deciding whether an event has occurred and are more willing to accept that a perceptual experience is an actual experience. This bias essentially involves a greater willingness to believe that an event is real on the basis of less evidence and is referred to as 'reality discrimination'. Bentall and Slade (1985) measured reality discrimination with a signal detection task with hallucinating and non-hallucinating patients. The reality monitoring task was a memory task in which the subject was asked to remember words that had either been said by the experimenter or had been generated by the subject. When asked to indicate, from a list of words, whether a word was previously read by the experimenter, generated by the subject himself or whether the word was new hallucinating patients more frequently mistakenly assigned self-generated words to an external source.

Stress vulnerability model

The stress vulnerability model (Zubin & Spring, 1977) examines roles played by stress and vulnerability to hearing voices. The model suggests that vulnerability is linked to our learning of how to manage difficulties as we grow up. The model explains that the interaction between stress and vulnerability may lead to a person hearing voices. Neuchterlain and Dawson (1984) explain that everyone is susceptible to stress and that vulnerability specifies the times in life where a person can no longer cope or function. The ability or inability to cope will be based on our predisposition and resources or support. The stress-vulnerability model is often referred to as that of a 'bucket' which can be large or small depending upon several factors, a small part being genetics, but the major contributor being life experiences (Brabban & Turkington, 2002). There is a long list of these; abuse, neglect, losing a parent at a young age, being bullied or socially isolated. The point at which someone may therefore hear voices is when they find they cannot cope with life (stress) but do not have the resources to cope due to their vulnerability.

There have been a number of theories developed about which of these life events are most likely to contribute to the development of hallucinations and delusions.

These are discussed below:

i. Trauma and abuse

Varese *et al.* (2012) reviewed 30 years of studies looking at the association between childhood trauma and the development of psychosis. As well as finding a link between childhood trauma and psychosis the research began to explore the potential reasons involved. The meta-review suggests that childhood adversities

when associated with maladaptive family functioning are linked with the highest risk of mental disorders. The reasons for this are that exposure to childhood trauma leads to long-term adult maladaptive psychological and behavioural consequences.

When it comes to voice hearing specifically there is research available which suggests that auditory hallucinations may be a result of physical, sexual or emotional trauma. Hammersley and Read (2007) argue that two-thirds of people diagnosed as schizophrenic have suffered physical or sexual abuse. Their evidence included a review of 40 studies which revealed childhood and adulthood abuse in the history of schizophrenic patients. The evidence from the reviews suggests that psychiatric patients who report abuse are much more likely to experience flashbacks from the associated trauma and perceive them as hallucinations. They also experience voices that bully them just as their abuser did which results in paranoia and a mistrust of people close to them. De Bellis (1997) explains that trauma may have psychopathological as well as developmental consequences. Childhood is seen as a unique period of progressive physical, behavioral, cognitive, and emotional development. Child abuse experiences may cause delays in, deficits of, or failures of multisystem developmental achievements in behavioral, cognitive and emotional regulation. It may therefore be the consequences of these regulatory difficulties which could explain why a person abused in childhood hears voices.

ii. Stress and the impact of emotion

Romme and Escher (2001) have suggested that for many people their voices first start during a period of emotional turmoil or following a traumatic experience. They found from interviewing voice hearers that when their voices started they resulted in feelings of confusion, panic and powerlessness. This was then often followed by

months or even years during which the person struggled to find ways to cope with their voices. The extent to which voice hearers were able to cope with their experiences determined the level of impact and distress that resulted.

1.4 Interventions for voice hearing

1.4.1 Pharmacological interventions

Within this perspective some have argued that pharmacotherapy is generally effective in treating acute psychosis and in preventing the frequency of relapse (Sanjuan *et al.*, 2010). Sommer *et al.* (2012) reviewed the treatment of hallucinations in schizophrenia. The first treatment option for hallucinations in schizophrenia was antipsychotic medication. Findings showed only 8% of first-episode patients still experienced mild to moderate hallucinations after continuing medication for one year following diagnosis. Early intervention is considered to be very important when treating positive symptoms in schizophrenia. The rationale for such an approach is that people are accessed at a relatively treatment-responsive stage of illness. The possible adverse consequences associated with untreated psychosis may be minimized by early pharmacological treatment thus improving symptomatic and functional outcomes (Perkins *et al.*, 2005).

The National Institute for Clinical Excellence (NICE) recommends that for people with newly diagnosed schizophrenia health professionals should offer oral antipsychotic medication (NICE, 2002). Barnes (2011) reviewed evidence from systematic reviews and RCTs regarding the pharmacological management and treatment of schizophrenia. The results suggest that there is preliminary evidence

that both low-dose antipsychotics and cognitive behavioural therapy (CBT) can improve presenting symptoms. The results of this meta-review contributed to guidelines drawn up by the British Association of Psychopharmacology. The guidelines are designed to provide information to professionals, patients and carers (British Association of Pharmacology, 2011).

Data comparing anti-psychotic medication with a placebo or psychosocial treatment is sparse. In a Cochrane Review Bola *et al.* (2011) analysed data from studies of antipsychotic medication in early psychosis. All studies had to have a majority of first and second episode schizophrenia spectrum disorders and compared initial antipsychotic medication treatment with placebo, milieu therapy (community based group psychotherapy) or psychosocial treatment. They found few good quality studies comparing the acute treatment of early episode schizophrenia with an antipsychotic medication compared to placebo or psychosocial treatment. The results they did analyze showed that initial treatment with medication reduced study attrition rates while also increasing the risk for medication-induced side effects. Further research appears required to assess the efficacy of anti-psychotic medication compared to a placebo or psychosocial treatment.

1.4.2 Non pharmacological interventions

NICE has published revised guidelines on treating and caring for people with schizophrenia. The British Psychological Society helped develop the guidelines via its membership of the National Collaborating Centre for Mental Health. According to the revised recommendations all patients with schizophrenia should be offered CBT and their family members should be offered family therapy (NICE, 2009).

Cognitive Behaviour Therapy for Psychosis (CBTp)

Cognitive behaviour therapy for psychosis has gained increasing interest over the last decade. Much of the research into CBTp has been carried out in the United Kingdom (Wykes *et al.*, 2008). Evidence for the effectiveness of CBTp has led to its inclusion in NICE guidelines as a treatment for persistent positive symptoms in schizophrenia (NICE, 2009).

Psychoeducation

Psychoeducation, in its literal definition, implies provision of information and education to a service user with a severe and enduring mental illness including schizophrenia. Psychoeducational approaches have been developed to increase patients' knowledge and insight into their illness and its treatment and to promote more effective coping and thereby improve prognosis (Xia *et al.*, 2011). In a Cochrane analysis Pekkala and Merinder (2002) reported that the provision of psychoeducation is accompanied by a higher level of compliance, lower rate of relapse and improved levels of functioning.

Counselling and supportive therapy

In the 1950's Carl Rogers developed 'person-centred' therapy as a reaction to the behaviourist approach of that time. Rogers placed emphasis on the importance of a client's internal emotional world (Thorne, 1992). One study has suggested that supportive therapy as it is now known has been cited as the individual psychotherapy of choice for most patients with schizophrenia (Lamberti & Hertz, 1995). This suggestion certainly does not fit with the NICE guidelines which suggest

that CBTp should be the preferred intervention for use with people with schizophrenic spectrum disorders. The NICE guidelines do, however, pre-date the Lamberti and Hertz study which may suggest that a change occurred in the years that followed. It may also be that those who Lamberti and Hertz questioned cited psychotherapy as their preferred intervention; however, it is CBTp which has been evidenced in many trials as being the most effective for using with people with schizophrenia and is therefore the preferred choice according to NICE.

Self-help groups

Professor Marius Romme and Dr Sandra Escher helped to pave the way for alternative support for people who hear voices (Romme & Escher, 1989). The work of Romme and Escher led to the first Hearing Voices Group (HVG) in the UK which was formed by Paul Baker in 1988. In the UK there is the 'Hearing Voices Network' and internationally there is 'Intervoice'. These are organisations that allow clients, non-patients and professionals to share their ideas about voice hearing. The prevailing attitude of these organisations is to prioritise the perspective of the voice hearer and suggest that there is no one cause or treatment for voice hearing (Cooke & Meddings, 1999). There have been limited trials carried out into the effectiveness of these HVG's. Meddings *et al.* (2004) used outcome measures with members of a number of HVG's. The outcome measure used showed some promising results such as feeling less controlled by voices. These will be discussed in more detail in the results section of this review.

1.5 Measuring voice hearing

In research studies the effectiveness of an intervention for voice hearing is measured using various tools. There are a number of tools available such as the Maastricht Interview (Romme, 1998) and the Cognitive Assessment of Voices Interview Schedule by Chadwick and Birchwood (1994). The Maastricht interview is a semi-structured questionnaire used to explore the experience of voice hearing. The Cognitive Assessment of Voices Interview Schedule is a semi-structured interview intended to help guide an assessment of cognitions in voice hearing. More recently two other tools have been developed and it is these which are now most widely used. These are the Beliefs about Voices Questionnaire – Revised (BAVQ - R) and the Psychotic Symptom Rating Scale (PSYRATS). These are described below:

1. Beliefs about Voices Questionnaire – Revised (BAVQ - R)

Chadwick and Birchwood (1994) developed a model for understanding what maintains voice hearing. The BAVQ measures beliefs, feelings and behaviour reacted to voice hearing. The scale was revised in 2000. The BAVQ –R is a thirty five item measure with three subscales. These subscales look at beliefs, resistance and engagement and all responses are based on a four point scale.

In a study by James (2002) the BAVQ – R was assessed for reliability and validity. The results showed that the BAVQ-R measured constructs that are potentially useful and relevant to understanding and treating patients suffering from chronic refractory hallucinations. Furthermore, the study found that the measure was valid and reliable

with the sub-scale scores being stable and measuring homogenous constructs. The BAVQ-R also exhibited test-retest reliability and internal consistency reliability

II. Psychotic Symptom Rating Scale (PSYRATS)

The Psychotic Symptom Rating Scale (PSYRATS) was developed by Haddock *et al.* (1999) to address the limitations of psychiatric tools such as the Positive and Negative Syndrome Scale (PANSS). These limitations related to its focus on a single dimension of symptoms. Whilst focusing on a single dimension this type of tool lacked the consideration of other important dimensions such as levels of distress and disruption to life. Assessing dimensions such as distress is important given that it is this type of effect of voice hearing that is highly related to depression and anxiety (Steel *et al.*, 2007).

The PSYRATS has two separate scales for auditory hallucinations and delusions. The auditory hallucinations scale consists of eleven items rated from zero to four. There are three characteristics of the auditory hallucinations scale which are emotional characteristics, physical characteristics and cognitive interpretation.

The PSYRATS has been shown to assess dimensions of hallucination and delusions reliably and validly in chronically psychotic patients but not in first episode patients. Item reliability has been investigated and subscale performance compared to the PANSS. The PSYRATS has good inter-rater and retest reliability. Validity was good as assessed by internal consistency, sensitivity to change and in relation to the PANSS (Drake *et al.*, 2007).

Conclusion

Voice hearing can cause individuals high levels of distress and has been shown to increase the likelihood of a person experiencing depression, anxiety, social isolation and suicidal ideation.

There are a number of biological and psychological explanations as to why people hear voices. These explanations have led to the development of a number of interventions. Psychopharmacological interventions and CBTp are both recommended in NICE guidelines for use with people with a diagnosis of schizophrenic spectrum disorders. The effectiveness of using medication to treat individuals with schizophrenic spectrum disorders has shown that there is an improvement in certain areas such as an alleviation of negative symptoms. Research suggests, however, that voice hearing is less affected by medication. CBTp has been shown to be effective when used with Individuals with a diagnosis of schizophrenia. Research suggests that this intervention can lead to number of improvements for individuals such as a reduction in social isolation. The impact for the symptom of voice hearing is less clear and there is limited evidence to suggest that there is any change to the distress caused by voices.

2 Method

Literature Review Question:

What evidence is there for the effectiveness of psychological interventions for voice hearing?

The aim of the current review was to explore the evidence that exists for the use of psychological interventions in voice hearing.

During the summer of 2013, over a six week period, a systematic review of existing literature was carried out by searching five databases: PsychInfo; ASSIA; Medline; Scopus; and Web of Science. Each of these databases was searched using the following key terms:

Interventions OR Therapy AND Hearing Voices OR Auditory Hallucinations AND Psychology/Hearing voices OR Auditory Hallucinations AND Cognitive Behaviour Therapy OR Counselling OR Psychoeducation OR Self Help OR Hearing Voices Groups OR Psychosocial AND Effective AND Psycholog*AND Intervention**

**Use of a truncation*

Variations of these terms were used for each of the databases, for example, for some databases it was possible to search for similar terms and to extend the search using truncations. All searches were limited to English language and journal articles or reviews. The search was deemed exhaustive when new database searches failed to detect any new articles. A total of 572 articles were generated at this stage. A list

of which key words were used and the number of articles found can be located in Appendix A.

The titles of all 572 articles were read to determine their relevance to the literature review question leaving 65 articles in total. The abstracts of remaining 65 articles were read through and a number of exclusion and inclusion criteria were applied at this stage in the systematic search. This enabled articles which were not suitable for inclusion in the review to be identified. These criteria were as follows:

Inclusion criteria

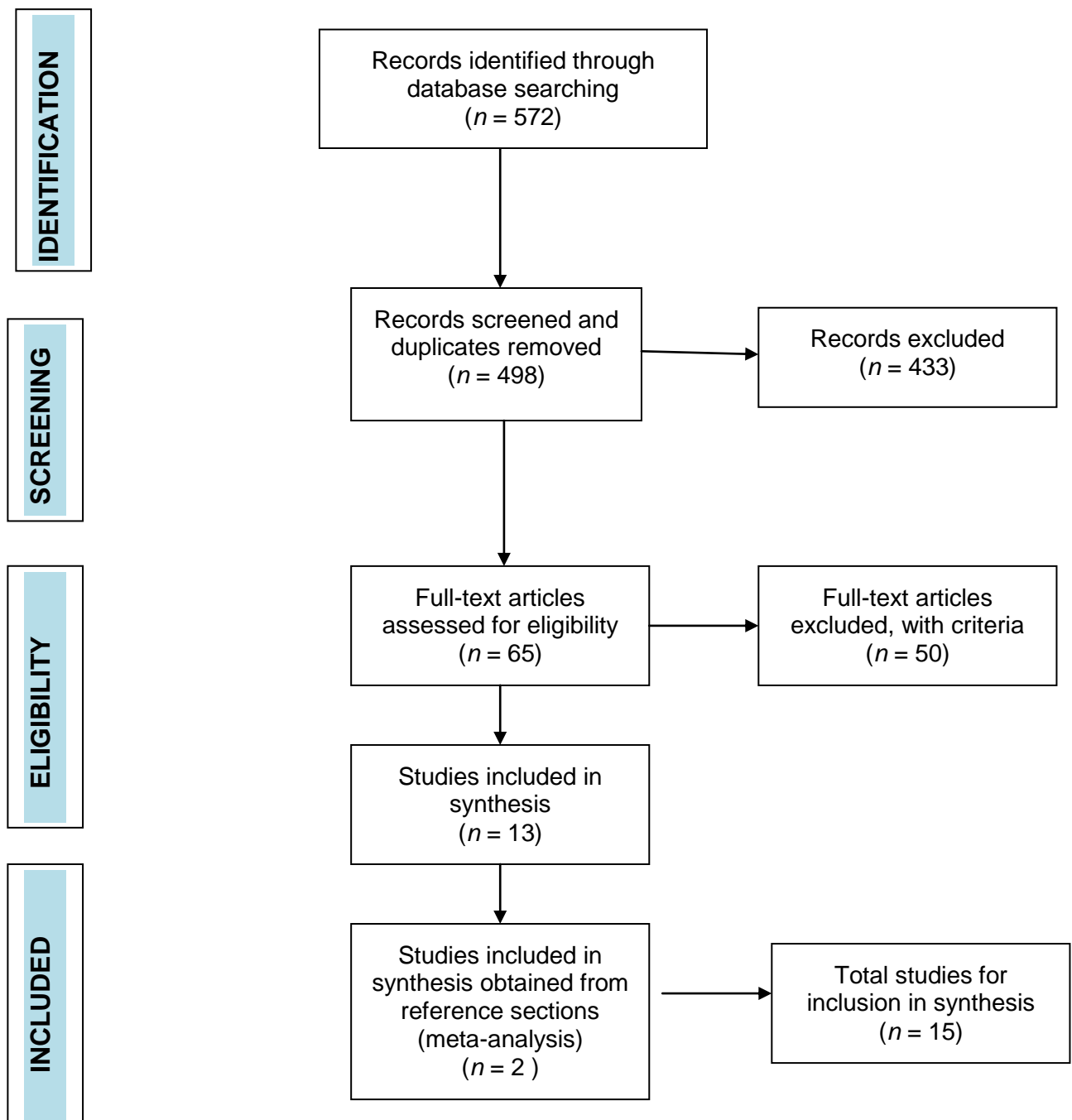
- Papers that are about psychological interventions for voices hearing
- Recent reviews of psychological interventions in voice hearing
- Cochrane Database Systematic Reviews

Exclusion criteria

- Papers that predate 2002 (restricted to this date to capture the most recent research in this area)
- Papers that are not written in English
- Any papers based on medication or physical treatment (i.e. ECT)

Figure 1 below shows the process of the systematic literature searching from start to finish.

Figure 1: A diagram to show systematic review process



A further two articles were also included from reading reference lists of several papers. The total number of articles for inclusion in the review was 15. The 65 articles were reduced to 15 by the use of the inclusion and exclusion criteria. More in depth reading of a number of articles was required as it was not possible to make a decision based on the information found in the abstract alone. The main reasons for further exclusion at this stage was that there were a high number of reviews looking at the evidence for the effectiveness of interventions such as CBT. As these reviews were looked at it became apparent that some were repetitious and tended to review the same studies with later papers including the addition of more recent studies. In order to avoid drawing on repeated evidence only the more recent reviews and also those published in the Cochrane Database of Systematic Reviews (CDSR) were included.

Quality Assessment

In order to assess quality a number of questions were answered for each study. These questions were based on a measurement tool called AMSTAR designed to assess systematic reviews (Shea *et al.*, 2007). Whilst not all of the final 15 papers were reviews it was decided to focus only on reviews as they would be providing the majority of information for use in this review. The decision to focus on reviews in the current review was because they provide comprehensive information about psychological interventions based on the best available evidence. The amount of papers assessed was 10. The details of this quality assessment and its results can be found in Appendix B. All papers achieved either High Quality (eight) or Acceptable (two). All studies shared one characteristic; none of them listed all excluded as well as included studies.

2.1 Data Extraction

In order to elicit information from each article so that they could be more easily critiqued a data extraction form was used. This tool was adapted using the principles outlined by Jones (2005). Jones outlined the following as being important factors to be extracted (see Appendix C for adapted form).

- Research question/aim
- Time frame (date of study and length)
- Study location (county and setting)
- Population
- Study type (method and analysis)

Each article was read and re-read and relevant information extracted. Table 1 below shows the information extracted from each of the 15 articles.

Table 1: Details of articles used in literature review

Title	Author, Year and Study Location	Aim	Sample & Setting	Method & Analysis
A randomised controlled of group cognitive therapy vs. enhanced supportive therapy for auditory hallucinations	Penn, Meyer, Evans, Wirth, Cai, & Burchinal (2009) US	To investigate the effectiveness of group CBT for auditory hallucinations compared to an enhanced supportive therapy (ST)	Service users with schizophrenic spectrum disorders and persistent auditory hallucinations from outpatient clinic and community mental health teams	Assessor blind RCT. Analyses using the general linear model to compare outcomes for the two treatment groups
Cochrane Reviews of non-medication-based psychotherapeutic and other interventions for schizophrenia, psychosis and bipolar disorder: A systematic literature review	Jung, & Newton, (2009) Australia	To create a table that would identify evidence based interventions in mental health services of a psychotherapeutic or psychosocial nature	Varied	Systematic review of Cochrane Reviews. Interventions were classified using The Joanna Briggs Institute (JBI) grades of recommendation

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
Cognitive Behaviour Therapy for Schizophrenia: Effect Sizes, Clinical Models and Methodological Rigor	Wykes, Steel, Everitt, & Tarrier (2008) UK	To explore the effect sizes of current CBTp trials including targeted and non-targeted symptoms, modes of action and effect of methodological rigor	Varied across studies	CBTp trials were used as source data for a meta-analysis and investigation of methodology. Clinical Trial Assessment Measure (CTAM) used to measure effect of trial methodology. Effect sizes calculated
Cognitive-Behavioural Therapy for Schizophrenia: A Review	Turkington, Dudley, Warman, & Beck, (2006) UK	To review the evidence for using CBTp in people with schizophrenia spectrum disorders	Varied across studies	Controlled trials were systematically reviewed (trials dated between 1990-2003)

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
A review of hearing voices groups: Evidence and mechanisms of change	Ruddles, Mason, & Wykes, (2011) UK	To review evidence for different types of HV groups and to evaluate the qualitative & quantitative evidence for possible predictors & mechanisms of change within HVG's	Varied sample and settings across studies	Systematic search of the following databases: PsychINFO, Web of Science, Ovid MEDLINE, EMBASE, and CINAHL. Studies included in the review were synthesized
Group cognitive-behavioural therapy for schizophrenia	Barrowclough, Haddock, Lobban, Jones, Siddle, & Gregg, (2006) UK	To evaluate the effectiveness of group cognitive behavioural therapy for schizophrenia	113 people with persistent positive symptoms of schizophrenia. Mental health services with the NHS	Two group randomised design. Cross-sectional analyses performed. Linear random effects model adjusted to include random effect to account for between group variations.

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
Cognitive behaviour therapy versus other psychosocial treatments for schizophrenia (Review)	Jones, Hacker, Cormac, Meaden, & Irving, (2013) UK	To review the effectiveness of CBT for people with schizophrenia when compared to other psychological therapies	Varied across studies	Systematic search of Cochrane Schizophrenia Groups Trials Register was conducted. Studies were reliably selected and assessed for methodological quality.
Cognitive Behavioural Therapy for Psychosis (CBTp) in Clinical Practice	Sivec, & Montesano, (2012) Carried out in US but based on studies across the US and UK	To review the literature that addresses the effectiveness of CBTp.	Varied across studies	Controlled trials were systematically reviewed (trials dated between 2001-2010)

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
What are the effects of group cognitive behaviour therapy for voices? A randomised control trial	Wykes, Hayward, Thomas, Green, Surguladze, Fannon, & Landau, (2005) UK	To test the effectiveness of group CBT on social functioning and severity of hallucinations	45 Participants with a diagnosis of schizophrenia with distressing hallucinations were allocated to CBT group and 40 TAU. All from community mental health teams.	Outcome scales were analysed using linear mixed modelling.
Group cognitive behavioural therapy for schizophrenia: a systematic review of the literature	Lawrence, Bradshaw, & Mairs, (2006) UK	To systematically review the controlled trials that have evaluated group CBT for people with a diagnosis of schizophrenia	Varied across studies	Controlled trials were systematically reviewed (trials dated between 1999-2005)

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
Effectiveness of psychoeducation for relapse, symptoms, adherence and functioning in psychotic disorders: A meta-analysis	Lincoln, Wilhelm, & Nestoriuc, (2007) UK	To evaluate the short & long term efficacy of psychoeducation with & without the inclusion of families with regard to relapse, symptom reduction, knowledge, adherence to medication & functioning.	Varied across studies reviewed	18 controlled trials were systematically reviewed. Effect sizes used to compare effectiveness of psychoeducation. (trials dated between 1982-2005)
Psychoeducation for schizophrenia	Xia, Merinder, & Belgamwar, (2011) UK	To assess effectiveness of psychoeducation interventions compared with standard levels of knowledge provision.	Varied across studies	44 trials were systematically reviewed

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
A randomised controlled trial of acceptance based cognitive behavioural therapy for command hallucinations in psychotic disorders	Shawyer, Farhall, Mackinnon, Trauer, Sims, Ratcliff, Lerner, Castle, & Mullen, (2012) UK	To evaluate whether CBT augmented with acceptance based strategies from Acceptance and Commitment Therapy could reduce negative impact of command hallucinations.	43 people with problematic command hallucinations were randomised to either TORCH (Treatment of Resistant Command Hallucinations) or the control, befriending.	Within groups analyses and comparisons based on blinded assessment data.
Cognitive behavioural therapy for major psychiatric disorders: does it really work? A meta-analytical review of well controlled studies	Lynch, Laws, & McKenna, (2010) UK	Examine effectiveness of CBT in studies which have attempted to guard against lack of blinding & failure to use a control intervention	Varied across studies	Data synthesized using standard meta-analytic techniques. Effect sizes of studies were extracted by investigators and checked twice.

Title	Author, Year & Study Location	Aim	Sample & Setting	Method & Analysis
Are Hearing Voice Groups Effective? A Preliminary Evaluation	Meddings, Walley, Collins, Tullett, McEwan B, & Owen (2004) UK	To examine the effectiveness of a hearing voices group.	12 group members fully took part in the evaluation. Age range was 27-57.	Several measures were used at the point of joining the group, after 6 months and after 18 months of attending the group. Measures included the use of standardised questionnaires at two time points and qualitative interviews. The majority of comparison was made single paired sample related t-tests. Effect sizes were reported.

3 Results

The final 15 articles selected for inclusion in this review covered a range of interventions for voice hearing. These interventions can be categorized into four groups which are CBTp, Psychoeducation, Supportive Therapy/Counselling and Self Help Groups. In the section below each paper is described under the relevant heading. CBTp was the most frequent intervention used in the literature search. There were only three papers which focused on voice hearing as the specific symptom. In the remainder of the papers voice hearing is included within the overall category of positive symptoms.

3.1 Cognitive Behaviour Therapy for Psychosis (CBTp)

NICE guidelines have led to the acceptance of using CBT for depression and anxiety in health services. Controlled studies of CBTp began in the early 1990's in the United Kingdom. NICE guidelines have included CBTp as a preferred treatment for schizophrenia since 2002. The inclusion of CBTp in these guidelines followed an increasing numbers of studies which demonstrated its effectiveness in managing symptoms of schizophrenia.

The literature search generated a number of review studies looking at the evidence for CBTp. These papers dated from 2002 – 2013 and reviewed mostly Randomised Controlled Trials (RCT's). The reviews are categorised into studies investigating the effectiveness of either CBTp with individuals or group CBTp.

3.1.1 Individual CBTp

According to NICE guidelines there are 31 RCT's which have shown CBTp to be effective when it comes to a variety of factors, such as symptom management (Kuipers *et al.*, 2010; NICE, 2009). RCT's are regarded as the gold standard in the hierarchy of evidence by which all treatments are judged (Everitt & Pickles, 2003).

Turkington *et al.* (2006) reviewed the literature focusing on what evidence there is for CBT for Schizophrenia. In their study they reviewed the evidence for various psychosocial interventions for use in patients with schizophrenia in comparison to CBT. The other psychosocial interventions were psychoeducation, social skills training, cognitive remediation and family interventions. A review was carried out looking into the effectiveness of each of these other interventions. The results of this review found that none of these non-CBT interventions proved significantly beneficial when used with people with a diagnosis of schizophrenia. Whilst each of these other interventions was not found to be effective as stand-alone treatments they were considered to be of value when used as an accompaniment to CBTp. The treatment studies of CBTp were largely found to have been positive with large effect sizes for reducing positive symptoms at the end of therapy. Interventions that lasted more than three months were more likely to reduce the risk of relapse.

Wykes *et al.* (2008) carried out a review of CBTp to explore the effect sizes of CBTp trials. The paper analysed 34 studies in total. The outcome under investigation for each study was the total symptom score on an appropriate scale. The results of this review showed that there were benefits regarding positive symptoms, negative symptoms, functioning, mood and social anxiety. The effect sizes ranged from 0.35 to 0.44. Whilst this review observed the same as other meta-analyses by showing that CBTp had beneficial effects on positive symptoms it also highlighted that treatment trials that made no attempt to mask group allocation to assessors were likely to have inflated effect sizes. Masking is the process by which assessors are blinded as to which group's measures they are assessing (CBT or control).

In 2010, Lynch *et al.* reviewed the evidence for CBT focusing on its use as an intervention for major psychiatric disorders. The evidence for the effectiveness of CBT in schizophrenia showed that of nine trials reviewed CBT was no better than non-specific control interventions in treating symptoms and did not reduce rates of relapse. Non-specific interventions were supportive counseling ($n=5$), befriending ($n=1$), group psychoeducation ($n=1$), recreational therapy ($n=1$) and social activity therapy ($n=1$).

