PROFESSIONAL DOCTORATES

Listening to the Voices? How relationships with voices change over time, and developments in therapeutic interventions for voice-hearing.

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Award date:
2019

Awarding institution:
Bangor University

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This thesis is submitted in partial fulfilment of the regulations for the

Doctorate in Clinical Psychology

June 2019

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Acknowledgements

Firstly I would like to acknowledge and thank the participants who contributed to this thesis. They were overwhelmingly generous with both their time and their stories. They opened a window for me, and hopefully those who read this thesis, onto their experiences of voice-hearing relationships.

I would like to thank both by supervisors for this project, Dr Mike Jackson and Dr Rachel Skippon. They have been patient, supportive and encouraging, and generous with both their time and knowledge. I could not have written *this* thesis without them.

I have to thank my family, my Mum and Mike (stepdad), Dad, and sister, Sarah. They have all fielded phone-calls full of doubt, and unfailingly offered the right words of support and encouragement. They have offered endless emotional and practical support. I could not have kept going without them.

Finally I would like to thank my friends and cohort, who, largely through the reach of fb, have cheered my successes, and encouraged me when I have struggled, and have collectively, and without fail, at all times of night and day, answered every request for help I have made.

For most of my journey through this, although cognitively I *knew* I could, I did not really *believe*, that I was able to write this thesis. But there were times when I neither knew nor believed I could do this. At those points, the people around me, believed for me. And their belief enabled me to keep going.

Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy

Signed:_____ Dated:_____

Listening to the Voices?

How relationships with voices change over time, and developments in therapeutic interventions for voice-hearing.

Abstract

This research project investigated voice-hearing as an experience, and the interventions aimed at supporting people who struggle with hearing voices.

A systematic review of the literature surrounding voice-hearing interventions was undertaken. It found a wide range of different interventions, but a limited evidence-base supporting them. Different approaches to voice-hearing were identified, and a continuum posited, whereby voice-hearing approaches ranged from regarding voices as something to be 'managed', to considering them something to be 'engaged with'. Different models of intervention were investigated: Cognitive, Relational, Mindfulness-based, and what the author termed a Meaningful Experience model. Goals of these different interventions were identified, and a superordinate goal of reducing voice-hearing distress noted. Therapeutic methods and change-mechanisms were identified. It was noted that a continuum exists whereby approaches to voice-hearing, and intervention methods move 'away from' the voices, seeing them as something to be 'managed', or 'towards' the voices, seeing them as something to be engaged with. A relationship between approaches towards voice-hearing, and intervention methods seemed apparent.

The research project investigated how voice-hearing relationships change and develop over time. Seven participants were interviewed. Narrative Analysis was used to analyse the transcripts, considering plot, coherence, characterisation and cultural positioning. A prototype 'story-arc' was created against which participants relationship developments could be mapped. There were six 'chapters' and an 'epilogue': First Experiences; Into the Chaos; Meet the Neighbours; The Unwanted Visitor; Turning points; and Making Friends. There appeared to be a relationship between narrative coherence and positive voice-hearing relationships. The importance of access to positive voice-hearing narratives and cultural positions appeared important both in terms of encouraging the development of positive voice-hearing relationships, and in increasing the sense of agency of the voice-hearer.

Psychology and Psychotherapy
Theory, Research and Practice
The British Psychological Society

Literature Review

Approaching the Voices: What does the literature tell us about developments in therapeutic approaches to voice hearing over the past ten years?

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(last accessed 23/05/19)

Abstract

This systematic review investigates the different therapeutic approaches to voice-hearing interventions that have developed over the past decade. It investigates the level of evidence-base and quality of research for different types of intervention, finding that there is more breadth than depth, with 'novel therapies' existing alongside more 'traditional' therapies. It considers views of voice-hearing, and places them into four approaches, where voices are something to be: managed, accepted, related to assertively, or engaged with as meaningful. The wide range of therapies available is considered, and therapies are put into four categories depending on the underlying therapeutic model that informs the intervention: Cognitive, Relational, Mindfulness-based, and Meaningful-experience.

Differing therapeutic goals are considered across the four categories, and a superordinate goal of reducing voice-hearing distress identified. Intervention methods and change-mechanisms are discussed, and qualitative research is considered in relation to how it can better inform understanding of change-mechanisms across different interventions. Parallels between views of voice-hearing and intervention techniques are considered, along with parallels between voice-hearers 'moving closer' to voices, and therapists 'moving closer' to working with voice-content. Clinical and research implications are discussed.

Approaching the Voices: What does the literature tell us about developments in therapeutic approaches to voice hearing over the past ten years?

Background

Voice-hearing has been described as 'hearing voices' "in the absence of an external stimulus … usually beyond the control of the person experiencing them" (Slade & Bentall, 1988). Estimates of the rates of voice-hearing in the adult UK population range from 0.8% (Birchwood et al., 2011) to between 2 – 10% (Kay et al., 2017). Voice-hearing ranks amongst the most prominent of treatment-resistant symptoms of psychotic experiences, (Birchwood et al., 2011).

There has been a widening of approaches to voice-hearing over the past decade. This is evidenced by the types of interventions, therapies, views of voice-hearing, and the different intervention targets now in existence. The treatments that have emerged over the past decade have their theoretical underpinnings rooted in these different approaches. This is reflected in the treatment approach and delivery. Thomas et al. (2014), have provided an excellent review of the emerging treatments for voice-hearing, including comprehensively reviewing the efficacy of the different therapies. They also signposted important directions for future research. The first of these was, "that the efficacy trials conducted to date and reviewed in recent meta-analyses, appear to have been quite limited in informing the specifics of how therapies should be applied to voices," (Thomas et al., 2014, p205). It is into this space that this review aims to fit. It aims to systematically describe the range of approaches to voice-hearing, clarifying what the current state of the research and evidence for different approaches is. It will not include reviewing the efficacy, as Thomas et al. have

done so already, and there is not enough new research from 2014 – 2018 to render this a useful addition. It will go on to identify the main components of the therapeutic approaches, considering:

- How the therapies relate to, or view, the voice-hearing experience;
- The goals of the therapies;
- An overview of therapeutic techniques employed, and the mechanisms of change;

Given the constraints of this review, it is not possible to describe in detail the techniques used in every individual therapy included in the review, or specific goals of each intervention researched.

Method

In order to identify changes and developments in therapeutic interventions for voice-hearing over the past decade, a systematic review was undertaken of articles published since 2008.

A focused search was undertaken as described below (Table 1). It is the information from this search that was used for the PRISMA diagram (Figure 1) below.

Table 1: Search Parameters for Systematic Review

Search type	***Databases searched***	***Terms used***
Focused Search from 2008-2018 *Wider search from 2008-2018*	PubMed, PsychInfo and Web of Science Bangor University library "search all" facility	Search titles only: ("hallucinations" and "auditory") or (voice hear*) (Schizo* & Therap*), (Counsel* & schizo*), (Hallucin* & schizo*), (AVATAR & schizo*), (AVH & schizo*), (AVH & psychosis), (AVH & therapy), (Counsel* & psychosis), (Counsel* & psychotic), (Computer* & psychotic), (Computer* & psychosis), (AVATAR & psycho*), (Hallucin* & psychosis), (Hallucin* & psychotic), (Hallucin* & therap*), (Voice & Hear*),

The wider search returned 3214 records with 530 titles of interest. Many of these were duplicates of returns from the focused search. Ultimately 17 extra papers were identified, which formed the majority of the 21 "other records identified".

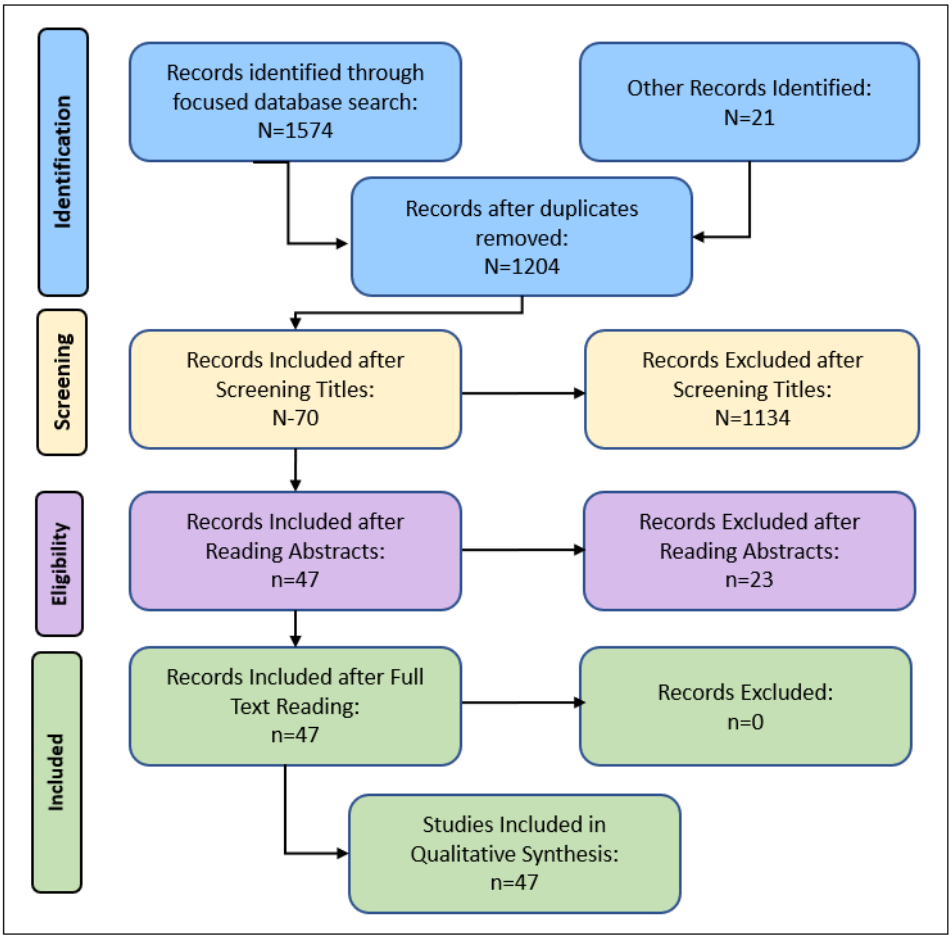
Inclusion Criteria:

Papers that reported research on therapeutic interventions that directly relate to voice-hearing. This included case-studies, case-series, open studies, and Randomised Controlled Trials (RCTs).

Exclusion Criteria:

Papers that researched therapeutic interventions for psychosis / schizophrenia, as a broader phenomenon.

Figure 1: Prisma Flow Chart of Systematic Search



Results

Forty-seven papers were identified which can be classified as below (Table 2).

Table 2: Types of Research Identified

Research Type	***Number of Papers***	***Authors***
Randomised Controlled Trials (RCTs)	12	Birchwood et al., 2014 Chadwick et al. 2009 Craig et al., 2018 du Sert et al., 2018 England, 2008 Hayward et al., 2017 Hazell et al., 2018 Leff, et al., 2013 Penn et al., 2009 Shawyer et al. 2012 Schnackenberg et al., 2017 Van Der Gaag, et al., 2012
Open/pilot studies (non-randomised)	4	Dannahy et al. 2011 Gottlieb et al., 2013 Louise et al., 2018 Shiraishi et al., 2014
Case Series	5	Carter and Wells, 2018 Hayward et al., 2009 Ison et al., 2014 Mayhew and Gilbert, 2008 Ruddle et al. 2014
Case studies	11[1]	Barrowcliff, 2008 Cichocki et al. 2016 Dellazizzo, du Sert, et al., 2018[2] Dellazizzo, Potvin, et al, 2018[2] Paulik, et al., 2013 Salvatore, et al., 2016 Singer and Addington, 2009 Stefaniak et al. 2017 Taylor, et al., 2009 Veiga-Martínez, 2008
Qualitative	13	Beavan et al., 2017 Birchwood et al., 2018[3] Dellazizzo, Percie du Sert, et al., 2018[3] Dos Santos and Beavan 2015 Dillon and Hornstein, 2013 Goodliffe et al., 2010[3] Hayward and Fuller, 2010[3] May et al., 2014[3] Oakland and Berry, 2015 Payne et al., 2017 Rácz et al., 2017 Schnackenberg, Fleming, and Martin, 2018[3] Schnackenberg, Fleming, Walker, and Martin, 2018[3]
Other	2	Longden et al., 2018 Louise et al. 2018

[1] – Taylor, Harper and Chadwick (2009) had two case-studies in one research paper
[2] – Case study of participant in du Sert's (2018) RCT
[3] – Qualitative follow-up to quantitative research

Although not referenced further in this review, as they did not directly research therapeutic interventions for voice-hearing, the literature search also identified a range of articles in the wider literature relating to therapeutic interventions for voice-hearing, (see Appendix One).

Interventions:

Interventions reviewed fell broadly into three categories: individual therapy; group sessions with a therapist, often following a manualised programme; and peer-support groups, which largely had little or nothing to do with mental health agencies. The peer-support groups were all identified as part of the Hearing Voices Network (HVN). Of the other interventions, the overwhelming majority were short in timescale. With the notable exceptions of Carter and Wells', (2018), 80-week intervention and Salvatore, et al.'s, (2016) 18-month intervention, interventions ranged from a one-off re-scripting session, with preceding orientation session (Ison et al., 2014), to 44 sessions (Schnackenberg, et al., 2017). Excluding the open-ended interventions, Carter and Wells, and Salvatore et al.'s interventions, the remaining 28 interventions reviewed had a mean of 13 sessions. Most interventions were delivered individually (24), with only six group interventions (HVN Groups were counted as one intervention).

Approaches to Voice-hearing:

The different voice-hearing therapies and therapeutic aims are closely interwoven, with different underlying philosophies regarding voice-hearing. These voice-hearing philosophies fall into four broad approaches. In the first approach the voices are something to be 'managed'. The second approach focuses on the voice-hearer-voice relationship, encouraging the voice-hearer to challenge the voices within a relational context. The third

approach sees voice-hearing as an experience to be accepted. The fourth approach regards voices as a meaningful aspect of the person's life, to be explored in relation to their past experiences. These different views of voice-hearing have necessarily influenced the development of different therapeutic models of voice-hearing, the aims of therapy, and the perceived mechanisms of change.

Categories of Voice-hearing Intervention

When considered in terms of therapeutic mechanisms used to promote change, all the interventions reviewed could be divided into four categories, based on the model of intervention used (Table 3): Cognitive, Relational, Mindfulness-based, and what this review has termed the Meaningful-Experience model. The cognitive model tends to take the first approach (above) to voice-hearing. The relational model has largely adopted the second approach; the Mindfulness-based model takes the third approach; and the Meaningful-Experience model takes the fourth. It should be noted that these are this author's categorisations and have not necessarily been explicitly referenced by the original researchers; further, these are loose categorisations with many of the therapies containing cross-model elements. These categories will be used when considering how therapies view voice-hearing, therapeutic goals, and methods of therapeutic change.

Table 3: Models of Voice-hearing Interventions

Model of voice-hearing intervention	***View of voice-hearing***	***Aims of interventions***	***Therapies***	***Researchers (Quantitative Research Only)***
Cognitive	Voice-hearing is mediated by cognitive difficulties, distortions, or normal biases in overdrive.	Change appraisals of the voices; reduce belief in voices; reduce distress due to voices; reduce obedience to voices	ATT	Carter and Wells, 2018
			CBT – COMMAND trial	Birchwood et al., 2014
			CBT / CBTp	Barrowcliff, 2008
				England, 2008
				Penn et al., 2009
				Singer and Addington, 2009
				Gottlieb et al., 2013
				Ruddle et al. 2014
			CBTv (GiVE)	Hazell et al., 2018
			COMET	Van Der Gaag, et al., 2012
			MIT	Salvatore, et al., 2016
			Psychoeducation programme	Shiraishi et al., 2014
			Other	Ison et al., 2014
Relational	Voice-hearing occurs within the context of internal relationships,	Change the relationship to the voice and become more assertive	Relating therapy	Hayward et al., 2009
				Paulik, et al., 2013
				Hayward et al., 2017
			AVATAR therapy	Leff, et al., 2013
				Cichocki et al. 2016
				Stefaniak et al. 2017
				Craig et al., 2018
				du Sert et al., 2018

Mindfulness-based	The voice-hearing experience is to be accepted	To accept the experience of voice-hearing	ACT	Veiga-Martínez, 2008
			CMT	Mayhew and Gilbert, 2008
			Mindfulness	Chadwick et al. 2009
				Taylor, Harper, and Chadwick, 2009
				Louise et al., 2018
				Louise et al. 2018
			PBCT	Dannahy et al. 2011
			TORCH	Shawyer et al. 2012
Meaningful Experience Model	Voices are meaningful and relate to the lived experience of the voice-hearer, (and convey something of importance from the sub-conscious)	To start to 'make sense of' the experience of voice-hearing in relation to the individual's past	EFC	Schnackenberg et al., 2017
			HVN groups	Longden et al., 2018
				Longden et al., 2018

ACT: Acceptance and Commitment Therapy
ATT: Attention Training Technique
CBT: Cognitive Behavioural Therapy
CBTp: CBT for psychosis
CBTv: CVT for voices
CMT: Compassionate Mind Training
COMET: Competitive Memory Training
EFC: Experience Focused Counselling
GiVE: Guided self-help cognitive-behavioural Intervention for VoicEs
HVNG: Hearing Voices Network Group
MIT: Meta-cognitive Interpersonal Therapy
PBCT: Person-based Cognitive Therapy
RCT: Randomised Controlled Trial;
TORCH: Treatment Of Resistant Command Hallucinations

State of Current research

The development of an evidence-base for any therapy, could be considered to follow the below progression, (Figure 2).

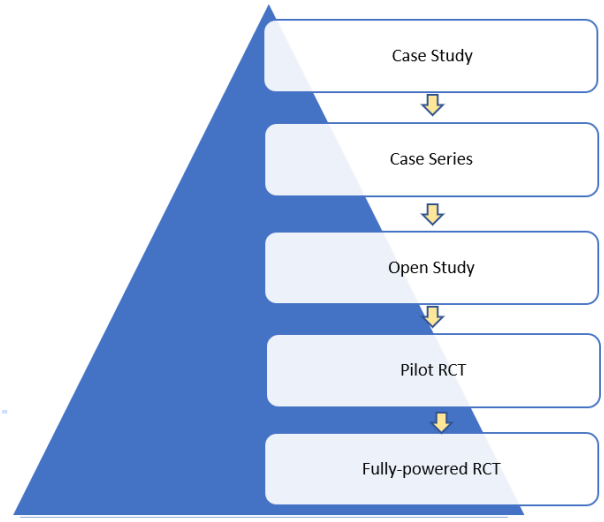


Figure 2: Development of Evidence-base

This can be used to inform assessment of the level of development of research across each of the four approaches to hearing voices. When considering this, it is clear that the research is at different stages in the different categories of voice-hearing interventions, (see Tables 4, 5, 6, and 7),

Table 4: Development of Research in Cognitive Model of Intervention

Therapy	***Case studies***	***Case Series***	***Pilot studies***		***RCTs***	***Qualitative Research***	***Other***	***No. of Research Projects***
			RCT	***Non-Randomised***				
CBT	2	1 (n=15)	1 (n=28)	2 (n=22) (n=21)	3 (n=65) (n=65) (n=197)	(1)[1]	-	9
CBT-style MIT, ATT, COMET, GiVE	1	2 (n=4) (n=1)	-	-	1 (n=77)	-	-	4
All above	3	3	1	2	4	(1)		13

ATT: Attention Training Technique
CBT: Cognitive Behavioural Therapy
COMET: Competitive Memory Training
GiVE: Guided self-help cognitive-behavioural Intervention for VoicEs
MIT: Meta-cognitive Interpersonal Therapy

Table 5: Development of Research in Relational Model of Intervention

Therapy	***Case studies***	***Case Series***	***Pilot studies***		***RCTs***	***Qualitative Research***	***Other***	***No. of Research Projects***
			RCT	***Non-Randomised***				
Relating Therapy	1	1 (n=5)	1 (n=29)	-	-	(1)	-	4
AVATAR Therapy	4[2]	-	2 (n=26) (n=17)	-	1 (n=150)	(1)	-	5
All above	5	1	3	0	1	(2)	0	9

[1] Qualitative research in brackets is follow-up research from quantitative research projects
[2] Two case-studies were generated from an RCT

Table 6: Development of Research in Mindfulness Model of Intervention

Therapy	Case studies	Case Series	Pilot studies		RCTs	Qualitative *Research*	Other	No. of *Research Projects*
			RCT	***Non-Randomised***				
ACT	1	-	-	-	2 (n=22) (n=43)	-	-	3
Mindfulness	2 (1 paper)	-	-	1 (n=14)	-	-	1 (cross-sectional analysis) (n=62)	3
TORCH	-	-	-	-	1 (n=43)	-	-	1
PBCT	-	-	-	1 (n=62)	-	(2)	-	1
CMT	-	1 (n=7)	-	-	-	-	-	1
All Above	3	1	0	2	3	(2)	1	9

CMT: Compassionate Mind Training *EFC: Experience Focused Counselling* *PBCT: Person-based Cognitive Therapy*

Table 7: Development of Research in Meaningful Experience Model of Intervention

Therapy	Case studies	Case Series	Pilot studies		RCTs	Qualitative *Research*	Other	No. of *Research Projects*
			RCT	***Non-Randomised***				
HVNG	-	-	-	-	-	5 (n=2) (n=11) (n=4) (n=8) (n=6)	2 (Questionnaire-based research) (n=29) (n=101)	7
EFC	-	-	1 (n=12)	-	-	(2) (n=25) (n=25)		1
All above			1		0	7	2	8

EFC: Experience Focused Counselling
HVNG: Hearing Voices Network Group

The Cognitive-based interventions have the most developed evidence-base. They have more RCTs, and RCTs with much larger n's than other studies reviewed. They also have the largest number of research projects generated, however, amongst that number are a variety of a-typical cognitive approaches that have generated only a single piece of research, often only at the case study or case series level of research.

Of the relational-based research, Relating Therapy has moved steadily from case-series to RCT, however, it only appears to have one group of researchers working on it. This will slow down the rate of research unless other researchers move onto this therapy. Avatar Therapy appears to have generated a lot of interest with three different research groups working on it. It appears to be rapidly increasing its evidence base. There have been two RCT pilot studies and a larger powered RCT.

The Mindfulness-based therapies have generated several RCTs, but participant numbers in these are still relatively low.

The Meaningful-Experience category has generated only one RCT. Hearing Voices Network Group (HVNG) research has tended to use qualitative evidence. "RCTs tend to be investigator-driven, relying on following manualised approaches that would not capture the participation, collaboration, and timeframes required for HVNG research that would be true to its underlying principles," (Brophy, 2017, p509). Longden et al (2018), have started generating some quantitative data, to build the evidence base, however, it is hard to conceive of how an HVNG RCT could be operationalised, especially considering their acceptance of all voice-hearers regardless of aetiology.

Experience Focused Counselling appears to have only one set of researchers working on it, thus, as with Relating Therapy, the 'output' of research will be slowed unless others join the research into this.

Quality of Research

Just as the evidence-base development across the different categories is at different stages, so the standard of research is at different levels. Some of this variance is appropriate to the level of research, e.g., trial RCT conducted as a pre-cursor to a fully powered RCT. The below table (Table 8) indicates the quality of research across a range of criteria.

Table 8: Quality of Research Studies

Model	*Researchers and Intervention*	*Study Type*	*N*	*Power*	*Type of Control Group*	*Length of Follow-up*	*Fidelity to Therapy Checks*	*Qualitative follow-up*	*Completion Criteria*
Cognitive Interventions	Gottlieb et al., 2013 Web-based CBTp	Open Pilot Study	21	"Limited statistical power"	N/A	Pre and post only	Web-based using same programme	no	50%
	Shiraishi et al., 2014 Brief group psychoeducation	Open study	22	80%	N/A	Pre and post only	None reported	no	None reported
	Hazell et al., 2018 CBTv	Pilot RCT	28	No	Waitlist	4 weeks	Yes	no	None reported
	England, 2008 CNI	RCT	65	>0.90	TAU	1 year	None reported	no	None reported
	Penn et al., 2009 CBT	RCT	65	80	Enhanced Supportive Therapy	12 months	yes	no	6 / 12 sessions
	Van Der Gaag, et al., 2012 (COMET)	RCT	77	0.8	TAU	Pre and post only	Yes	no	None reported
	Birchwood et al., 2014 COMMAND trial Cognitive Therapy for Command Hallucinations	RCT	197	80%	CT+TAU vs TAU	18 months post-randomisation	yes	yes	Completion considered to be "Completion of all manualised elements"

Model	*Researchers and Intervention*	*Study Type*	*N*	*Power*	*Type of Control Group*	*Length of Follow-up*	*Fidelity to Therapy Checks*	*Qualitative follow-up*	*Completion Criteria*
Relational Interventions	du Sert et al., 2018 Avatar Therapy	Pilot clinical trial randomized partial crossover trial	17	None reported	TAU	3 months	None reported	No	None reported
	Leff, et al., 2013 Avatar Therapy	Proof of concept Randomised, single blind, partial crossover trial	26	80%	TAU	3 months	None reported	No	None reported
	Hayward et al., 2017 Relating Therapy (RT)	RCT RT+TAU vs TAU	29	No	TAU	36 weeks post-randomisation	Yes	No	None reported
	Craig et al., 2018 Avatar Therapy	Single-blind RCT	150	90%	Supportive Counselling	24 weeks post-randomisation	Yes	No	None reported
Mindfulness-based Interventions	Louise et al., 2018 (iMPV)	Non-randomised Pilot study	14	-	-	2 months	None reported	No	None reported
	Chadwick et al. 2009 Mindfulness	Replication and Feasibility trial	22	No	Waitlist	Pre-and-post	None reported	No	6 / 10 sessions
	Dannahy et al. 2011 Group PBCT	Uncontrolled evaluation.	62	80%	Uncontrolled evaluation	1 month	Yes	Yes	6+ sessions
	Shawyer et al. 2012 TORCH	RCT	43	exceeding 80%	Manualised befriending intervention vs TORCH vs Waitlist	6 months	Yes	No	None reported
Meaningful Experience	Schnackenberg et al., 2017	RCT - EFC	12	No	TAU	Pre-and-Post only	Yes	Yes	None Reported

CBTp: Cognitive Behavioural Therapy for Psychosis
CBTv: Cognitive Behavioural Therapy for Voices
CNI: Cognitive Nursing Intervention
COMET: Competitive Memory Training
EFC: Experience Focused Counselling
iMPV: Individual Mindfulness Program for Voices
PBCT: Person-based Cognitive Therapy
RCT: Randomised Controlled Trial
TORCH: Treatment Of Resistant Command Hallucinations
TAU: Treatment as Usual

The level of research development, and quality of research, taken together, indicate that whilst there has been a lot of research output over the past decade, it is at varying levels of development and quality. One of the most notable shortcomings across the range of research is the length of follow-up. Whilst some of the studies have follow-up of a year post intervention, others have pre-and-post measures only. When the chronicity of voice-hearing, and continuing outcome changes post-intervention (Craig et al., 2018), is considered, the length of time of some follow-ups appears to be inadequate.

There appears to be more breadth than depth across this field. Whilst there are some innovative and novel interventions taking this area into new and exciting directions, there needs to be a degree of development of depth and robustness of the research moving forward.

Each of the four models of intervention discussed above (Cognitive, Relational, Mindfulness-based, and Meaningful Experience) have different: underlying therapeutic philosophies regarding voice-hearing; goals or aims; and methods and change-mechanisms. These will be discussed in turn.

Therapeutic approaches to voice-hearing

Therapies that come under the cognitive category do not appear to have a 'declared' view of voice-hearing so much as an implicit one. However, the cognitive view of voice-hearing could be considered as an experience "mediated by dysfunctional cognitive processes," (Kay et al., 2017 p315). These processes would include faulty appraisals regarding the power of voices, low meta-cognitive abilities, and bias-difficulties, such as higher 'jump to conclusion' rates. Their approach towards the voice-hearing experience is to try to ameliorate the negative

effects of it through changing appraisals of voice content, and introducing coping strategies. Voices are considered something to be 'managed' through use of cognitive techniques.

Therapies using the Relational Model see voice-hearers as having a genuine relationship with the voices that they hear. Two different therapies have emerged: Relating Therapy, and Avatar Therapy. Both therapies aim to change the relationship *with* the voice.

Relating Therapy "[conceptualises the] voice hearing experience within a relational framework," (Hayward & Fuller, 2010, p363), and notes that "similarities exist between social relationships and the relationship with the voice," (p363). Relating Therapy has its theoretical underpinnings in Birtchnell's, (1996), relating theory, which posits that relating is the intersection between two axes of power and proximity, represented at their two poles by 'upper – lower' and 'distant – close', and voice-hearers often place themselves as 'lower' in power than their voices, and subsequently try to create 'distance' between themselves and the voice.

In developing Avatar Therapy, Leff et al., (2013) posited that, "The development of persecutory auditory hallucinations can be formulated as an exteriorisation of a severely critical component of the psyche that cannot be tolerated. IF this is correct, then ignoring the voices negates the possibility of re-assimilation of this rejected component of the patient's internal world," (p428). As such, engaging with the voices on a meaningful level was deemed a vital component of Avatar Therapy.

Mindfulness-based interventions all have an "active acceptance of voices as an alternative to suppression or resistance," (Louise et al., 2018, p3). Two of the therapies in this category describe themselves as using CBT combined with Mindfulness or ACT techniques, (Dannahy

et al., 2011; Shawyer et al., 2012), however, they have an explicit acceptance of the voice-hearing experience, and are not focussed on changing appraisals of the voices, as such they have been included in the Mindfulness-based category.

Compassionate Mind Training (CMT) "does not focus on people challenging or arguing with their voices because this maintains a conflictual and aversive relationship" (Mayhew & Gilbert's, 2008, p132) likely to maintain the experience, rather it aims to introduce compassion towards both the voices and the voice-hearer. CMT could have come under the Meaningful-Experience Model, however, its use of Mindfulness has led to its inclusion here.

Interventions in the Meaningful-Experience category are rooted in the Hearing Voices Network (HVN), philosophy "…that hearing voices is a meaningful human experience, …Voices themselves are not viewed as abnormal or aberrant, rather conceptualized as a meaningful and interpretable response to social, emotional, and/or interpersonal circumstances," (Corstens, et al., 2014, p285-6). HVNGs "actively value" voices and validate the experience of the person.