The most recent paper included in this review was from 2012 by Sivec and Montesano. This paper reviewed similar studies to those previously mentioned (Wykes *et al.*, 2008; Turkington *et al.*, 2006) but included an update of more

recent treatment trials. The majority of trials were favourable in support of using CBTp for managing symptoms. However the effect size of trials varied from between 0.08 to 0.40. This paper explains that differences in methodologies of trials led to varied effect sizes being reported.

3.1.2 Group CBTp

CBTp has also been researched for use in a group format. Wykes *et al.* (2005) carried out a trial investigating the effects of group CBTp for auditory hallucinations. Participants were allocated to either group CBTp ($n = 45$) or a control group who received treatment as usual (TAU, $n = 40$). The results of this trial showed that group CBT improved social functioning. Hallucinations were only reduced however when group therapy was delivered by experienced therapists.

Barrowclough *et al.* (2007) evaluated the effectiveness of group CBT for schizophrenia. In total 113 people with persistent positive symptoms were assigned to either a group CBT programme or were given treatment as usual. No significant differences were found between the CBT and control group on measures of symptom, functioning or relapse. The CBT group did however reduce feelings of hopelessness and low self-esteem. The results of this study supported the outcome of the trial by Wykes *et al.* (2005).

Penn *et al.* (2009) carried out a RCT of group CBT compared with enhanced supportive therapy (ST) for auditory hallucinations. In total 65 people with schizophrenia spectrum disorders and persistent hallucinations were randomly assigned to a group. They found that only ST showed a reduction in negative beliefs through twelve months follow up while CBT was shown to lead to a reduction in psychotic symptoms through twelve month follow up. Group CBT was not found to result in a reduction in voice distress or intensity.

A systematic review of the literature for group CBT for schizophrenia was carried out by Lawrence *et al.* (2006). The aim of the review was to assess whether group CBT was more effective than treatment as usual or active treatment. The review incorporated the results of five controlled trials which used outcome measures to determine effectiveness of treatment. Session frequency and duration varied from six sessions in six weeks to sixteen sessions in eight weeks. One study dated 1999 showed that there was a significant reduction in auditory hallucinations based on PSYRATS scores. However the most recent trial in 2005 carried out by the same author (Wykes) found no significant difference between group CBT and Treatment As Usual (TAU). The main conclusions of this review were that group CBT is more effective than TAU in reducing levels of social anxiety. However the benefits of group CBT were reduced when comparing CBT to an active treatment (i.e. supportive counseling).

3.1.3 Acceptance- based Cognitive Behavioural Therapy

Acceptance-based Cognitive Behavioural Therapy combines CBT with strategies from Acceptance and Commitment Therapy. Shawyer *et al.* (2012) conducted a trial investigating the effectiveness of acceptance- based Cognitive Behavioural Therapy in people with command hallucinations. Participants were assigned to the treatment group or a control group of befriending. Participants did report improvement in their command hallucinations, however, no significant group differences were found in primary and secondary outcome measure using blinded assessments.

3.2 Psychoeducation

Psychoeducation (PE) for schizophrenia and other psychotic disorders is widely adopted but insufficiently evaluated according to Lincoln *et al.* (2007). A meta-analysis was carried out by Lincoln *et al.* (2007) which looked at the evidence for using PE for treating psychotic disorders. In total 18 studies were evaluated with a focus on the effectiveness of PE on relapse, symptoms, knowledge, adherence and functioning. The findings showed that PE had a medium effect size at post- treatment for preventing relapse and a small effect size for knowledge. There was no effect on symptoms, functioning and medication adherence. When families were involved in PE the effects were greater in reducing symptoms by the end of treatment.

Xia *et al.* (2011) assessed the effectiveness of psychoeducation interventions compared with standard levels of knowledge provision. The main findings from the trials examined were that psychoeducation when compared to standard levels did seem to reduce relapse, readmission, and length of stay in hospital. No change was reported in positive or negative symptoms.

3.3 Supportive Therapy/Counselling

NICE guidelines for the treatment of schizophrenia suggest that health professionals should not routinely offer counseling and supportive psychotherapy (as specific interventions) to people with schizophrenia. The preferred option for intervention is CBTp or family therapy (NICE, 2009). Most trials involving supportive therapy have used it as a comparison treatment for other more targeted psychological approaches rather than investigating it as a primary intervention. This may be because supportive therapy is not a well-defined unique intervention, has no overall unifying theory and is commonly used as an umbrella term describing a range of interventions from 'befriending' to a kind of formal psychotherapy (Buckley *et al.*, 2007).

3.4 Self-help/hearing voices groups

Ruddle *et al.* (2011) evaluated evidence for hearing voices groups and the mechanisms of change for successful interventions. The study searched the evidence base to find papers which described or evaluated Hearing Voices

Groups (HVG's). Of the three studies which described open ended HVG's voice frequency and power significantly decreased after attending. There were, however, no control groups and a very small sample size. The review also looked at problems solving and skills based groups (six studies). Only one of the papers had evaluated their program and showed significant improvements on all voice typography items except loudness, anxiety and depression. Once again there was no control group used. The paper points out that there is no reliable evidence at present to suggest that HVG's are more or equally effective as other group approaches and therefore further RCT's are needed.

Meddings *et al.* (2004) used a number of outcome measures with members of a hearing voices group. These measures were given at the start of attending the group, after six months and then after eighteen months of starting to attend the group. Results showed that after attending the group people used far more coping strategies, people were able to talk to far more people about their voices, empowerment increased, self-esteem was higher, the frequency of voice hearing reduced, and people felt better able to cope with their voices. Further findings showed that at six and eighteen months voices were perceived as less powerful and members reported feeling less controlled by their voices. Power and control may be key improvements as they have been found to relate to a number of other variables including depression and violence which could in turn relate to distress and hospital admissions (Chadwick *et al.*, 2000; Cheung *et al.*, 1997). The findings of this paper show great promise about the effectiveness of

self-help groups for voice hearing. There are methodological considerations highlighted in the paper. These include the lack of a control group and minimal repetition of outcome measures.

Summary

Overall papers in this review showed CBT to have the largest evidence base by far when compared to other psychosocial interventions such as supportive counseling. The evidence shows some positive outcomes in the use of CBTp such as a reduction in symptoms, reduced rates of relapse and reduced hospitalisations. However the RCT results of trials where CBT was compared to an active treatment (i.e. supportive counseling) were less promising than in trials using TAU. The evidence for the effectiveness of other interventions, whilst not as strong as CBT, does suggest that there may be benefits to using certain components as a complement to CBT. There is a lack of large scale trials investigating the effectiveness of self-help groups for voice hearing. The evidence that has been reported, albeit based on small scale studies, does show a variety of benefits for people accessing groups.

3.5 Methodological Issues

In synthesising the evidence a number of methodological issues presented.

These issues are as follows:

Non masked (blind) assessors.

Studies which have not used masked assessors have produced better results for the effectiveness of CBTp than studies which did use masking. This suggests that when assessors know which group they are assessing the effect sizes for CBT are better than in studies where assessors do not know. The most recent review by Sivec and Montesano (2012) certainly supports this. In this paper several meta-analyses of RCT's found that once they removed non-masked studies the average effect size decreased. Furthermore this review by Sivec reports that meta-analytic studies by Zimmerman *et al.* (2005) found sizes went from 0.54 to 0.29 and Wykes *et al.* (2008) reported a reduction from 0.492 to 0.307. Taking into consideration the studies which did not use masking the mean effect size in each of these reviews were around 0.30. Using Cohen's (1988) benchmarks (0.20 is small, 0.50 is medium and 0.80 is large) this mean effect size is small (Cohen, 1988).

Improvement in positive symptoms not maintained at follow up

Whilst studies investigating the effectiveness of CBTp have demonstrated promising benefits these are often reported during the treatment phase and immediately afterwards. Several of the reviews cited within this review (Sivec & Montesano, 2012; Wykes *et al.*, 2008) found that benefits regarding positive symptoms were no longer present at extended follow up (i.e. six to twelve months after active treatment) in many but not all studies. It has been suggested that when CBTp is combined with other interventions (motivational

interviewing, family involvement) there is promise for maintenance of benefits over time (Jenner *et al.*, 2006)

Frequency and number of sessions

The many RCT's of CBTp have varied regarding the number of sessions offered, the frequency of sessions and their length. The NICE guidelines for the treatment and management of schizophrenia suggest that at least 16 sessions of CBT should be offered (NICE, 2009). There are variations between the number of sessions offered within the RCT's which exists for CBTp. Lawrence *et al.* (2006) found that studies using group CBTp varied in the amount of sessions offered. The number of session offered ranged from six weekly (Wykes *et al.*, 1999) to sixteen sessions over eight weeks (Kinsep *et al.*, 2003). Wykes and Tarrier (2008) have pointed out that there needs to be some clarity of what 'dose' of therapy people are receiving across services. They state that 'a simple-to-apply measure for psychological treatments needs to include aspects of therapy e.g., how many sessions the person receives'. This, they suggest, 'could be easily gleaned from a simple process measure collected by therapists and later tested for reliability'.

Level of therapists training

There is likely to be a great deal of difference in the level of experience of therapists and how much supervision they receive. Whilst the majority of studies of CBTp are delivered by expert psychologists and advanced practice

nurses/therapists (Sivec & Montesano 2012) the level of therapist expertise varies across other research trials. Farhall *et al.* (2009) in a study of the effectiveness of CBT in outpatients with psychosis found there were no positive changes in symptom management. The paper suggests a number of reasons for this finding one of which is that it is likely that therapist expertise was less than in most efficacy studies. Farhall explained that 'although it is not clear what level of expertise is required to gain clear benefits from individual CBTp, no more than one of the therapists in the study is likely to be as experienced as the effective therapists in the Wykes *et al.* (2005) study'. The therapists in the Wykes *et al.* (2005) study had extensive CBT training which included expert supervision for a series of individual cases for at least a year following initial training. It would be useful to investigate further the level of therapist expertise that is required in order to achieve benefits for those receiving CBTp.

RCT's using active treatment versus TAU

Those studies which used TAU as the control revealed greater efficacy than those that used an active treatment (supportive counseling for example). Sivec *et al.* (2012) summarised that in CBTp studies in which the control is TAU the average effect size for positive symptoms ranged from 0.30- 0.40. In the studies which used an active treatment the average effect size dropped to around 0.20. These findings suggest that the effectiveness of CBTp differs when it is compared to groups receiving some other form of treatment versus those receiving only TAU.

4. Discussion

The majority of evidence found for this review related to the use of CBT as an intervention for use in schizophrenia and other psychotic disorders. NICE guidelines have included CBTp as a preferred treatment for schizophrenia since 2002. The inclusion of CBTp in these guidelines followed an increasing numbers of studies which demonstrated its effectiveness in managing symptoms of schizophrenia. This review included papers which conducted RCT's of CBTp versus TAU as well as CBT versus active treatment. Also included were meta-analyses which had reviewed RCT's for CBT over the last three decades. The evidence between trials does vary but there is evidence to suggest that CBTp is an effective intervention for use with people with a diagnosis of schizophrenia and other psychotic disorders. Factors such as symptom reduction, relapse reduction, improvement in social functioning, medication adherence and reductions in hospital admissions have been reported in some trials of CBTp. Despite the large amount of trials conducted there remain a number of methodological issues which have to be considered when understanding the true effectiveness of CBTp.

As Sivec *et al.* (2012) pointed out in their review of CBTp trials there are a number of factors which appear to have an impact of the effect sizes of trials. These factors are as follows:

- The use of a follow up assessment several months after treatment end: studies varied in whether significant benefits were maintained at follow up.
- The inclusion of an active control group (i.e. supportive counselling): some studies show smaller effect sizes when CBTp is compared to active treatment as opposed to TAU.
- Raters who are blinded to group assignment: smaller effect sizes were found for studies using masking procedures.

Two other important factors to consider are the difference in the level of experience of therapists in trials and the content of sessions being offered.

Wykes *et al.* (2008) found that there have been no investigations of the different elements of treatment in a direct head-to-head comparison. CBTp in schizophrenia varies in its emphasis on cognitive and/or behavioural dimensions of therapy and at the extreme end of the continuum merges with some form of psychodynamic treatments. Clinical emphasis in any model is also dependent on the services in which it is provided and the background professional training of the therapists. The superiority of any model has never been investigated and as there is a shift from efficacy to effectiveness studies this is an important consideration.

Whilst there is an abundance of evidence to suggest CBTp is effective as an intervention, the factors raised by Sivec, Wykes and colleagues highlight problems with trials which perhaps merit further investigation.

The evidence for interventions other than CBTp is less well researched. There is evidence to suggest that psychoeducation, supportive counseling and peer self-help groups can lead to some improvement in functioning for those involved. The trials are however much smaller than those using CBTp as treatment and as such are considered to be less rigorous.

In this reviews most recent paper Jones *et al.* (2013) conducted a Cochrane review investigating CBT versus other psychosocial treatments for schizophrenia. In total 31 papers were compared and Jones *et al.* (2013) reported that trials were often small and of limited quality. When CBT was compared to other psychosocial therapies no difference was found for outcomes relevant to adverse effects/events. Relapse was not reduced nor was re-hospitalisation. There were no differential effects found on positive or negative symptoms of schizophrenia but there may have been some longer term effects for affective symptoms. The findings of this very recent paper are in contrast to a vast majority of the evidence presented in this review.

It would seem that whilst the evidence base for using CBTp to improve functioning is mounting, its impact on voice hearing specifically is less well known. Considering voice hearing is known to cause a great deal of distress to those who have the experience it seems pertinent that more is done to understand how to support those most affected. Much of the evidence points to

the impact of interventions on positive symptoms with regards to reducing the frequency with which they are experienced. There may be other outcomes which are also important and relevant for voice hearers. These may include having better control over voices and a change in beliefs about voices. These outcomes, which are not readily measured in intervention trials, need to be investigated more fully.

5. Limitations of current literature review

Most of the papers looked at in this review used measures for investigating the effectiveness of an intervention. These measures focus on factors such as illness relapse, hospital admissions, compliance to treatment, symptom reduction (negative and positive) and social functioning. Whilst some studies have noted a change in positive symptoms following intervention they have rarely specified to which symptoms this refers. Considering this review is about the effectiveness of psychological interventions for voice hearing it cannot be concluded (in some papers) with certainty how much voice hearing specifically improved following treatment.

The papers which have used voice hearing as a specific symptom to measure have found less favourable results regarding the effectiveness of CBT in managing symptoms. Wykes *et al.* (2005) found that group CBT did improve social functioning but unless therapy was provided by experienced CBT therapists auditory hallucinations were not reduced. Penn *et al.* (2009)

demonstrated that CBT led to a reduction in psychotic symptoms through twelve month follow up, however, CBT was not found to result in a reduction in voice distress or intensity.

6. Conclusion

There is increasing evidence for using CBT with people who have a diagnosis of schizophrenia or other psychotic disorders (CBTp). Research suggests that it is best delivered individually and by more experienced therapists.

Although the evidence base for CBTp is growing the benefits relate largely to general symptom reduction, reduced relapse rates, reduced hospital admissions, better medication adherence and improved social functioning. Less is known about its effectiveness for auditory hallucinations as a specific symptom or experience. The limited evidence available about using CBTp with voice hearing suggests that whilst there are some reported changes to the frequency of voices heard there is little if no change to the distress or intensity caused by the experience.

7. Suggestions for further research

Given the lack of evidence regarding the effectiveness of interventions for voice hearing as a specific symptom it would be helpful to explore this with the people who experience it.

The various methodological issues explored in this review could be controlled for in future RCT's of CBTp. This would involve using masked assessors, higher trained and more experienced therapists, longer term follow up assessments and adhering to the amount of sessions suggested in NICE guidelines.

There seems to be a variety of interventions used with people who hear voices. It would be interesting to know more about how a person who hears voices begins the journey of trying to obtain support for this often distressing experience. Knowing more about what helps, and what does not, may prove useful to services when considering how to support those who are struggling with voice hearing.

Literature Review References

Aleman, A., Nieuwenstein, M., Böcker, K.B.E. & De Haan, E.H.F. (2000). Mental imagery and perception in hallucination-prone individuals. *Journal of Nervous and Mental Disease*, 188, 830-836.

Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23.

Barnes, T.R.E. (2011). Evidence-based guidelines for the pharmacological treatment of schizophrenia: Recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology*, 1, 1–54

Barrowclough, C., Haddock, G., Lobban, F., Jones, SH., Siddle, R., Roberts, C. & Gregg, L. (2006) Group cognitive-behavioural therapy for schizophrenia: Randomised controlled trial. *British Journal of Psychiatry*, 189 (6), 527-532.

Beavan, V. & Read, J. (2010). Hearing voices and listening to what they say: The importance of voice content in understanding and working with distressing voices. *Journal of Nervous and Mental Disease*, 198 (3), 201-205.

Bentall, R.P. & Slade, P.D. (1985). Reality testing and auditory hallucinations: A signal-detection analysis. *British Journal of Clinical Psychology*, 24, 159–169.

Bentall R.P., Kaney S. & Dewey M.E. (1991). Paranoia and social reasoning: An attribution theory analysis. *British Journal of Clinical Psychology*, 30, 13-23.

Birchwood, M. & Iqbal, Z. (1998). Depression and suicidal thinking in psychosis: A cognitive approach. In: Wykes, T., Tarrier, N. & Lewis, S. (Eds.) *Outcome and Innovation in psychological treatment in schizophrenia*. Chichester: John Wiley.

Birchwood, M., Peters, E., Tarrier, N., Dunn, G., Lewis, S., Wykes, T., Davies, L. & Lester, H. (2011). A multi-centre randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations. *Bio Med Central Psychiatry*, 11, 155.

Bola, J., Lehtinen, K., Cullberg, J. & Ciompi, L. (2001). Psychosocial treatment, antipsychotic postponement, and low dose medication strategies in first episode psychosis: A review of the literature. *Psychosis: Psychological, Social and Integrative Approaches*, 1, 4-18.

Buckley, T A., Pettit, T. & Adams, C. (2007). Supportive therapy for schizophrenia. *Cochrane Database Systematic Review*, 3, CD004716.

Brabban, A. & Turkington, D. (2002). *The Search for Meaning: Detecting Congruence between Life Events, Underlying Schema and Psychotic Symptoms*. Brunner- Routledge: Hove.

Brabban, A., Tai, S. & Turkington, D. (2009). Predictors of outcome in brief cognitive behaviour therapy for schizophrenia. *Schizophrenia Bulletin*, 35, 859 – 864.

- Carter, D., Kackinon, L. & Copolov, D. (1996). Patient's strategies for coping with auditory hallucinations. *The Journal of Nervous and Mental Disease*, 184, 159-164.
- Chadwick, P. & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *British Journal of Psychiatry*, 164, 190–201.
- Chadwick, P., Birchwood, M. J. & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. New York: Wiley.
- Chadwick, P., Sambrooke, S., Rasch, S. & Davies, E. (2000). Challenging the omnipotence of voices: Group cognitive behaviour therapy for voices. *Behaviour Research and Therapy*, 38(10), 993-1003.
- Cheung, P., Schweiter, I. & Crowley, K. (1997). Violence in schizophrenia: Role of hallucinations and delusions. *Schizophrenia Research*, 26, 181-190.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2nd Ed.)* Hillsdale, NJ: Lawrence Erlbaum Associates.
- Cooke, A. & Meddings, S. (1999). Working with voices: 10 years gone. *Clinical Psychology Forum*, 124, 46 – 48.
- Darzi, A. (2008). *High quality care for all: NHS next stage review report*. Richmond: Surrey.

De Bellis, M. D. (1997). Posttraumatic stress disorder and acute stress disorder. In Ammerman, R. T. & Hersen, M. (Eds.) *Handbook of Prevention and Treatment with Children and Adolescents*. New York: John Wiley & Sons.

Drake, R., Haddock, G., Tarrier, N., Bentall, R. & Lewis, S. (2007). The Psychotic Symptom Rating Scales (PSYRATS): Their usefulness and properties in first episode psychosis. *Schizophrenia Research*, 89 (1-3), 119-122.

Everitt, B. & Pickles, A. (1999). *Statistical aspects of the design and analysis of clinical trials*. London: Imperial College Press.

Farhall, J., Freeman, N. C., Shawyer, F. & Trauer, T. (2009). An effectiveness trial of cognitive behaviour therapy in a representative sample of outpatients with psychosis. *British Journal of Clinical Psychology*, 48, 47– 62.

Flanagan, S. (1989). *Hildegard of Bingen: A Visionary Life*. Routledge: London.

Hammersley, P., Read, J. & Rudegeair, T. (2007). Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment*, 13, 101-110.

Haddock, G., Slade, P.D., Bentall, R.P., Reid, D. & Faragher, E.B. (1998). A comparison of the long-term effectiveness of distraction and focusing in the treatment of auditory hallucinations. *British Journal of Medical Psychology*, 71, 339 –349.

Haddock, G., Tarrier, N., Morrison, A. P., Hopkins, R., Drake, R. & Lewis, S. (1999). A pilot study evaluating the effectiveness of individual inpatient cognitive-behavioural therapy in early psychosis. *Social Psychiatry and Psychiatric Epidemiology*, 34, 254 – 258.

Hearing Voices Network. (2009). *Hearing Voices Network Consultation Report*. Retrieved: 12 September 2013 from www.hearingvoices.org/wp./11/HVN-Consultation-Report-2009.doc.

James, J. (2002). *Psychometric Investigation of the Validity and Reliability of the Beliefs about Voices Questionnaire-Revised in a Sample of Psychotic Outpatients*. Unpublished Doctoral Thesis. Philadelphia College of Osteopathic Medicine.

Jenner, J. A., Nienhuis, F. J., Van De Willige, G. & Wiersma, D. (2006). “Hitting” voices of schizophrenia patients may lastingly reduce persistent auditory hallucinations and their burden: 18-month outcome of a randomized controlled trial. *Canadian Journal of Psychiatry*, 51, 169 –177.

Jones, C., Hacker, D., Cormac, I., Meaden, A. & Irving, C. (2013). Cognitive behaviour therapy versus other psychosocial treatments for schizophrenia. *Cochrane Database Systematic Review*, 4, CD008712

Jung, X. T. & Newton, R. (2009). Cochrane reviews of non-medication-based psychotherapeutic and other interventions for schizophrenia, psychosis, and bipolar disorder: A systematic literature review. *International Journal of Mental Health Nursing*, 18 (4), 239-249.

Kinsep, P., Nathan, P. & Castle, D. (2003). Cognitive behavioural group treatment for social anxiety in schizophrenia. *Schizophrenia Research*, 63, 121-129.

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G. & Bebbington, P. (2006). Cognitive, emotional, and social processes in psychosis: Refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin*, 32, 24-31.

Kuipers, E., Onwumere, J. & Bebbington, P. (2010). Cognitive model of caregiving in psychosis. *British Journal of Psychiatry*, 196, 259-65.

Lamberti, L. & Hertz, M. (1995). Prodromal symptoms and relapse prevention in schizophrenia. *Schizophrenia Bulletin*, 4, 541-551.

Lawrence, R., Bradshaw, T. & Mairs, H. (2006). Group cognitive behavioural therapy for schizophrenia: A systematic review of the literature. *Journal of Psychiatric Mental Health Nursing*, 13, 673-681.

Leudar, I. & Thomas, P. (2000). Voices of Reason, Voices of Insanity. *Open Mind*, 103, 12-14.

Lincoln, T.M., Wilhelm, K. & Nestoriuc, Y. (2007). Effectiveness of psychoeducation for relapse, symptoms, knowledge, adherence and functioning in psychotic disorders: A meta-analysis. *Schizophrenia Research*, 96 (1-3), 232-45.

Lloyd-Jones, M. (2005). Role development and effective practice in specialist and advanced practice roles in acute hospital settings: Systematic review and meta-synthesis. *Journal of Advanced Nursing*, 49 (2), 191–209.

Lynch, D., Laws, K. R. & McKenna, P. J. (2010). Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta analytical review of well-controlled trials. *Psychological Medicine*, 40, 9 –24.

Meddings, S., Walley, L., Collins, T., Tullett, F., McEwan, B., & Owen, K. (2004). *Are hearing voices groups effective? A preliminary evaluation*. Unpublished research paper, Sussex, UK.

Morrison, A. P. & Baker, C. A. (2000). Intrusive thoughts and auditory hallucinations: A comparative study of intrusions in psychosis. *Behaviour Research and Therapy*, 38, 1097–1106.

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusion. *Behavioural and Cognitive Psychotherapy*, 29, 257–276.

Morrison, A.P., French, P., Walford, L., Lewis, S.W., Kilcommons, A., Green, J., Parker, S. & Bentall, R. P. (2004). Cognitive therapy for the prevention of psychosis in people at ultra-high risk: randomised controlled trial. *British Journal of Psychiatry*, 18, 291–297.

Morrison, A. P., Renton, J.C., Williams, S., Dunn, H., Knight, A., Kreutz, M., Nothard, S., Patel U. & Dunn G. (2004). Delivering cognitive therapy to people with psychosis in a community mental health setting: An effectiveness study. *Acta Psychiatrica Scandinavica*, 110 (1), 36-44.

Morrison, A.P., Hutton, P., Shiers, D. & Turkington, D. (2012). Antipsychotics: Is it time to introduce patient choice? *British Journal of Psychiatry*, 201, 83-84

Mosby's medical dictionary. (8th Ed.) (2009). St Louis, MO: Mosby/Elsevier.

National Institute for Clinical Excellence. (2002). *Clinical Guideline 1: Schizophrenia—Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence. (2009). *Schizophrenia Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care*. London: National Institute for Clinical Excellence.

NHS Choices. (2009). *Psychosis*. Retrieved October 1 2013 from <http://www.nhs.uk/conditions/hallucinations/Pages/Introduction.aspx>

Nuechterlein, K. & Dawson, M. E. (1984). A Heuristic Vulnerability-Stress model of Schizophrenia. *Schizophrenia Bulletin*, 10, 300-312.

Pekkala, E. & Merinder, L. (2002). Psychoeducation for schizophrenia. *Cochrane Database of Systematic Reviews*, 2, CD002831.

Penn, D. L., Meyer, P.S., Evans, E., Wirth, R. J., Cai, K. & Burchinal, M. (2009). A randomized controlled trial of group cognitive-behavioral therapy vs. enhanced supportive therapy for auditory hallucination. *Schizophrenia Research*, 109 (1-3), 52-59.

Perkins, D.O., Gu, H., Boteva, K. & Lieberman, J.A. (2005). Relationship between duration of untreated psychosis and outcome in first episode schizophrenia. *American Journal of Psychiatry*, 162, 1785–1804.

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G. & Morgan, C. (2002). Psychological treatments in schizophrenia: Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine*, 32, 763–782.

Place, C., Foxcroft, R. & Shaw, J. (2011). Telling stories and hearing voices: Narrative work with voice hearers in acute care. *Journal of Psychiatric and Mental Health Nursing*, 18 (9), 837-842.

Rachman, S. J. & De Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy*, 16, 233–238.

Rector, N. A. & Beck, A.T. (2004). Cognitive behavioural therapy for schizophrenia: An empirical review. *Journal of Nervous Mental Disorders*, 189 (5), 278–287.

Rethink. (2003). *Hearing Voices*. Retrieved 1 October 2013 from <http://www.rethink.org/diagnosis-treatment/symptoms/hearing-voices>.

Romme, M. & Escher, A. (1989).Hearing voices. *Schizophrenia Bulletin*, 15, 209–216.

Romme, M. (1998). *Understanding Voices: Coping with auditory hallucinations and confusing realities*. Gloucester: Handsel Publishing.

Romme, M. & Escher, A. (2001). *Accepting Voices*. London: MIND.

Romme, M., Escher, S., Dillon, J., Corstens, D. & Morris, M. (2009). *Living with voices: 50 stories of recovery*. Ross-On-Wye: PCCS Books.

Ruddle, A., Mason, O. & Wykes, T. (2011). A review of hearing voices groups: Evidence and mechanisms of change. *Clinical Psychology Review*, 31 (5), 757-766.

Sanjuan, J., Aguila, E.J. & Artigas, F. (2010). Pharmacological treatments of hallucinations. In: Aleman, A. & Laroi, F. (Eds.) *Treatment of hallucinations*. Oxford: Oxford University Press.

Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliff, K., Lerner, C., Thomas, N., Castle, D., Mullen, P. & Copolov, D. (2012). A randomised control trial of acceptance based cognitive behavioural therapy for command hallucinations in psychotic disorders. *Behaviour Research and Therapy*, 50, 110–121.