Goals of Therapy

In the Cognitive-based interventions two broad goals are commonly discussed: increasing the individual's coping abilities regarding their voices; and reducing voice-hearing distress through challenging individuals' beliefs regarding the voices. Birchwood et al.'s (2014) COMMAND trial is of note here, as its expressed aim was not to reduce voice-hearing distress, but to reduce adherence to command hallucinations. They aimed to "weaken and change beliefs about voices' power thus enabling the individual to break free of the need to comply or appease and thereby reduce harmful compliance behaviour and distress," (Birchwood et

al., 2011, p156). Whilst this outcome goal was described in relation to command hallucinations, the common element across most of the Cognitive interventions is the goal of "[changing] beliefs about voices' power". At this point however, it should be noted that van der Gaag et al.'s (2012), stated goal was to reduce depression associated with voice-hearing, rather than to try and change the voice-hearing appraisal, however, the underlying aim of reducing voice-hearing distress was held, in common with most of the therapies using the Cognitive model.

Both Relating Therapy and Avatar Therapy aim to help participants move 'towards' their voices and become more assertive in relation to them. Leff et al. (2013) reported that voice-hearers are often advised to ignore their voices. Avatar therapy wanted to "give patients control over their 'voices'," (p428). Both Relating Therapy and Avatar Therapy aim to decrease the power imbalance between voice-hearer and voice.

In line with the underlying philosophy of mindfulness, which is to "non-judgementally, and purposely, [pay] attention to present-moment experiences," (Louise et al., 2018, p2), the goals of the Mindfulness-based interventions were to support participants to accept and "relate differently to distressing experiences such as voices." (Dannahy et al. 2011, p115). Mayhew and Gilbert's (2008) Compassionate Mind Training had the additional aim of supporting participants to feel more self-compassionate. Shawyer et al.'s (2012) TORCH intervention included the stated aim of reducing "the negative impact of command hallucinations," (p110).

The Hearing Voices Network Group (HVNG), and Experience-Focussed Counselling (EFC), both aim to be a "normalising and de-pathologising approach," where the goal is "…to develop a

balanced more understanding relationship with the voices, rather than just learning to assert oneself towards the voices," (Schnackenberg et al., 2018 p998). The intention is to bring "order, life context, and increasing calmness to what can often be experienced as a very chaotic and anxiety-provoking experience of voice-hearing," (Schnackenberg et al., 2017, p15).

Therapeutic Techniques and change-mechanisms

The techniques of the different types of intervention are closely related to intervention goals and approaches to voice-hearing. Cognitive-based interventions aim to reduce voice-hearing distress through changing appraisals of the voices. To achieve this a range of traditional CBT methods are utilised: psychoeducation; exploring alternative explanations; identifying situations where voice-hearing increases or decreases; use of coping strategies etc. Birchwood et al (2014), specifically targeting command hallucinations, with the stated aim of decreasing obedience to them, used a proto-typical version of CBTp. They described "the essence of the therapy" as testing "the perceived power of the voice by assessment of evidence for the omniscience of the voice, the apparent ability … to predict the future," (p25).

In line with having a slightly different stated goal (reduction of voice-hearing associated depression, not change of voice-hearing appraisals), van der Gaag's et al.'s Competitive Memory Training, (COMET), used an atypical cognitive approach. Their manualised approach used 'over-learning' positive self-image and pairing this with "the humiliating messages of the voice," until the participant was able to listen to them and "still be in a self-confident mood," (p163). Carter and Wells, (2018) Attention Training Technique, involved their participant "systematically apply[ing] selective attention, attention switching, and divided attention" (p2), to learn to disengage from the voice-content. However, this seemed an intensive

intervention as the participant was seen nine times over three weeks in the active phase of the case-series, and had to practice attention switching three times a day, putting high demands on their time.

Noting from previous research (Lysaker et al., 2013), that "All the aspects of metacognition are impaired in persons with schizophrenia," (p236), Salvatore et al.'s (2016) Meta-cognitive Interpersonal Therapy (MIT) aimed to promote metacognition and "develop a sense of agency over the symptoms" (p241). MIT had three phases:

1) Validating and normalising the patient's experience, building in behavioural coping strategies, and improving metacognition with strategies such as 'thought labelling';
2) Increasing awareness of when voice-hearing occurs, and building awareness of "disturbed interpersonal schemas [that] lead to the emergence of the symptoms", and "promoting high level mastery strategies for [voice-hearing]" (p239);
3) Improving metacognitive skills and encouraging re-engagement with healthy activities;

Ison et al. (2014), while still aiming to reduce voice-hearing distress and convictions in voice-content, have used very different cognitive methods. Their study used a "one-off image re-scripting session" (p129). Ison et al., looking at the close links between Post Traumatic Stress Disorder (PTSD) and psychosis, speculated that "there is evidence that up to 75% of people who hear voices experience recurrent intrusive images that could play a role in maintaining the distress associated with the experience." (p131). They drew on the evidence of imagery re-scripting, rooted in cognitive models of PTSD, to suggest that it could be "an effective tool for reducing distress associated with intrusive images," which could then "indirectly reduce

the level of distress associated with voices," (p131). In the first session patients were given the rationale for the intervention, and spent some time discussing an intrusive memory without any attempt to change or challenge it. The second session used a 3-stage re-scripting protocol as outlined by Arntz and Weertman, (1999), and patients were given CDs of the sessions to listen to at home. The remaining sessions were follow-up sessions only.

As there are two main therapies in the Relational Intervention category, they will be taken in turn:

Relating Therapy (RT) has three phases: Socialisation to RT; Exploration of themes within participants' relational histories; Exploration and development of assertive approaches to relating. RT helped participants identify parallels between how they related to their voices internally, and how they related to people socially. It then "Enhanc[ed] awareness of reciprocity with the voice / voice-hearer relationship," (Hayward et al., 2009, p216); followed by use of chair work and imagery to help participants practice assertiveness relationally.

In Avatar Therapy (AT), patients would select the dominant or most troublesome voice and create a virtual reality Avatar to represent this voice. A therapist would start with a 'script' generated by the participant of what the voice would say to them. However, controlling the Avatar, the therapist gradually changed the 'script' "so that it progressively came under the patients' control," (Leff et al., 2013, p429). Slowly the Avatar's character was "changed by the therapist from being abusive to … supportive of the patient," (p429). This occurred over six 30-minute sessions. Leff, et al.'s, 2014 paper goes into more details regarding this therapy.

Cichocki et al., (2016), used the same method as 'standard' AT, however, instead of having a computer-based Avatar, their patient made a mask representing the voice, while a therapist

acted as the voice for the mask. In all other respects this therapy was the same as AT, and proved to have similar positive outcomes. The benefits of this approach are in its low-tech, low-cost availability.

The Mindfulness-based models all have elements of Mindfulness consistent with the underlying Mindfulness philosophy of non-judgemental observation (Williams & Penman, 2011).

Chadwick et al's, (2009) intervention comprised of twice-weekly sessions for five weeks, and home practice using meditative CDs. This was followed by a further five weeks of unsupported home practice. The sessions "comprised of two 10-minute mindfulness meditations" (p406), followed by group reflection and guided discovery. The meditations were guided to minimise rumination or unhelpful engagement with the voices, and "referred explicitly to psychotic experiences and reactions to them, as well as other difficult bodily, emotional, and mental sensations," (p406). Unlike many Mindfulness-based Interventions, Louise et al.'s (2018), Individual Mindfulness Program for Voices was delivered on an individual, rather than group basis. It entailed four weekly sessions, with guided practise and discussion. These session "included several experiential practices that simulated the voice-hearing experience" (p4), to allow participants to practice responding mindfully to voices.

Dannahy et al's (2011), group Person-based Cognitive Therapy (PBCT) integrated traditional CBTp and mindfulness practice, whilst TORCH, (Treatment of Resistant Command Hallucinations, Shawyer et al., 2012), used "CBT augmented with acceptance-based strategies from Acceptance and Commitment Therapy," (p113). TORCH was a manualised intervention, "core modules included belief modification and acceptance-based interventions… Belief

modification involved identifying and modifying the key beliefs that "hook" clients into compliance and lead to distress, such as the power of the voice," (p113). Key ACT strategies included "cultivating the capacity to notice voices… rather than believe and act on them; …[and] accepting voices even though one may not like them," (p113).

Mayhew and Gilbert's (2008), Compassionate Mind Training (CMT) is based on a developing body of evidence regarding the evolutionary need to self-sooth, and the importance of self-compassion in increasing our abilities in self-soothing, (Mayhew & Gilbert, 2008; Gilbert, 2009). This different theoretical base results in CMT using slightly different methods to the other Interventions in the Mindfulness-based category. CMT aimed to help "people focus on their difficulties in terms of safety behaviours and to become understanding and compassionate to those safety behaviours (e.g., de-shame and de-pathologise)," (p116). Participants were encouraged to view their experiences through the prism of their personal histories and were taught support techniques such as guided muscle relaxation, guided imagery, and creation of a compassionate self.

It is difficult to separate out the approach to voices, goals, and methods, in the Meaningful-experience interventions, as they are all so closely interwoven, especially in the group setting. The methods are the embodiment of the approach to voices, which involves "accepting the voices as a real experience, honouring the subjective reality of the voice-hearer, and recognising that voices are something that the voice-hearer can – with support – deal with successfully," (Corstens et al., 2014, p288). There are two main 'delivery models' in this approach: Group – Hearing Voices Network Groups (HVNG); and Individual – Experience Focused Counselling (EFC), the "individualised approach of the [Hearing Voice Movement]" (Schackenberg et al., 2017, p13).

HVNGs could be considered to have two different change-mechanisms. The first is in the underlying ethos of the group, and approach to voices, which in itself can be considered change-promoting; the second is in specific techniques used within groups. Dillon and Hornstein, (2013) offer a good insight into both these elements of change.

HVNGs all 'sign up' to a set of shared values. They have a general goal of "helping voice-hearers to articulate and better understand their individual experiences," (Dillon & Hornstein, 2013, p290). Under the 'ethos' aspect of change-mechanisms, the HVNGs "create sanctuary, safe spaces to share taboo experiences, …People are free to share and explore their experience in detail, including the content of what their voices say, without the threat of censorship, loss of liberty or forced medication." (Dillon & Hornstein, 2013, p289).

In terms of specific techniques used within sessions, a technique known as Voice Profiling is used, where group members are asked about their voices: What do the voices say? What tone do they use? Who are they? A key principle is the lack of prescription, there is no 'one way' of seeing voice-hearing or acting in relation to it.

Experience Focussed Counselling (EFC) holds to the same tenets as the HVN. The EFC "process consists of the sequential use of the Maastricht Interview, Report and Construct (Romme & Escher, 2000)". (Schnackenberg et al., 2017 p15). This is used to create a mutual sense-making of the voice-hearing experience. The 'Report' is a summary of the interview, while "'Construct' provides a structured format to help the [voice-hearer] identify *who* and *what* the voices may represent within his/her life's context," (Schnackenberg et al., 2017 p15).

Qualitative Research

Alongside quantitively-based research output, a large amount of qualitative research has been undertaken For most of the intervention categories, the qualitative research is follow-up from a quantitively-based study (see Table 9). The notable exception is the Meaningful-Experience model where the majority of research has been qualitative (see Table 10).

Table 9: Qualitative Research Following Quantitative Studies

Model	***Original Research***	***Follow-up Qualitative Research***
Cognitive	RCT COMMAND trial (CBT for command hallucinations) (Birchwood et al., 2014)	Qualitative study using semi-structured interviews. (n=20) (Birchwood et al., 2018)
Relational	Case Series – Relating Therapy (Hayward et al., 2009)	IPA research regarding Hayward et al.'s 2009 Case Series (n=10) (Hayward & Fuller, 2010)
	RCT – Avatar Therapy (du Sert et al., 2018)	Content Analysis of of du Sert's Avatar Therapy sessions (n=12) (Dellazizzo, Percie du Sert, et al., 2018)
Mindfulness-based	Uncontrolled Evaluation – Group Person-based Cognitive Therapy (Dannahy et al., 2011)	Interim qualitative review on Dannahy et al.'s 2011 PBCT trial Five post-therapy Focus groups, (n=18) (Goodliffe et al., 2010)
		Qualitative review on Dannahy et al.'s 2011 PBCT trial (n=10) (May et al., 2014)
Meaningful-experience	RCT of Experience Focussed Counselling (EFC) (Schnackenberg et al., 2017)	Applied Thematic Analysis EFC as a trauma-sensitive approach (n=25) (Schnackenberg, Fleming, & Martin, 2018)
		Applied Thematic Analysis EFC – understanding past and current distress (n=25) (Schnackenberg, Fleming, Walker, & Martin, 2018)

Table 10: Qualitative Research from Meaningful-Experience Interventions

Author	***Type of research / article***	***n***
Dillon and Hornstein, 2013	Experientially grounded perspective on HVNGs	2
Oakland and Berry, 2015	Thematic analysis of experiences in HVNGs	11
Dos Santos and Beavan, 2015	IPA on HVNGs	4
Beavan et al., 2017	Small scale study into the efficacy of HVNGs, using questionnaires HVNG	29
Payne et al., 2017	IPA on experience of eight voice-hearers at HVNGs	8
Rácz et al*., 2017*	IPA into the experience of voice-hearing and the role of self-help groups	6
Longden et al., *2018*	Systematic Assessment of HVNGs using customized 45-item questionnaire	101

The qualitative research gives insight into what participants see as important elements of the various interventions. Some findings may support hypothesised change-mechanisms, while other findings may suggest mechanisms of change not considered from the intervention-model viewpoint.

Birchwood et al.'s 2018 qualitative follow-up to the 2014 Command Trial found normalisation and peer support helpful, something not considered as a change-mechanism in this intervention.

Hayward and Fuller's (2010) qualitative analysis of Hayward et al.'s (2009) case series highlighted three main themes. Of these, the second theme, developing a new relating style, and "understanding issues and connections between experiences," (p367), and the shift of power from powerless to becoming more assertive (theme three) would offer support to the aims and methods of Relating Therapy.

du Sert et al.'s (2018) Avatar Therapy RCT generated three qualitative papers: two case studies, which help create a more detailed understanding of the process as experienced by

participants; and one content analysis of themes emerging from the therapy. These themes gave added evidence to the hypothesised change-mechanisms created by the intervention techniques. Increased assertiveness towards the voices over the course of the intervention was an element across all five identified themes.

Goodliffe et al., (2010), identified themes of voice-acceptance, self-acceptance, and "a changing sense of self," (p447) in relation to Dannahy et al's (2011) PBCT. May et al., (2014), replicated these findings, (see Table 11).

Table 11: Themes identified by May et al., (2014)

Theme	***Associated sub-theme***
Relating to voices	Value of a mindfulness approach Importance of changed beliefs about voice strength and power
Relating to self	Sense of self-separate to voices Developing a positive view of self
Relating to others	Changed social relationships during and following the group

These themes would indicate that the intervention methods are working in the way intended.

The research into the Meaningful-Experience interventions gives rich data regarding the change-mechanisms utilised.

Dillon and Hornstein, (2013), reported on the "transformative power of these groups for people long considered unreachable," p286, writing that "Creating "possible selves" that challenge the pessimism of professionals or family members is fundamental to the work of all support groups and is often astonishing in its effectiveness," p293.

Oakland and Berry, (2015), Dos Santos and Beavan (2015), Payne et al., (2017), and Rácz et al.. (2017) all reported themes from their research (see Table 12 for complete list). Of these themes, it was possible to draw out some replicating themes across the studies:

- The importance of the group (all studies)
- Sense of agency (all studies excluding Racz et al.)
- Sense of hope / freedom (all studies excluding Racz et al.)
- Sharing, connecting, acceptance; (all studies excluding Racz et al.)
- Relationships with the voices; (Dos Santos & Beavan, Payne et al., and Racz et al.)

These all give indications of potential change-mechanisms for these interventions.

Beavan et al., (2017) and Longden et al., (2018), both conducted quantitative-style outcome-based research. Beavan et al identified that group members reported feeling more understood, better at being with people, and more hopeful; these could all be considered part of the HVNG change-mechanisms. Longden et al reported that "Group attendance was credited with a range of positive emotional, social, and clinical outcomes. Aspects that were particularly valued included: opportunities to meet other voice-hearers, provision of support that was unavailable elsewhere, and the group being a safe and confidential place to discuss difficult issues," (p184). HVNGs were perceived as facilitating recovery processes, and "to be an important resource for helping them cope with their experiences," (p184). These all add supporting information regarding the change-mechanisms underlying HVNGs.

Schnackenberg, Fleming, and Martin, (2018) investigated EFC as a trauma-sensitive approach. Findings supported this, which could indicate that working with trauma could be one of the change-mechanisms of EFT.

Table 12: Meta-synthesis of the themes found in qualitative research on HVNGs

Research	***Superordinate Themes***	***Subordinate Themes***
Oakland and Berry, (2015)	Discovery "taking the plunge" "participants' initial experiences of the group"	Introductions and motivations – how they found the group, why they went
		First thoughts and reflections "it's like a big step" – initial anxieties and worries about attending group
	Group Structure	Facilitation "no one in a group has power over you", lots of concerns about the power imbalance between professionals and group members, which just does not exist in the group
		Group control "It's their rules" – ownerships of the group by the members very valued. The group will always be there, not time limited / going to be discharged
	Acceptance "the veil being lifted" – experiences of being accepted by the group.	Acceptance of their experiences by the group "was a significant event" in contrast to their social networks
		Acceptance of the social person – "sense of being accepted as people rather than being viewed purely by their experiences or as a patient"
	Hope "Inspiration to know you can do it too"	
	Group benefits	Opportunity to talk, "let off steam"
		"Somebody who knows from experience" Experienced trial and error – advice on coping strategies more valued when they come from group members than professionals, "some of the strategies shared in the group had a huge impact on individuals' perceptions of their ability to manage and feel in control"
Dos Santos and Beavan, (2015)	First experiences, first discoveries	Secrecy at onset of voices (p30)
		Discovering the group through others (p30)
		First experience of the group (p30)
	Experiences within the group	The importance of attending
		Social connections
		The importance of sharing
		The importance of feedback
		Supportive nature of the group
		Process and role of facilitators
		Other group members
	Beyond the group	Willingness to share
		Improvements in self-esteem
		Relating to the voices
		Sense of agency in recovery

Research	*Superordinate Themes*	*Subordinate Themes*
Payne et al., (2017)	Healing: connecting with humanity	The "nurturing" effect of connecting
		Challenges to connecting
	Group as an emotional container	Safety to unload
		"Always there": ongoing presence
	Making sense of the voices and me	An opportunity to explore safely
		Gaining wisdom
		"Clearer in myself": personal growth
	Freedom to be myself and grow	"The group shapes the group" ethos of ownership
		"Fun sometimes": group as a play space
Rácz et al., (2017)	The role of the voice;	
	The relationship between the voice and 'I';	
	The role of the self-help group and	
	The role of the voice hearing method.	

When considering all the qualitative research above, some cross-intervention-model themes emerge. First is a shift in voice-voice-hearer relationships (Birchwood et al., 2018; Hayward & Fuller, 2010; Payne et al., 2017; Rácz et al., 2017; Dos Santos & Beavan, 2015). A subtly different parallel theme was the shift from feeling powerless to more assertive towards the voices (Hayward & Fuller, 2010), or that beliefs about the voices' strength and power had changed (May et al. 2014).

A second emerging cross-intervention-model theme related to acceptance of self, and the development of a more positive view of the self, (Craig et al., 2018; May et al., 2014; Oakland & Berry, 2015; Payne et al., 2017; Dos Santos & Beavan, 2015). Parallel with this was the importance of the relationship with voices, (Dos Santos & Beavan, 2015; Hayward & Fuller, 2010; Payne et al., 2017; Racz et al., 2017).

The importance of peer support (Birchwood et al, 2018) or of the group, was a theme that came out in all group-based interventions (Dos Santos & Beavan, (2015; May et al, 2010; Oakland & Berry, 2015; Payne et al., 2017; Rácz et al., 2017),

Discussion

When considering the therapeutic approaches to voice-hearing described above, these approaches could be considered as being on a continuum (see Figure 3).

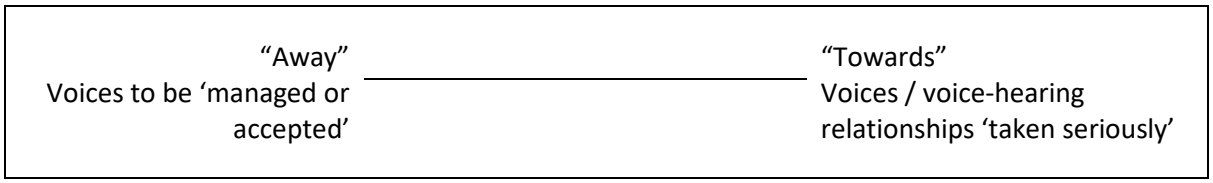


Figure 3: Continuum of Approaches to Voice-hearing

Each therapy within the different models would be positioned slightly differently along this continuum. The Cognitive and Mindfulness-based interventions could be considered to be nearer the "Away" pole, where they are moving 'away' from the concept of voices as something to be engaged with. They view voices as something to be managed (Cognitive), or Accepted (Mindfulness), but not 'engaged with'. The Relating and Meaningful Experience interventions could be seen as being nearer the "Towards" pole, seeing voices as something to be engaged with relationally. However, the Relational Model sees the voices as something to become more assertive towards, whilst the Meaningful Experience interventions see the voices as something to be explored and understood more.

These different approaches become more manifest in the goals of therapy across the different intervention models, and the methods of change used.

When considering the goals of the different intervention models, whilst on one level they may appear quite disparate – changing appraisals of the voices through reality testing (Cognitive), explicitly accepting the voice-hearing experience, and increasing self-compassion (Mindfulness), becoming more assertive towards voices (Relational) or trying to understand the relationship more (Meaningful-experience), underlying them is a superordinate goal of reducing voice-hearing distress. What differs are the perceived mechanisms or subordinate-goals that will move the participant closer to the superordinate goal of reduced distress and improved quality of life and functioning.

Looking at the methods used across the four intervention models, it is possible to see significant variance, even within categories. Within the Cognitive model there are the 'traditional' CBT techniques of reality testing and appraisal modification, but also the Competitive Memory Techniques of the COMET study, and Ison et al's (2014), Imagery Reprocessing methods.

Mirroring the 'approach to voice-hearing continuum', the goals and methods of voice-hearing interventions could be put onto the same continuum. Some intervention techniques involve disengaging with, or 'ignoring' the voices with little attempt to change the voice-hearing experience itself, rather, the attempt is to change the appraisals of the voices. Other interventions aim to engage with the voices, using methods that involve interacting with them.

Whilst the Cognitive and Mindfulness models have quite different methods, their aims in many ways, are to change appraisals. However, the Cognitive interventions aim to change the appraisal of the voice-content, while the Mindfulness-based interventions aim to change

the appraisals of the experience, creating space for it, rather than trying to move away from, or suppress it. Whilst most of the Cognitive Interventions do attend to voice-content, it is in the context of 'reality testing' and disproving voice power and malevolence. There is not an attempt to engage with the voices. The Relational and Meaningful-Experience interventions however, have voice-engagement at their heart. They both see the voice-voice-hearer relationship as key to the intervention. However, the Relational Interventions see the voices as something to be asserted over. Relating Therapy especially, used assertiveness training as a key part of the intervention. Avatar Therapy also uses elements of assertiveness towards the voices, however, it also uses 'script modification' to attempt to move the voice from tormentor to supporter in the voice-hearer's mind. Neither of these interventions appear to attempt to engage with the voices in terms of exploring what the voice-content might mean in relation to the voice-hearer's life. The concept that the voice-content may be in some way meaningful to the voice-hearer is absent from this process. This would appear to be a key difference between the Relational and Meaningful-Experience interventions when considering their methods and the underlying change-mechanisms.

One way of considering the development of voice-hearing interventions is in viewing therapists moving closer to the voice-hearing experience alongside their clients. Voice-hearing interventions have moved from 'coping strategies', (ignoring voice-content), to 'appraisal change', (noting, but not engaging with, voice-content), to relational change, (engaging directly with voice-content), to considering voice-content as meaningful in the context of the voice-hearer's life. These changes may reflect increased confidence in psychological models of voice-hearing, and applying understanding of these models to therapeutic interventions.

Strengths and Limitations:

This review has aimed to give a 'road-map' of the therapies available and currently being researched for people hearing voices. As such it has used a 'broad brush' approach, which is both a strength and limitation, where it lacks depth, it has breadth to introduce the clinician to the range of interventions available. It has not been possible to fully appreciate the depth of data generated by the qualitative research. Research on therapies for psychosis that does not directly reference voice-hearing, has been omitted, however, much of this would almost certainly have therapeutic approaches relevant to voice-hearing.

Clinical Implications:

When considering all the interventions discussed above, one of the key clinical implications is intervention duration. National Institute for Health and Care Excellence, (NICE) guidelines (2014), recommend that people experiencing psychosis, including voice-hearing, should be offered 16 sessions of CBTp. However, fewer than 10% of patients are offered CBTp in the UK (Hazell, et al., 2018). In terms of accessing therapy, the intervention length of Avatar Therapy would support its wider adoption, however, proper training and equipment would be needed to support this. The HVNGs are also important due to their open-ended, referral-free nature. They provide significant support on an ongoing basis, which, when considering the chronicity of voice-hearing, is important.

Research Implications:

Whilst the different interventions largely share the same superordinate goal, their approaches to voice-hearing mean that the techniques used can be completely contradictory. Whilst some methods involve trying to 'compete' with the voices, others see them as having a meaningful 'message'. Some methods involve 'ignoring' the voices, whilst

others engage with them. Interestingly, all the interventions discussed above have had positive outcomes, so further research, perhaps into voice-hearer 'satisfaction' and 'recovery' in terms of living a fulfilling life would be helpful in identifying the interventions that will most support voice-hearers.

References

Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: theory and practice. *Behaviour Research and Therapy*, *37*, 715–740.

Barrowcliff, A. L. (2008). Cognitive-behavioural therapy for command hallucinations and intellectual disability: A case study. *Journal of Applied Research in Intellectual Disabilities*, *21*(3), 236–245.

Beavan, V., de Jager, A., dos Santos, B., Jager, A. De, & Santos, B. (2017). Do peer-support groups for voice-hearers work ? A small scale study of Hearing Voices Network support groups in Australia Do peer-support groups for voice-hearers work ? A small scale study of Hearing Voices Network support groups in Australia. *Psychosis*, *9*(1), 57–66. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2016.1216583

Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L., et al. (2014). Cognitive behaviour therapy to prevent harmful compliance with command hallucinations (COMMAND): A randomised controlled trial. *The Lancet Psychiatry*, *1*(1), 23–33. Elsevier Ltd. Retrieved January 7, 2019, from http://dx.doi.org/10.1016/S2215-0366(14)70247-0

Birchwood, M., Mohan, L., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L. M., et al. (2018). The COMMAND trial of cognitive therapy for harmful compliance with command hallucinations (CTCH): A qualitative study of acceptability and tolerability in the UK. *BMJ Open*, *8*(6), 1–8.

Birchwood, M., Peters, E., Tarrier, N., Dunn, G., Lewis, S., Wykes, T., Davies, L., et al. (2011). A multi-centre, randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations. *BMC PSYCHIATRY*, *11*, 155–161. Retrieved December 13, 2018, from http://www.biomedcentral.com/1471-244X/11/155

Birtchnell, J. (1996). *How humans relate: a new interpersonal theory*. Hove: Psychology Press.

Branitsky, A. (2017). Commentary: Assessing the impact and effectiveness of hearing voices network self-help groups. *Frontiers in Psychology*, *8*, 3. Department of Psychology and Education, Mount Holyoke College, South Hadley, MA, US brani22a@mtholyoke.edu; Branitsky, Alison,brani22a@mtholyoke.edu: Frontiers Media S.A. Frontiers Research Foundation. Retrieved from https://search.proquest.com/docview/2084064028?accountid=14874

Brophy, L. (2017). Responding to the Needs of Voice Hearers and Expanding Access to Evidence-based and Innovative Psychosocial Interventions: Commentary on "Are Hearing Voices Networks Compatible with Cognitive Behavioural Therapy for Psychosis?" (Kay, Kendall, & Dark, 2017. *Australian Social Work*, *70*(4), 508–510. Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Carlton, VIC, Australia

lbrophy@unimelb.edu.au; Brophy, Lisa,4/207 Bouverie Street,Carlton,Australia,3010,Centre for Mental Health, Melbourne School of Po: Taylor & Francis. Retrieved from https://search.proquest.com/docview/1942926459?accountid=14874

Carter, K. E. P., & Wells, A. (2018). Effects of the Attention Training Technique on Auditory Hallucinations in Schizo-Affective Disorder: A Single Case Study. *Case Reports in Psychiatry*, *2018*, 5. Hindawi. Retrieved from https://doi.org/10.1155/2018/1537237

Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy*, *37*(4), 403–412. Retrieved January 4, 2019, from https://www-cambridge-org.ezproxy.bangor.ac.uk/core/services/aop-cambridge-core/content/view/3C7536DDEC1E04D57384A2D580DDEF1B/S1352465809990166a.pdf/mindfulness_groups_for_distressing_voices_and_paranoia_a_replication_and_randomized_feasibility_trial.pdf

Cichocki, Ł., Palka, J., Leff, J., & Cechnicki, A. (2016). The use of masks in the treatment of patients with chronic auditory hallucinations. *PSYCHOTERAPIA*, *1*(176), 17–28. Retrieved December 30, 2018, from http://www.psychoterapiaptp.pl/uploads/PT_1_2016/ENGver17Cichocki_Psychoterapia_1_2016.pdf

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: Implications for research and practice. *Schizophrenia Bulletin*, *40*(SUPPL. 4), 285–294. Retrieved January 7, 2019, from https://academic.oup.com/schizophreniabulletin/article-abstract/40/Suppl_4/S285/1873862

Craig, T. K. J. J., Rus-calafell, M., Ward, T., Fornells-Ambrojo, M., McCrone, P., Emsley, R., & Garety, P. (2015). The effects of an Audio Visual Assisted Therapy Aid for Refractory auditory hallucinations (AVATAR therapy): Study protocol for a randomised controlled trial. *Trials*, *16*(1), 1–9. Trials. Retrieved December 30, 2018, from http://dx.doi.org/10.1186/s13063-015-0888-6

Craig, T. K. J., Rus-Calafell, M., Ward, T., Leff, J. P., Huckvale, M., Howarth, E., Emsley, R., et al. (2018). AVATAR therapy for auditory verbal hallucinations in people with psychosis: a single-blind, randomised controlled trial. *LANCET PSYCHIATRY*, *5*(1), 31–40. Elsevier. Retrieved January 20, 2019, from http://www.ncbi.nlm.nih.gov/pubmed/29175276

Dannahy, L., Hayward, M., Strauss, C., Turton, W., Harding, E., & Chadwick, P. (2011). Group person-based cognitive therapy for distressing voices: Pilot data from nine groups. *Journal of Behavior Therapy and Experimental Psychiatry*, *42*(1), 111–116. Elsevier Ltd. Retrieved from http://dx.doi.org/10.1016/j.jbtep.2010.07.006

Dellazizzo, L., Percie du Sert, O., Phraxayavong, K., Potvin, S., O'Connor, K., & Dumais, A. (2018). Exploration of the dialogue components in Avatar Therapy for schizophrenia patients with refractory auditory hallucinations: A content analysis. *Clinical Psychology and Psychotherapy*, (June), 878–885.