Shea, B.J., Grimshaw, J.M., Wells, G.A., Boers, M., Andersson, N. & Hamel, C. (2007). Development of AMSTAR: A measurement tool to assess the methodological quality of systematic reviews. *Bio Med Central Medical Research Methodology*, 7 (10), 7-10.

Shergill, S., Murray, R. & McGuire, P. (1998). Auditory hallucinations: A review of psychological treatments. *Schizophrenia Research*, 32, 137-150.

Shorto, R. (1999). *Saints and Madmen: Psychiatry Opens Its Doors to Religion*. New York: Henry Holt & Company/Macmillan.

Sivec, H. J. & Montesano, V. L. (2012). Cognitive behavioral therapy for psychosis in clinical practice. *Psychotherapy*, 49 (2), 258-270.

Sommer, E., Slotema, C.W., Daskalakis, Z. J., Derks, E. M., Blom, J.D. & Van der Gaag, M. (2012). The Treatment of Hallucinations in Schizophrenia Spectrum Disorders. *Schizophrenia Bulletin*, 38 (5), 893-894.

Steel, C., Garety, P. & Freeman, D. (2007). The multidimensional measurement of the positive symptoms of psychosis. *International journal of methods in psychiatric research*, 16, 88-96.

Tarrier, N. & Wykes, T. (2004). Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? A cautious or cautionary tale? *Behavioural Research Therapy*, 4, 1377–14.

Thorne, B. (2002). *The mystical power of person centred therapy: Hope beyond despair*. London: Whurr Publishers.

Thornicroft, G. (2004). The personal impact of schizophrenia in Europe. *Schizophrenia Bulletin*, 69, 125-132.

Tiwari, A. K., Zai, C. C., Müller, D. J. & Kennedy, J. L. (2010). Genetics in schizophrenia: Where are we and what next? *Dialogues in Clinical Neuroscience*, 12, 289–303.

Turkington, D., Kingdon, D. & Weiden, P.J. (2006). Cognitive behavior therapy for schizophrenia. *American Journal of Psychiatry*, 163 (3), 365-373.

Varese, F., Smeets, F., Drukker, M., Lieveise, R., Lataster, T. & Viechtbauer, W. (2012) Childhood Adversities Increase the Risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies. *Schizophrenia Bulletin*, 38, 661-671.

Vercammen, A., Knegtering, H., Bruggeman, R. & Aleman, A. (2010). Subjective Loudness and Reality of Auditory Verbal Hallucinations and Activation of the Inner Speech Processing Network. *Schizophrenia Bulletin*, 15, 912-918.

Whitaker, R. (2010). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Crown Publishers.

World Health Organisation. (1994). *ICD-10 Classifications of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organisation.

Wykes, T., Parr, A. M. & Landau, S. (1999). Group treatment of auditory hallucinations - Exploratory study of effectiveness. *British Journal of Psychiatry*, 175, 180-185.

Wykes, T., Hayward, P., Thomas, N., Green, N., Surguladze, S. & Fannon, D. (2005). What are the effects of group cognitive behaviour therapy for voices? A randomised control trial. *Schizophrenia Research*, 15, 201-210.

Wykes, T., Reeder, C., Landau, S., Everitt, B., Knapp, M. & Patel, A., (2007). Cognitive remediation therapy in schizophrenia: Randomised control trial. *British Journal of Psychiatry*, 190, 421-427.

Wykes, T., Steel, C., Everitt, B. & Tarrier, N. (2008). Cognitive behaviour therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin*, 34, 523–537.

Xia J., Merinder, L.B. & Belgamwar, M.R. (2011). Psychoeducation for schizophrenia. *Schizophrenia Bulletin*, 37(1), 21–22.

Zimmermann, G., Favrod, J., Trieu, V. H., & Pomini, V. (2005). The effect of cognitive behavioural treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis. *Schizophrenia Research*, 77, 1–9.

Zubin, J. & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology*, 86, 103–126.

Research Report: Talking about hearing voices: A Narrative Analysis of Experience

Abstract

Introduction: People who hear voices can find the experience very distressing. Mental health services vary in their willingness to talk to voice hearers about their experiences. Medication, Cognitive Behavioural Therapy and Family Therapy are the main treatment options offered to people who hear voices. None of these consistently result in a reduction of voice hearing and distress.

Some people who hear voices choose to seek support for their distress outside of traditional mental health services.

Aim: This research project aimed to explore the journey that people go on from starting to hear voices to talking to others about this experience.

Method: Participants were recruited from Early Intervention, Assertive Outreach and Community Mental Health Teams. Unstructured interviews were carried out to explore the experiences of voice hearers. All interviews were tape recorded and transcribed. Transcriptions were then analysed using Narrative Analysis.

Results: Eight participants were interviewed. Most participants spoke about wanting to talk about their voice hearing. Various barriers seemed to have prevented this from happening easily. When opportunities to talk did come most participants reported being able to cope better with and manage their voice hearing. The various accounts formed a range of story types but the most common was a 'quest plot' that demonstrates a striving for resolution which is reached by overcoming multiple obstacles.

Conclusions: The participants in this study had mixed experiences regarding the personal impact of talking about their voice hearing. There were a number of obstacles to talking about voices, some of which were external, such as a lack of encouragement from professionals and perceived societal stigma. There were internal barriers too, beliefs and ideas that inhibited discussion such as readiness or believing there was no benefit to talking about voice hearing.

1. Introduction

1.1 Explanations for Voice Hearing

The impact of voice hearing on individuals can be devastating. The experience can impact on a person's quality of life and self-esteem and can contribute to experiences of depression, anxiety and likelihood of attempting suicide (Birchwood & Iqbal, 1998).

When it comes to understanding voice hearing there are some parts of society who view it as solely being a symptom of mental illness. This belief is often held in psychiatry, for example by the American Psychiatric Association which classifies voice hearing as a prime symptom of psychosis (APA, 1994). The classification of voice hearing as a symptom of mental illness was forged by Schneider in 1959. It was Schneider's position which went onto underpin the diagnosis of schizophrenia in the Diagnostic Statistical Manual (DSM- IV, American Psychiatric Association) and the International Classification of Diseases (ICD – 10, WHO 1993). Both the DSM – IV and ICD – 10 are used in psychiatry worldwide to determine a mental health diagnosis based on a person's symptomology.

In contrast to this belief there are others who do not share the view that voice hearing is merely a symptom of mental illness. Romme and Escher (2011) highlight that only one in three of those who hear voices become psychiatric patients. They propose that "the difference between patients hearing voices and non-patients hearing voices is their relationship with the voices. Those who never became patients accepted their voices and use them as advisers"

(Romme & Escher, 2011, p1). The work carried out by Romme and Escher shows that not all voice hearing is negative although they do advocate that it is important to talk to those who are distressed by voice hearing.

1.2 Services responses to Voice Hearing

Some research suggests that when it comes to talking about voice hearing professionals are all too often failing to do so. Coffey and Hewitt (2008) interviewed twenty voice hearers within community mental health services and twenty psychiatric nurses working in the community. Whilst voice hearers expressed a need to talk about their voice hearing nurses explained they were aware of the impact of voice hearing but felt that their responses to this were limited due to a perceived restriction in their skill set (Coffey & Hewitt, 2008).

There have been attempts made to support nurses to develop therapeutic skills when working with people who have a diagnosis of severe mental illness. In 1992 the Thorn Programme was developed as a Psycho Social Intervention (PSI). The aim was to deliver new training to Community Psychiatric Nurses to provide care for people who had serious mental illness. Initially the programme was carried out at two UK sites but there are now eleven Thorn validated courses within the UK. The programme has a number of values. One of which is to 'enable practitioners to employ an open and collaborative therapeutic approach which seeks to understand and value the experiences of service users and their families/carers (Thorn Initiative, 1992). It would seem that the values outlined in this programme could help to

develop nurses' levels of confidence in their clinical skills that some research seems to suggest they can be lacking (Coffey & Hewitt, 2008).

A number of evaluations of the Thorn Programme have been conducted. Sin and Scully (2008) reported on a survey which was carried out examining the impact of psychosocial training on a service in Berkshire. The paper found that there were high levels of implementation of the training and a strong association between PSI training and career progression. The authors make a number of recommendations for further research. One of which is to evaluate the impact of PSI training from the carer and service user perspective.

Brooker and Brabban (2004) in another evaluation of PSI training found that although there was strong evidence to show that staff did develop skills during PSI training the level of skill development was disappointing.

Particular studies looking at the development of Cognitive Behavioural Therapy (CBT) skills during PSI training revealed that these had often been developed to only a moderate level during training and that trainees were not implementing key elements of the therapeutic approach (Devane *et al.*, 1998; Repper, 1998).

In 2006 Brabban and Kelly carried out an evaluation of PSI training in early intervention in psychosis services. The study distributed a brief style survey questionnaire to Early Intervention (EI) representatives and teams. In total 52 questionnaires were returned which represented 44% across the UK. The conclusions of the evaluation showed that the majority of services do appear

to recognise the importance of the PSI approach and had appropriately trained members of staff within local EI teams. Nevertheless there was still room for improvement. The authors suggested that the skill mix of local EI teams needed to be examined and monitored regularly to ensure teams had the capability to deliver high quality, evidence based interventions. In addition it was recommended that training providers and commissioners should work collaboratively to ensure appropriate levels and types of PSI training are made available locally for those who require it (Brabban & Kelly, 2006).

The main treatment offered to people who have a diagnosis of schizophrenia or other psychotic disorders is typically medication. NICE guidelines recommend that oral anti-psychotic medication be offered for people with newly diagnosed schizophrenia (NICE, 2009). The problem with this approach is that voice hearing does not always decrease with the use of medication but can remain a very distressing experience. According to Ritsher, "Voice hearing is often considered to be one of the most pathognomonic symptoms encountered in mental health settings. Someone hearing a voice typically receives a diagnosis of schizophrenia or another serious mental health illness and is treated with psychiatric medication" (Ritsher, 2004, p220). Interestingly, however, between 25% and 50% of individuals continue to experience positive symptoms despite taking medication (Gould *et al.*, 2001).

Over the last few decades there has been progress made in terms of supporting people who have a diagnosis of schizophrenia or other psychotic

disorders. Support comes in a variety of formats ranging from psychological therapies within services to support groups which are led by service users.

Controlled studies using Cognitive Behavioural Therapy in psychosis (CBTp) began in the early 1990's in the United Kingdom. NICE guidelines have included CBTp as a preferred treatment for schizophrenia since 2002. The inclusion of CBTp in these guidelines followed an increasing number of studies which demonstrated its effectiveness in managing symptoms of schizophrenia. Whilst trials have provided results in favour of CBTp the focus has been on the overarching category of positive symptoms rather than on voice hearing as a single symptom. Trials which have focused on the effectiveness of CBT for voice hearing alone have shown less promise than studies which incorporate voice hearing under the umbrella of general symptom improvement. An example of this was found in a study by Wykes *et al.* (2007) where results showed that group CBT improved social functioning but that auditory hallucinations were only reduced when therapy was delivered by experienced therapists.

The social impact for individuals who hear voices can be profound. For example 80% of people with a diagnosis of schizophrenia who hear voices will experience long term problems with social functioning and long term unemployment (Thornicroft, 2004). If the impact of voice hearing is so negative for some individuals then it seems important to explore a number of types of support and intervention not just CBTp. An area which has been

explored in the literature is that of peer support groups, in particular, hearing voices groups.

In 1988 Prof Marius Romme and Dr Sandra Escher, both psychiatrists, created the first hearing voices group 'Foundation Resonance'. This led to the creation of the Hearing Voices Network (HVN). The HVN is a volunteer led organisation which aims to support anyone who hears voices to understand, learn and grow from their experiences in their own way.

Following the creation of the first hearing voices group in 1988 the first UK group was developed. The UK now has over 150 groups nationwide. These groups are designed to create a space where individuals who hear voices can meet to talk about their experiences. There have been a number of studies carried out over the last 30 years which have explored the usefulness of hearing voices groups. Martin (2000) conducted interviews with voice hearers attending a group. Participants indicated that they most valued the non-threatening space, reduced isolation and normalization.

Meddings and Wally (2004) examined the effectiveness of a hearing Voices Group. Their findings showed a range of benefits experienced by group members. They valued the opportunity to talk to others and to share their experiences. Coming to the group gave them more hope and allowed them to make positive changes in their lives. The mutual support provided in the group also helped to improve members social functioning both in and out of the group setting.

Ruddle *et al.* (2011) carried out a systematic review of the evidence for hearing voices groups. The study found that whilst there was evidence to

suggest that groups were beneficial to members on a number of dimensions (i.e. coping skills) studies were small and control groups for comparison were lacking. The paper points out that there is no reliable evidence at present to suggest that hearing voices groups are more than, or as effective as, other group approaches and therefore further RCT's are needed.

1.3 Society responses to voice hearing

Another potential barrier to people talking about their voice hearing is stigma from society. Fear of rejection and discrimination by society could understandably prevent some people from being honest about their voice hearing. The World Health Organisation in 2001 reported that 1 in 4 people worldwide will be affected by a mental health disorder in their lives.

“Treatments are available but nearly two-thirds of people with a known mental disorder never seek help from a health professional. “Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders”, says the World Health Organization (WHO, 2001, p1).

Intervoice, a national charity which provides support to voice hearers, explains that many people who hear voices keep the experience to themselves due to fear that they will be branded ‘crazy’ by society (Intervoice, 2009).

Professor Marius Romme explains that “because of the fears and misunderstandings in society and within psychiatry about hearing voices, they are generally regarded as a symptom of an illness, something that is

negative, to be got rid of and consequently the content and meaning of the voice experience is rarely discussed” (Romme, 2006, p1). It is hardly surprising that some people stay silent about their voice hearing given the evidence about how society and mental health professionals can view the experience.

1.4 Individuals responses to voice hearing

Romme and Escher (1993) developed a three staged model that they suggested people may go through when they hear voices. The first is the ‘Startling’ phase representing the time when a person starts to hear voices often denying the experience and withdrawing into themselves. The next stage is called the ‘Organisational’ phase which is when the person begins to normalize the experience and the process of selection and communication with the voices begins. Lastly is the ‘Stabilization’ phase and is when the person begins to handle their voices in such a way that shifts control from the voices back to themselves. Similar to the Diclemente and Prochaska (1982) model a person’s readiness to talk could relate to which stage they are at regarding their voice hearing.

McGlaughan (1987) developed a theory about how people cope when they hear voices. This theory suggests that individuals’ reactions and recovery style fall into one of two categories. These categories are called ‘Integration’ and ‘Sealing-Over’. Integration is when a person shows curiosity about their illness and is interested in understanding it and often enlists the help of professionals. Sealing-Over is when someone avoids reminders about their

illness, lacks awareness about it and minimizes the impact it has on their lives. Startup and Wilding (2006) suggest that interventions should not be used to try and change a person's own style but rather they should be tailored to suit an individual's recovery style.

Another factor which has been shown to impact on a person engagement in an intervention is insight. In Psychology insight is defined as "a type of self-understanding encompassing both intellectual and emotional awareness of the unconscious nature, origin and mechanisms of one's attitudes, feelings and behavior" (Mosby's Medical Dictionary, 2009). Research which has investigated individual insight into an illness suggests that the poorer the insight the more likely a person will drop out of treatment (Tait *et al.*, 2003; Jackson *et al.*, 2001).

To conclude research suggests that people who hear voices are not routinely given the chance to talk about their experiences. This is despite the fact that the impact of voice hearing can be very distressing. It seems that people frequently want to talk but that there are a number of barriers to this and not least the reluctance and lack of training of some professional's involved and societal stigma. Also it is important to consider how ready a person is to talk about their voices. Diclemente and Prochaska (1982) developed a five stage model to help understand readiness to change. The likelihood of someone wanting to talk about their voice hearing could depend on which stage they are at. Those who are at the 'pre contemplative' stage will be less likely to see the benefit of discussing their experiences. In contrast, people who are

at the 'action' stage may be more likely to want to engage in such discussions.

1.5 Current Research Project

It is apparent that some people who hear voices do find ways of talking and are able to access support for their voice hearing. Missing from the research is an exploration of the journey people go on regarding their voice hearing and finding the right support. There may be various reasons for a shift in a person's journey from wanting to talk about hearing voices to actually engaging in such a conversation. It may, for example, require someone to have confidence and tenacity to look outside of traditional mental health services for support. It may be to do with timing and the person being ready to talk. It may also be that some services differ in their ability to offer support and to talk about voice hearing. This project aimed to explore stories of people who continue to seek support for their voice hearing and who are engaged in on going conversations about their experiences.

1.1 Research question

What do narratives about the experience of hearing voices tell us about how decisions are made to talk to others and engage in discussions of this experience?

2. Method

Investigating an individual's experiences and their impact indicates the use of a qualitative approach. Qualitative research is useful for studies at the individual level to find out, in depth, the ways in which people understand and make sense of events. It seemed important to select an approach that would honour the meaning that people have made of their experiences.

Three qualitative approaches were researched namely Interpretative Phenomenological Analysis, Grounded Theory and Narrative Analysis.

In order to answer the research question Narrative Analysis was chosen as the preferred qualitative method. This type of analysis focuses on how people make sense of their experiences through the formation and telling of stories.

2.1 Design

This study used an unstructured interview approach with people who hear voices. One main difference between unstructured interactive interviews, semi structured interviews and structured interviews are the degree to which participants have control over the process and content of the interview (Cassell & Symon, 2011; Fontana & Frey, 1998; Morse *et al.*, 2002). There are disadvantages to using an unstructured interview approach.

Unstructured interviews can lack the reliability and precision of more structured approaches. However, an unstructured interview was considered to be well suited in this instance to both the research question and to Narrative Analysis. The reason for this is that it allowed participants to tell

their story without an overly imposed structure. Furthermore, using unstructured interviews enabled participants to direct the interview into the areas that they felt were relevant and wished to talk about. Bloch (2009) explains that using unstructured interviews with Narrative Analysis is a technique for studying more in depth how people talk about things. Bloch suggests that it allows a person to mention what they want to say on their own (without prompting from the researcher). In other words you would use Narrative Analysis if you wanted to find out how people explained a certain point of view rather than merely what their point of view was.

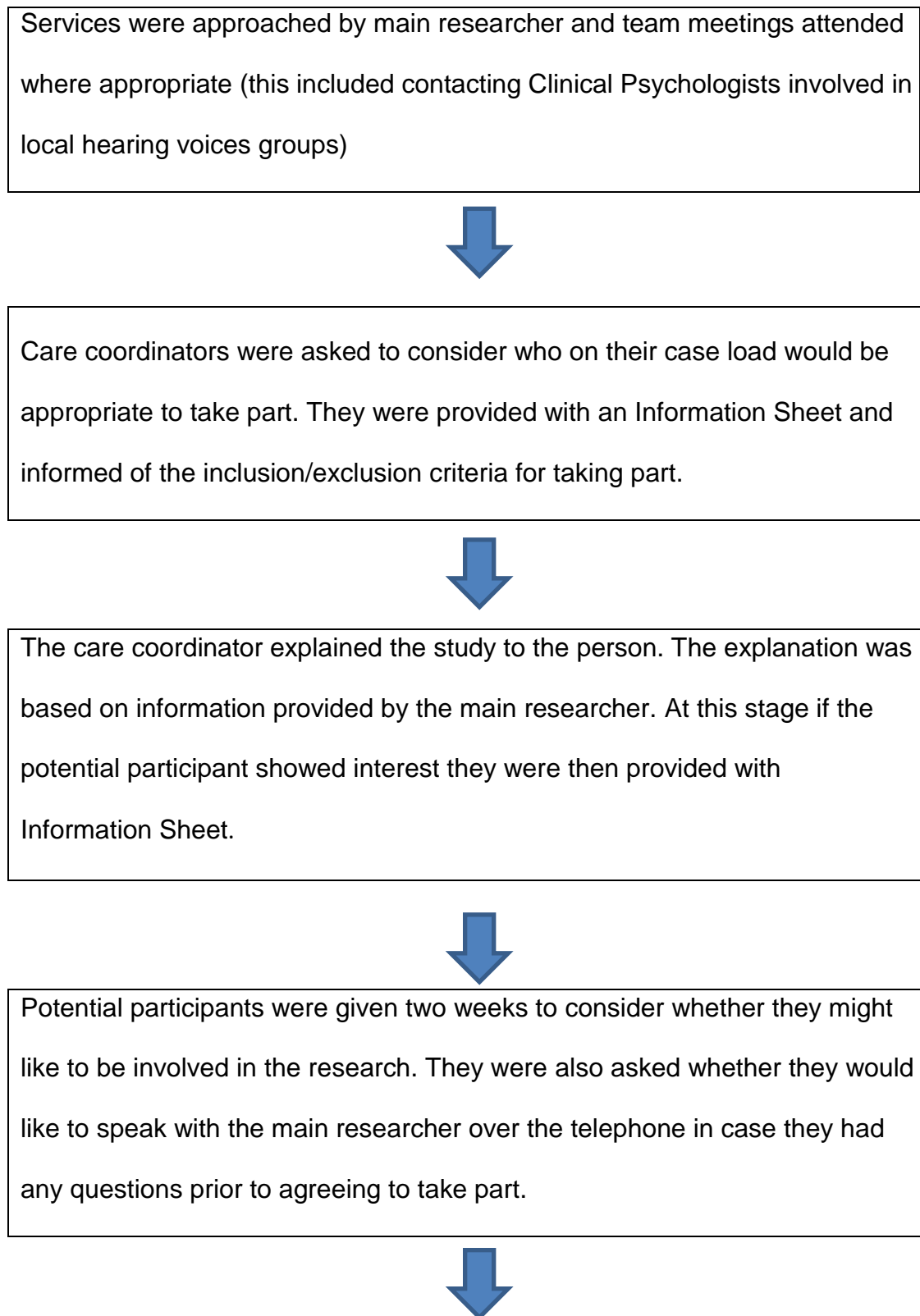
2.1.1 Ethics

Ethical approval was granted by the East Midlands Ethics Committee Board in March 2012. Submissions to the local Research and Development (R&D) Departments of the counties of Leicestershire and Northamptonshire were made and permission granted (see Appendix D for ethics letter). The approval from the Ethics board and both R&D departments allowed for recruitment of participants from all Early Intervention Services, Assertive Outreach and Community Mental Health Teams in these counties.

2.1.2 Recruitment

The recruitment process began with approaching services. Figure 2 below shows how recruitment was carried out.

Figure 2: Recruitment Process of study



For the participants who decided to take part, a time and date convenient to them and the main researcher was arranged for the interview. At the interview the researcher and participant read through the Information Sheet allowing time for questions and gaining consent. It was made clear that the person could decide not to go ahead with the interview and that this would not affect the care they receive (also detailed in consent form).

2.1.3 Sample

In keeping with the research aims and ethics guidelines, a number of criteria had to be considered before participants could be asked for interview. These are outlined in Table 3:

Table 3: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Participants needed to be eighteen years of age or above and under the care of Mental Health services in Leicestershire or Northamptonshire. They needed to hear voices, be able to provide full consent to taking part and speak fluent English.	Any individuals who were not under the care of Mental Health services in Leicestershire or Northamptonshire were not considered for inclusion. Any individuals, who did not hear voices, did not speak fluent English or could not provide full consent, were not considered for inclusion in the study.

Following the recruitment procedure as outlined above a number of services who were approached explained they were unable to identify anyone within their service who met the criteria for taking part. One of the main reasons given was that due to being acutely unwell clients could not provide full consent. The final sample of eight was recruited from Early Intervention Services (four), an Assertive Outreach Team (one) and Community Mental Health Teams (three). The ages of the participants ranged from twenty four to sixty two and there were five females and three males. Table 4 shows details about the sample.

Table 4: Details of study sample

Participant	Age	Gender	Mental Health Service
Anna	62	Female	Assertive Outreach
Pam	60	Female	Community Mental Health
Jack	32	Male	Early Intervention
Mandy	30	Female	Early Intervention
Roger	27	Male	Early Intervention
Suzy	24	Female	Early Intervention
Mohammed	43	Male	Community Mental Health
Alison	54	Female	Community Mental Health

NB: All participant names are pseudo names to protect confidentiality.

Out of the eight participants five were attending or had attended a hearing voices group. The other three participants had never attended a support group but engaged in on going conversations about their voices with family, friends and professionals.

2.2 Procedure

2.2.1 Information Sheet and consent

An Information sheet (see Appendix E) was provided for each person who showed an interest in taking part. This detailed the study's aims and objectives. Included in this Information Sheet was the right to withdraw as well as information about the provision of aftercare should participation cause distress. All participants were given the chance to read this sheet before agreeing whether they wanted to meet with the researcher. A consent form (see Appendix F) was then given to participants to read and sign when they met with the researcher.

2.2.2 Interviews

Interviews were either conducted at the premises of the mental health service where the participant was receiving care or at their home. All interviews were tape recorded. The range of interview duration was between 30 to 85 minutes. One participant wanted their care coordinator present during the interview. The remainder of the interviews were carried out with only the researcher and participant present although a family member or care coordinator/keyworker was nearby. Participants were invited to ask questions and offered a summary report of the study to be sent upon

completion. The researcher decided with one participant that they may need to talk to their care coordinator following the interview. This was because the interview had led the participant to realise that they had some issues they wanted to discuss further. Therefore the researcher ensured that staff at the centre where the participant was interviewed supported her to contact her Community Psychiatric Nurse.

2.3 Analysis

Narrative Analysis is interested in how people use story telling as a way of talking about, and making sense of, experiences. Allowing someone to tell their story enables them to use language which is meaningful to them so that they can do their best to portray their experience to the listener. Narrative Analysis aims to take into consideration context, both that within which the experiences were had but also the context of the interview. In addition, it considers the resources available to someone during these experiences and in an interview and how this may shape how they then tell their story.

Narrative Analysis provides an alternative approach to the qualitative approaches of thematic analysis for learning about people's experiences. Mishler suggests Narrative Analysis as an alternative to other forms of thematic analysis such as Interpretative Phenomenological Analysis (IPA) and Grounded Theory. He states "looking at how interviewees connect their responses into a sustained account, that is, a story brings out the possibilities of interviewing that are not visible when attention is restricted to question-answer exchanges". Mishler believes that "the model of a "facilitating" interviewer, who asks questions, and a vessel like "respondent"

who gives answers, is replaced by two active *participants* who jointly construct narrative and meaning” (Mishler, 1999, p67). Further to this, according to Catherine Kohler Reissman, Narrative Analysis interrogates intention and language – *how* and *why* incidents are storied not simply the content to which the language refers (Reissman, 2008).

Furthermore, Narrative Analysis prompts the reader to think beyond the surface of a text which was thought to be particularly valuable when attending to the research question in this study. If other people (in society and mental health services) can impact on a person’s opportunity to discuss their voice hearing, it is important that the chosen method of analysis is able to consider the impact that others have for example on a person’s story telling. The processes involved in Narrative Analysis shift attention to details of what a narrator accomplishes by developing their story in a certain way.

2.3.1 Selection of Narrative Analysis approaches

There are many different approaches to Narrative Analysis. Two broad approaches were selected according to the aim of the research, Narrative Structure and Narrative Type. These are described below.

i. Structural Narrative Analysis

James Gee’s (1991) approach to Structural Narrative Analysis was decided upon for the first step in the process. This allowed for a detailed look at the content of the individual’s story enabling the identification of key themes. It also allowed for analysis of the finer linguistic elements of the story for

example how a person uses language to convey meaning to the listener. This is important as it is considering not only *what* is said but also *how*.

ii. Narrative Type Analysis (plot, positioning and typology)

- *Plot and positioning (Emerson and Frosh)*

Emerson and Frosh (2009) developed narrative interpretation which involves focusing on certain elements of a narrative. This approach was created as a development of Gee's Structural Analysis. This method was decided upon because it focusses upon the broader social constructs and discourses that influence the accounts that develop. According to Emerson and Frosh it is "sensitive to subject meaning-making, social processes and the interpretation of these in the construction of personal narratives around 'breaches' between individuals and their social contexts" (Emerson & Frosh, 2004, p9). This relates to the research questions as it enables the researcher to consider the social influences on the person and the impact that this has on their experiences and how they make sense of this.