Dellazizzo, L., Potvin, S. S., Phraxayavong, K., Lalonde, P., & Dumais, A. (2018). Avatar Therapy for Persistent Auditory Verbal Hallucinations in an Ultra-Resistant Schizophrenia Patient: A Case Report. *FRONTIERS IN PSYCHIATRY*, *9*, 131. Frontiers. Retrieved November 10, 2018, from http://journal.frontiersin.org/article/10.3389/fpsyt.2018.00131/full

Dellazizzo, L., du Sert, O. P., Potvin, S., Breton, R., Pelletier, J., Renaud, P., & Dumais, A. (2018). Avatar Therapy for persistent auditory verbal hallucinations: a case report of a peer research assistant on his path toward recovery. *Psychosis*, *10*(3), 213–219. Routledge. Retrieved from https://doi.org/10.1080/17522439.2018.1499799

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *PSYCHOSIS-PSYCHOLOGICAL SOCIAL AND INTEGRATIVE APPROACHES*, *5*(3, SI), 286–295. Retrieved January 13, 2019, from http://www.tandfonline.com/action/journalInformation?journalCode=rpsy20

England, M. (2008). Significance of cognitive intervention for voice hearers. *Perspectives in Psychiatric Care*, *44*(1), 40–47.

Fernández-Caballero, A., Navarro, E., Fernández-Sotos, P., González, P., Ricarte, J. J., Latorre, J. M. J. M., Rodriguez-Jimenez, R., et al. (2017). Human-Avatar Symbiosis for the Treatment of Auditory Verbal Hallucinations in Schizophrenia through Virtual/Augmented Reality and Brain-Computer Interfaces. *Frontiers in Neuroinformatics*, *11*(November), 1–6. Retrieved from http://journal.frontiersin.org/article/10.3389/fninf.2017.00064/full

Van Der Gaag, M., Van Oosterhout, B., Daalman, K., Sommer, I. E., & Korrelboom, K. (2012). Initial evaluation of the effects of competitive memory training (COMET) on depression in schizophrenia-spectrum patients with persistent auditory verbal hallucinations: A randomized controlled trial. *British Journal of Clinical Psychology*, *51*(2), 158–171. British Psychological Society. Retrieved January 7, 2019, from www.wileyonlinelibrary.com

van der Gaag, M., Valmaggia, L. R., & Smit, F. (2014). The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: A meta-analysis. *SCHIZOPHRENIA RESEARCH*, *156*(1), 30–37. Elsevier B.V. Retrieved from http://dx.doi.org/10.1016/j.schres.2014.03.016

Gilbert, P. (2009). *The Compassionate Mind*. London: Constable & Robinson Ltd.

Goodliffe, L., Hayward, M., Brown, D., Turton, W., & Dannahy, L. (2010). Group person-based cognitive therapy for distressing voices: Views from the hearers. *PSYCHOTHERAPY RESEARCH*, *20*(4), 447–461. Retrieved January 7, 2019, from http://www.tandfonline.com/action/journalInformation?journalCode=tpsr20

Gottlieb, J. D., Romeo, K. H., Penn, D. L., Mueser, K. T., & Chiko, B. P. (2013). Web-based cognitive-behavioral therapy for auditory hallucinations in persons with psychosis: A pilot study. *Schizophrenia Research*, *145*(1–3), 82–87. Elsevier B.V. Retrieved November 11, 2018, from http://dx.doi.org/10.1016/j.schres.2013.01.002

Hayward, M., Berry, K., McCarthy-Jones, S., Strauss, C., & Thomas, N. (2014). Beyond the omnipotence of voices: Further developing a relational approach to auditory hallucinations. *Psychosis*, *6*(3), 242–252. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2013.839735

Hayward, M., & Fuller, E. (2010). Relating therapy for people who hear voices: Perspectives from clients, family members, referrers and therapists. *Clinical Psychology and Psychotherapy*, *17*(5), 363–373. University of Surrey, Guildford, United Kingdom m.hayward@surrey.ac.uk; Sussex Partnership NHS Foundation Trust, United Kingdom ; Hayward, Mark,Surrey,Guildford,United Kingdom,GU2 7XH,Psychology Department, University of Surrey,m.hayward@surrey.ac.uk: John Wiley & Sons. Retrieved from https://search.proquest.com/docview/763163937?accountid=14874

Hayward, M., Jones, A.-M. M., Bogen-johnston, L., Thomas, N., & Strauss, C. (2017). Relating Therapy for distressing auditory hallucinations: A pilot randomized controlled trial. *SCHIZOPHRENIA RESEARCH*, *183*, 137–142. Elsevier B.V. Retrieved from http://dx.doi.org/10.1016/j.schres.2016.11.019

Hayward, M., Overton, J., Dorey, T., & Denney, J. (2009). Relating Therapy for People Who Hear

Voices: A Case Series. *CLINICAL PSYCHOLOGY & PSYCHOTHERAPY*, *16*(3), 216–227.

Hayward, M., Strauss, C., & Bogen-johnston, L. (2014). Relating therapy for voices (the R2V study): study protocol for a pilot randomized controlled trial. *Trials*, *15*, 325. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/420/CN-01106420/frame.html

Hazell, C. M., Hayward, M., Cavanagh, K., Jones, A. M., & Strauss, C. (2018). Guided self-help cognitive-behaviour Intervention for VoicEs (GiVE): Results from a pilot randomised controlled trial in a transdiagnostic sample. *Schizophrenia Research*, *195*, 441–447. The Authors. Retrieved from https://doi.org/10.1016/j.schres.2017.10.004

Ison, R., Medoro, L., Keen, N., & Kuipers, E. (2014). The Use of Rescripting Imagery for People with Psychosis Who Hear Voices. *BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY*, *42*(2), 129–142.

Kay, G., Kendall, E., & Dark, F. (2017). Are Hearing Voices Networks Compatible with Cognitive Behavioural Therapy for Psychosis? *Australian Social Work*, *70*(3), 312–323. Taylor & Francis.

Kennedy, L., & Xyrichis, A. (2017). Cognitive Behavioral Therapy Compared with Non-specialized Therapy for Alleviating the Effect of Auditory Hallucinations in People with Reoccuring Schizophrenia: A Systematic Review and Meta-analysis. *Community Mental Health Journal*, *53*(2), 127–133. Springer US. Retrieved November 10, 2018, from http://dx.doi.org/10.1007/s10597-016-0030-6

Leff, J., Williams, G., Huckvale, M. A., Arbuthnot, M., & Leff, A. P. (2013). Computer-assisted therapy for medication-resistant auditory hallucinations: Proof-of-concept study. *British Journal of Psychiatry*, *202*(6), 428–433.

Leff, J., Williams, G., Huckvale, M., Arbuthnot, M., & Leff, A. P. (2014). Avatar therapy for persecutory auditory hallucinations: What is it and how does it work? *Psychosis*, *6*(2), 166–176.

Longden, E., Read, J., & Dillon, J. (2018). Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups. *COMMUNITY MENTAL HEALTH JOURNAL*, *54*(2), 184–188. Institute of Psychology, Health and Society, University of Liverpool, Liverpool, United Kingdom Eleanor.Longden@gmw.nhs.uk; School of Psychology, University of East London, London, United Kingdom ; National Hearing Voices Network, Sheffield, United Kingdo: Springer. Retrieved from https://search.proquest.com/docview/1914295080?accountid=14874

Louise, S., Rossell, S. L., Lin, T. W., Monique, S., & Neil, T. (2018). Does mindfulness help people adapt to the experience of hearing voices? *Psychiatry Research*, *270*, 329–334. Retrieved January 19, 2019, from https://doi.org/10.1016/j.psychres.2018.09.013

Louise, S., Rossell, S. L., & Thomas, N. (2018). The acceptability, feasibility and potential outcomes of an individual mindfulness-based intervention for hearing voices. *Behavioural and Cognitive Psychotherapy*. Cambridge University Press. Retrieved from https://search.proquest.com/docview/2068607960?accountid=14874

Lysaker, P. H., Vohs, J., Ballard, R., Fogley, R., Salvatore, G., Popolo, R., & Al., E. (2013). Metacognition, self-reflection and recovery in schizophrenia. *Future Neurology*, *8*, 103–115.

Martins, M. J. R. V., Castilho, P., Carvalho, C. B., Pereira, A. T., Santos, V., Gumley, A., & De Macedo, A. F. (2017). Contextual Cognitive-Behavioral Therapies across the psychosis continuum a review of evidence for schizophrenia, schizoaffective and bipolar disorders. *European Psychologist*, *22*(2), 83–100.

May, K., Strauss, C., Coyle, A., & Hayward, M. (2014). Person-based cognitive therapy groups for distressing voices: A thematic analysis of participant experiences of the therapy. *Psychosis*, *6*(1), 16–26. Retrieved January 7, 2019, from

http://www.tandfonline.com/action/journalInformation?journalCode=rpsy20

Mayhew, S. L., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: A case series report. *Clinical Psychology and Psychotherapy*, *15*(2), 113–138. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emed8&NEWS=N&AN=2008203310

National Institute for Health and Care Excellence, (NICE). (2014). *NICE Guidelines CG178 - Psychosis and schizophrenia in adults: choice and schizophrenia in adults: prevention and management Clinical guidelines, Reviewed November 2017*. Retrieved from https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

Newman Taylor, K., Harper, S., & Chadwick, P. (2009). Impact of mindfulness on cognition and affect in voice hearing: Evidence from two case studies. *Behavioural and Cognitive Psychotherapy*, *37*(4), 397–402. United States.

Oakland, L., & Berry, K. (2015). Lifting the veil: a qualitative analysis of experiences in Hearing Voices Network groups. *PSYCHOSIS-PSYCHOLOGICAL SOCIAL AND INTEGRATIVE APPROACHES*, *7*(2), 119–129. Retrieved January 13, 2019, from http://www.tandfonline.com/action/journalInformation?journalCode=rpsy20

Paulik, G., Hayward, M., & Birchwood, M. (2013). Cognitive Behavioural relating therapy (CBRT) for voice hearers: A case study. *Behavioural and Cognitive Psychotherapy*, *41*(5), 626–631.

Payne, T., Allen, J., & Lavender, T. (2017). Hearing Voices Network groups: experiences of eight voice hearers and the connection to group processes and recovery. *Psychosis*, *9*(3), 205–215. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2017.1300183

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 hallucinations. *Schizophrenia Research*, *109*(1–3), 52–59. Elsevier B.V. Retrieved from http://dx.doi.org/10.1016/j.schres.2008.12.009

Rácz, J., Kaló, Z., Kassai, S., Kiss, M. M. M., & Pintér, J. N. (2017). The experience of voice hearing and the role of self-help group: An interpretative phenomenological analysis. *International Journal of Social Psychiatry*, *63*(4), 307–313. Institute of Psychology, Eotvos Lorand University, Budapest, Hungary kassai.szilvia@ppk.elte.hu; Institute of Psychology, University of Szeged, Szeged, Hungary ; Kassai, Szilvia,1064 Budapest Izabella 46,Budapest,Hungary,1056,Doctoral School of Psychology: Sage Publications. Retrieved from https://search.proquest.com/docview/1918854819?accountid=14874

Rehm, I. C., Foenander, E., Wallace, K., Abbott, J. A. M., Kyrios, M., & Thomas, N. (2016). What role can avatars play in e-mental health interventions? Exploring new models of client-therapist interaction. *Frontiers in Psychiatry*, *7*(NOV), 1–6.

Romme, M., & Escher, S. (2000). *Making sense of voices*. London: Mind Publications.

Ruddle, A., Livingstone, S., Huddy, V., Johns, L., Stahl, D., & Wykes, T. (2014). A case series exploring possible predictors and mechanisms of change in hearing voices groups. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*(1), 60–79. Retrieved January 17, 2019, from www.wileyonlinelibrary.com

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. North Croydon CMHT,

Tamworth Road Resource Centre, Croydon, United Kingdom anna.ruddle@slam.nhs.uk; Department of Psychology, Institute of Psychiatry, King's College London, London, United Kingdom ; Research Department of Clinical, Educational and Health: Elsevier Science. Retrieved January 17, 2019, from https://search.proquest.com/docview/877850150?accountid=14874

Salvatore, G., Ottavi, P., Popolo, R., & Dimaggio, G. (2016). Metacognitive Interpersonal Therapy for Treating Auditory Verbal Hallucinations in First-onset Schizophrenia. *Journal of Contemporary Psychotherapy*, *46*(4), 235–243. Springer US. Retrieved November 10, 2018, from https://link-springer-com.ezproxy.bangor.ac.uk/content/pdf/10.1007/s10879-016-9336-5.pdf

Dos Santos, B. `, & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *JOURNAL OF MENTAL HEALTH TRAINING EDUCATION AND PRACTICE*, *10*(1), 26–38. Retrieved January 13, 2019, from www.intervoiceonline.org

Schnackenberg, J., Fleming, M., & Martin, C. R. (2017). A randomised controlled pilot study of Experience Focused Counselling with voice hearers. *Psychosis*, *9*(1), 12–24. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2016.1185452

Schnackenberg, J., Fleming, M., Walker, H., & Martin, C. R. (2018). Experience Focussed Counselling with Voice Hearers: Towards a Trans-diagnostic Key to Understanding Past and Current DistressA Thematic Enquiry. *COMMUNITY MENTAL HEALTH JOURNAL*, *54*(7), 1071–1081. Springer US. Retrieved from http://dx.doi.org/10.1007/s10597-018-0280-6

Schnackenberg, J. K., Fleming, M., & Martin, C. R. (2018). Experience Focussed Counselling with Voice Hearers as a Trauma-Sensitive Approach. Results of a Qualitative Thematic Enquiry. *Community Mental Health Journal*, *54*(7), 997–1007. Springer US. Retrieved from http://dx.doi.org/10.1007/s10597-018-0294-0

Schnackenberg, J. K., & Martin, C. R. (2014). The need for Experience Focused Counselling (EFC) with voice hearers in training and practice: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *21*(5), 391–402. England: Wiley/Blackwell (10.1111). Retrieved November 11, 2018, from http://doi.wiley.com/10.1111/jpm.12084

Scott, W., Mcarthur, A., & Tufanaru, C. (2018). Effectiveness of psychotherapies that engage with the voices of Voice Hearers: a systematic review protocol. *JBI Database System Rev Implement Rep*, *16*(6), 1373–1380. Australia. Retrieved December 30, 2018, from http://es.connect.jbiconnectplus.org/ViewSourceFile.aspx?0=19720

du Sert, O. P., Potvin, S. S., Lipp, O., Dellazizzo, L., Laurelli, M., Breton, R., Lalonde, P., et al. (2018). Virtual reality therapy for refractory auditory verbal hallucinations in schizophrenia: A pilot clinical trial. *Schizophrenia Research*, *197*(197), 176–181. Retrieved November 10, 2018, from https://doi.org/10.1016/j.schres.2018.02.031

Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliff, K., Larner, C., et al. (2012). A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. *Behaviour Research and Therapy*, *50*(2), 110–121. Elsevier Ltd. Retrieved from http://dx.doi.org/10.1016/j.brat.2011.11.007

Shiraishi, N., Watanabe, N., Kinoshita, Y., Kaneko, A., Yoshida, S., Furukawa, T. A., & Akechi, T. (2014). Brief Psychoeducation for Schizophrenia Primarily Intended to Change the Cognition of Auditory Hallucinations An Exploratory Study. *JOURNAL OF NERVOUS AND MENTAL DISEASE*, *202*(1), 35–39.

Singer, A. R., & Addington, D. E. (2009). The Application of Cognitive Therapy for Command Hallucinations. *Cognitive and Behavioral Practice*, *16*(1), 73–83. Elsevier B.V. Retrieved from http://dx.doi.org/10.1016/j.cbpra.2008.03.003

Slade, P. D., & Bentall, R. P. (1988). *Sensory deception: towards a scientific analysis of hallucinatons*. London: Croom Helm.

Smailes, D., Alderson-day, B., Fernyhough, C., McCarthy-Jones, S., & Dodgson, G. (2015). Tailoring Cognitive Behavioral Therapy to Subtypes of Voice Hearing. *Frontiers in Psychology*, *6*(December), 1–10.

Stefaniak, I., Sorokosz, K., Janicki, A., & Wciórka, J. (2017). Use of an AVATAR in Cognitive-Behavioural Therapy of a person who is chronically experiencing negative auditory hallucinations – Case Study. *Advances in Psychiatry & Neurology*, *26*(4), 275–289.

Strauss, C., Thomas, N., & Hayward, M. (2015). Can we respond mindfully to distressing voices? A systematic review of evidence for engagement, acceptability, effectiveness and mechanisms of change for mindfulness-based interventions for people distressed by hearing voices. *Frontiers in Psychology*, *6*, 12. School of Psychology, University of Sussex, Brighton, United Kingdom c.y.strauss@sussex.ac.uk; School of Health Sciences, Swinburne University of Technology, Melbourne, VIC, Australia ; Strauss, Clara,Pevensey I,Brighton,United Kingdom,BN1 9QH,School of P: Frontiers Media S.A. Frontiers Research Foundation. Retrieved from https://search.proquest.com/docview/1765604143?accountid=14874

Suryani, F. K. (2015). A Critical Review of Symptom Management of Auditory Hallucinations in Patient with Schizophrenia. *JKP (Jurnal Keperawatan Padjajaran - Padjajaran Nursing Journal)*, *3*, 150–157.

Thomas, N., Hayward, M., Peters, E., van der Gaag, M., Bentall, R. P., Jenner, J., Strauss, C., et al. (2014). Psychological Therapies for Auditory Hallucinations (Voices): Current Status and Key Directions for Future Research. *SCHIZOPHRENIA BULLETIN*, *40*(4), S202–S212.

Thomas, N., McLeod, H. J., & Brewin, C. R. (2009). Interpersonal complementarity in responses to auditory hallucinations in psychosis. *British Journal of Clinical Psychology*, *48*(4), 411–424. Retrieved November 10, 2018, from www.bpsjournals.co.uk

Thomas, N., Rossell, S., Farhall, J., Shawyer, F., & Castle, D. (2011). Cognitive Behavioural Therapy for Auditory Hallucinations: Effectiveness and Predictors of Outcome in a Specialist Clinic. *BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY*, *39*(2), 129–138.

Veiga-Martínez, C., Perez-Alvarez, M., & Garcia-Montes, J. M. (2008). Acceptance and commitment therapy applied to treatment of auditory hallucinations. *Clinical Case Studies*, *7*(2), 118–135.

Williams, M., & Penman, D. (2011). *Mindfulness a practical guide to Finding Peace in a Frantic World*. London: Piatkus.

Appendix One - Papers excluded from review but relevant to this area:

Table 13: Papers Excluded from Review Relevant to Therapeutic Interventions in Voice-hearing

Article Type	Number	Reference
Study Protocols	4	Birchwood et al., 2011 Hayward, et al, 2014 Craig et al., 2015 Scott et al., 2018
Meta-analyses and reviews	7	Ruddle et al., 2011 Schnackenberg and Martin, 2014 van der Gaag, et al., 2014 Thomas et al., 2014 Strauss, et al., 2015 Kennedy and Xyrichis, 2017 Martins et al., 2017
Theory-based papers	6	Thomas et al., 2009 Thomas et al., 2011 Leff et al., 2014 Hayward et al., 2014 Smailes et al., 2015 Suryani, 2015
Commentary	6	Corstens et al., 2014 Rehm et al., 2016 Fernández-Caballero et al., 2017 Brophy, 2017 Branitsky, 2017 Kay et al., 2017

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Empirical Paper

Relating to the Voices: A Narrative Analysis of how the relationship between voice-hearers and their voices develops over time.

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(last accessed 23/05/19)

Abstract

Culturally stigmatised, voice-hearing is traditionally related to psychotic disorders. Not all voice-hearers experience their voices negatively. Therapeutic approaches are increasingly interested in voice-hearing relationships. However, there is little research into how voice-hearing relationships develop over time. Narrative analysis (NA) was used to investigate this. Seven participants were interviewed using a single narrative-inducing question. Transcripts were analysed across Lieblich et al's (1998) two dimensions of NA, looking at plot, coherence, character, and cultural positioning. There appeared to be relationships between: narrative coherence and positive voice-hearing relationships; positive voice-hearing relationships and the availability of positive cultural positions; positive voice-hearing relationships and the availability of a supportive space to explore voice-hearing experiences.

A prototype 'story-arc' was created against which participants relationship developments could be mapped. There were six 'chapters' and an 'epilogue': First Experiences; Into the Chaos; Meet the Neighbours; The Unwanted Visitor; Turning points; Making Friends.

Almost all participants at some point expressed some positivity towards their voices. They described ambiguous or complicated relationships, however, many reported not wanting their voices to leave them. Relational-change appeared to be promoted by: proactive change by the participants in how they related to their voices; change of voice-content; change of appraisal regarding the voices. The availability of positive cultural narratives regarding the experience and identity of voice-hearing seemed to support the development of more positive voice-hearing relationships, however, these did not appear to be generally available outside of therapeutic spaces and voice-hearing communities.

Background

The experience of voice-hearing is traditionally related to schizophrenia or other psychotic disorders (Jackson et al., 2011). Culturally, voice-hearing in Western Europe, Northern America, is a highly stigmatised experience. Responses to voice-hearing can vary from discrimination and social exclusion (Mawson et al., 2011; Schizophrenia Commission, 2018) to being detained under the Mental Health Act (1983).

Whilst many find voice-hearing distressing, there are people who experience voice-hearing positively (Jackson et al., 2010; Peters et al., 2016). Nor are voice-hearers passive in their experiences, rather they react "*cognitively, emotionally and behaviourally*" to their "*perception of [their] voices*" (Perona-Garcelán et al., 2016, p454). Research has found that beliefs about voices strongly predicted voice related distress (Byrne et al., 2003). Whilst Holt and Tickle, (2015), have conducted research into how "people construct an understanding of the origin and maintenance of their experience of hearing voices" (p256) there appears to be little research exploring how people develop their initial voice-hearing relationships.

There are a range of different psychological approaches to treating voice-hearing: Cognitive (Birchwood et al., 2014; England, 2008; Hazell et al., 2018; Penn et al., 2009; van der Gaag, et al., 2012); Mindfulness-based (Chadwick et al. 2009; Dannahy et al. 2011; Louise et al., 2018; Shawyer et al. 2012); Relational (Craig et al., 2018; Hayward, et al., 2017; Leff, et al., 2013); and Meaningful-experience models (Beavan et al., 2017; Longden et al., 2018; Schnackenberg et al., 2017). Recent interest in how voice-hearers relate to their voices has led to the development of relationally-based therapies, (Craig et al., 2018; Hayward et al., 2017; Leff et al., 2013) which aim to change how voice-hearers relate to their voices.

Despite relationship-change regarding voice-hearing being the aim of many therapeutic interventions, there appears to be little research into how relationships between voice-hearer and voices change over time. Chin et al., (2009) researched the voice-hearing relationship, however, the development of the voice/voice-hearer relationship does not appear to have been investigated. As such, this research set out to answer the question: How does the relationship between voice-hearers and their voices develop over time?

Method

Aims, Approach and Methodology

As relationships are socially constructed, a social-constructivist epistemology was used, that is, "*the assumption that people are social beings who are creating, and being created by, their understandings of the world around them*," (Banister et al., 2007 p244). Narratives are one of the ways that people construct and make sense of their world. Narratives and relationships are closely interwoven. Narratives help create identity and sense of self. Bruner, (2004) talks of the importance of being in a community with shared meanings in narrative creation. This is important in terms of voice-hearing and the social narratives surrounding it that isolate and alienate people from others, and from themselves.

As this research aimed to investigate how voice-hearer's relationships change over time, Narrative Analysis (NA) seemed ideally placed to investigate these changes because of the way that narratives shape our relationships, and because of NA's ability to investigate change over time: there are "*three key features of a narrative, namely that it has a temporal dimension, it is meaningful, and it is inherently social in that stories are produced for specific audiences*." (Elliott, 2005, p11).

Ethics

Ethical approval for this research was received from Bangor University School of Psychology, the Health Research Authority, Yorkshire and The Humber - Leeds East Research Ethics Committee, and North Wales Research and Development.

Participants

Seven participants were recruited as below (Table 1).

Table 1: Participant Information

Name[1]	***Age at time of research***	***Age 1st started hearing voices***	***Recruited from***	***Interview Location***	***Interview length***
Martin	29 years	Before 2013	Early Intervention in psychosis service	Home	55 minutes
Lee	34 years	Has been hearing voices for approx. 7 years	Early Intervention in psychosis service	3rd Sector Agency	73 minutes
Katie	47 years	16 years	Early Intervention in psychosis service	NHS Premises	78 minutes
Iain	60 years	Heard a voice as a child, and teenager, stopped in early 20's and then restarted several years later	Community Mental Health Team	NHS Premises	101 minutes
Scott	48 years	38 years	Hearing Voices Network Group[2] (HVNG)	HVNG Premises	64 minutes

[1] All names are pseudonyms

[2]Peer Support Group (see Literature Review for more details)

Name[1]	***Age at time of research***	***Age 1st started hearing voices***	***Recruited from***	***Interview Location***	***Interview length***
Eliza	37 years	As long as she can remember	HVNG	HVNG Premises	76 minutes
Sarah	53 years	47 years	HVNG	HVNG Premises	65 minutes

Design

A narrative interview design was used, which is "*an interview design that focuses on the elicitation and provocation of storytelling*," (Wengraf, 2001, p127). Within this design, Wengraf's (2001), "*Single Question (aimed at inducing narrative)*" (p129) was used as the basis of the interviews, however, when needed, scaffolding questions were utilized. This design was selected to privilege the experiences and voices of the participants. Starting with a single question created space which allowed participants to retell their experiences in the way that they wished. It empowered participants to narrate their experience with as little influence from the researcher as possible beyond setting the outlines of the research area. The aim of the Single Question is to "*for as long as possible … give up control, refuse to take up offers of partial control, and maintain the maximum of power-asymmetry against yourself,*" (Wengraf, 2001, p129). As this population often experiences deleterious contact with powerful agencies, this privileging of their voice and experiences was important.

Procedure

Participants were interviewed across a range of settings (see Table 1). Participants were orientated towards the approach, and then asked:

> *"I would like to understand your experience of hearing voices and how it has developed over time; in particular, the relationship you have with the voices you hear, how those relationships started, and changed as time has passed. Have any changes in these relationships occurred as your life has changed and moved on? It would be helpful to understand how you have made sense of the experience of hearing voices, and whether your understanding has changed during this time."*

Initial 'story summaries' were generated focusing on the 'plot' aspects of the participants' narratives. These were reviewed with the participants to minimise researcher bias. This was used to inform further analysis. This co-creation of initial plot generation helped continue to privilege the participants' voices and experiences.

Reflexive Statement

I have been strongly influenced by Eleanor Longden's 2013 Ted Talk (viewed 2014-15). She stated: that voice-hearing was "a complex, significant and meaningful experience" (Longden, 2013). The idea that sense could be made of the voices, that they could be positively engaged with, and that there was the possibility of meaningful recovery, was somewhat revolutionary for me and shaped my thinking and attitudes thereafter. This drove my choice of research.

I believe that narratives shape and create the world we live in, both positively and negatively. I am interested in the way that social positions are made available to, or closed off to, different groups of people. I also feel it is important to give voice to the under-privileged, under-powerful, and stigmatised. This is reflected in my choice of using narrative analysis.

Analysis

Overview:

NA is not a rigid set of techniques, but an umbrella term for a range of approaches that can be selected from as is most suitable for the question being explored (Elliott, 2005; Murray & Sargeant, 2011; Phoenix et al., 2010).

Following Skippon's (2010) method of NA, selected NA techniques were used to analyse the transcripts across Lieblich et al's (1998) two dimensions. Lieblich, et al., (1998) proposed that NA takes place across two dimensions (see Figure 1**Error! Reference source not found.**).