- *Typology (Frank)*

Extensive reading was carried out about the idea of considering the bigger picture of a person's story. An example of this is the work of Jefferson and Hollway (2004) who argue that to simply fragment a narrative is to lose a sense of the whole story and how it is directly represented in the real world. The principle in this type of approach is that as well as taking the narrative apart it should also be looked at in its whole. The researcher decided on an approach by Arthur Frank (2010) who values the importance of identifying narrative typology. The reason for choosing this particular approach over

others, such as Jefferson and Hollway, was because of its potential for clinical application which will be discussed later.

Narrative Typology is particularly relevant as it allows an examination of the types of stories that are used by the participants and how these shape the accounts that are given. In addition to this identifying a type of narrative can provide insight into how the person views themselves within their experiences and the role of others in this. Frank argues that looking for a narrative typology can show how the story teller is affected by their available narrative resources. The narrator is positioned by the stories they know and feel comfortable telling. Frank worked with illness stories and identified three core narratives that most stories fall into. Box 1 displays the three core narratives as identified by Frank (2010).

Box 1: Three core narratives (Frank, 2010)

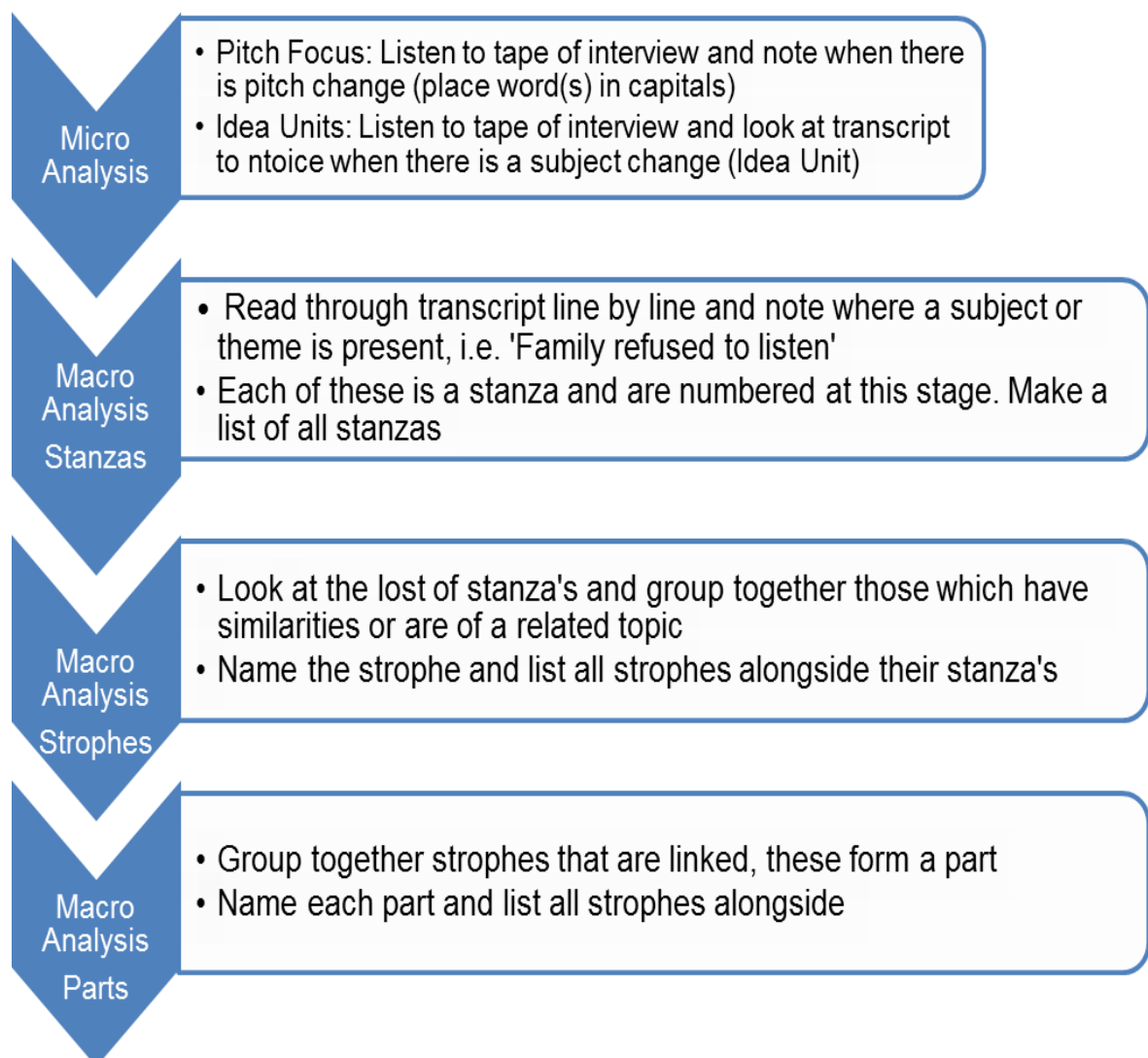
- 1) **Restitution plot:** a person becomes unwell but is restored to good health due to the marvels of modern medicine. It is all about the body returning to its former image before the illness. The illness has been managed and the body has been repaired.
- 2) **Chaos plot:** a person has multiple problems, crystallised by an illness but not usually limited to that illness. One bad thing has led to another and life is collapsing around them. Actor's efforts to stop the collapse are futile and everything has been tried. The suspense is stifled by forces that cannot be controlled and the plot leads to no resolution which is its chaos.
- 3) **Quest plot:** a character encounters a sequence of obstacles and gains wisdom and stature through the process of overcoming these. The ill person meets suffering head on in the belief that something is to be gained from the illness experience.

Frank suggests that illness narrative is not an externalised construct but rather an interactive experience that the ill person enters. How families, friends and health professionals react to an illness affects the stories a person tells themselves and others. Frank also explains that someone's story may begin with one plot, perhaps restitution, and then, as the illness takes an unexpected turn, can become a story marked by chaos.

2.3.2 Process of Narrative Analysis approaches (how it was done)

Figure 3 gives an overview of each stage of the micro and macro analysis.

Figure 3: The process of carrying out the micro and macro analysis



Below are more details of each stage of the Structural Analysis

a) Gee's Structural Narrative Analysis:

Gee's (1991) approach to Narrative Analysis is carried out at two levels. These are what he referred to as 'micro' and 'macro' analysis.

- *Micro analysis*

Whilst transcribing, the researcher paid particular attention to what Gee calls 'pitch glide'. It is when there is a spoken emphasis signaling focus on a particular part of a sentence. This is the information that the speaker wants the hearer to notice. In order to explore this words and longer parts of sentences where the tone and/or volume changed (particularly getting louder) were capitalized. This enabled the researcher to consider what the speaker may have been trying to get across. This is related to the idea that it is important to not only consider *what* is said but also *how*. Next 'idea units' were identified. These can be identified by taking into account intonation. Idea units are typically separated by at least a brief pause. An 'idea unit' ends when there is an indication that the narrator is moving onto the next one and were identified by a forward slash. Below in Box 2, is an excerpt from an interview to demonstrate micro analysis.

Box 2: Interview excerpt to demonstrate micro analysis

P3: And so I WENT THERE/and the, you know the lady I spoke to she was like well, as if it was NORMAL /and I said no, you know the whole thing was that this WASN'T NORMAL

Next interview transcripts were examined closely for what Gee refers to as ‘macro analysis’. This is a process whereby content is considered at different levels and then grouped according to topics. This is made up of three components: ‘stanzas’, ‘strophes’ and ‘parts’. These are described further in Table 5 below. Examples from an interview are also provided to aid understanding.

Table 5: James Gee’s components of macro analysis with examples.

Component	Description	Example
Stanza	A group of lines about a single topic	<p>Stanza 4): Experiences were NOT normal</p> <p>P: and so I WENT THERE/and the, you know the lady I spoke to she was like well as if it was NORMAL /and I said no, you know the whole thing was that this WASN'T NORMAL/</p>
Strophe	Related pairs or series of stanza’s	<p>Strophe a) Reaction of health professionals not helpful</p> <ul style="list-style-type: none"> • Stanza 4: Experiences were NOT normal • Stanza 26 - Hospital was caring but main focus was medication and rest
Part	Strophes that fall into larger units that make up the story	<p>Part 1) Hearing voices and not being helped</p> <ul style="list-style-type: none"> • Strophe a) Reaction of health professionals not helpful • Strophe b) Care and interventions not helpful • Strophe c) No one to talk to about voices

b) *Narrative Type Analysis*

- *Emerson and Frosh narrative interpretation (positioning and plot)*

Emerson and Frosh suggest a number of ways in which this analysis can be done. These are referred to as levels of narrative interpretation. The levels used in this part of the analysis are described in Box 3 here:

Box 3: Emerson and Frosh's levels of narrative interpretation

- I. Psychological subjects: who or what is the subject of the stanza?
Each interview transcript was closely examined so that changes in subject position could be identified. Examples of positions are 'I' and 'You' and these were identified to highlight who the narrator was talking about. This symbolises who the story is about and how they influence a person experience.
- II. Mainline and off mainline plot: What is the main point of what is being told and are there changes to this plot? Each transcript was carefully examined in order to identify what seemed to be the mainline plot. Any deviation from this was noted forming an off mainline plot in the narrative.

- *Frank's Narrative Typology*

The process of identifying narrative typology was done by reading the story and considering it as a whole. Using the three types of illness narrative proposed by Frank, the researcher decided which best fitted the narratives for each participant. In some stories, as Frank suggested, there was more than one narrative type. Attention was paid to what had happened to elicit a change in the typology of the narrative.

2.4 Enhancing Quality

Reliability and validity are more traditionally associated with quantitative research. Qualitative researchers have to grapple with these concepts using a different approach and considering alternative criteria for establishing and maintaining quality such as trustworthiness and reflexivity. Merrick (1999) stated that 'reliability and validity depend on the relationship between the researcher and the research process, as well as between the researcher and the interpretative community'.

2.4.1 Trustworthiness

Trustworthiness encompasses effort to reduce – or at the very least make explicit – sources of bias by the researcher (Stiles, 1993). Researcher expectations and assumptions were considered in a bracketing interview carried out prior to beginning interviews. This was conducted between the main researcher and academic supervisor (see Appendix G for full bracketing interview data). Bracketing interviews are a useful way to explore the impact of the researcher's personal and professional experiences during data collection and analysis. Rolls and Relf (2006) explain that bracketing

interviews enable the researcher to hold the tension of the dialectic process of investigating the nature of the participants' experience, at the same time as holding their own experience. The bracketing interview carried out in this project considered three areas. These can be seen in Box 4:

Box 4: bracketing interview considerations

- What assumptions does the main researcher have about what they might find in interviews?
- What does the main researcher understand about voices hearing and service responses?
- How does the main researcher feel about Narrative Analysis?

The main researcher was able to look back at their bracketing interview when carrying out interviews and analysis. This helped to start the process of developing a reflexive approach to carrying out research.

Another method of demonstrating trustworthiness is with the use of 'triangulation'. Denzin and Lincoln (1994) describe one method of this referred to as '*Investigator triangulation*'. This involves using several different researchers or evaluators to review the findings in order to reduce potential bias. In this project, the main researcher and academic supervisor both looked at and carried out analysis on two of the interview transcripts. This led to a discussion about what was found in the analysis as carried out by both parties. Attention was paid to examples of when the two investigators (Trainee and supervisor) agreed but moreover differed in the outcomes of

their analysis. Further to this supervision was used to discuss the findings on a regular basis.

2.4.2 Reflexivity

Literature on being reflexive in research was considered by the main researcher. The following quote by Townley explains this: “In the context of ethnography, reflexivity not only refers to the process of maintaining methodological integrity, but also making the reader aware of any personal influences that could affect the conclusions drawn in the research findings” (Townley, 2008, p2). The researcher therefore used supervision and a reflective diary to address their contribution to data collection and analysis. In keeping a reflective diary throughout the entire process from initial idea to outcome the researcher actively sought to challenge thoughts and assumptions they had. Another important reason for keeping a diary was that it allowed the main researcher to note observations and thoughts as they happened. This ensured that observations important to analysis and write up were not forgotten.

3. Results

What do Narratives about the experience of hearing voices tell us about how decisions are made to talk to others and engage in this discussion?

The results of the two approaches to analysis (structure and type) which were carried out are provided for each participant. Excerpts from interview transcripts are given for each participant to aid understanding. Each

participant has been given a pseudonym. The researcher is referred to using her initials (LO).

Given the detail of the first stage of analysis (micro and macro) and the constraints of the word limit it is just the 'parts' directly relevant to the research question that are presented (full micro and macro analysis details can be found in in Appendix H). These relevant 'parts' within each participant's story can be seen in Table 6 below.

Table 6: Participants story parts

(Parts displayed in **bold** are those which are directly relevant to the research question).

Participant *	Parts
Anna	1) Harsh old days where you had no choice
	2) Voices have power
	3) A long life of trauma and struggles
	4) Hearing Voices Group has enabled positive change in life
	5) Hearing Voices Groups are a refreshing and helpful intervention
	6) Services are better nowadays but diagnosis is still an issue
Pam	1) Trauma and loss triggered voices
	2) Supported to stay safe but no one to talk to about voices
	3) Hearing voices takes over life
	4) Caring family but still have unmet needs

Jack	1) Hearing voices and not being helped
	2) Not helping self to helping self
	3) Stress and de-stress
	4) Hearing voices and paranoia go hand in hand
	5) Overthinking and overwhelming
	6) Recovery versus relapse
	7) Insight, hope and acceptance: the light at the end of the tunnel
Mandy	1) Cannot talk to many people
	2) Voices are persistently mean and confusing
	3) Mixed experiences of services
	4) Always different
	5) Issues with medication
Roger	1) Evil versus good voices
	2) Hospital's main focus was medication and keeping you calm
	3) Group and therapy helped understanding of experiences (also me helping others to understand)

	4) Learning to manage emotions with help
	5) Recovery is starting afresh
Suzy	1) Mental health team involvement
	2) Voices put you down and discourage talking
	3) Group provides a space to talk and helps with coping
	4) Group support has been invaluable (hope for others)
	5) Managing voices better is helping to rebuild life
Mohammed	1) Frightening voices and hallucinations holding my life back
	2) Looking for an explanation for voices and hallucinations
Alison	1) Ignorance about mental health makes it harder to get support
	2) Talking to others helps and enables positive change
	3) Group gives strategies to manage voices, giving confidence

*NB: Not real names, pseudonyms used

3.1 Anna

3.1.1 Micro and Macro Analysis

Part 1) Harsh old days where you had no choice

Anna had made several attempts to talk about her voice hearing in the past. The support she was subsequently offered in response to these attempts had been unhelpful until she found a hearing voices group. Throughout the interview Anna made comparisons between the hearing voices group she attended and the previous unhelpful responses from services. She talked about how the group was a “DIFFERENT ENVIRONMENT ENTIRELY” whereas with the unhelpful service experiences “YOU NEVER GET ANYTHING THAT BUILDS YOU UP IN A NICE WAY”. These examples show how Anna was perhaps establishing the group as her companion, rather than enemy, in her on-going journey towards seeking understanding.

Stanza 7: Old type of support not helpful

Anna: “I was, I would TRY anything basically/ because I had been to X¹ for a year, of erm, five day therapy, intensive therapy and it had DONE ME MORE HARM THAN GOOD, because I’d got all these BOXES, that they OPENED UP/ but never actually DEALT with the stuff because you’re only there for a year. So I left there in a pretty BAD STATE” (pp.2).

¹ X was a therapeutic unit for adults

Part 4) Hearing Voices Group has enabled positive change in life

Part 5) Hearing Voices Groups are a refreshing and helpful intervention

Stanza 8: Tentative when first came to group

Anna: “Yeah, so I came to the hearing voices group, a bit TENTATIVE (1 sec), erm/ BUT it’s the ONLY PLACE in the WORLD I CAN GO where everybody KNOWS where I’m coming from” (pp. 3)

Stanza 9: Group was first time to have met other people with similar experiences

Stanza 10: Learning new coping strategies

Anna: “Yeah, because you can SAY SOMETHING and there is ALWAYS SOMEONE in that room that has experienced it and DEALT WITH IT/ And you can also get different STRATEGIES to deal with the stuff you’re going through (1 sec) like listening to white noise can sometimes block them out, loud music, erm, you know, distraction techniques and things like that” (pp. 4)

Stanza 11: Group is a ‘little family’

Anna: “Yes, we all help each other/ it’s like A LITTLE FAMILY, to be honest, because everybody that is there now has been going for a long long time” (pp. 3)

The interview with Anna had begun with her telling a story about how her attempts to get help for her voice hearing had been negative. As the interview progressed so did Anna's story, towards a time when she found support which was positive and helpful.

3.1.2 Narrative interpretation

a) Psychological subjects

Throughout the interview Anna switched between the 'I' position and the 'you'. This related to who she was talking about. For example, when she appeared to be referring solely to herself she used 'I'. When Anna shifted to the 'you' position it demonstrated times when she was referring to something that was true of other people too. Examples are given here:

Box 5: Anna's positions

'I' position

Anna: "SHE WANTS me to have PTSD therapy but I don't whether I could cope with that because I have GOT TO RELIVE EVERYTHING and urm/Here I get my CBT" (pp. 3)

'You' position

Anna: "There was a BIG DIFFERENCE then to now because/THEN, you used to have to take the medication whether you wanted to or not. They used to give you ECT whether you WANTED IT OR NOT" (pp. 1)

b) Mainline and off mainline plots

Anna's story began when she talked about the old days of services and how little control and choice she had back then. The plot then moved onto her finding a place (hearing voices group) where she could talk about her voices and the positive impact that this had on her. The main meanings generated here seem to be that times had changed between services in the old days and now. Also the support she had now found (group) appeared to give her confidence and hope as opposed to previous attempts (i.e. therapeutic unit) which had taken these away.

3.1.3 Narrative typology

Anna's story began by her recounting her past trauma's and what had happened to her in mental health services. As she described her earlier experiences the narrative appeared to be rather chaotic. She seemed to have repeatedly bad experiences which impacted terribly on her well-being. There was a lack of hope which seemed to have been exacerbated by her negative encounters with services. However, as her story progressed the plot for Anna seemed to shift. She had encountered a number of obstacles in her life but appeared to have reached a point where she had gained wisdom through the process of overcoming them. The turning point seemed to be when she found somewhere (the group) that she could be herself without fear of not being understood. Like a 'quest' in the end there was a certain romance to the story. There were the enemies (previous unhelpful services and trauma) from which Anna had been saved (by the group).

3.2 Pam

3.2.1 Micro and Macro Analysis

Part 2) Supported to stay safe but no one to talk to about voices

Pam attended a local drop in centre of a mental health charity. She spoke about how services and family members intervened when there was a crisis. At these times she was kept 'safe', for example being placed in hospital. However, she described not being able to talk about her voices except when she attended the charity centre. This seemed to make Pam frustrated and upset.

Stanza 13: Angry she cannot talk about painful issues

This is an example of when Pam spoke about not being able to talk to a partner about the voices

Pam: "And I said to him (partner), I want to talk about her (voice) and he says 'no'. He says 'because you will start crying and he said we are in a public place', he sssaid (stutters) 'look, you're crying now' and so I said to him/ 'are you going to HELP ME OR NOT?' And he said 'I am not going to let you talk about her', I said well 'F**K OFF THEN', you know?" (pp.4)

Stanza 46: Professionals don't help with voices

The next excerpt relates to Pam being unable to talk to a professional.

LO: “And so when you go and see the Psychiatrist or you go to see your CPN do they ever mention to you ways in which you can get help for your voice hearing?” (pp. 17)

Pam: “They say to me, she says, my CPN reckons that um, that I always get ill at this time of year, because it’s getting near the anniversary, near to December and I go through a bad time but she said I have got to learn to cope with the voices. I am trying to cope, I am trying” (pp. 17)

LO: “So she says that you need to try and learn to cope, um, but do you get given any ideas about how to cope?” (pp. 17)

Pam: (overlapping)” she doesn’t really know how to tell me what to do, she doesn’t hear them you know so she doesn’t really know how to advise me/ she said to me you know just [inaudible] ring up the Crisis Team. I rang up the crisis team because I had the voices recently and I rang them up and they said they would email Sally ⁵ and tell her that I have been in touch” (pp.18)

Pam’s story appeared to reflect an ongoing struggle to make sense of experiences. She mentioned a number of times how much she had wanted to talk about her voices but that she had been unable to. This appeared to be largely due to how others reacted. The main type of response Pam got when she expressed her distress was one of panic for example being placed in hospital.

⁵ Not the real name of her Community Psychiatric Nurse, pseudo name used

3.2.1 Narrative interpretation

a) Psychological subjects

Throughout the whole of the interview Pam only used the “I” position. At no point did she use another position (such as “you”) which might demonstrate that she didn’t position herself as the same as others. This lack of using the ‘you’ position may show that Pam had not had opportunities to be with other people who might have shared experiences. Whilst she did have the staff at the charity centre to talk to about her voices she didn’t speak with other service users about her distress. This, along with other restrictions to her talking, may suggest that Pam felt alone in her experiences.

b) Mainline and off mainline plots

Pam’s story had a mainline plot running throughout it regarding great loss and sadness with very little resolution. The lack of resolution was in part as a result of not being able to talk about her voice hearing. This was despite the fact that the voices had only begun following a major bereavement. There were times when this plot was moved away from, for example when she described how her daughter helped her and when complete strangers came to her aid in a crisis. The main plot however dominated and appeared to reflect a lack of opportunity for her to make sense of her difficult experiences.

3.2.3 Narrative typology

The type of story Pam told fitted with the 'chaos narrative'. Pam had multiple problems with some related to illness but not limited to that. One bad thing had led to another and life had collapsed around her. Some attempts, albeit medical and crisis driven, seemed to have been made to assist her but these had been futile. As with a chaos narrative Pam's story was disjointed and the underlying message was that life had not got better. What was left was a plot with no resolution which was its chaos.

3.3 Jack

3.3.1 Micro and Macro analysis

During his interview Jack talked about having tried a number of services to get help with his voice hearing. This included a hearing voices group. Interestingly, he did not find the experience helped him, however, he did state that it was perhaps because it was offering something he didn't need such as social contact. There were a number of points in his story where Jack talked about how he just wanted the voices to go away. For example: "I was looking for some sort of RELIEF from it" and "I just wanted them to CEASE really". The support he was offered and the medication he was prescribed had not given him this.

Part 1) Hearing voices and not being helped

Jack talked about accessing various types of service and either getting support for his voice hearing which was not helpful or not getting support at all. The examples given by Jack were of a third sector service and an inpatient unit. Examples are given here to illustrate these points.

Stanza 3: Some support didn't help

Jack: "Uh, (1 sec) yeah (sighs) uh, she (staff from third sector) said that you know/ its, SHE NEVER REALLY/ it wasn't particularly good. / It was good to just let out what was happening/ but in terms of um, HELPING/ or trying to overcome the voices, IT DIDN'T" (PP. 1)

Stanza 6: Hospital provided only basic care (no therapy)

Jack: "Hearing voices/ And TO BE HONEST WITH YOU/whilst I was in hospital, I didn't receive any, um, therapy /or anything like that" (pp. 2)

LO: "Ok, what sort of things did you do with your time then when you were in hospital?" (pp. 2)

Jack: "Not a lot. It's very, very MONOTONOUS, not a lot to do. It's AS IF they just want you to eat, sleep and REST" (PP. 2)

3.2.1 Narrative interpretation

a) Psychological subjects

During the interview Jack switched between the “I” position and the “you”. On the whole when talking about his voices and paranoia he remained in the “I” position. The times when Jack switched to the “you” position seemed to when he talked about people in general and experiences other people had.

Examples of Jack’s positioning can be seen here:

Box 6: Jacks Position

I’ position

Jack: “Well that’s it, I mean when you can hear/ when I WAS HEARING voices being around other people didn’t help because I had PARANOIA/ I think paranoia is very, a very POTENT thing really” (pp. 7)

‘You’ position

Jack: “if you’ve got a MENTAL HEALTH PROBLEM, err, drinking is not the answer/ you know it’s just ADDING to your problems” (pp. 6)

The experiences Jack had identified as being similar to other peoples related to general struggles such as with mental health and use of alcohol. When it came to his more specific difficulties (hearing voices and paranoia) Jack spoke in a way which indicated that he was talking about his experiences in isolation.

b) Mainline and off mainline plot

The mainline plot within Jack's story in the beginning was regarding a lack of opportunity to talk about his voice hearing or inadequate support from services. There seemed to be dissatisfaction for Jack in this initial plot because it seemed he was looking for answers which he did not find. This then led to a change in plot whereby Jack turned to himself for finding solutions to his problems. It seemed as though Jack had taken back the responsibility of getting better rather than looking to others for this.

3.3.3 *Narrative typology*

The illness narrative that best fits for Jack is the 'quest' plot. He described encountering a number of obstacles and how he had gained wisdom through the process of overcoming these. He had to overcome almost insurmountable obstacles to try and get back to a life he once knew. The obstacles he described were not just his voice hearing and associated distress but also services he had encountered. It would seem that there were a number of villains in Jack's story such as certain services, paranoia and alcohol. His quest seemed to be his attempts to get "BACK ON TOP OF THE GAME". Jack strived to get to this point by turning inwards for support. Jack was maybe, therefore, the hero in the story. One strategy that Jack had employed for holding his own in conditions of extreme vulnerability had been to put distance between when his difficulties started and the present day. This was reflected by his reference to needing to take time to get

better. He said it was about putting some TIME between the two (his illness starting and recovery). Unlike other quest plots in this study Jack was alone in his quest as he was without companions.

3.4 Mandy

3.4.1 Micro and macro analysis

Mandy's main source of support was her care coordinator. Other than this she explained not having many people to talk to about her voices. Mandy explained that some people did not allow her to talk such as her own family. It seems likely from listening to Mandy's story that she had found talking to people about her problems difficult even before she started hearing voices.

Part 1) Cannot talk to many people

Stanza 3: Cannot talk to family about voices

Mandy: "She (mum) doesn't like you talking about it (the voices) and things like that. She just tells you to SHUT UP" (pp. 2)

This lack of opportunity to talk was perhaps exacerbated by the beliefs she had about herself as a person with autism. This, as explained earlier, could be representative of a general theme in Mandy's life of finding it hard to talk. Having said this Mandy did show interest in talking at times throughout her interview but explained that some people had not allowed this.

Stanza 12: Having autism means it's easier to talk to doll than family

Mandy: "But you see, you see, autistic children more like play with their dolls and play with their (1 sec) because they CAN'T COMMUNICATE. Like I..." (pp. 6)

LO: "It's not easy is it?" (pp. 6)

Mandy: "No, I find it EASIER TO TALK TO A DOLL THAN it is to, to..." (pp. 6)

Stanza 14: Voices build up because cannot talk to many people

Mandy: "But because you can't talk about it in your HOUSE, you find, you have to, IT BUILDS UP and builds up because you can't, you can't talk to all your friends all the time, you have to... And THEY DON'T LISTEN, you know what I mean" (pp. 7)

Mandy explained that it was good to have her care coordinator to talk to but it only helped "A BIT". When speaking about not being able to talk to others Mandy's speech became hurried. There were other times in the interview when Mandy spoke in this way and it seemed to be when talking about experiences that had distressed her.

3.4.2 Narrative interpretation

a) Psychological subjects

Mandy mostly spoke within the 'I' position suggesting that she was speaking to the listener from her own perspective. The times throughout the interview when Mandy switched to the 'you' position were when she talked about other people with special needs. This shift in position may reflect her describing views of others which she herself could relate to. Examples of Mandy's positions are shown here:

Box 7: Mandy's positions

'I' position:

Mandy: "But I can't say/but I don't like taking them tablets, especially when I've been at work all day and I just WANT TO RELAX." (pp. 16)

'You' position:

Mandy: "special needs children the age, you look a lot, a bit younger than what you are because you/ well you're like a BABY in a way" (pp. 6)

b) Mainline and off mainline plot

In her story the main plot appeared to be Mandy not being able to talk about her voices. The experience of not being able to talk seemed to have been an ongoing struggle for Mandy dating back to a time before she even started to hear voices.

There was a small shift to a plot whereby she could talk to her coordinator when they met weekly. This was an example of an off mainline plot for Mandy, however, it seemed that this did not bring her enough satisfaction and she was, for the most part, stuck within the mainline plot.

3.4.3 Narrative typology

Mandy's narrative fitted less neatly into one of the three typologies than the other participants' narratives possibly because the interview had been the shortest of all the interviews (30 minutes). However there was a sense of there being no resolution. It seemed that her problems were multiple and not exclusively related to the voices that she heard. There also seemed to have been attempts on her behalf to find a resolution but these attempts seemed to have been futile. In this sense Mandy's story best fits within the 'chaos narrative'. According to Frank (2010) the challenge of listening to this type of story is to refrain from steering the teller away from the difficulty of telling. The main researcher identified with this as it had been hard to hear Mandy's story.

3.5 Roger

3.5.1 Micro and Macro analysis

Part 2: Hospital's main focus was medication and keeping you calm

In his interview Roger spoke about his time in a psychiatric hospital. He described how hard it was to manage his feelings in hospital and that this was not helped by his attempts to talk and getting little back.

Stanza 41: You could talk in hospital, but got little back

LO: “And when you were in hospital did you have anybody to talk to about how you were feeling or was it just to take medication?” (pp. 16)

Roger: “Yes I mean there were people you could talk to like nurses and stuff but, you know they DIDN’T HAVE A LOT TO SAY BACK. I mean all they did was just kind of listen and that’s pretty much it” (pp. 16)

He later talked about how difficult it was for him in hospital because of his fears and anxieties. This experience, it seemed, had been unhelpful even though he later reflected on the fact that he was ill and needed to be kept safe. In the next part of his story Roger explained that when he came out of hospital he had been totally overwhelmed by feelings of what he later realised was anxiety. He did not actively try and talk about his voices at this point because he did not believe he was unwell.

Stanza 43: Used to feel crippled by overwhelming emotions and feelings

Roger: “Yes DEFINITELY. Erm yes, because like I said before I had this FEAR INSIDE of me, I had all these emotions and feelings and I felt OVERWHELMED/ and it kind of CRIPPLED ME in a way. I couldn’t do what I needed to do or what I WANTED TO DO” (pp. 17)

The next part of Rogers's story represented a time when he had begun to realise he was unwell. It was around this time that Roger started to become interested in talking about his voice hearing. This seemed to demonstrate a change for Roger in that once he had realised he was unwell he then started to consider the potential value of talking. At this stage in his story Roger explained that he had been introduced to the idea of attending a hearing voices group.

Part 3) Group and therapy helped understanding of experiences (I also helped others to understand)

Roger explained that when he started to go to a hearing voices group he began to make some sense of his difficult experiences which had previously "CRIPPLED" him.

Stanza 44: Now understand reasons for my breakdown

LO: "Did it (feeling crippled) literally stop you from going anywhere?" (pp. 17)

Roger: "Yes. And then you kind of get the explanation and stuff. Like for example, you know, the whole reason like you might have had a PSYCHOTIC BREAKDOWN or episode is you kind of have ALL THIS STUFF and you're kind of pushing it in a closet and pushing it and pushing it until you can't close that door anymore and everything just SPILLS OUT AT ONCE/ And, you know, it's all about MANAGING THOSE FEELINGS AND EMOTIONS AND MANAGING YOUR CLOSET, I mean what you put in there and, you know, not

to put too much in there and allowing yourself TO FEEL THESE EMOTIONS sometimes..." (pp. 18)

Roger described how going to the group had enabled him to learn more about his difficult emotions and voices and that this led to him starting to "CHALLENGE THEM" (voices).

Stanza 46: Learning how to challenge voices

LO: "So almost like tolerating them in a way or sitting with them" (referring to difficult emotions, pp. 18)

Roger: "Yes and they kind of help with the voices as well because I started learning how to CHALLENGE THEM" (pp. 18)

Roger explained that his voices were still horrible but that the support he got at the hearing voices group enabled him to take some control back. This helped because it meant that, for Roger, the voices "DON'T RUN MY LIFE".

3.5.1 Narrative interpretation

a) Psychological subjects

Roger adopted both an 'I' and 'You' position in his story. Examples of when this happened can be found in box 8 below:

Box 8: Roger's positions

'I' Position

Roger: "Because when I left hospital, I mean I was taking my meds and everything but I had this FEAR INSIDE OF ME so I was really really afraid to do stuff. And I couldn't understand it. I just thought maybe it's like the side effects of the med..." (pp. 8)

LO "You had this HORRIBLE FEELING but you didn't know what the reason was for it?" (pp. 8)

Roger: "Yes. So I'd GET PANIC ATTACKS and I didn't know that they were panic attacks, I'd just think it's because of the MEDICATION" (pp. 9)

'You' Position

Roger: "And then you kind of become AWARE of what you're actually doing and then once you become aware of it, you are learning" (pp. 18)

Towards the end of his story Roger began to talk about his individual therapy and about how it was perhaps time for him to leave the group. At this point he shifted back to the 'I' position. It was as though he had come full circle from being alone, having the group and then being back on his own. The difference between the 'I' position at the start and the end of his story was the shift from a negative to positive experience.

b) Mainline and off mainline plot

Roger's mainline plot related to a catalogue of frightening experiences of which he had been unable to make sense. This lack of sense making came from both

himself (readiness to change) and service responses. The plot went off-line when he had started to realize that he was unwell and that he might benefit from talking. At this stage he had been introduced to the hearing voices group and this had provided him with a place to make sense of his difficult experiences. As the plot changed so did Roger's confidence and belief in his abilities to make a recovery.

3.5.3 Narrative typology

Roger's story began in a way that best fitted with a 'chaos' narrative because in the beginning his story seemed hopeless, progressing from bad to worse. There was, however, then a shift from him not getting help to finding support which was right for him. At this stage the story became more like a 'quest narrative'. Unlike a 'chaos' plot, he was now on course for finding some sort of resolution and this was his quest. He had gained and continued to gain wisdom through the process of overcoming his difficulties.

3.6 Suzy

3.6.1 Micro and macro analysis

Part 2) Voices put you down and discourage talking

In her story, Suzy began by jumping straight to when she started to attend a hearing voices group. She explained how her voices tried to stop her going and how they "THREATENED" her. It was later in her story that Suzy went back in time to talk about when her voices first started.

Stanza 4: Voices telling me not to go

LO: "How did you first find out about it (group)?" (pp. 1)

Suzy: "Erm I was told through the X^X team that there was a group erm but for a while I didn't want to go and then one day I went and I've been ever since" (pp. 1)

LO: "What was it that made you think you didn't want to go? What was the reason (2 secs) did you have some worries" (pp. 1)

Suzy: "I was nervous and the voices were telling me not to go" (pp. 2)

Stanza 28: Voices threatened when decided to go to group

LO: "And so when you first heard about it you were a bit unsure, the voices were saying don't go..." (pp. 11)

Suzy: "Yes" (pp. 11)

LO: "Why do you think they didn't want you to go?" (pp. 11)

Suzy: "Erm I'm not quite sure because... They just used to threaten me, you know, 'if you go we'll do this, we'll do that'" (pp. 11)

^X Team which Suzy was receiving care from

Suzy explained that she had managed to go “AGAINST THEM” (the voices) and went to the group. At this point in her story Suzy began to talk about what she had gained since going to the group although to begin with she was worried “WHETHER THEY’D (THE GROUP) WOULD LIKE ME AND GET ON WITH ME”.

Part 3) Group provides a space to talk and helps with coping

Part 4) Group support has been invaluable (hope for others)

Suzy gave many examples of how the group had helped her to manage and cope with her voices. This had enabled her to start going out again after a long period of not doing so.

Stanza 54: Without group confidence wouldn’t have grown

Stanza 55: Group encouraging and supportive

LO: “So the group’s made a really big difference in your life. I know it’s difficult because obviously you can’t go back in time but if you hadn’t have gone to the group what do you think maybe your life would have been?” (pp. 22)

Suzy: “Erm I don’t think I’d have as much confidence as what I’ve got. Erm and I don’t think I’d feel as supported and encouraged to do things” (pp. 23)

Suzy’s story came to an end with her bringing it up to the present day. She explained that she had to leave the group as it was time for her to move on. She

explained that she was worried about this but was looking forward to maybe meeting new people at a different group.

3.6.2 Narrative interpretation

a) Psychological subjects

Suzy used the 'I' position at all times except once when she talked about a specific strategy she has learned. This one occasion where she used the 'you' position was when Suzy explained an idea to LO. In this instance it appeared to reflect how it was originally described to her. This occasion is shown here for illustration:

Box 9: Suzy's position

'You' Position

Suzy: "Erm and it's where you get anxiety and you get to a certain point where it can't get any worse and it starts to come down again. And so when it gets to its peak you know it's going to come back down eventually" (pp. 15)

Despite speaking for much of her interview about the advantages of talking at the hearing voices group Suzy remained in the 'I' position. This made her story different to other participants who had spoken about attending a hearing voices group. Unlike these other participants Suzy had not shifted to the 'you' position.

This could suggest that Suzy, whilst benefiting from attending a group, had not incorporated her experiences as jointly shared with others.

b) Mainline and off mainline plot

The mainline plot for Suzy related to how her life had been taken over by the onset of her voice hearing. She had lost a great deal as a result of this such as an intimate relationship and her independence. The voices had tried to stop her from getting help when it was offered. The plot changed when Suzy summoned the strength to stand up to her voices and went for help in the form of a hearing voices group. This plot change continued as she discovered a place where she was able to gain confidence and learn ways to manage her voices. Whilst still very much on a journey to getting better, the change in plot in Suzy's story (from not talking to being able to talk) represented the possibility of a more positive future.

3.6.3 Narrative typology

It seemed that Suzy's story was about becoming unwell and finding the right intervention. This allowed her to move towards restoration to at least a reasonable, albeit inexact, version of her life before the illness. At face value Suzy's story would appear to fit with the 'restitution plot'. She had become unwell but what followed was a restoration to better health. Her story, however, also deviated from this when thought about in more depth. She had been moving toward being better after becoming very unwell but there were also times in her

story when she moved from bad to worse. This last observation would suggest that she was at time experiencing a 'chaos' plot as she shifted from being unwell to being well and back again.

3.8 Mohammed

3.8.1 Micro and macro analysis

Part 2) Looking for an explanation for voices and hallucinations

Throughout his interview Mohammed talked about trying to find for an explanation for his voice hearing and other hallucinations. This desire to find an explanation seemed to be the driving force behind Mohammed's repeated attempts to talk to others. It seemed as though he was looking for answers in the hope that he would feel better for it. Mohammed had thought about his own explanations but had also been given explanations by others.

Stanza 11: Went to see a Muslim priest for answers (first person to talk to about voices)

Stanza 12: Priest suggested voices were a spell

Mohammed: "I remember going to a Muslim priest and I felt when I was talking to him, he said, he said that someone is playing games with you, you know. He said they're just trying to get at you. He said they're doing a spell but they're trying to get, you know, trying to cause as much harm as possible" (pp. 3)

When talking to mental health professionals about his voice hearing, Mohammed explained how he had been given explanations which he did not agree with.

Stanza 28: Doctors have said illness is genetic

Stanza 29: Not happy about suggestion illness is genetic

Mohammed: "I mean the doctors have said my illness, schizophrenia, erm that's for life. Err and the other thing they've, he's also said that it's genetic" (pp. 6)

LO: "And how do you feel about that?" (pp. 7)

Mohammed: "Well (laughs) I'm not happy about that. I, I, I don't, I don't, I don't agree with that because I believe that err what I experienced in the workplace err was the trigger, you know, and, you know, it kind of caused me to feel depressed, anxious and so paranoid and you just..." (pp. 7)

Mohammed had his own ideas and one of which was that his difficulties had been brought on by stress. This explanation seemed to be the one which was most plausible to Mohammed. This is perhaps due to the fact that his voices followed a breakdown which itself had been triggered by a stressful life event.

3.8.2 Narrative Interpretation

a) Psychological subjects

Mohammed stayed within the 'I' position throughout his entire interview. He talked in depth about his experiences and what it was like to hear voices. Mohammed had made a number of attempts to talk to others about his voices in a bid to understand them. When Mohammed described other people's opinions about his voices or when he spoke about the voices themselves he did so by giving them their own position. It seemed as though he was separating himself from them and explaining that they were not the same as him. Mohammed's position for others (people and voices) was 'They're'. Examples of these two positions are shown here:

Box 10: Mohammed's positions

'I' Position

Mohammed: "Erm I used, / used to be in my bed and I used to feel something talking to me through my mind, some POWERFUL FORCE, and I couldn't, I couldn't, erm I couldn't understand" (pp. 8)

'They're' Position

Mohammed: "He (Priest) said they're doing a spell but they're trying to get, you know, trying to cause as much harm as possible. They're not going to do anything serious to you but, you know, that's what's happening, they're PLAYING GAMES with you" (pp. 3)

Mohammed had not spoken to other people who heard voices. This perhaps suggests that he viewed his experiences as his and his alone.

b) Mainline and off mainline plot

Mohammed's story seemed to reflect a journey about trying to find out why he heard voices. The mainline plot was about him looking to various people for answers about his difficulties. This seemed to be the driving force in his continual attempts to talk to others about his voices. He wanted to move on with his life by completing a university course for example. It appeared as though his problems held him back. He had started to explore the idea of attending a hearing voices group which perhaps represented the potential introduction of an alternative (off mainline) plot. This off mainline plot being him looking to other voices hearers for answers rather than people who did not share his experiences (priests and mental health professionals).

3.8.3 Narrative Typology

Mohammed had spent a long time trying to find answers to his problems. He had not yet found an explanation that was sufficient for him. It seems therefore that Mohammed was on a 'quest' as he was left still looking for answers. Mohammed was journeying through his difficulties and facing suffering head on in the belief that something was to be gained from his illness experience.

3.9 Alison

3.9.1 Micro and macro analysis

Part 1) Ignorance about mental health makes it harder to get support

Alison spoke throughout her interview about how other peoples ignorance at times had prevented her from opening up. She explained that this ignorance was from society, family and mental health professionals.

Stanza 6: Staff are ignorant in mental health centre

Alison: "But they are still ignorant at the walk in centre because I went there with my son and urm, because I have got mental health problems they said why are you hearing voices and I said I just want someone to talk to" (pp. 1)

Stanza 9: Don't talk to a lot of people about voices as they think I am just crazy

Alison: "Urm but I don't talk about my voices to everybody because some people have still got this oh hear voices you know, crazy person" (pp. 2)

Stanza 40: Some mental health professionals can be ignorant about voices

Alison: "I think often like urm professionals are even ignorant about it, you know about when you hear voices you know" (pp. 11)

Alison explained that when she could talk about her voices it helped her enormously. She described how sometimes, she just needed to talk and that this could prevent a crisis.

Stanza 8: Staff can assume I need hospital whereas I just need to talk

Alison: "But, but, a lot of people automatically think it's a hospital situation when it's not, if the person listens to me then it eases the situation the whole scenario" (pp. 2)

Part 2) Talking to others helps and enables positive change

Although Alison spoke about not being able to talk to some people, she also described places where she could talk. Alison found that the voluntary service which she had been attended for several years was a place she could talk. Also she had recently started to attend a hearing voices group and reported finding this helpful.

Stanza 25: Hearing voices group is where I can talk about voices

Stanza 27: I can talk at HVG because other people have similar experiences

LO: "So urm, do you, who do you talk to mostly then about your voices, is that here or is that with the CPN?" (pp. 6)

Alison: "I am here at the group once a fortnight which I think is really positive because people have different ways of handling it" (pp. 6)

LO: "And so the Hearing Voices group is that somewhere where you feel perhaps you can talk to people?" (pp. 6)

Alison: “Definitely because they are experiencing the same as me. I mean I can’t, I can’t talk at the drop in centre because people have got different mental health illnesses. And even people with other mental health might be ignorant of it, they might have a mental illness but not understand” (pp. 7)

3.9.2 Narrative Interpretation

a) Psychological subjects

Alison did not move from the “I” position at all throughout her interview. She did use the position of “they” but that was when she described the opinions of other people. In her story Alison talked about not being able to talk to many people due to their ignorance. This may be the cause for her only staying within the “I” position because she viewed her experiences as being hers alone. An example of Alison using the “I” position regarding her own experience is shown below:

Box 11: Alison’s position

“I position”

Alison: “every time I seem to meet somebody they don’t understand and they go away from me. So urm.....I, I, I tend to stay away from the opposite sex. But then part of me is saying oh I need somebody you know” (pp. 8)

b) Mainline and off mainline plot

Alison’s story consisted of frustration and sadness at other people’s “ignorance” in not understanding mental health problems and especially voice hearing. This

even extended to her family and some mental health professionals. One of her main needs seemed to be to talk about her voices; however, it had been hard for her to find the opportunities for this. When Alison did find somewhere she could talk, the plot shifted slightly in that she now had somewhere to open up. Interestingly, however, when Alison was given the chance to talk in a one to one setting, with a Psychologist, she reported that this was too hard for her. She explained that this Professional had started to delve into her past. Alison said that “I am always trying to block the past so it makes it easier and I can hear the voices getting louder because we were going into past events”. It seemed that the plot shifted back to the mainline (cannot talk about experiences and voices) albeit for her own personal reasons.

3.9.1 Narrative Typology

Alison’s story felt chaotic at times in the way she described not being able to get help, being in and out of hospital, her unresolved life trauma and ongoing stressful life events. Things has gone from bad to worse and back to bad before getting worse again. There were points in the middle of the story, though, where Alison seemed to be on her own ‘quest’ to get the support she needed which was to be able to talk about her voices. At this stage of the interview it seemed that Alison had perhaps found this in the form of the hearing voices group. Alison’s story, however, then seemed to shift back again to ‘chaos’. This was when she had been offered more space to talk but had rejected this as she could not seem to cope with the suggestion of delving into her past.

4 Shared and unshared stories

4.1 Shared stories

Whilst each story was individually considered for each participant there were some overlaps across some of the stories. These shared elements of participant's stories are shown in Box 12 below:

Box 12: Shared stories from study

a. You want to talk but there are barriers to this (barriers vary).

All participants described a desire to talk about their voice hearing but not finding this straightforward. There were barriers to talking and these varied from services (Anna, Jack, Roger and Mohammed) to friends and family (Anna, Pam, Mandy, Suzy and Alison). Also some participants spoke about barriers within themselves when it came to talking such as readiness (Roger and Jack).

b. You can't understand unless you hear voices/have been through similar experiences

It seemed for a number of the participants that talking to others who heard voices is important (Anna, Roger and Suzy) because it allows for a shared experience with people who really understand.

c. Medication helps but isn't enough

Whilst medication is not dismissed as being unhelpful it is described by several of the participants as not helping with the voices (Jack, Mandy and Roger). Also the unpleasant side effects were described as an unwanted and unhelpful addition to this.

d. Knowing that voices may not go away but learning to manage them is important

Several participants described reaching a point where they knew that their voices may not go away. There was, however, a shared story of how finding ways to manage them helped and that talking to others could provide the information to do this (Pam, Mandy and Roger).

e. Power and control imbalance between voices and you. Taking control helps.

Taking control back from the voices was another shared story. The point at which this began to happen for participants was when they talked to others about their voices (Anna, Roger and Suzy).

Another shared story, although not as explicit as the ones above, was regarding 'readiness' to engage in conversation. The participants who were regularly engaging in discussion about their voice hearing spoke of needing to be at the right point to be able to do this (Anna, Roger and Suzy). For some of the remaining participants it appeared that they were at the stage of being ready to talk more and could see the potential benefits to this (Pam, Mandy and Mohammed).

4.2 Unshared stories

Whilst there were shared experiences between participants in this study there were also differences. One of the main differences was in relation to where participants found the most helpful support. Whilst a number of participants turned to others for such support there were also participants who spoke about finding the answers and support within themselves. This is especially true for Jack who tried to get support from a number of people and services but who in the end found his own personal resolution to his problems. Unlike other participants Jack did not want to talk to other people who heard voices. He explained that it would not give him what he longed for which was for the voices to cease.

5 Discussion

5.1 Summary of findings

The participants in this study gave their own individual stories regarding their voice hearing and their attempts to engage in discussion about this. Whilst each participant had their own story to tell there were recurring story parts which represent shared experiences. Most of the participants spoke about wanting to talk about their voice hearing but finding the opportunity was not always possible. The reasons for this were varied but included barriers from professionals, friends or family, or the person themselves feeling unable to talk. There were a number of reasons given for these barriers but there was a general sense of people fearing how others might react. This fear seemed to be based at times on people's previous experiences of getting a negative reaction. Some of the participants, who were eventually able to engage in discussion about their voices, reported a sense of relief. The benefits as described by these participants were better management of their voices, increased coping strategies and a better understanding of their experiences.

Some of the participants did not report feeling relief when they talked about their voices. One participant explained that talking to others about his voices did not help because he didn't learn anything he didn't already know. He also explained that talking did not help him to achieve his goal of making his voices cease. Another of the participants described that talking about their voices was unhelpful when they got little or no response back. It may be that for some people having others listen is not enough. They want something more such as an

acknowledgement of their distress. In addition to this some participants spoke about there being a right time to start talking about their voices. This perhaps represents an element of 'readiness' to engage in such discussions which could act as an internal barrier to talking.

For the most part participants looked to other people for help and whilst this help was not always available, when the right kind was found it made a positive difference for the person. Once again this was not the case for all participants. Jack actually spoke about the detrimental effect on him of some people trying to 'help'. The reasons for this were that the attempts to help him appeared to be either ill-conceived or insensitive. In his story it required Jack to take charge of his own recovery by looking to himself as the source of help. Alison also spoke of times when other peoples 'help' had not been good for her. This reflected the times when others reacted to her distress by placing her in hospital rather than allowing her to talk which is what she actually needed.

This study looked at the types of stories people tell and how the type of story can influence the account that is provided. A person's story type perhaps represents how they progress in their story and whether it is towards a positive or negative place. It seems that there are characters in people stories who also frame the type of story being told. Within a single story type (quest) it was possible for there to be variations in the role the narrator played. Some of those whose narrative fitted the quest plot spoke of sharing this quest with others such as members in a group. These other people acted as companions without whom movement towards a more positive state would not have been possible. In others quest

accounts it seemed that the narrator was the sole passenger on the journey reaching a positive outcome without the involvement (or perhaps need) of others.

In a more general sense it seemed that those who considered themselves to have good resources were able to see recovery as a real possibility. Conversely those who talked about having little or no resources presented as less optimistic about the chances of any real recovery.

5.2 Findings and previous literature

Previous research which has examined what people who hear voices want (with regards to talking) and what they are offered reveals discrepancy between the two (Coffey *et al.*, 2004; Martin, 2000; Coffey & Hewitt, 2008). Some of the findings from this study reflect this whereby participants spoke of a desire to talk about their voice hearing but were not offered this. One of the participants in this study, however, spoke about not wanting to talk if it was specifically about his voice hearing.

The benefits of talking about voice hearing have been explored in the literature and studies suggest that there are advantages to this for those involved. An example was having more control over voices (Martin, 2000; Meddings & Wally, 2006; Place *et al.*, 2011; Thornhill *et al.*, 2004; Beavan & Read, 2010; Coffey & Hewitt, 2008). The stories from some participants in this study would support this. A greater sense of understanding, learning of new coping strategies and overall better management of voices are amongst the benefits as reported by some participants in this study.

The use of medication was referred to by all participants in this study. Whilst the message in their stories was not that medication was of no use to them most of them stated that it did not help with their voices. This finding reflects some of the research into the use of medication in people diagnosed with mental health problems. Gould *et al.* (2001) suggests that between 25% and 50% of individuals continue to experience positive symptoms despite taking medication. Also, several of the participants were clear about medication not being enough and that more needed to be offered such as therapy. These findings are in keeping with previous literature and support the notion that a purely medical approach is not helpful (Coffey *et al.*, 2004; Coffey & Hewitt, 2008). Further to this several of the participants in this study who had spent time as inpatients in psychiatric institutes spoke about receiving care that was only physical and medical in nature. These participants were able to reflect on how much they had wanted to talk about their voices because of how distressing the experience was for them at the time. One participant in particular explained that whilst staff did on occasion listen they gave nothing back. This, he explained, left him feeling no better because he had not been given any advice or guidance on how to manage his difficult emotions.

The concept of a 'readiness' to talk came up in the stories of several of the participants in this study. This may be best understood by considering a stage model such as that of Diclemente and Prochaska (1982) with regards to understanding readiness to change. They note five stages that a person goes through when it comes to making changes. It could be that the participants in this study who were regularly engaging in discussion about their voices were at a later stage, namely 'action', compared to those who were still considering talking more being at the 'contemplative' stage.

5.3 Strengths and limitations

This research study used unstructured interviews which allowed the participants more opportunity to take the story where they wanted it to go. This allowed them more freedom to tell a story free from an imposed structure. Whilst this was regarded as a strength in this study, it could conversely be considered a limitation. This is due to a potential lack of consistency between interviews as not all participants were asked the same questions.

Although the interviews were unstructured the amount that the researcher said varied between interviews. In some the researcher said less largely because the person being interviewed spontaneously elaborated. The interviews where the researcher said more were where the participant spoke less which required more probing from the researcher. The researcher's comments were aimed to encourage the participant to engage fully. At points, however, the researcher could perhaps have inhibited the amount she said to limit the level of co-construction of the narrative.

The inclusion and exclusion criteria in this study did not exclude people with other difficulties as well as hearing voices such as depression, anxiety, OCD and autism. This is important as it perhaps more realistically represents the complex presentations of people who hear voices.

The use of Narrative Analysis allowed the researcher to explore individual stories. This included a consideration of what resources were, or continued to be, available to people in constructing and understanding their stories. Also by looking in detail at their use of language the researcher was able to tap into how the participant chose language to convey what was important in their story.

Further to this, paying attention to shifts in position ('I' and 'you') enabled the researcher to notice who the participant seemed to be referring to in their story. This also allowed for an in depth exploration of the sense participants made of their experiences, which experiences they understood to be specific to themselves, which they shared with others and which belonged only to other people.

Another possible limitation of this project relates to the process of conducting the structural analysis. Interview transcripts when analysed using Gee's approach varied in their numbers of stanzas, strophes and parts. Whilst the researcher did their best to select which parts were most relevant to the research question it is probable that some did not make the final cut which perhaps should have done. This might mean that some parts of peoples stories which were relevant, albeit indirectly, were omitted in the write up.

5.4 Implications

5.4.1 Staff training

The findings in this study would suggest that mental health services which come into contact with people who hear voices need to be offering something different/more to service users. A good example of this would be to provide training to nurses and other front line staff such as primary mental health workers. This training could be delivered by Clinical Psychologists and form a part of a mandatory training programme. An area in which training may be beneficial would be with regards to motivational interviewing and counselling skills. The reason for this is that it may equip staff with the confidence and knowledge to engage in discussions with service users about sensitive topics such as voice hearing. It

would be interesting to explore with staff what prevents them from engaging in discussions with voice hearers about their experiences. If the reasons include a lack of confidence and training as has been suggested by the literature then training may well help to address this.

Miller (1983) pioneered a conceptual model and some clinical guidelines for 'Motivational Interviewing' (MI). It focused on responding differentially to client speech within a generally empathic person-centered style. Special attention focused on evoking and strengthening the client's own verbalized motivations for change. The approach has been largely used in alcohol and drug services with regards to exploring a person readiness to change. This approach can be complemented by the model of change by Prochanska and Diclemente (1982) who suggest that people enter a number of stages when they are considering making a change in their lives. This model has been referred to in this study in relation to some of the participant's narratives about 'the right time to talk'.

The findings of this study suggest that more needs to be done to create opportunities for voice hearers to talk about their experiences. This could involve professionals in mental health services more routinely attempting to engage in conversation with voices hearers about their voices. It may be that professionals establish with their clients whether they want to talk and then provide this. Also professionals could do more signposting to peer support groups. The advantage of the latter is that it would give people the opportunity to get together with other people who hear voices. Having a space to talk with other people who hear voices has been described as positive in previous literature (Thornhill *et al.*, 2004). In this study this was also told in some of the participants stories. The

experience of being with other people who hear voices allowed some participants in this study to share coping strategies and left them feeling like they were not alone.