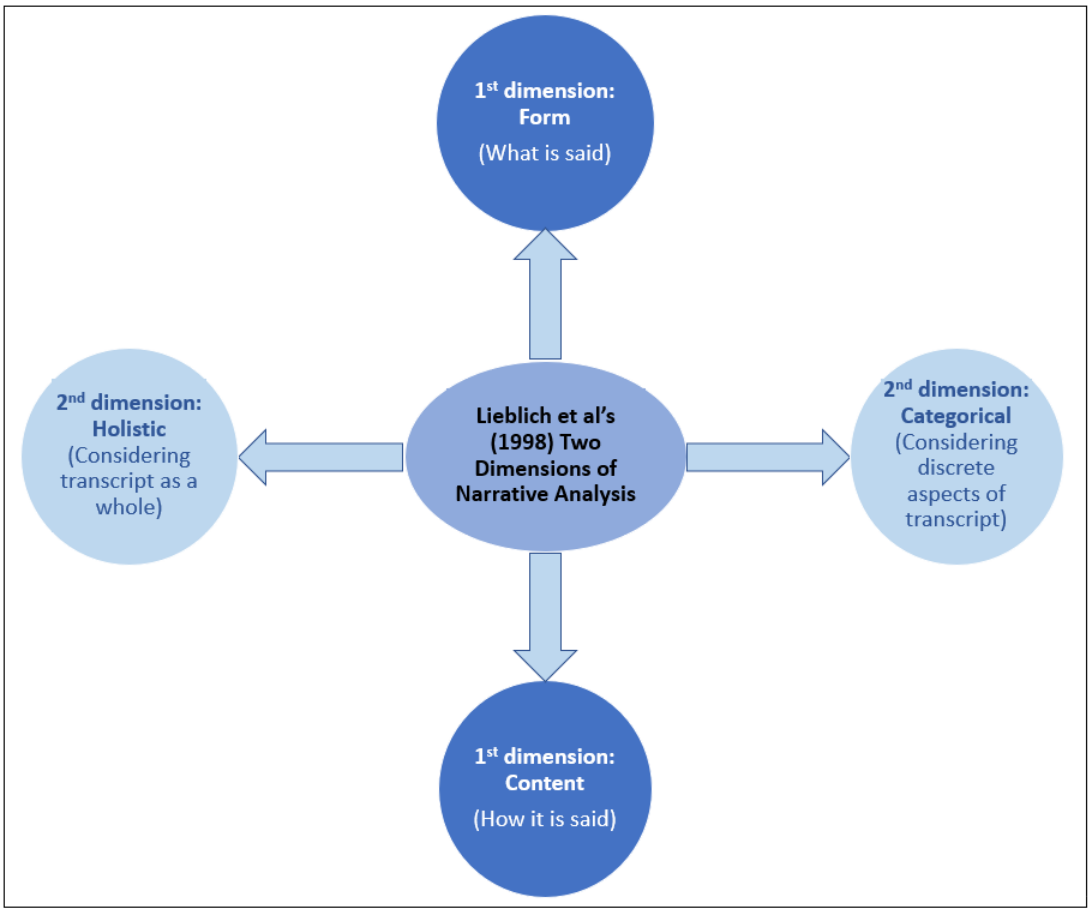

Figure 1: Lieblich et al's (1998) Two Dimensions of Narrative Analysis

These two dimensions of NA were used as a framework against which a range of other Key NA methods of analysis were used. In Lieblich et al.'s (1998) Content-Form dimension, the Content 'pole' considers '*what* is said'. It analyses what happened, considering: the meaning ascribed to experiences (Baerger & McAdams, 1999; Elliott, 2005; the use of cultural resources and positioning, looking particularly at how participants both took up cultural positions (Baerger & McAdams, 1999; Riessman, 1993), and experienced having cultural positions being imposed upon them; and the temporal dimension of the story (Elliott, 2005; France & Uhlin, 2006). The Form 'pole' considers '*how* the story is told'. It considers: the structure of the plot (Labov & Waletzky, 1967); plot coherence (Linde, 1993), including temporal dimensions and meaning ascribed to experiences; choice of language and performance (Lieblich et al., 1998; Phoenix et al., 2010; Riessman, 1993), considering *how* the stories were told in order to convey the important aspects of participants' experiences, (emphasis, volume, tone and non-verbal mannerisms); and the use of cultural resources.

In the Holistic-Categorical dimension, the Holist 'pole' looks at the narrative in its entirety and seeks to understand narrative 'as a whole'. The Categorical 'pole' "break[s] the text into relatively small units of content and submit[s] them to … "*content analysis*"" (Lieblich et al., 1998, p112. It does not "*attempt to preserve the integrity of the whole account*," (Elliott, 2005, p34). Labov and Waletzky's (1967), Structure of Narrative (see Figure 2) was used when considering the transcripts both holistically and categorically. This identifies component features needed to make a coherent narrative.

Plot Element	Description
Abstract	Summary of the subject matter
Orientation	Information about the setting: time, place, situation, participants
Complicating action	What actually happened, what happened next
Evaluation	What the events mean to the narrator
Resolution	How it all ended
Coda	Returns the perspective to the present

Figure 2: Labov and Waletzky's Structural Model of Narrative, taken from Elliott, (2005), p42

This Structure of Narrative was used to help identify the 'overarching narrative' at the 'Holistic Pole', and to identify 'micro-plots' at the 'Categorical Pole'. These micro-plots sometimes formed 'stand-alone stories', but often, although they could be taken as 'stand-alone stories', they were also used to move the over-arching narrative along and create the overall narrative. These 'micro-stories' could be considered as pearls on a necklace: each pearl is complete in itself, but put together, they form the string of pearls that make up the entire necklace. Whilst Labov and Waletzky's (1967) Structure of Narrative was used as to help consider what made a coherent narrative and was used as the framework for consideration of narratives, performative aspects were used to help identify key 'plot points' within narratives.

Each transcript was analysed against both poles of Lieblich et al.'s dimensions, using different analytic methods as appropriate to each dimension / pole. There was a complex analytic interaction between Lieblich et al.'s (1998) Two-Dimensional framework, and the other NA methods selected to analyse transcripts within that framework, (see Figure 3).

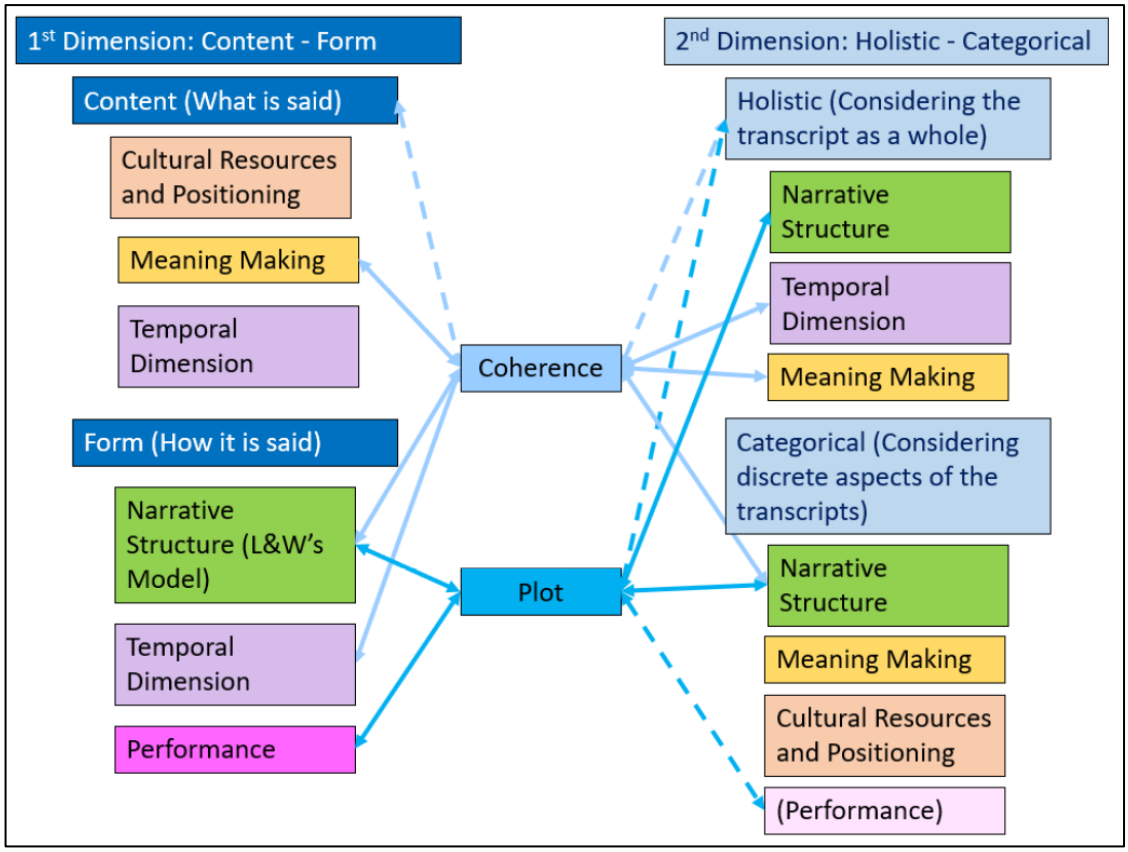

Figure 3: Interaction of Different Elements of Narrative Analysis Used in Relation to Lieblich et al.'s Two Dimensions of Narrative Analysis

Coherence

Coherence was a key consideration within the analysis. Coherent plots followed Labov and Waletzky's (1967) Structural Model of Narrative, they had a temporal dimensional, moving the listener from past to present, and experiences were ascribed meaning by the participants.

Characterisation, and identity, (Elliott, 2005) was examined. Participants' appraisals of their voices 'characters', and the impact of these appraisals on relationships was a focus here.

Story-summaries

Following Skippon's (2010) method, 'Story-summaries' were created for each participant, capturing the 'plot' of their story, using Labov and Waletzky's, (1967) model, reflecting the important turning points, participants' evaluation and sense-making, conclusion, and coda.

Inter-plot commonalities

Labov and Waletzky's (1967) model was used to identify commonalities in plot and structure at a holistic level. Again following Skippon's (2010) method, an 'over-arching storyline' or 'story-arc' was created, using the below levels of data-refinement (see Figure 4).

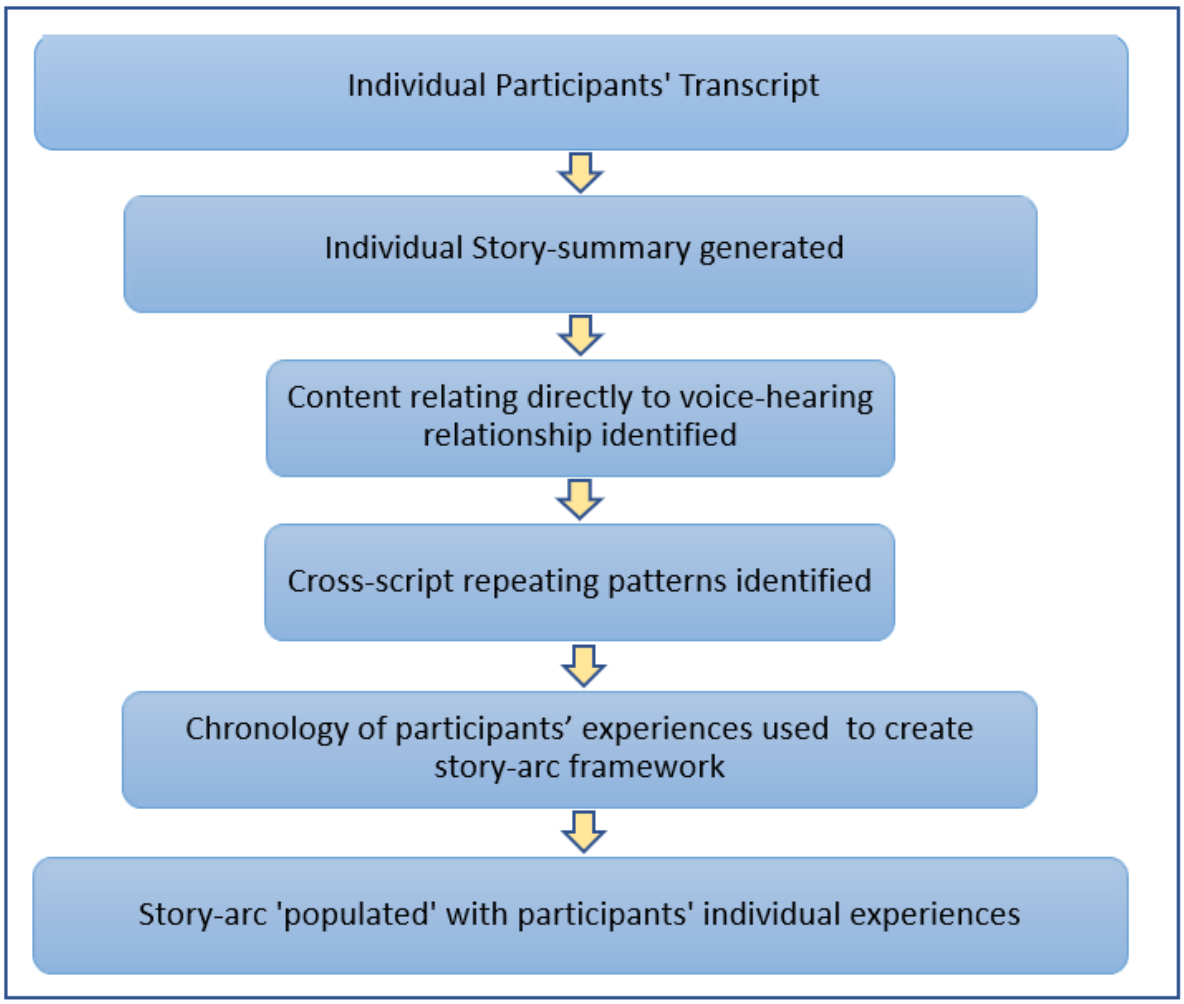

Figure 4: Illustration of Story-Arc Creation Process

The story-arc was a prototypical experience of voice-hearing, against which participants' different experiences could be mapped. It was "expressed in a series of chapters, each of which reflected significant plot developments. The transitions between chapters represented not chronological passage of time, but rather substantial shifts in the meaning of the events," (Skippon, 2010, s2-p9).

Results

Participant Involvement:

Engagement in interviews:

During the interviews the researcher kept largely silent, using minimal encouragers to support the flow of narrative and indicate her engagement in the process. Participants all engaged willingly with this process, however, Lee, Iain, Martin, and Sarah, needed prompting questions to support the telling of their stories. Sarah and Martin gave 'overviews' of their experiences, describing them in 'broad strokes', they then needed scaffolding questions to support the unfolding of more detailed narratives within the broad framework they initially described. Lee and Iain would often return to the present, describing their current (at the time of interview) experiences. Iain asked the researcher several times what her explanation for his experiences might be. She responded with reflective comments such as, "*it sounds really confusing*". Katie, Scott, and Eliza, all narrated their experiences with minimal or no further questions or comments from the researcher.

Responses to story-summaries:

Lee did not respond to follow-up contact but did not withdraw consent for the use of his data. Martin responded via brief email stating he was happy with his story-summary. Iain stated that his story-summary 'made him think about his experiences', and that he was happy with it in terms of reflecting his experiences. Katie, Scott, and Elisa, all felt that the story-summaries reflected their experiences. Elisa, who talks regularly about her voice-hearing, reported that it was the first time she'd seen her story 'as a whole' rather than as separate elements used to illustrate different parts of her voice-hearing experiences. Sarah reported

that overall it was accurate, however the ending (her current situation) had over-emphasised how positive things were, rather, she still found the voices very difficult.

Plot and Coherence

There were varying levels of coherence in participants narratives when evaluated through use of temporal plot development and ability to map narratives onto Labov and Waletzky's model, (see Table 2).

Table 2: Levels of Coherence across participants' narratives and development of relationship with voices

Level of coherence	***Participants***	***Development of Relationship with voices***
Coherent narrative created from single narrative-inducing question. Little or no further questions / comments needed. Could easily map the holistic narrative onto Labov and Waletzky's model.	Eliza	Had achieved what appeared to be a generally positive relationship with her voices, felt that the voices were an important positive aspect of her life.
	Scott	Had achieved what appeared to be a generally positive relationship with his voices, stated he was not sure if he would feel "cured" if the voices went (Line 239).
	Katie	Had achieved what appeared to be a generally positive relationship with her voices, stated that she thought that she would feel "lonely" if the voices went.
Able to give a broad overview of their experiences following the single narrative-inducing question. Needed 'scaffolding' questions to create more detailed narratives. Could map the holistic narrative onto Labov and Waletzky's model.	Martin	At time of research related to voices as "self-talk"
	Sarah	Had developed a more positive relationship with her voices, but stated in feedback discussion that although she felt they served a purpose in her life, she still often struggled with them
Unable to give coherent narratives from the single-narrative inducing question. Much of the interview told in	Lee	Unclear what his current relationship with voices really was like, and although he did describe a change in the voice-content, the development

Level of coherence	*Participants*	*Development of Relationship with voices*
present tense, describing current experiences. Prompting questions were needed to draw out somewhat confused backgrounds. Could not easily map a holistic narrative onto Labov and Waletzky's model.	Iain	of his relationship was less coherently narrated Had had a sometimes positive relationship with his voice, but confirmed in feedback discussion that he was very frustrated by it.