Providing more teaching to mental health staff to help them to develop their counselling skills may prove helpful. Skills such as active listening may be helpful in enabling them to become more confident. Miller and Rollinick (2001) began to develop ways in which to teach health care professionals skills of active listening. One of their strategies designed to help staff address individual's motivation to change relates what is known as the 'OARS' principles. These principles can be seen in Box 13:

Box 13: O.A.R.S.: 4 Strategies of motivational interviewing in the early stages of treatment: Motivational Interviewing: Preparing People for Change Miller and Rollnick (2001)

Open-Ended Questions

- Open questions gather broad descriptive information
- Facilitate dialogue
- Require more of a response than a simple yes or no
- Often start with words like “how” or “what” or “tell me about”
- Usually go from general to specific
- Convey that our agenda is about the consumer

Affirm

- Must be done sincerely
- Supports and promotes self-efficacy
- Acknowledges the difficulties the client has experienced
- Validates the client’s experience and feelings
- Emphasizes past experiences that demonstrate strength and success

Reflective Listening

- Reflective listening begins with a way of thinking
- It includes an interest in what the person has to say and a desire to truly understand how the person sees things
- It is essentially hypothesis testing
- What do you think a person means may not be what they mean?
- Repeating – simplest
- Rephrasing – substitutes synonyms
- Paraphrasing – major restatement
- Reflection of feeling – deepest

Summarize

- Summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on
- Summaries can link together client’s feelings of ambivalence and promote perception of discrepancy

The teaching of these types of tools to mental health professionals may help them to feel more skilled when it comes to asking about the voice hearer about their experiences. It may also prove beneficial for staff to have peer supervision in order to provide a space to talk about cases where they may need additional support when it comes to discussing voice hearing.

5.4.2 Improving Access to Psychological Therapies

Mental health services are increasingly orientated towards a model of recovery and a movement helped by the provision of better access to psychological therapies. Improving Access to Psychological Therapies is an NHS programme that has been rolled out in services across England. It offers interventions approved by the NICE. The introduction of IAPT for adults with depression and anxiety disorders came in 2006. The original aim of the programme was to improve provision of psychological therapies in the treatment of depression and anxiety in the hope that it would positively impact on the number of people who are fit to work.

More recently in 2012 the Improving Access to Psychological Therapies (IAPT) for Severe Mental Illness (SMI) project started to be implemented. The project aims to increase public access to a range of NICE approved psychological therapies for psychosis, bipolar disorder and personality disorders. In a similar way to the original IAPT programme a number of NHS organisations in the UK are being used as demonstration sites. The four year action plan aims to ensure that all people with psychosis, bipolar disorder and personality disorders who could benefit from evidence based psychological therapies have access to these interventions. This programme will be able to provide services with the opportunity to teach and train mental health staff in the use of therapeutic skills with people with a severe mental illness (IAPT, 2012).

5.4.3 Cognitive Behaviour Therapy for Psychosis (CBTp)

CBTp has been well researched and is now recommended in NICE guidelines as a preferred treatment option. The vast evidence base suggests that people who

have CBTp experience better outcomes than those who receive treatment as usual (Sivec & Montesano, 2012; Wykes *et al.*, 2007; Turkington *et al.*, 2006). These outcomes vary but include a reduction in hospitalisations and an improvement in positive symptoms. Studies place voice hearing within the category of positive symptoms and whilst reporting improvements with this symptom group less is reported about the specific changes that occur with voice hearing as a single symptom. There may be other outcomes which are also important and relevant for voice hearers including having better control over voices and an altered belief about voices. These outcomes which are not readily measured in intervention trials need to be investigated more fully. Further RCT's which either focus on only voice hearing or which deepen investigation into the quality of changes is needed to determine the effectiveness of using CBTp for voice hearing.

Bola *et al.* (2011) found there were only a few good quality studies comparing the treatment of schizophrenia with an antipsychotic medication compared to placebo or psychosocial treatment. Further research is warranted to explore how psychosocial interventions such as CBTp compare to medication alone regarding symptom management. This would enable health professionals and patients to be better informed about the options available when it comes to treatment. An example of the types of individual who would potentially benefit from this further research could be those who experience disabling side effects from medication or those for whom medication is ineffective.

5.4.4 Hearing Voices Groups (HVG)

The recommendation of providing a space to talk more about voice hearing, whether it be one to one or in a group, would be dependent on sufficient resources. Service cuts and increasing caseloads may mean that trying to offer more time to people is not straightforward. In these situations creating more peer support groups could be more cost effective. It would mean that a group of people could be seen by one or two professionals which could be a more valid use of time and resources.

Only one participant in this study had attended a HVG and not found it helpful. Some of those who reported having benefitted from attending such groups reported that it had been the HVG which had been the turning point in their journey towards recovery. Two of the participants explained that they felt it was important to have professionals facilitate the group. The reasons they gave were largely related to knowing that if something untoward happened (such as a member was suicidal or became aggressive) then there would be someone there to help.

The literature that exists about HVG's demonstrates that groups can vary from being service user led from the beginning or being facilitated by professionals who then leave the group or groups where professionals always attend. In 2009 the Hearing Voices Network (HVN) published a report. One of the aims of the report was to evaluate how groups were running and establish what worked well and what needed improving. The information collected came from group members across the UK (252 members from eight groups). When it came to asking about who should facilitate groups the majority of respondents reported

that they wanted voice hearers to be trained to facilitate rather than professionals. Respondents wanted groups to be more self-help than professionally led. Another finding was that members felt there needed to be more liaison with psychiatry and more training for GP's, psychiatrists and other health workers on the HVN approach (HVN, 2009). Many of the respondents felt that services needed to be challenged regarding the traditional views held and to explore alternative explanations and approaches. Several respondents felt strongly that more needed to be done to challenge traditional psychiatry's approach to voices. However some professionals spoken with felt concerned that it was important that HVN's message should not be 'too radical' as it might alienate some voice hearers and professionals who were attached to a biomedical framework.

There is limited reliable evidence to suggest that hearing voice groups are effective. Small scale studies have been conducted which suggest members experience great benefits from attendance such as more control over voices and better coping skills (Meddings *et al.*, 2004). Yet evidence is based on very small study samples and control groups are lacking. Further RCT's are required for the benefit of hearing voices groups to be reliably established (Ruddle *et al.*, 2011).

5.4.5 Timing and personal resources

Understanding more about timing and personal resources with regards to talking about voice hearing is also important. This study has touched on the concept of there being a 'right time to talk' and that this is different for different people. It may prove useful for mental health professionals to consider where a person is at regarding their readiness to talk and perhaps change.

Interventions could be tailored according to the stage which a person is at. An example of this might be that if a person is at the pre contemplation stage attending a group which involves talking to others about change may not be right for them. Rather than this they may need other support in the meantime until they are ready to move into the next stage (contemplative). A theory which could help understand someone's likelihood to talk about their voices is by Romme and Escher (1993). This theory suggests that there are three phases to voice hearing. The first is the 'Startling' phase and represents the time when a person starts to hear voices and is often denying the experience and withdrawing into themselves. The next stage is called the 'Organisational' phase which is when the person begins to normalize the experience and the process of selection and communication with the voices begins. Last is the 'Stabilization' phase and is when the person begins to handle their voices in such a way that shifts control from the voices back to themselves. Once again professionals working with voice hearers could consider this theory to shape an intervention. Understanding which phase someone is in could be achieved by listening to their narrative.

McGlashan's 1987 theory regarding the different coping styles people adopt when they hear voices could also be utilised when working with individuals. If someone is curious about their illness and is interested in understanding it (Integration style) then staff could provide information that enables the person to learn more about their difficulties and how to manage them (McGlashan, 1987). However if an individual is avoidant when it comes to thinking about their illness and minimizes the impact it has on them (Sealing-Over style) staff need to be more sensitive about how to approach working with this type of person. It may be that

work needs to be done to help them come to terms with their difficulties before they can be expected to understand more about it and how to cope.

This suggestion is certainly in line with the research of Startup and Wilding (2006) who suggest that interventions should not be used to try and change a person's own style but rather they should be tailored to suit an individual's recovery style.

5.4.6 Story Telling (Narratives)

Lastly the way people narrate their lives could be another important factor in aiding understanding. Frank (2010) who developed the Narrative Typology approach referred to the importance of gaining understanding about how people place themselves in their story. Frank suggests that clinicians could use narrative typology to assist people to become more reflective narrators of their own lives. If clinicians knew what to listen out for in their clients stories they could "help them to reflect on what sort of story they have been telling – what enabled that story and how that story was affecting their lives. More importantly as well what story they were not telling leading them to ask why not" (Frank, 2010 in Holstein & Gubrium, 2012, chapter 2, p48).

Furthermore by actively creating a space for people to tell their story it may allow them to step outside of themselves and witness what is happening to them. This stepping outside of oneself could allow the person to see a number of other possibilities which, whilst lost in their story, up to now have seemed impossible. Also for the listener (i.e. mental health professional) hearing a person's story may shed light on the reasons for their current situation and what may be stopping them from moving on. It is not necessarily about trying to change a person's story, for example from one of chaos to one of quest, rather than this it is about

gaining a better understanding of a person's story as this might assist in the selection of what is likely to be most helpful to that person. If someone is telling a quest story but places themselves as the sole passenger on the quest they may benefit from some support to help expand their own personal strengths and resources. Those who are also on a quest but who find it helpful to be with others on their journey might benefit from having contact with others such as in a hearing voices group.

5.5 Conclusion

The participants in this study had mixed experiences regarding the personal impact of talking about their voice hearing. There were a number of barriers which participants reported had gotten in their way of talking. Some of these barriers were external such as a lack of encouragement from professionals and societal stigma. There were also internal barriers to talking and reasons within the person which made talking less likely to talk such as readiness or believing that there was no benefit to talking about voice hearing.

Considering a person's readiness to talk about their voice hearing could provide mental health professionals with valuable information. This could help tailor an intervention for an individual.

All participants told their stories in such a way that may reflect how they viewed themselves in their own narrative. Working with story types could encourage a person to recognise the position they hold and what influences this. This could then enable an exploration with an individual about what is keeping them in their position. This exploration could lead to services or those around the person, such as family and friends, to take action to shift the position they themselves hold in

the story. This shift could result in a positive change in the life of the person hearing voices.

References for research report

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th Ed.)* Washington, DC: American Psychiatric Association.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. London: Penguin Books.

Beavan, V. & Read, J. (2010). Hearing voices and listening to what they say: The importance of voice content in understanding and working with distressing voices. *Journal of Nervous and Mental Disease*, 198 (3), 201-205.

Birchwood, M. & Iqbal, Z. (1998). Depression and suicidal thinking in psychosis: A cognitive approach. In: Wykes, T., Tarrier, N. & Lewis, S. (Eds.) *Outcome and Innovation in psychological treatment in schizophrenia*. Chichester: John Wiley.

Bloch, S. & Wilkinson, R. (2009). Acquired dysarthria in conversation: Identifying sources of understanding problems. *International Journal of Language and Communication Disorders*, 44, 769-783.

Brooker, C. & Brabban, A. (2004). *Measured Success: A Scoping Review of Evaluated Psychosocial Interventions Training for Work with People with Serious Mental Health Problems*. London: National Institute for Mental Health in England.

Brabban, A. & Kelly, M. (2006). *Training in psychosocial interventions in early intervention teams: A National Survey*. London: National Institute for Mental Health in England.

Carter, D., Kackinon, L. & Copolov, D. (1996). Patient's strategies for coping with auditory hallucinations. *The Journal of Nervous and Mental Disease*, 184, 159-164.

Cassell, C. & Symon, G. (2011). Assessing 'good' qualitative research in the work psychology field: A narrative analysis. *Journal of Occupational and Organizational Psychology*, 84 (4), 633-650.

Coffey, M. & Hewitt, J. (2008). 'You don't talk about the voices': Voice hearers and community mental health nurses talk about responding to voice hearing experiences. *Journal of Clinical Nursing*, 17 (12), 1591-1600.

Coffey, M., Higgon, J. & Kinnear, J. (2004). 'Therapy as well as the tablets': An exploratory study of service users' views of community mental health nurses' (CMHNs) responses to hearing voices. *Journal of Psychiatric and Mental Health Nursing*, 11 (4), 435-444.

Denzin, N. & Lincoln, Y. (2000). *Handbook of Qualitative Research*. London: Sage Publication Inc.

Devane, S., Haddock, G., Lancashire, S., Baguley, I., Butterworth, T., Tarrier, N., James, A. & Molyneaux, J. (1998). The Clinical Skills of Community Psychiatric Nurses Working with Patients who have Severe and Enduring Mental Health Problems: An empirical analysis. *Journal of Advanced Nursing*, 27, 253-260.

Diclemente, C. & Prochaska, J.O. (1982). Self change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. *Addictive Behavior*, 7, 133-142.

Drury, V., Birchwood, M., Cochrane, R. & MacMillan, F. (1996). Cognitive therapy and recovery from acute psychosis: A controlled trial: Impact on psychotic symptoms. *The British Journal of Psychiatry*, 169 (5), 593-601.

Emerson, P. & Frosh, S. (2004). *Critical narrative analysis in psychology*. New York: Palgrave Macmillan.

Escher, S. (2012). *Useful instruments for exploring hearing voices and paranoia*. New York: Routledge/Taylor & Francis Group.

Fontana, A. & Frey, J. H. (1994). Interviewing: The art of science. In Denzin, N.K & Lincoln, Y.S (Eds.) *Collecting and Interpreting Qualitative Materials*. California: Sage Publications Inc.

Fontana, A. & Frey, J. H. (1998) Interviewing: The art of science. In Denzin, N.K & Lincoln, Y.S (Eds.) *Collecting and Interpreting Qualitative Materials*. California: Sage Publications Inc.

Frank, A.W. (1995). *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press.

Frank, A.W. (2010) *Letting Stories Breathe: A socio- narratology*. Chicago: University of Chicago Press

Frank, A. W. (2010). Practicing Dialogical Narrative Analysis. In Holstein, J.A. & Gubrium, J.F. (2012). *Varieties of Narrative Analysis* (pp. 48-49). Sage Publications Inc.

Gee, J. P. (1991). A linguistic approach to narrative. *Journal of Narrative and Life History*, 1 (1), 15-39.

Georgakopoulou, A. & Bamberg, M. (2005). Small is beautiful: Small stories as a new perspective in narrative analysis. *Paper presented to the 9th International Pragmatics Association Conference*, Riva Del Garda, 10-15 July 2005.

Gergen, K. J. & Gergen, M. (1991). From theory to reflexivity in research practice. In Steier (Ed.) *Method and reflexivity: Knowing as systemic social construction*. (pp. 76-95). London: Sage.

Goodwin, C. (1984). Notes on story structure and the organization of participation. In Atkinson, J.M. & Heritage, J. (Eds.) *Structures of social action* (pp. 225-246). Cambridge: Cambridge University Press.

Gould, R.A., Mueser, K.T., Bolton, E., Mays, V. & Goff, D. (2001). Cognitive therapy for psychosis in schizophrenia: An effect size analysis. *Schizophrenia Research*, 48, 335-342.

Hearing Voices Network (2009). *Hearing Voices Network Consultation Report*, April 2009. Retrieved 1 October 2013 from www.hearing-voices.org/wp.../11/HVN-Consultation-Report-2009.doc

Hettema J., Steele J. & Miller W.R. (2005). Motivational Interviewing. *Annual Review of Clinical Psychology*, 1, 91–111.

Hollway, W. & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.

Improving Access to Psychological Therapies. (2012). *Improving Access to Psychological Therapies for Severe Mental Illness*. Retrieved on 1 October 2013 from <http://www.iapt.nhs.uk/smi/>

Jackson, H., McGorry, P., Henry, L., Edwards, J., Hulbert, C., Harrigan, S., Dudgeon, P., Francey, S., Maude, D., Cocks, J. & Power, P. (2001). Cognitively orientated psychotherapy for early psychosis (COPE): A 1 year follow up. *British Journal of Clinical Psychology*, 40, 57-70

Jones, M. & Coffey, M. (2012). Voice hearing: A secondary analysis of talk by people who hear voices. *International Journal of Mental Health Nursing*, 21 (1), 50-59.

Kitly, S. (2000). Telling the illness story. *International Alliance of Patients Organisations: The patient's network magazine*, 5, 3-7.

Kuipers, E., Fowler, D., Garety, P., Chislm, M., Freeman, D., Dunn, G., Bebbington, P. & Hadley, C. (1998). London East Anglia randomized controlled trial of cognitive-behaviour therapy for psychosis. *British Journal of Psychiatry*, 173, 61-68.

Manning, P. K. & Cullum-Swan, B. (1994). Narrative, content and semiotic analysis. In Denzin, N.K. & Lincoln, Y.S. (Eds). *Handbook of Qualitative Research*. London: Sage Publications Inc.

Marsh, D. & Furlong, E. (2002). Ontology and Epistemology in Political Science. In Marsh, D. & Stoker, G. (Eds.) *Theory and Methods in Political Science*. Basingstoke: Palgrave.

Martin, P.J. (2000). Hearing voices and listening to those that hear them. *Journal of Psychiatric and Mental Health Nursing*, 7, 135-141.

Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. New York: Cambridge University Press.

McGlashan, T.H. (1987). Recovery style from mental illness and long-term outcome. *Journal of Nervous and Mental Disease*, 175, 681 -685.

Meddings, S., Walley, L., Collings, T., Tullet, F., McEwan, B. & Owen, K. (2004). *Are hearing voices groups effective? A preliminary evaluation*. Retrieved on 1 October 2013 from <http://voices.schubblade.org/assets/2007/8/1/voiceseval.pdf>

Merrick, E. (1999). An exploration of quality in qualitative research: Are “reliability” and “validity” relevant? In Kopala, M. & Suzuki, L. (Eds.) *Using qualitative methods in psychology*. (pp. 25-37). California: Sage.

Miller, W.R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy*, 11, 147–172.

Miller, W. R. & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. London: Guilford Press.

Mishler, E.G. (1999). *Storylines: Craft artists' narratives of identity*. Cambridge: Harvard University Press.

Morse, J.M., Barrett, M., Mayan, M., Olsen, K. & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1 (2), 1-19.

Mosby's medical dictionary. (8th Ed). (2009). St Louis, MO: Mosby/Elsevier.

National Institute for Clinical Excellence (2002). *Clinical Guideline 1: Schizophrenia—Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. London: National Institute for Clinical Excellence.

Place, C., Foxcroft, R. & Shaw, J. (2011). Telling stories and hearing voices: Narrative work with voice hearers in acute care. *Journal of Psychiatric and Mental Health Nursing*, 18 (9), 837-842.

Primeau, L.A. (2003). Reflections on self in qualitative research: Stories of family. *American Journal of Occupational Therapy*, 5 (1), 9-16.

Prochaska, J.O. & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, research and practice*, 19, 276-288.

Repper, J. (1998). Using Single Case Experimental Design to Evaluate the Clinical Effect of a Multidisciplinary Training in Psychosocial Interventions for People with Serious Mental Health Problems. *Nursing Times Research*, 3 (5), 374-385.

Riessman, C. (2008). *Narrative methods for the human Sciences*. California: Sage.

Ritsher, J., Lucksted, A., Otlingham, P. & Grajales, M. (2004). Hearing Voices: Explanations and Implications. *Psychiatric Rehabilitation Journal*, 27, 219-227.

- Rolls, L. & Relf, M. (2006). Bracketing interviews: Addressing methodological challenges in qualitative interviewing in bereavement and palliative care. *Mortality*, 11 (3), 286-305.
- Romme, M. & Escher, S. (1993). *Accepting Voices*. London: Mind Publications.
- Romme, M., Escher, S., Dillon, J., Corstens, D. & Morris, M. (2009). *Living with voices: 50 stories of recovery*. Ross-On-Wye: PCCS Books.
- Romme, M. & Escher, S. (2011). *Accepting Voices*. London: Mind Publications.
- Ruddle, A., Mason, O. & Wykes, T. (2011). A review of hearing voices groups: Evidence and mechanisms of change. *Clinical Psychology Review*, 31 (5), 757-766.
- Schegloff, E. (1997). Narrative analysis: Thirty years later. *Journal of Narrative and Life History*, 7, 97-105.
- Schneider, K. (1959). *Clinical Psychopathology (5th Ed.)* New York: Grune and Stratton.
- Sin, J. & Scully, E. (2008). An evaluation of education and implementation of psychosocial interventions within one UK mental healthcare trust. *Journal of Psychiatric and Mental Health Nursing*, 15, 161–169.
- Sivec, H. J. & Montesano, V. L. (2012). Cognitive behavioral therapy for psychosis in clinical practice. *Psychotherapy*, 49 (2), 258-270.
- Smith, J. A. (Ed) (2003). *Qualitative Psychology*, London: Sage.

Startup, M., Wilding, N. & Startup, S. (2006). Patient Treatment Adherence in Cognitive Behaviour Therapy for Acute Psychosis: The Role of Recovery Style and Working Alliance. *Behavioural and Cognitive Psychotherapy*, 34, 191-199.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review*, 13, 593–618.

Tait, L., Birchwood, M. & Trower, P. (2003). Predicting engagement with services for psychosis: Insight, symptoms and recovery style. *British Journal of Psychiatry*, 182, 123-128.

Tarrier, N. & Wykes, T. (2004). Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia: A cautious or cautionary tale? *Behaviour Research and Therapy*, 42, 1377–1401.

Thorn National Steering Group (2005). Retrieved on 23 September 2013 from <http://www.thorn-initiative.org.uk>

Thorne, S. (2006). Nursing education: Key issues for the 21st Century. *Nurse Education Today*, 26, 614–621.

Thorn Model (2012). Retrieved on 23 September 2013 from <http://www.thorn-initiative.org.uk/ThornModel/>

Thornhill, H., Clare, L. & May, R. (2004). Escape, enlightenment and endurance: Narratives of recovery from psychosis. *Anthropology and Medicine*, 11 (2), 181-199.

- Thornicroft, G. (2004). The personal impact of schizophrenia in Europe. *Schizophrenia Bulletin*, 69, 125-13.
- Turkington, D., Kingdon, D. & Weiden, P.J. (2006). Cognitive behavior therapy for schizophrenia. *American Journal of Psychiatry*, 163 (3), 365-373.
- World Health Organisation. (1992). *ICD-10 Classifications of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organisation.
- World Health Organisation. (2001). *The World Health Report 2001 - Mental Health: New Understanding, New Hope*. Geneva: World Health Organisation.
- Wykes, T., Hayward, P., Thomas, N., Green, N., Surguladze, S., Fannon, D. & Landau, S. (2005). What are the effects of group cognitive behaviour therapy for voices? A randomised control trial. *Schizophrenia Research*, 15, 201-10.
- Wykes, T., Reeder, C., Landau, S., Everitt, B., Knapp, M., Patel, A., Romeo, R. (2007). Cognitive remediation therapy in schizophrenia: randomised controlled trial. *British Journal of Psychiatry*, 190, 421–427.

Critical Appraisal

Talking about Hearing Voices: A Narrative Analysis of Experience

1 In the beginning

Deciding on a project was the first stage of my research journey. I knew that I wanted to conduct research with adults with severe and enduring mental health problems. The reasons for this were because prior to training I had worked with adults in an inpatient psychiatric hospital who were very unwell. I remembered several people in particular whose lives had been virtually destroyed due to having severe and enduring mental health difficulties. Many of these individuals had histories of abuse and trauma. Initially I wanted to carry out research into the impact of childhood abuse on people who subsequently develop mental health difficulties. Whilst this area fascinated me I received feedback from very experienced research tutors who explained the complexities of carrying out this type of research from an ethics perspective. This felt frustrating, however, I understood the feedback and realised I needed to rethink my research ideas. After exploring a number of options I grew interested in research conducted with voice hearers. I started reading about the work of Marius Romme and Sandra Escher. I became fascinated by the hearing voices movement that they began in the late 1980's and early 1990's.

During my first few research supervision meetings discussion centred on several research ideas regarding voice hearing. Following some literature searching the decision was made to design a project regarding support people receive for their voice hearing.

2 Ethics and Research and Development

Applying for ethical approval felt daunting and overwhelming to start with. At this stage I went on a training course in GCP (Good Clinical Practice) which helped me to make more sense of the process. I soon realised that as long as you were organised and planned well in advance then the process needn't be so difficult. The process of gaining approval for Research and Development (R&D) proved harder than ethics. On reflection this was perhaps because of applying to two different counties each of which had their own versions of what was required.

3 Literature review

Having been through the process of applying for ethical and R&D approval I had learned the importance of being methodical in my approach. Once I had started to search the literature I began keeping a record of what databases had been searched and what keywords had been tried. This was very useful when it came to writing the review. Writing the literature review was very time consuming however it was important to demonstrate that I had been thorough and systematic in my approach to searching the existing literature.

4 Recruitment

Recruitment began by approaching clinicians who I had already contacted about my research. At this stage there were a number of leads and one of which resulted in the first interview. On reflection I should perhaps have approached all relevant services with an initial email to maximise scope for recruitment.

Balancing other university assignments and writing the literature review took up some of the time I had wanted to dedicate to recruitment in the beginning. I

decided to allocate time specifically for the purpose of recruitment. Once I did this I was able to keep lines of communication active with various services.

Several of the participants suggested by services were unable to take part in the end for various reasons and this felt like a set back because each potential interview comes as such a relief. Once the January of the year of hand in (2013) arrived one last attempt was made to contact services with whom little or no response had been made. This led to one more interview. Then as the thesis hand in date grew closer several participants came forward expressing an interest in taking part. This was very pleasing as it meant that I had more interview data to draw upon.

5 Interviewing

When it came to the first interview I was nervous and not sure what to expect. However, having two recording devices (one for back up) helped to manage my anxiety about the interview not recording. In this first interview, and throughout the others, I was struck by the openness and honesty with which people spoke to me. A mixture of feelings was generated for me. There was sadness at some of the terrifying experiences people had encountered but also admiration for people's ability to survive. One concept coming through several stories was that of 'hope'. Several models of recovery in mental health include 'hope' as a component important in the process. The 'Personal Recovery Framework' by Andresen *et al.* (2003) classifies 'hope' as one of four domains of recovery. This model was created from interviews carried out with people who have lived with mental health difficulties.

Time had been spent planning for how to keep participants safe such as providing support should they become distressed. It had not occurred to me what impact talking to people about their difficulties could have on me as the researcher. In clinical practice we use supervision to discuss issues such as transference and countertransference. I realised the importance of using my research supervision as and when necessary to talk about these issues. As a Final Year Trainee Clinical Psychologist stress is common. I found the need to remind myself of my own work-life balance in order to maintain a focussed approach.

Using unstructured interviews initially made me feel somewhat uneasy. The reason for this was due to not having an idea where the interview was going to go. Also unstructured interviews have been less commonly used by past Trainee's at the University. This meant that there were much fewer projects for me to look at for guidance and inspiration. Despite all of the above I took time to reflect (alone and in supervision) on the process. I realised that the whole idea of using unstructured interviews was so that people could move the story where they wanted it to go. This enabled participant's to be more in control as opposed to the researcher. Whilst this reflection gave me encouragement I also had to grapple with the uncertainty of whether I was collecting information relevant to my research question. As the interviews progressed the information being collected was rich and interesting some of which was directly relevant to my research question and some not.

The interviews varied in length which was due to how much the participant said. In the longer interviews the stories seem to flow easily. In these cases I found myself saying less as the person being interviewed had a lot to say. In the

interviews where the person said less, in particular interview two, I found myself saying more. I did this because I wanted to encourage them to feel they could say what they wanted. I also realised, however, on reflection that I could have perhaps said less as this may have given them more space to talk themselves.

6 Transcribing

Transcribing is time consuming and tiring. In order to manage this I took regular breaks to try and stay refreshed enough to be a competent transcribe. The method of analysis (Narrative) I chose perhaps exacerbated how hard going I found the process. There was a need to pay attention to detail, for example to pitch, which meant that careful and repeated listening was necessary to pick up the finer linguistic details for micro analysis. Having said this, listening intently did mean that I got to know the interviews well and became increasingly familiar with the way a story was told.

Eventually I decided to use a transcription service for several of my interview tapes. I still had to take time to listen to the tapes once receiving the transcripts as I needed to carry out the micro analysis. The time I saved on the actual transcribing was of great value to me.

As soon as I had conducted an interview I listened to the tapes. This allowed me to learn from what I felt I had done well and what I wanted to change for the next interview. The first interview was very interesting but I noticed that there were times when my questions were perhaps suggestible. I found referring back to my bracketing interview at this stage helpful. This allowed me to consider the assumptions I held prior to starting interviews. Whilst bearing this in mind I tried to manage the way I asked questions in the other interviews.

Whilst transcribing and in my research supervision I began to reflect on my position as interviewer versus therapist. It was very important to use my clinical skills during interviews, however, when transcribing I noticed an occasional tendency to become more of a therapist than interviewer. This I put down to the fact that I was talking to people about very sensitive topics and so almost couldn't help but give a natural therapeutic response. This perhaps related to me being a trainee where we were constantly reminded of the need to develop our therapeutic skills such as reflection and validation.

7 Analysis

Once I had decided on my area of research I began to consider what type of qualitative approach would best fit this. Following the generation of some initial research questions I considered Interpretative Phenomenological Analysis (IPA), Grounded Theory (GT) and Narrative Analysis (NA). I gathered information about each approach so that I could make an informed decision as to which would be the most applicable to my project's aim. The theme of my project was beginning to take shape and it started to become clear to me that I wanted to find out about the journey people take when deciding to talk about their voice hearing. I considered my research to be interested in when a person's voice hearing began, what had happened since and what led to the decision to talk about the voice hearing. This led me to consider the concept of how people use stories to talk about their experiences. As I read about IPA, GT and NA I began to move towards NA because of how it is interested in the way people use storytelling to share and make sense of their experiences.

Once I had decided on Narrative Analysis (NA) I began to explore the various types within the approach. After some extensive reading and attendance at workshops where I was able to discuss the various types of NA I thought it was important to consider the structure of stories. One of the leading authors in this area is Catherine Reissman who refers to two main methods used in Structural Narrative Analysis (Reissman, 2008). The first of these approaches is by William Labov. Labov's approach considers all stories to be made up of six stages. The more that I read about these stages the more rigid the approach seemed and I began to doubt whether I really wanted to fit participants narratives into Labov's strict framework (Labov, 1977). The other approach I read about was by James Gee (Gee, 1991). This approach, whilst still following a set framework appeared to be more flexible than Labov's. The more I read about Gee's approach the more I discovered that the approaches use of stanzas, strophes and unit ideas lent itself readily to my research question. I read some interview examples carried out by Reissman which demonstrated how to use the approach. After this I began to use Gee's approach with the first two transcripts and found it useful.

Further to the structure of stories I also wanted to explore the context of experiences and the impact this may have on a person's experiences and how they make sense of this. It was at this stage I started to read about Emerson and Frosh (2004) and I found their approach of considering context in understanding people's experiences fitted well not only with Gee's approach but also with the research I was conducting. This then led to me deciding on the final stage of analysis. I explored a number of approaches which considered stories as a 'whole' as well as their 'parts'. After considering several approaches within this type of analysis I decided on Frank's (2010) Narrative Typology. The reason for

choosing this over others approaches, such as Jefferson and Hollway (2000) was due to its potential for clinical application.

The process of using a less well known type of qualitative analysis proved to be a challenge. It was hard to find training and guidelines which explained the process. I was able to find an abundance of information on IPA and GT. Whilst it did at times prove frustrating it felt important to remain with NA as it was true to the research question. In the end I attended a small conference at Oxford University where I took part in a workshop about Narrative Analysis. Amongst practical experience this gave me ideas about where to gather more information about the process. In hindsight it would have been helpful to have had some advice from an expert in the use of Narrative Analysis. This may have enabled me to feel more confident in using the approach and would also have provided me with a space to explore any uncertainties I had about applying the approach.

The micro analysis part of Gee's approach was arduous. Listening to the tapes and trying to identify when pitch changed was not easy. There were times when I had to keep rewinding sections to establish if I had indeed heard a change in pitch. At these times I considered that if I had not picked it up clearly first or second time then it was likely to not be significant. Whilst conducting the macro analysis I had to keep asking myself whether the stanza's being generated were to suit my pre-conceptions or whether they actually reflected what the person was saying (their meaning). Once again I found referring back to the bracketing interview helpful. It enabled me to look at what assumptions I had pre-interviewing and to consider whether this was causing a bias in my interpretation.

When conducting my analysis I often considered the subjectivity of the interpretation. Whilst reading around the subject I came across a quote from Gergen (2001) which helped me to make sense of the concept of 'truth' in research. Gergen states "To tell the truth is not to furnish an accurate picture of what actually happened but to participate in a set of social conventions ...To be objective is to play by the rules within a given tradition of social practices ...To do science is not to hold a mirror to nature but to participate actively in the interpretive conventions and practices of a particular culture. The major question that must be asked of scientific accounts, then, is not whether they are true to nature but what these accounts offer to the culture more generally". (Gergen, 2001, p806). This description of the concept of truth complemented my epistemological position. Taking a Social Constructionist stance I held the view that people's experiences are influenced by their social world and that language is the medium through which they interpret and convey their experiences. Searching for 'truth' in people's experiences seemed futile. If research findings reflect how people seem to make sense of their experiences and if this information can benefit others then the pursuit for this information, in my opinion, is worthwhile.

8 The write up

When writing my thesis I found it hard at times to know whether I was being clear in how I described my actions and my decision making. When so immersed in the information it was hard at time to consider how my writing would read to an outsider. I had to take time away from sections, even paragraphs, to retain a fresh perspective. It was also hard to know what to prioritise for inclusion in the write

up. With a limit on words selecting certain material over other material is necessary. It was sometimes hard to know how to decide between findings that seemed possibly equal in importance. There were times when I perhaps began to stray off on a tangent. I tried to curb this by constantly reminding myself of the research question.

There was certainly one area which I knew to be a personal weakness when it comes to writing. This is with grammar and punctuation. In an attempt to improve this over the course of the Doctorate I have read books and chapters to try and improve on this. In order to manage my own anxieties about this I drew on the support of peers at times. This helped to highlight several factors such as use of commas and staying within the same tense.

Despite all of this I also felt excited when writing my thesis. As the various parts came together I found that my faith in what I was trying to achieve strengthened. I believed in what I was doing and felt like I owed it to the people who had participated to present their views. It was an honour for me that people had been willing to share their often difficult stories. It was this which helped to keep me motivated when writing up my research.

9 Limitations

As highlighted in the discussion section of the research report there were aspects of my study which may be deemed as drawbacks. Having said that, some of the potential limitations relate to my determination to stay true to the research aims. An example of this is my use of unstructured interviews. The reason for using this type of interview was so that I could give people the opportunity to tell a story according to what they want to say. Imposing a structure in interviews would have

meant that I may have had too much control over the direction in which the stories were headed. Despite my thoughts about using unstructured interviews I understand they are considered by some to be a less reliable method for conducting qualitative research. I also wonder whether using semi structured interviews would have resulted in me using less closed questions. When in the moment, during the interviews, I perhaps didn't have the space to carefully plan my questions. Whilst I accept the disadvantages of using unstructured interviews I still believe that my decision to use them was the right one.

Qualitative research can have its own limitations due to issues regarding robustness and quality. Throughout my research I did use tools such as a 'bracketing interview' and 'reflective diary.' I am aware of a number of other ways in which researchers can attempt to enhance the quality of their work. One of these is triangulation of which there are several types and I used 'investigator triangulation' with two interview transcripts. I did this by giving the transcripts to my research supervisor to analyse. This enabled me to see what similarities and differences we came up with in our analysis. Ideally, with less constraint on time, I should perhaps have done this with more than two interview transcripts as this may have helped to increase the validity of my study. Despite this last point I did make the effort to demonstrate my trustworthiness to the reader. I referred back to the outcomes of my bracketing interview at regular points throughout the analysis. This enabled me to engage in an on-going reflection of the potential for bias in my interpretations. An example of this was with one of my assumptions prior to carrying out interviews. This assumption was that services do not offer enough in terms of understanding and support to voice hearers. This assumption could have clouded my decision when it came to deciding which interview

excerpts to include in the results. I could have solely provided examples of when people were not given support by services as opposed to the times when they were. However I did not do this and tried as best I could to provide all sides of people's stories.

10 Dissemination

There are a number of ways in which I plan to disseminate my research study. Firstly all participants were offered a summary of the study upon completion. All of the participants decided they wanted a summary with three wanting access to the entire project. In addition to this I plan on providing the mental health services from which I recruited participants a summary of findings. The University of Leicester will have a copy of my research in their archives and a copy will also be held in the Clinical Psychology library. I will of course retain a copy as will my research supervisor.

There is an annual qualitative research conference being run by the British Psychological Society (BPS) in the late summer of 2013. I submitted a summary of my research and it was accepted for presenting in poster format by the BPS conference team.

In the September of my final year there will be a research conference which is organised by all third year Trainees. This will present an opportunity for me to talk about my research, either in the form of a presentation or as a poster.

Finally I would really like to submit my research for publication in a peer reviewed journal. There are a number of potential journals I might aim for but the one I have chosen is 'Psychosis' which is published by Taylor and Francis (guidelines for submitting to this journal can be found in Appendix I). Aiming to submit

research for publication has made me consider the originality of my work and its relevance to clinical practice. Although more positive than in the past, I am aware of the resistance that qualitative research can meet in mainstream Psychology journals. This last point was raised by Turpin *et al.* (1997) who wrote about standards for research projects involving qualitative methods. Turpin *et al.* explained that “clinical investigations where conclusions are unable to go beyond the immediacy of the case material in their contribution to knowledge will not be considered as having potential for publication” (Turpin *et al.*, 1997, p6). Taking all of this into consideration I know that I will have to clearly demonstrate the quality of my research and its potential for clinical application when submitting for publication

11 Summary

The process of conducting research at a doctorate level of education has without doubt been the biggest academic challenge I have ever faced. There have been many ups and downs along the way. Whilst it has been a challenge I have also found it a rewarding process and feel proud of what I have achieved. Meeting the research participants and listening to their stories has been a real honour. It is really for them and others like them that research such as this should be conducted. There are of course things that I would change were I to conduct my research again, however, there are also many things I would do the same.

References for Critical Appraisal

- Andresen, R., Oades, L. & Caputi P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37, 586-594.
- Emerson, P., & Frosh, S. (2004). *Critical narrative analysis in psychology*. New York: Palgrave Macmillan.
- Frank, A.W. (2010). *Letting Stories Breathe: A socio- narratology*. Chicago: University of Chicago Press.
- Gee, J. P. (1991). A linguistic approach to narrative. *Journal of Narrative and Life History*, 1, 15-39.
- Gergen, K. (2001). Psychological science in a postmodern context. *American Psychologist*, 56, 803-813.
- Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.
- Labov, W. (1977). *Therapeutic Discourse: Psychotherapy as Conversation*. New York: Academic Press.
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L. & Rodgers M. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *Swindon: Economic and Social Research Council*.

Riessman, C. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested guidelines for trainee and course. *Clinical Psychology Forum*, 108, 3-7.

Appendix A

Record of database search and key words used

*denotes a way of searching for all possible word endings, such as service, services (truncation)

Date of Search	Database	Key Search Terms	Results
05/07/2013	Psychinfo	Therap* AND hearing voices AND Psycholog*	11 articles found 5 selected for further reading
05/07/2013	Psychinfo	Interventions AND hearing voices AND Psycholog*	17 articles found 1 selected for further reading
05/07/2013	Psychinfo	Interventions AND hallucinations AND Psycholog*	69 articles found 16 selected for further reading
02/08/2013	Medline	Therap* AND hearing voices AND psycholog* AND interventions	293 articles found 26 selected for further reading
02/08/2013	Medline	Interventions AND hallucinations AND Psycholog*	11 articles found 2 selected for further reading
02/08/2013	Medline	Hearing voices AND psychoeducation AND effectiveness	94 articles found 14 selected for further reading
02/08/2013	Medline	Hearing voices AND counseling AND effectiveness	61 articles found 2 selected for further reading
10/08/2013	Scopus	Therap* AND hearing voices AND psycholog* AND interventions	8 articles found 2 selected for further reading
10/08/2013	Scopus	Interventions AND hallucinations AND Psycholog*	17 articles found 1 selected for further reading
10/08/2013	ASSIA	Therap* AND	11 articles found

		hearing voices AND psychologist* AND interventions	0 selected for further reading
10/08/2013	Psychinfo	Auditory hallucinations AND effectiveness AND Cognitive behavioural therapy AND psychologist*	6 articles found 3 selected for further reading
10/08/2013	Psychinfo	Auditory hallucinations AND effectiveness AND self help AND psychologist*	3 articles found 1 selected for further reading
10/08/2013	Psychinfo	Auditory hallucinations AND effectiveness AND psychosocial approach* AND psychologist*	2 articles found 0 selected for further reading
10/08/2013	Psychinfo	Auditory hallucinations AND effectiveness AND non- directive AND psychologist*	0 articles found 0 selected for further reading
10/08/2013	Psychinfo	Auditory hallucinations AND hearing voices groups AND self help AND psychologist*	2 articles found 0 selected for further reading

Appendix B Summary of quality assessment
outcomes using the AMSTAR checklist

AMSTAR question	Did the study address a clearly defined research question	Did at least two people select studies and extract data?	Was a comprehensive literature search carried out?	Did the authors clearly state if or how they limited their review by type of study?	Were the included and excluded studies listed?	Were characteristics of the included studies provided?	Was the scientific quality of the included studies assessed and documented?	Were appropriate methods used to combine the individual study findings?	* Overall quality of study: High quality (++) Acceptable (+) Low Quality (-)
Authors									
Jung, X & Newton, R (2009)	Yes	Yes	Yes	Yes	No	Yes	No	Yes	++
Wykes T, Steel, C, Everitt B & Tarrier N (2008)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	++
Turkington D, Dudley R, Warman D & Beck, A (2006)	Yes	Cannot say	Yes	No	No	Yes	No	Yes	+
Ruddles, A, Mason, O & Wykes, T (2011)	Yes	Cannot say	Yes	Yes	No	Yes	Yes	Yes	++

AMSTAR question	Did the study address a clearly defined research question	Did at least two people select studies and extract data?	Was a comprehensive literature search carried out?	Did the authors clearly state if or how they limited their review by type of study?	Were the included and excluded studies listed?	Were characteristics of the included studies provided?	Was the scientific quality of the included studies assessed and documented?	Were appropriate methods used to combine the individual study findings?	* Overall quality of study: High quality (++) Acceptable (+) Low Quality (-)
Authors									
Sivec, H & Montesano, V (2012)	Yes	Cannot say	Yes	No	No	Yes	Yes	Yes	+
Lawrence, R, Bradshaw, T & Mairs, H (2006)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	++
Lincoln, T.M, Wilhelm, K & Nestoriuc, Y (2007)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	++
Xia, J, Merinder, L & Belgamwar, M (2011)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	++
Lynch D., Laws K. R. & McKenna P.J (2010)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	++

*Overall quality was determined according to the number of criteria met. High Quality was assigned for papers meeting 6 or more criteria, Acceptable was assigned for studies meeting between 4 and 5 criteria and Low Quality was for studies meeting 3 or less criteria.

Appendix C

Data extraction form (adapted from Jones *et al.*, 2007)

Details of publication: Author Title Source Year	
Type of study: (literature review, survey, case study, evaluation, experiment/quasi experiment etc.)?	
Author's purpose: What are the broad aims of the study? What are the study research questions and/or hypotheses? What are the authors trying to achieve in writing this?	
Theory: Is any theory referred to in the research? How is the study informed by, or linked to, an existing body of empirical and/or theoretical research?	
Study Context: Study context (country, sector and organisational setting etc.) Study participants (age, sex, ethnicity, occupation, role etc.)	
Methods: What methods of data collection are employed?	

What is the sample	
Findings: What are the key findings? What are the key ideas, models, concepts, arguments and assumptions How relevant are the findings to what we are seeking to understand or decide?	
Reliability and validity How reliable/convincing is it - how well-founded theoretically/empirically is this (regardless of method)?	
Conclusion In conclusion, what use can I make of this?	

Appendix D: Ethics and Research and Development Approval Letters

NRES Committee East Midlands - Northampton

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839425
Facsimile: 0115 8839294

22 March 2012

Mrs Laura O'Halloran
Trainee Clinical Psychologist
Leicestershire Partnership Trust
104 Regent Road,
Leicester
LE1 7LT

Dear Mrs O'Halloran,

Study title: Talking about hearing voices: a narrative analysis of experience

REC reference: 12/EM/0067

Thank you for your letter of 20 March 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity		
Interview Schedules/Topic Guides	1	26 January 2012
Investigator CV		25 January 2012
Letter of invitation to participant	2	19 March 2012
Other: CV - Dr Berry		
Other: CV - Dr Scordellis		
Other: CV - Dr Crossley		
Other: Evaluation		
Participant Consent Form	2	19 March 2012
Participant Information Sheet	2	02 March 2012
Protocol	1	23 January 2012
REC application	95546/285455/14/811	06 January 2012
Response to Request for Further Information		20 March 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/EM/0067

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Mr Ken Willis
Chair

Email: jessica.parfremment@nottspct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"
Copy to: *Sponsor/R&D Contact – LPT*

Research and Development
Bevan House,
Kettering Parkway South,
Northamptonshire, NN15 6XR

Direct Dial: (01536) 480 314
Fax No: (01536) 480 333

Associate Medical Director: Dr Sean Scanlon
Head of Quality Support: Rose Patrick
R&D Manager: Stephen Zingwe
Date 19th July 2012

Laura O'Halloran
Trainee Clinical Psychologist,
Leicestershire Partnership Trust,
104 Regent Road Leicester LE1 7LT

Dear Laura O'Halloran

NHFT Ref: 141.12
Title: Talking about hearing voices: a narrative analysis of the experience
Project Status: Approved
End Date: 31/03/2013

I am pleased to confirm that with effect from the date of this letter, the above study now has Trust Research & Development permission to commence at Northamptonshire Healthcare NHS Foundation Trust.
All documents received by this office have been reviewed and form part of the approval.
The documents received and approved are as follows: (Some may not apply to the SZ and Alcohol arm)

Document Title	Version	Date	REC Approval
Evidence of insurance or indemnity		31/03/2013	
Interviews schedules/Topic Guides	1	26 Jan 2012	22 March 2012
Investigator CV		25 th Jan 2012	22 March 2012
Letter of invitation to participant	2	19 March 2012	22 March 2012
Other: CV-DR Berry, CV- Dr Scordellis, CV-Dr Crossley			22 March 2012
Other: Evaluation			22 March 2012
Participant Consent form	2	19 March 2012	22 March 2012
Participant Information sheet	2	02 March 2012	22 March 2012
Protocol	1	23 January 2012	22 March 2012

REC application	95546/2854 55/14/811	06 Jan 2012	22 March 2012

Please be aware that any changes to these documents after approval may constitute an amendment. The process of approval for amendments should be followed. Failure to do so may invalidate the approval of the study at this trust.

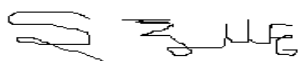
We are aware that undertaking research in the NHS comes with a range of regulatory responsibilities. Attached to this letter is a reminder of your responsibilities during the course of the research. Please ensure that you and the research team are familiar with and understand the roles and responsibilities both collectively and individually.

You are required to submit an annual progress report to the R&D Office and to the Research Ethics Committee.

The R&D Office is keen to support research, researchers and to facilitate approval. If you have any questions regarding this, or other research you wish to undertake in the Trust, please contact this office.

We wish you every success with your research.

Yours sincerely



Stephen Zingwe
Research and Development Manager

CC:

Encs: Researcher Information Sheet

Direct dial: 0116 295 7641
Email: david.clarke@leicspart.nhs.uk

Tel: 0116 295 7500
Fax: 0116 295 7599
Web: www.leicspt.nhs.uk

DC/LW-LO'H/PSYC0626

Mrs Laura O'Halloran
Trainee Clinical Psychologist
c/o University of Leicester
104 Regent Road
Leicester
LE1 7LT

29th April 2012

Dear Laura

RE: Talking about hearing voices: a narrative analysis of experience

Thank you for applying for NHS Permission (also known as Research Governance Approval) for the above-named study. I am pleased to inform you that the formal review of the project is now complete. The outcome of this review is given below:

Full Approval	<input checked="" type="checkbox"/>	Approval in Principle	<input type="checkbox"/>	Approval refused	<input type="checkbox"/>
---------------	-------------------------------------	-----------------------	--------------------------	------------------	--------------------------

Your responsibilities are set out in the attached agreement, which must be signed and returned to the Research Office. You should keep a copy for your records. All research must be managed in accordance with the requirements of the Dept. of Health Research Governance Framework (RGF), and to ICH-GCP standards. In order to ensure compliance with these standards, the Trust may randomly select your study for audit against these standards at any time, and may employ an external agency for this purpose.

This approval is contingent upon the validity of the following information:

Study Summary			
Chief Investigator (Supervisor):	Dr. Jon Crossley & Dr Jo Scordellis (LPT)	HC/LoA ¹	Yes/No
Principal Investigator:	Mrs Laura O'Halloran (LPT)	HC/LoA	Yes/No
Indemnity Provider:	NHS CNST		
NIHR Portfolio:	No		
Target Recruitment	4-10		
Target End Date	31 st March 2013		
Approved Documentation			
CV: Dr Christopher Berry (NHFT)	N/A		09/08/2007
CV: Dr. Jon Crossley	N/A		N/A
CV: Laura O'Halloran	N/A		N/A
CV: Dr Jo-Anne Scordellis	N/A		N/A
Information for Participants	Version 2		19/03/2012
IRAS Form	95546/285455/14/811		23/01/2012
Letter to Participant	Version 1		23/01/2012
Participant Consent Form	Version 2		19/03/2012
R&D SSI Form	95546/285483/6/130/136410/233644		20/01/2012


¹ Honorary Contract or Letter of Access

Research Protocol	Version 1	23/01/2012
Invitation Return Slip	Version 2	19/03/2012

The duration of this approval extends only to the date specified in your NRES submission (31/03/2013), and you should inform the Trust if this is to be extended. Action may be taken to suspend Trust approval if not conducted to these standards, and the study must commence within two years of the REC approval date, and within six months of R&D Approval.

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact me.

Kind regards



Dr. Dave Clarke
[Associate Director of Research & Development]

Appendix E: Information Sheet for Participants



Version Two
Date: 02/03/2012

Participant Information Sheet

Title of study

'Talking about hearing voices: a narrative analysis of the experience'

Main Researcher: Laura O'Halloran, Trainee Clinical Psychologist, Leicester University

Contact details

- email address: lw171@le.ac.uk
- telephone: 07895 170122

*I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. **Your Care Coordinator or the Main Researcher will go through the information sheet with you and answer any questions you have.** We'd suggest this should take about 20 minutes. Talk to others about the study if you wish.*

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Ask if there is anything that is not clear.

Part 1

What is the purpose of the study?

The aim of the study is to explore people's experiences of talking to others about hearing voices. The study wants to find out more about what leads a person to seek support for their voice hearing, and what impact doing this may have on their quality of life.

Why have I been invited?

The reason you have been asked to take part is because you are under the care of a Local Mental Health Service and are accessing support for your voice hearing. You are under no obligation to take part.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I agree to take part?

If you agree to participate then you will be asked to take part in an interview which will last approximately 45-60 minutes depending on how much you would like to say. The interview will involve you telling your own story about when you started hearing voices, when and why you decided to seek support for your voice hearing and the impact of this on you.

The aim of the interview is to allow you to tell your story and you will have the opportunity to say as much, or as little, as you feel comfortable to do. All interviews will take place at the premises of the Mental Health Service under which you are currently receiving care.

Part 2

What if I change my mind after saying yes?

If after initially agreeing to take part you decide to change your mind this is fine, if you let the main researcher or your care coordinator know within one month of agreeing to take part then any information you may have given will simply be removed from the study and not used.

What will happen to the information that I provide?

If you agree to take part you will be assigned an individual participant number which will then be attached to any information you then provide, this number will not be able to identify you in any way. The interview will be tape recorded, typed up and only looked at by the few people involved in conducting this research. The main researcher will look at interviews from a number of participants to see if there are any shared experiences or ideas.

Will my information be confidential?

All information you provide will be kept safe and confidential. Your personal details will not be kept alongside your interview transcript and only the main researcher and the research supervisor will know your details. All information used for the study will be anonymous so that you cannot be personally identified. The only people who will look at the full interview transcripts are the few people who are involved in conducting this research.

What will happen to the results of the research study?

The results of the study will be written up into a final report. No information included in the final report will allow for personal identification. The final report will be shared with Mental Health Service under which you are currently receiving care. The final report will also be held in the Clinical Psychology Library at the University of Leicester and it is hoped that the report may also be published in a psychology journal to make the outcomes more widely known. It is possible that quotes from an interview will be included in the final research write up, however these will not allow for personal identification.

Are there any disadvantages to me taking part?

Talking about difficult experiences can cause people to become distressed. If you were to feel distressed following being interviewed there will be the opportunity for you to talk to someone.

What happens if I want to talk to someone after taking part?

If after taking part in the interview you feel you want to talk to someone about any of the issues raised then you will be encouraged to contact your care coordinator. You will, of course be welcome to ask questions to the interviewer immediately after the interview too. During the interview if you disclose anything which may put yourself or others at risk then the Researcher will have to report this to the relevant authority.

Are there any benefits to taking part?

If you decide to participate then you will be helping to improve how we understand individual's experiences when it comes to hearing voices. Your participation will also enable us to further understand what it is that helps some people who hear voices; this may benefit future individuals who have the same experiences.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the East Midlands Research Ethics Committee.

Appendix F: Study consent form



Version 2, 19/03/2012

INFORMED CONSENT FORM

Title of study: Talking about Hearing Voices: a narrative analysis of experience
Name of Principal Investigator: Mrs. Laura O'Halloran
Centre/Site number:
Study number:
REC approval number:
EudraCT number:

Participant ID:

Thank you for reading the information about our research project. If you would like to take part, please read and sign this form.

PART A: Consent for the current study

PLEASE INITIAL THE BOXES IF YOU AGREE WITH EACH SECTION:

1. I have read the information sheet version one dated 02/03/2012 for the above study and have been given a copy to keep. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I agree to my interview being audio recorded and I understand that transcripts of my interview will be anonymised. ☐
4. I understand that relevant sections of my medical notes and data collected during the study may be looked at by the Main Researcher and their Supervisor from Leicester University or by staff from the team under which I am receiving care within the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
5. I understand that if the researcher has concerns about my well being after taking part then they will make contact with my care coordinator in case I require further support. ☐
6. I understand how some of the information I give will be produced in a report and that it will be stored securely within the University of Leicester, I understand that the report may also be published in a relevant psychology journal. ☐
7. I know how to contact the research team if I need to. ☐

8. I agree to participate in this study

☐

Participant: name

Date

Signature

Person taking consent:

Date

Signature

Appendix G: Bracketing Interview

Bracketing Interview 26/06/2012

Laura O'Halloran
Jon Crossley

What are my assumptions about what might be found from interviews?

- Services are not offering enough in terms of understanding and support to voice hearers
- Hearing voices groups and other support groups are very good and helpful.

Exceptions

There may be cases where the person does feel they got enough support from services. Also, some individuals may not have found HVG helpful.

What do I understand about voice hearing/service responses?

- It is largely distressing experience.
- Services and staff such as CPN's may pathologise the experience. This may result in them actively avoiding discussion about the voice hearing. The reason for this is that they are trained to discourage engaging in conversation for fear of giving the experience any place in reality.
- The voice hearer may see themselves as having a relationship (even if a bad one) with the voice(s).
- Voice hearing may be linked to trauma and abuse in the past.
- The way in which a person has had the experience explained to them may determine how they manage/cope. For example, if they see a Psychiatrist who tells them it is purely a symptom of a biological disorder then they may feel there is nothing they can do to change it. This could lead to a fatalistic feeling and loss of control for the person.

Exceptions

Not all people who hear voices find it distressing. Also, some staff and services may be good at acknowledging the experience as real. Not all voice hearers will necessarily want to talk about it.

What do I feel about Narrative Analysis?

- It gives more freedom to the participant as they can tell their story with less structure being imposed
- I am becoming more confident in the approach. I still have a lot to learn but am attending a workshop in July which I hope will help.

Appendix H: Micro and macro analysis for each participant: Each table shows all Parts, Strophes and Stanzas for each participant. Each part is made up of a number of strophes which in turn are made up of a number of stanzas.

Anna's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Harsh old days where you had no choice	a) Harsh and unhelpful interventions	4-Harsh interventions years ago in services 7- Old type of support not helpful 52 -In old days, you would be ignored in services 53 -In old days, you didn't talk about problems 58- Hearing voices = multiple diagnoses
	b) Lack of control over decisions	3-Lack of choice and control years ago in services 34- Hates confrontation 35-Last chance saloon
2) Voices have power	c) Cruelty of voices	5- Voices are still there and are controlling 14- Self-harming shuts voices up 28- Voices are not nice 29-Voices blame you for things you haven't done 30-When voices stop, they return with a vengeance 43- The voices are vengeful when you are low 45- The constancy of the voices is debilitating 46-Rather than hurt others, hurt self instead
	d) Voices are changeable	1- Abuse and start of voices (imaginary friend) 2-Voice changed from good to bad 30- When voices stop, they return with a vengeance 43- The voices are vengeful when you are low 44- The voices can be ignored when you are in a good frame of mind 62- How strong you are affects voices control over you
3) A long life of trauma and struggles	e) Trauma	1- Abuse and start of voices (imaginary friend) 4-Harsh interventions years ago in services 14-Self-harming shuts voices up

	f) Struggles	42-It's just one bad thing after another 57-Different Doctor, different diagnosis 58-Hearing voices = multiple diagnoses
4) HVG has enabled positive change	g) New coping strategies and trust building	9- Group was first time have met other people with similar experiences 10- Learning new coping strategies (HVG) 19- Confidentiality is important in the group 44- The voices can be ignored when you are in a good frame of mind 62- How strong you are affects voices control over you 66- The HVG is trustworthy
	h) Confidence and helping others	31- Helping others is satisfying 32-Motherly figure of group 36- HVG was a chance to leave the house 37-HVG builds up your confidence, it doesn't put you down 38- People missing me makes me feel good 48- You can be yourself in the group 51- Rewarding to make a contribution 69- HVG led to finding other support
5) Hearing Voices Groups are a refreshing and helpful intervention	i) HVG offer understanding and shared experiences	9- Group was first time have met other people with similar experiences 13- People in group understand, whereas outside group others do not 20- Sharing of advice is useful 24- Other group members have tried drugs, alcohol and self-harm to cope 25-There is always someone like you in the group 27- If you haven't heard voices you cannot fully understand 47- The group understands and brings you closer 64- HVG is a space to talk

	j) HVG is like a supportive family	15- Group members look out for each other's 22- The group does not judge 23-Group is like a crutch 26- Taking to others lifts a weight 31- Helping others is satisfying 38- People missing me makes me feel good 47- The group understands and brings you closer 48-You can be yourself in the group 65- Good to finish HVG on a positive note 66-The HVG is trustworthy
6) Services are better now but diagnosis is still an issue	k) Choice and control now possible	54- There is understanding now and you can talk about problems 55-Patient has more rights now, staff have to listen 56-Choice is yours nowadays
	l) Diagnosis: misguided and misunderstood	16-Hearing voices experience is similar across diagnoses 17-Not only schizophrenics who hear voices 57- Different Doctor, different diagnosis 58-Hearing voices = multiple diagnoses

HVG – Hearing Voices Group

Pam's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Trauma and loss triggered voices	a) Close to disabled daughter who was totally dependant	33- Looking after disabled daughter 34- Letting someone you love go 38- Special relationship with daughter 39-There with daughter right until the end 40 -Daughter alive in heart and mind
	b) Losing daughter was a significant trauma	5- Voices began after huge trauma 6- Pain of losing someone 7-Great sadness with loss 34- Letting someone you love go 36- Mixed emotions when thinking of daughter
2) Support to stay safe but no one to talk to about loss	c) Family and professionals keep me safe	3- Needs protecting from self 4-Lucky to have someone to talk to when in a crisis 9- Finally asked for help 17- Thinking of family can keep you safe 23- Needing to be looked after 31- Lucky to be cared for 32-Daughter is an angel 35- Professionals give me strategies for coping with distress 41- Need to see Psychiatrist due to voices worsening
	d) Not able/allowed to talk about losses	12- A need to talk about painful issues not met 13- Angry couldn't talk about painful issues 20- Couldn't talk about loss 22- Engulfed in grief

3) Hearing voices takes over life	e) Voices are cruel	1- Voices command self-harm 8-Voices are very upsetting 14- Voices took advantage of vulnerability 25- Voices stop you sleeping 43- Voices sometimes go but come back worse 44-Voices say horrible things 45-If I talk back to voices it makes it worse, so best to stay silent
	f) Voices change me	3- Needs protecting from self 15- Voices make you do things out of character 19- Disappointed to wake up 21- Aggressive when unwell 30- Behaviour frightened self and others
4) Caring family but still have unmet needs	g) Daughter plays a positive role in life	17-- Thinking of family can keep you safe 29- Forgiveness of family 31-- Lucky to be cared for 32-Daughter is an angel
	h) Complex unresolved issues maintain distress	22- Engulfed in grief 36- Mixed emotions when thinking of daughter 41- Need to see Psychiatrist due to voices worsening 46-Professionals can't help with voices

Jack's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Hearing voices and not being helped	a) Reaction of professionals not helpful	<p>4 – Experiences not normal 7 – Wanted to talk about voices to someone 26 - Hospital was caring but main focus was medication and rest 38 - Being discharged from hospital can be like a ticking time bomb 40 - Being told directly what to do is not helpful 41 - Advice given may sound simple but it is not 41 - How advice is delivered is key</p>
	b) Care and interventions not helpful	<p>2- Anti-medication at the start 3 - Some support didn't help 6 - Hospital provided only basic care 7 - Medication didn't help with voices, plus bad side effects 9 - Hearing voices group not helpful as learnt nothing new 10 - Group not needed for social support as had this 26 - Hospital was caring but main focus was medication and rest 40 - Being told directly what to do is not helpful 42 - How advice is delivered is key 44 - Mixed wards (people with drug/alcohol dependence) is not helpful for people with mental health problems 45- Violence seen on wards made symptoms worse, i.e. paranoia</p>
	c) No-one to talk to about voices	<p>7 – Wanted to talk about voices to someone 27 - Wanted to talk about voices in hospital but couldn't 28 - In hospital talking about difficult issues was avoided</p>
2) Not helping self to helping self	d) Unhelpful strategies used to cope made	<p>15 - Used alcohol to cope 17 - Had visual hallucinations when drinking 20 - Alcohol added to problems</p>

	things worse	32 Chaotic environment makes things worse
	e) Learning how to help self	55- Acceptance is important 56- Having hope is important in recovery 57- Setting achievable goals helps 58 -You need to believe things will get better 60 - Light at the end of the tunnel (hope)
3) Stress and de-stress	f) Stressful life events exacerbate problems	1 - Impact of stress 16 - Stressful life events worsened situation 32 - Chaotic environment makes things worse
	g) Slowing down and reducing stress key to recovery	18 - It is important to de-stress 21 - You need time to get better, slow life down 33 - Taking it easy is important and having things in order is important 42 - Having insight is key in recovery
4) Hearing voices and paranoia go hand in hand	h) Frightening and negative experiences	4 - Experiences not normal 13 - Confidence badly knocked by voices 14 - Scary experience (voice hearing) that wasn't wanted 17 - Had visual hallucinations when drinking 19 - Hard as never had experienced anything like it (voices) 31 - Voices and visual hallucinations blow your mind
	i) Paranoia prevented recovery	23- Paradox of needing to get out of house but struggle as symptoms worsened 24 - Paranoia is potent 25 - Paranoia makes going out a challenge 30 - Paranoia and voices go hand in hand 45- Violence seen on wards made symptoms worse, i.e. paranoia
5) Overthinking and overwhelming	j) Overthinking worsens problems	36- Depression is part of it 37 - Feelings of hopeless led to feeling suicidal 39 - You can't be sure you are getting better

		47 - Rumination is part of the problem
	k) Overwhelming experiences	4 - Experiences not normal 13 - Confidence badly knocked by voices 14 - Scary experience (voice hearing) that wasn't wanted 17 - Had visual hallucinations when drinking 19 - Hard as never had experienced anything like it (voices) 31 - Voices and visual hallucinations blow your mind 54 - I thought I was tough minded until this (fragility)
6) Recovery versus becoming unwell	l) Fragility and uncertainty of relapse	38 - Being discharged from hospital can be like a ticking time bomb 39 - You can't be sure you are getting better 44 - Mixed wards (people with drug/alcohol dependence) is not helpful for people with mental health problems 45- Violence seen on wards made symptoms worse, i.e. paranoia 54- I thought I was tough minded until this (fragility)
	m) Getting better and moving forwards	21- You need time to get better, slow life down 22 - Getting back on top 43 - Having insight is key in recovery 46- Change in medication helped alleviate some difficulties 57- Having hope is important in recovery 58 -Setting achievable goals helps
7) Insight, hope and acceptance: light at the end of the tunnel	n) Knowing you are getting better	43 - Having insight is key in recovery 55- Acceptance is important 56- Having hope is important in recovery 58 - You need to believe things will get better 60 - Light at the end of the tunnel (hope)

Mandy's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Cannot talk to many people	a) Not many people to talk to	3 - Cannot talk to mum about voices 14 - Voices build up because cannot talk to many people 15 - Cannot talk about voices at home or work
	b) Family does not help, makes it worse	2- Mum won't accept voices 3- Cannot talk to mum about voices 5-Mum cares, but not about voices 6- Friends family listens, unlike own family 7- Step father is hostile 9- Real dad can't look after P4
2) Voices are persistently mean and confusing	c) Voices are mean	13 - Voices are horrible 14 - Voices build up because cannot talk to many people 18 - Voices can be aggressive 49 - These experiences very stressful for P4 51 - Main voice can be very mean
	d) Voices are persisting and confusing	16 - Voices never go away 17 - Hard to understand voice hearing 19 - Voices follow you everywhere 45 - Voices very confusing, who is who?
	e) Main voice is 'father figure' who wants to take me away	46- Care coordinator encourages discussion about main voice heard 47- Main voice like a 'father figure' 48- P4 once packed bags to leave following voices commands
3) Mixed experiences of services	f) When first in services saw multiple people	33 - Taken' to GP because couldn't cope with stress 34 - Crisis team involved 36 - In the beginning, saw many different people

		37 - Found it hard seeing many different people
	g) Regular contact with one professional helpful	38-Now has stable care coordinator 39- Has regular contact with care coordinator 40- Routine of seeing care coordinator important 41- Seeing care coordinator helps a bit
4) Always different	h) Special needs makes me different	11-Special needs makes P4 feel like a baby 12-Having autism means P4 finds it easier to talk to doll than family
	i) Hearing voices makes me different	1-Experience of voice hearing makes P4 different
5) Issues with medication	j) Doesn't like being on medication	25-Medication helps but not all the time 32-Doesn't like medication but voices won't go away 31-Not keen being on medication
	k) Sensitive to medication due to epilepsy	26-P4 hyper sensitive to many medications 27-P4 has history of seizures

Roger's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Evil versus good voices	a) Voices imitate others and are sinister	63 - Evil voices suddenly bombarded 65-Evil voices played tricks which was scary 66-Evil voices lie and threaten 67-Evil voices tried to turn against group 76 - Voices know when you are vulnerable 80-Lost all friends due to bad voices 81-Bad voices pretended to be friends being horrible 86-Bad voices imitating people makes it hard to build relationships
	b) Voices are manipulative (two realities)	51-Was previously living inside own head (2 realities) 52-Voices dragged me into their reality 53-Voices are very convincing 54-In hospital, voices non stop 57- Voices are good at explaining themselves 58-Voices convinced me I was telepathic 60- Voice hearing is traumatic 68 - Choices can change tactic when you do 83- Voices dislocated me from society
	c) Good and bad	61- Good and evil voices 62-Good voice always been linked to spirituality 70- Dilemma: listen to good or bad voices? 71-Gave control to good voices which got me out of bad voices control
2) Hospital's main focus was	d) Can't get advice in hospital	17 - In hospital, had feelings that couldn't manage 40- You'd talk in hospital but get little back 41-Medication can help but there is a another side to support too

medication and keeping you calm	e) It's about taking medication and calming down	9 - In hospital it was about medication and keeping you calm 42 - Medication can help but there is a another side to support too
3) Group and therapy helped understanding of experiences (also me helping others to understand)	f) Varying explanations for voices	4- Varying explanations given for voice hearing (self, doctor and psychologist) 51- A blend of explanations is a fair compromise
	g) Developing an understanding helps	10 - Came to group as wanting to understand what was happening 20- Didn't previously understand anxiety (assumed a side effect) 21-Now able to recognise anxiety and manage it 50-Developing a way of understanding voices for me 72--Good to have more ways of understanding voices 73-Compassionate (good voices) versus critical (bad voices) 74-Has helped to learn voices are not an external force 75-Thoughts for some people, voices for others
	h) Trust develops and you can help others	22-Eventually felt able to share in group 23-Felt safe and comfortable enough to trust group 24-Others opening up in group gives you courage to do the same 26 -Group members have similar experiences and can understand (outside people cannot) 27-Felt inspired by group members 33-Hope that others get as much from group 35-Feels good to help others too 36-Best way to learn is to teach 37-Would advise people to give group a try
4) Group gives strategies to manage voices,	i) Confidence grew	22- Eventually felt able to share in group 49-Have a way to go but can see progress

giving confidence	j) Taking control	46- Now learning to challenge voices 47-Voices are horrible and so gaining more control is important 55-Triumph – stop listening to voices and talking back (hard) 56-Realising which reality needed to live in, wasn't voices version 59- Shift of control from voices to me 71--Gave control to good voices which got me out of bad voices control
-------------------	-------------------	---

	k) Learn strategies	19- Group gave ways to cope with anxiety 28- Group members bring coping strategies to share 48- Learning to manage voices
5) Learning to manage emotions with help	l) Realising need others	22- Eventually felt able to share in group 39- Turning point was realising needed help 44- Now understand breakdown can be due to pushing problems back in closet 87- Realising need for people in life 88-Without MH team would be isolated
	m) No longer blocking emotions	18- Before the group, wasn't coping with emotions 19-Group gave ways to cope with anxiety 20-Didn't previously understand anxiety (assumed a side effect) 44- Now understand breakdown can be due to pushing problems back in closet 45-Important to allow self to feel (rather than block) emotions
6) Recovery is starting afresh	n) Letting self be helped	87- Realising need for people in life 88-Without MH team would be isolated

	o) Trying to get back into society	34- May be the right time to move on 82- Family can see change in me 84- Now I am staring again 85-Learning to reintegrate
--	---------------------------------------	---

Suzy's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Voices negative impact on life (couldn't cope)	a) Multiple losses due to voices	18-Everything changed when voices started (moved home) 19-Got so bad, could not leave the house 25-Experienced many losses since voices started 26-Confidence badly shaken by voices 27-Mum now carer (had to give up job) 37- Lost many friends due to voices impact
	b) Voices made it hard to manage emotions	14-Before the group, didn't cope with voices at all 20-Panic attacks hard to manage 21-Panic attacks got me down 32- Couldn't talk to anyone about voices before group
2) Mental health team involvement	c) See psychiatrist for medication	10-Came to mental health team via crisis 11-Psychiatrist manages medication 12-Psychiatrist checks medical needs 16-Told by medic, voices were a mental illness 17-Voices began=crisis
	d) Mental health team a good support	1-Came to hearing voices group via mental health team 12 -Regular contact with keyworker is good 15- Was told about group by mental health team (didn't ask)
3) Voices put you down and discourage talking	e) Voices are cruel	22- Voices telling me to hurt myself 23-Voices taunting me 24-Bad voices only (no good) 28- Voices threatening when made decision to try group

	f) Voices are anti-group and talking	<p>4- Voices were telling me not to go to group</p> <p>5-Went against voices and tried group</p> <p>9- Prior to group could talk to one family member (but not about voices)</p> <p>28- Voices threatening when made decision to try group</p> <p>32- Couldn't talk to anyone about voices before group</p> <p>33- Voices didn't let me talk to anyone before group</p>
4) Group provides a space to talk and helps with coping	g) New strategies make a difference	<p>2- Learnt new coping strategies in group</p> <p>41-Putting strategies into place is good (i.e. anxiety)</p> <p>42-Strategies for paranoia helpful when trying to go out</p> <p>43-Challenging thoughts helps (learned in group)</p>
	h) Talking to others helps enormously	<p>30-Helps to talk to people in similar situation</p> <p>32- Couldn't talk to anyone about voices before group</p> <p>44- LO suggests it maybe helps to know you are not alone</p> <p>45-P4 agrees it is good to know not the only one</p>
5) Group support has been invaluable (hope for others)	i) Group has been key to recovery	<p>34- Group has made biggest difference in start of recovery</p> <p>35-Group has been better than medication in managing voices</p> <p>36-Starting to get out again, slowly but surely</p> <p>38- Starting to socialise again</p> <p>39-Group support helps to manage voices</p>
	j) Building trust and confidence	<p>43-Challenging thoughts helps (learned in group)</p> <p>54-Group helped confidence grow again</p> <p>55-Group has been encouraging and supportive</p>
	k) New members can be helped by existing ones	<p>46 New group members could bring new ideas</p> <p>47 New members shy, like I was</p> <p>48 Would advise others to try group and persevere</p> <p>49 Having existing group members is good for new members</p>

		50 Having existing members may have helped to relax when I first came to group
6) Managing voices better is helping to rebuild life	51 Better able to manage difficult emotions	39-Group support helps to manage voices 40- Putting strategies into place is good (i.e. anxiety) 41-Putting strategies into place is good (i.e. anxiety) 42-Strategies for paranoia helpful when trying to go out
	52 Using skills to rebuild life	36-Starting to get out again, slowly but surely 38- Starting to socialise again
	53 Anxious about future	56- Feeling worried about moving mental health services 57-Will have chance in new group 58-May need to turn to others if gap between groups

Mohammed's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Frightening voices and hallucinations holding my life back	a) Terrifying experiences	4-Voices seemed very powerful 13 - Stopped taking medication due to weight gain but ended up sectioned in hospital 16 - Voices feel real even though no one is there 33 - My first experience of hallucinations felt alien like 34 - Felt like I was being taken over by the devil
	b) Difficulties prevent me from getting on	24 - Need to make sense of voices rather than just take medication as they slow you down 25 - Started a university course but medication makes me too tired so had to quit 26 -Cannot see things improving
2) Looking for an explanation for voices and hallucinations	c) Other people have explanations for my experiences	11 - Went to see a Muslim priest for answers (first person to talk to about voices) 12 - Priest suggested voices were a spell 27 - Doctors have said my illness is for life 28 - Doctors have said illness is genetic 29 - Not happy about suggestion illness is genetic 31 - Psychiatrists don't agree with me, they have a text book that says it is genetic 36 - Saw another priest for exorcism and felt a bit better

	<p>d) My own explanation is unclear, stress or a spirit?</p>	<p>2 - Stress of suing work took a lot out of me 3 - Left job, became ill and started having hallucinations 10 - Wondered if old work manager had placed a curse on me 15 - Assaulted in street and had more hallucinations afterwards 17 - Still felt confused after seeing priest 21 - Wondered if voices might be a spirit 24 - Need to make sense of voices rather than just take medication as they slow you down 29 - Not happy about suggestion illness is genetic 30 - Believe that illness is triggered by workplace stress 31 - Psychiatrists don't agree with me, they have a text book that says it is genetic 32 - Work stress initially made me depressed, then voices began 35 - To this day I still cannot explain why I have these voices</p>
--	--	---

Alison's Parts, Strophes and Stanzas

Parts	Strophes	Stanzas
1) Ignorance about mental health makes it harder to get support	a) Society can be ignorant about mental health	9 - Tend not to talk to many people as they think I am crazy 18 - Cannot volunteer for cubs because of my mental health problems 21 - Feel saddened by peoples ignorance about mental health 22 - Physically disabled neighbour doesn't get bullied, but I do for MH problems 30 - Not all mental health illnesses are the same, people don't understand this 32- Peoples ignorance about mental health can prevent me from talking
	b) Family doesn't always understand my mental health	8 - Tend not to talk to many people as they think I am crazy 23 - If hospitalised, mum can't understand and wont visit 24 - Some other family members are ignorant about mental health
	c) Mental health services and professionals do not always understand voices	6 - Staff at mental health walk in centre are ignorant 9 - Some staff assume I need hospital where as I just need to talk 40 - Some professionals can themselves be ignorant about voices 41-Psychiatrists do not tend to understand voices
2) Talking to others helps and enables positive change	d) Feel better after talking to people	7 - If I can talk about voices it eases distress 8 - Some staff assume I need hospital where as I just need to talk 10 - Started to attend hearing voices group recently and it helps to share feelings 25 - Hearing voices group is where I can talk about voices 27 - I can talk at HVG because other people have similar experiences

	e) Learning ways to manage distress is positive	<p>11 - Hearing voices group gives me coping strategies so don't need increase in medication</p> <p>14 - Need to manage stress or may end up back in hospital</p> <p>26 - HVG experiences has been positive and helps me to cope better</p> <p>33 - X^x has taught me skills such as relaxation that helps</p> <p>34 - It is important to keep occupied</p>
	f) Getting support from other is very important	<p>13 - Police helped me get my daughter out</p> <p>15 - Having good support for having son with learning disability helps me with stress</p> <p>17 - Having respite from caring from sin helps me relax</p> <p>20 - Being able to help others at church is positive for me</p> <p>28 - X has helped me to understand other peoples mental health too</p> <p>29 - X has been very supportive with various needs</p> <p>33 - X has taught me skills such as relaxation that helps</p> <p>35 - A good friend helps with paperwork as it stresses me</p> <p>44 - Keeping my same CPN has helped as it is consistent and I like her</p>

^x 3rd sector service which P9 accesses

Appendix I: Guidelines for targeted journal (for literature review)

Target Journal: Psychosis (Publisher: Taylor and Francis)

Manuscript preparation

1. General guidelines

- Manuscripts should be consistent with the Aims and Scope of the journal.
- Papers are accepted only in English. American or British English spelling and punctuation is preferred provided usage is consistent throughout.
- The following word limits apply (including the abstract, tables, figures, and references):

Research articles and reviews will not exceed 5,000 words;

First person accounts (both kinds) 3,500 words;

Brief Report - 1,000 words;

Opinion Pieces - 1,000 words;

Letters to Editor - 400 words;

Book Reviews - 1,000 words.

Please do not submit Abstracts for Letters to Editor or Book Reviews.

- Submitted manuscripts should be anonymised to allow for review. A separate title page should be submitted containing the author name.
- Manuscript should be assembled in the following order: main text; acknowledgements; appendixes (as appropriate); references; table(s) with caption(s) (on individual pages).
- A separate [Abstracts](#) of 200 words (100 words for First person accounts and Opinion Pieces) should also be provided for review papers, research papers and brief reports.
- Each paper should have up to five [keywords](#) .
- Section headings should be concise.
- Please include, in the Discussion section, a subsection subtitled Clinical Implications (or Practical Implications if you see implications beyond mental health services, eg primary prevention).
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- Authors must adhere to [SI units](#) . Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors are encouraged to identify at least one 'preferred reviewer' when submitting.

2. Style guidelines

- Description of the Journal's [article style](#) , [Quick guide](#)
- Description of the Journal's [reference style](#) , [Quick guide](#) .
Visit [CiteRefs](#) for assistance in ensuring accurate referencing according to APA style.

Word templates

[Word templates](#) are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk (please mention the journal title in your email).

3. Figures

We welcome figures sent electronically, but care and attention to these guidelines are essential as importing graphics packages can often be problematic.

- **Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.**
- Figures must be saved individually and separate to text. Please do not embed figures in the paper file.
- Avoid the use of colour and tints for purely aesthetic reasons.
- Figures should be produced as near to the finished size as possible.
- All figures must be numbered in the order in which they appear in the paper (e.g. figure 1, figure 2). In multi-part figures, each part should be labeled (e.g. figure 1(a), figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly.
- The filename for the graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

Please note that it is in the author's interest to provide the highest quality figure format possible. Please do not hesitate to contact our Production Department if you have any queries.

4. Tables

Tables should be numbered consecutively with Arabic numbers in order of appearance in the text. Type each table double-spaced on a separate page, with a short descriptive title typed directly above and with essential footnotes below.

5. Reproduction of copyright material

Contributors are required to secure permission for the reproduction of any figure, table or extensive extract (more than fifty words) from the text of a source that is copyrighted or owned by a party other than Taylor & Francis or the contributor. This applies to direct reproduction as well as 'derivative reproduction', where the contributor has created a new figure or table that derives substantially from a copyrighted source. Authors are themselves responsible for the payment of any permission fees required by the copyright owner. Copies of permission letters should be sent with the manuscript upon submission to the Editor(s).

6. Informed consent

Manuscripts must include a statement that informed consent was obtained from human subjects. Authors should protect patient anonymity by avoiding the use of patients' names or initials, hospital number, or other identifying information.

7. Code of experimental ethics and practice and confidentiality

Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.

For human subjects or patients, describe their characteristics. For human participants in a research survey, secure the consent for data and other material - verbatim quotations from interviews, etc. - to be used. Specific permission for any facial photographs is required. A letter of consent must accompany any photographs in which the possibility of identification exists. It is not sufficient to cover the eyes to mask identity.

It is your responsibility to ensure that the confidentiality of patients is maintained. All clinical material used in your article must be disguised so that it is not recognisable by a third party. Where possible and appropriate, the permission of the patient should be obtained. Authors are invited to discuss these matters with the editor if they wish.

8. Drug names

Generic rather than trade names of drugs should be used, although trade names may be mentioned in parentheses in the first text reference to the drug.

9. Competing financial interests

A competing interest exists when your interpretation or presentation of information may be influenced by your personal or financial relationship with other people or organizations. Authors should disclose all financial and non-financial competing interests.

Authors are required to complete a declaration of competing interests and submit it together with the manuscript. All competing interests that are declared will be listed at the end of published articles. Where an author gives no competing interests the listing will read 'The author(s) declare that they have no competing interests'. Please consider the following questions:

1. In the past five years have you received reimbursements, fees, funding, or salary from an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? Is such an organization financing this manuscript? If so, please specify.
2. Do you hold any stocks or shares in an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? If so, please specify.
3. Do you hold or are you currently applying for any patents relating to the content of the manuscript? Have you received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript? If so, please specify.
4. Do you have any other financial competing interests? If so, please specify.

If you are unsure as to whether you, or one of your co-authors, has a competing interest please discuss it with the editorial office.

10. Affirmation of authorship

All authors are expected to have made substantive intellectual contributions and to have been involved in drafting or revising the manuscript. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Acquisition of funding, collection of data, or general supervision of the research group, alone, does not justify authorship. With the submission of a manuscript, it is assumed that all authors have read and approved the final manuscript.

11. Acknowledgements

All contributors who do not meet the above criteria for authorship should be listed in an acknowledgements section. Examples of those who might be acknowledged include those who provided general, technical, or writing assistance. Acknowledgement of funding/grants are also included in this section.

Manuscript submission

All submissions should be made online at the ***Psychosis*** [ScholarOne Manuscripts site](#) . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. To ensure blinded review authors should only include identifying information on a title page which can be uploaded separately.

Manuscripts may be submitted in any standard Word format or PostScript. This journal does not accept Microsoft Word 2007 documents. Please use Word's "Save As" option to save your document as an older (.doc) file type. LaTeX files should be converted to PDF prior to submission because Manuscript Central is not able to convert LaTeX files into PDFs directly.

Authors are required to recommend at least two potential reviewers for their paper.

Copyright and authors' rights

As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). For further information and FAQs, please see:

<http://journalauthors.tandf.co.uk/preparation/permission.asp> .

Exceptions are made for Government employees whose policies require that copyright cannot be transferred to other parties. We ask that a signed statement to this effect is submitted when returning proofs for accepted papers.

Proofs

PDF proofs will be e-mailed to the corresponding author. To avoid delay in publication, only necessary changes should be made, and corrections should be returned promptly.

Reprints

Corresponding authors will receive free online access to their article through our website and a complimentary copy of the issue containing their article. Reprints of articles published in this journal can be purchased through Rightslink® when proofs are received. If you have any queries, please contact our reprints department at reprints@tandf.co.uk .

Page charges

There are no page charges to individuals or institutions.

Appendix J

Epistemological position of main researcher

Denzin and Lincoln (2000) state that “epistemology asks – how do I know the world? What is the relationship between the inquired and the known?

The main researcher took a social constructionist stance. From a social constructionist perspective, language is more than just a way of connecting people. People *exist* in language. Consequently, the focus is not only on the individual person but rather on the social language which is generated, sustained and abandoned (Gergen and Gergen, 1991).

To this end, the main researcher held the view that people’s experiences are influenced by their social world, and that language is the medium through which they interpret and convey their experiences. The analysis conducted in this research project considered the process of how participants position themselves and others in their experiences.

Additionally, the analysis allowed a focus on how individuals use language to make sense of their experiences and to then convey this to the list.

Appendix K: Chronology of research process

Step	Date
Research proposal submitted: version 1	May 2011
Research proposal submitted for peer review: version 2	September 2011
Research proposal resubmitted, version 3	November 2011
Research proposal resubmitted, version 4 (accepted via peer review)	December 2011
Ethics application	Began in November 2011, submitted by January 2012. Ethical approval gained March 2012
Research and Development applications	Began February 2012. Approved May 2012
Recruitment of participants	Began July 2012
Conducted interviews	October 2012 – April 2013
Transcription, analysis and write up	Began October 2012 - May 2013
Research Viva	July 2013
Amendments to thesis following	July 2013 - October 2013

Viva	
Further minor amendments	October – November 2013