Coherence appears to mirror the positive development and change of participants' relationships with their voices. Participants who appeared to have the most coherent narratives appeared to have the most positive and psychologically coherent framework of understanding of their experiences. They also appeared to be the participants who most described their voice-hearing relationships as being positive aspects of their lives.

Cultural Resources and positioning, Performance

Availability of cultural resources played an important role in the explanatory-sense-making experiences of participants and impacted participants' relationships with their voices.

Eliza was never afraid of voice-hearing:

> *"[in] my teenage years, I read a lot, [of] Jungian psychology and [understood] my experience as part of ... my subconscious … expressing, itself through these voices,"* (Lines 143-145).

Lee used a supernatural explanation for some of his experiences,

> *"[I had] spirits coming to see me, and ghosts,"* (Line 265).

Iain rejected the supernatural position, but that left him with a medical-model understanding, or the 'folk-culture' interpretation of that:

> *"I don't think it's my twin[3],"* (Line 628).

> *"I'm either, schizophrenic, or I'm crazy*," (Line 82).

Different cultural understandings seem to have influenced different participants' beliefs regarding the possibility of creating relationships, which potentially influenced the subsequent development of those relationships.

The concept of having or increasing personal agency regarding voice-hearing did not appear to be a culturally available position to most participants. This seemed to become accessible only through therapy or contact with voice-hearing communities. Only limited and largely negative cultural positions (schizophrenic, mad, dangerous, unstable, ill,) appeared to be initially available to most participants,

Martin:

> *"…the paranoid schizophrenic diagnosis, … kind of, writes you off*," (Lines 105-106).

None of these positions were conducive to developing positive voice-hearing relationships, or believing this was possible. Only when alternative explanations became available did many participants' relationships begin to change:

[3] Iain had a stillborn twin brother

Sarah:

> *"I found out that I wasn't alone, other people had developed these relationships with the voices. … the more I came, the more I began to talk about me voices and open up, … it just seemed more and more feasible, that I could do this,"* (Lines 39-44).

Characterisation

Participants' characterisations of their voices (evil, well-meaning etc), seemed to map onto their changing relationships with them, this is explored in more detail in Chapter Three of the story-arc (below).

Holistic Analysis

A proto-typical story-arc was created from the participants' individual holistic narratives. Each participant's narrative can be followed through this story-arc, although they each experienced the different 'chapters' uniquely.

The Story-arc

Chapter One – First Experiences

All participants were able to recount their first experience of voice-hearing. However, their appraisals of this experience, and subsequent relationships with them were markedly different. Both Scott and Sarah started by hearing whispering, which then turned into voices. For Martin, Katie, Scott, and Sarah, it was a traumatic, frightening, or confusing experience. This seemed to set the tone for their relationships with their voices and their experiences continued in that manner for a significant period of time.

Martin:

"[there was] a lot of confusion at the start, not knowing what they were," (Line 47).

Katie concealed her experiences,

> *"I never told anybody that I was hearing voices, I'd worked out by now …. that this wasn't normal,"* (Lines 17-19).

Fear of the implications of voice-hearing marked Scott's first experiences:

> *"[I], kept it to meself cos … I've got a wife and, three kids, I don't want to end up locked up somewhere,"* (Lines 5-6).

Lee, Eliza, and Iain, had different first experiences. For Lee it was more akin to discovering an extra ability. Both Eliza and Iain had experienced voice-hearing or unusual communication in their childhood and experienced this positively. Eliza's early childhood was filled with communication with invisible friends. Then, aged nine, she started hearing voices in what could be considered a more 'traditional manner'.

> *"I started hearing, [a] critical voice and … a voice that … just constantly, describe[d], what I was doing,"* (lines 66-68).

Iain had had a voice in his childhood with whom he was,

> *"…very good friends,"* (line 217).

This voice stayed with him until his late teens. Iain's voice returned when he started a relationship with his current wife, and was derogatory towards her.

Chapter Two – Into the chaos

All the participants, however they initially experienced voice-hearing, appeared to find voice-hearing and/or the consequences of it brought at least some element of disruption, confusion, or chaos into their lives.

Scott's experiences,

> *"…bled into the real world,"* (Lines 173-174).

> *"I had like a, full breakdown, and were hearing loads of … different, voices, and then, I think wife finally had enough of me, … so I finished up living with me Mum and Dad …[then] they got fed up of me,"* (Lines 14-16).

Iain's wife moved into a separate bedroom to him. Distress over voice-content affected the mental-health of most of the participants. Katie,

> "*… got heavily into drug use, [to] escape from it," (Line 19).*

Sarah experienced extreme levels of paranoia due to what the voices told her,

> *"The voices were saying these people are out to get you, I believed … that the police were… following me all the time, … as a result, I would kick off with t'police sometimes, and I got arrested a few times … it just all got too much for me, … I remember, walking about, in my nightie, and leggings, like, four five o'clock in the morning, with me dog," (*Lines 71-75).

Martin found the voice-driven anxiety highly distressing:

> *"[I would] be having panic attacks from what I was hearing, … I remember going out at like five in the morning for a run in the snow, to try and cure the anxiety,"* (40-42).

Although Eliza experienced perhaps the least distress and chaos in relation to her voice-hearing, she described her experience in her teens as:

> *"…very chaotic … it was more the sort of, … surviving, … coping with my suicidality, .. was always a bigger issue, … …[it] was more [of a] problem than, the actual voices," (*Lines 161-165).

Narratives of this element of participants' experiences seemed largely to be filled with confusion, fear, and distress. Martin eloquently described his experience of confusion:

> *"…trying to make sense of it, it's like a hall of mirrors,"* (Lines 80-81).

Chapter Three – Meet the neighbours

The participants experienced their voices differently. As participants 'got to know' their voices, the voices seemed in many cases, to be entities separate from the participant, with different identities, personalities, opinions, and functions:

Martin:

> *"[There were] different personalities like a deity, it's like [a] goddess type thing, one said it was like an organ in my body [saying],*
>
> *"oh this is your heart speaking,"*

> *… There's ones with different forces behind them … you get the angelic kind, calming, reassuring compassionate, inner voice, but then you also have the opposite of that, the hostile, negative, scary, powerful, fierce-some voice,"* (Lines 78-91).

Lee:

> *"…they were people I knew, … old friends, distant relatives, close relatives, … they used to come over as good cop bad cop a bit, where one voice would want to fight, … the other'd just, help you out at every, chance they possibly could,"* (Lines 79-84).

Katie, Scott, Eliza, and Sarah, all heard voices with distinct personalities and they all came to name at least some of their voices. Scott had ten voices, but three key ones: Del, Max, and M'Lady. Sarah had Sherlock and Freddy, and then later, a voice that she only referred to as,

> *"…a good voice,"* (Line 34).

Katie had Edward-in-the-Wall, Rose, No Name, and Seela, who all arrived at different times. Eliza had numerous voices that came and went over the years. These included the Critical Voice, the Observer, Dee-mon, Domina, a Sea God, an invisible friend, and Aslan, her spiritual guide,

> *"[Domina's] very, keen, on, excitement, and adrenalin and, fun, … any sort of, intense experience, she's got, quite different values to me, but, she seems, to really like me … she doesn't understand things like tiredness, she thinks pain's great, I don't think pain is great,"* (Lines 350-358).

Apart from Lee, and perhaps, to a lesser extent Martin, all the participants' voices appeared to have their own separate identities, including inter-voice relationships:

Scott:

> *"Max and Del are always arguing and falling out, because, they both want me to, live me life a different way,"* (Lines 84-85).

Iain was the only one of these participants not to name his Voice, although it clearly had an existence of its own in Iain's mind. Iain described conversations, arguments, and the voice's clear, (and different to Iain's) opinion regarding his wife.

Chapter Four – The Unwanted Visitor

For all participants there seemed to be times, sometimes extended periods of time, when their voices were aggressive, threatening, or argumentative. Sarah, Scott, and Iain, all explicitly described times when they had wanted the voices to go,

Scott:

> *"It were me goal, to get rid of them,"* (Lines 230-231).

Lee's voices told him they would kill his children. Iain's voice was derogatory about his wife much of the time. Sarah found her voices, repeatedly telling her that she was in danger and being watched, frightening. Martin's voice constantly belittled him. Katie described Edward as,

"…evil to start with," (Line 117).

Eliza was the only participant who was explicit in never having wanted her voices to go. Rather, she found the time when she was on medication, which muffled them, very distressing:

> *"They help me function, the voices have always helped me navigate life … not being able to hear them was actually really confusing and really, destabilising,"* (Lines 236-240).

However, her description of Dee-mon indicates that she did not have an easy relationship with all her voices,

> *"Dee-mon … comes along when I'm very, overwhelmed, and she will, feed off it and she will happily make me more scared and more vulnerable … and more full of self-hatred,"* (Lines 336-337).

Chapter Five – Turning Points

Most of the participants had what could be considered significant turning points in their relationships with their voices. Although change was a slow process, Martin, Katie, Scott, Eliza, and Sarah, all described what could be considered turning points that changed their relationships with their voices.

Martin and Eliza both had 'internal' turning points in their attitude to the voices:

Eliza:

> *"The hearing voices network … was the first experience I had of people, taking an interest, in those experiences, in a curious, accepting, helpful, constructive way, …*

> *seeing the the voices were important, helped me … realise, that my way of relating to the voices had been very, … dismissive,"* (Lines 273-278).

> *"I ... decided to commit to change how I relate to, myself and to the voices, … within 24-hours of making that decision, three … voices … came to me and said 'we're so relieved that you made this decision because now, hopefully, we can express ourselves the way we'd like to,'"* (Lines 302-305).

Martin:

> *"[The] first step to recovery is believing you can recover, and, this was like a crucial point, for me,"* (Lines 108-109).

He started doing kickboxing and paying attention to the positive things in his life and,

> *"…everything just, flipped on its head,"* (Line 233).

He described therapeutic support that assisted with,

> "*…making sense of the bad stuff, [therapist]'s quite good at stuff like that, seeing things from a different perspective or an angle*," (Lines 251-253).

Scott and Sarah's turning points were attending group and doing voice profiling[4] and dialoguing[5].

[4] Profiling 'who' the voice is
[5] Talking to the voice

Scott:

> "*…the whole change really were me coming to this group, and … admitting I were hearing voices,*" (Lines 86-87).

For Katie it was work on a timeline that she did with her therapist which allowed her to relate changes in her voice-hearing to her external environment:

> *"The whole thing was very confusing, because I couldn't see a relationship at all between me and [the] voices, [and] what was happening in life, we wrote out… the timeline, an I began to see, … when [something] happened, the voices started doing something different, and that to me was a kind of epiphany,"* (Lines 279-297).

Whilst Lee and Iain have had some changes in their relationships with their voices, these do not appear to have been 'turning points' that led to the same sense of resolution or understanding that the other participants appeared to experience.

Chapter Six – Making friends

These turning points marked the start of a change for the better in participants' relationships with their voices. For most participants, the voices, at least at some point, became a source of comfort and/or wisdom.

Sarah found her 'good voice', would,

> *"…offer, little breathing exercises that I could do, so that helped, … he's not there all the time but when he does speak to me he's really comforting,"* (Lines 294-299).

Martin:

> *"…the self-deprecating voice [said] 'I'm proud of you, for going [to kickboxing] today' so it turned from, like a self-discriminating voice, to self-praisal,"* (Lines 140-142).

Eliza found her voices helped her connect with her spirituality, while Max became Scott's

> "*best friend,"* (Line 40).

Although Iain had not had the same turning point as the other participants, he described supportive conversations with his voice after his brother died:

> *[Voice] "'you'll be alright mate, don't worry about it … talk to me, … We'll get through it,'*
>
> *[Iain] 'you mean I'll get … through it',*
>
> *[Voice] 'nope,* <u>we'll</u> *get through it,'"* (Lines 555-558).

Lee was the only participant who seemed to have found least support or benefit coming from at least some element of the relationship he had with his voices; however, he did talk positively about seeing ghosts and spirits as part of his unusual experiences,

> *"…these, spirits and stuff appear, and try to communicate with you, and, they're all about your house and … they're really surprised that I can see them yeah? And I* <u>love</u> *it, I* <u>absolutely</u> *love it, my life would be boring without it," (Lines 261-263).*

Epilogue – Living with the voices

At the time of interviews, all the participants were still hearing voices. Their attitudes towards their voices ranged from complicated to positive. Eliza and Scott were clear that they did not want their voices to go. Lee was perhaps the least ambiguous about wanting his voices to go,

> *"It'll never go, I don't want them to go, but it's fading away, … I'm hopeful that it will reach a point, .. where it was, .. for the 20 years before I started noticing that I was hearing them …"* (Lines 43-45).

He also stated,

> *"I'm missing some [voices] already, and I'm glad that some are gone," (Lines 237).*

> *"If you put the positive and the neutral together, they definitely outweigh the negative now, whereas before, it was very negative,"* (Lines 23-25).

Iain expressed ambiguity,

> *"He's my friend. I treat him as a friend, … I think he's I think he's fucking great me, when he's, not going on about [my wife], because … I really don't, like that,"* (Lines 363-367). *"I would like it to stop, but then again, if it did stop, I might be heartbroken,"* (Lines 671-672).

Sarah still finds the voices really difficult to live with a lot of the time, and is still learning to communicate with them. She did describe having rare times of companionship,

> *"…we have, regular programmes that we watch now, and Freddy likes the soaps, so I watch soaps, … it's like living with two people,"* (Lines 339-340).

She described still trying to reach a point of balance with her voices. However, she still felt that,

> *"I wouldn't want them to go away now, because they help me,"* (Lines 55-56).

Katie:

> *"…it's been a journey really, … from hearing that first voice, Edward, the first time in school, .. it's been, one tremendous journey of … discovery,…It sounds strange, but I hope they don't [go]. I think I'd be lonely. I think I'd almost feel, 'Why have you left me? That's not fair. What did I do wrong?'"* (Lines 412-417).

Scott:

> *"To be honest, … if mine went, I'd be quite, … upset. … it'd be like losing friends in a sense. I … would definitely miss them, and I don't even know if I'd see meself as cured,"* (Lines 232-239).

Martin had moved furthest from the voice-hearing experience:

> *"I say now, it's just, … self-talk, I see it as now, me talking to myself,"* (Line 49).

Holistically, the participants' narratives appeared to follow a sequence over time, however, time spent at different 'chapters' varied. Notably, although Iain and Lee have had relationship changes, they do not appear to have had the 'turning point' that set their voice-hearing relationships on a new trajectory in the way that other participants had.

Discussion

The creation of the story-arc demonstrates that all the participants in this research had, to differing degrees, relationship developments with their voices. However, participants did move differently through the story-arc, and for some, the changes they experienced were less driven by agency than circumstance. Table 3 (below), describes the types of change-promoting events and relationship developments.

Table 3: Change-promoting events and relationship development

Type of change-promoting event	***Types of relationship development***	***Participants***
Proactive change by participants regarding how they related to their voices,	Voice-content changed. A more positive relationship developed	Martin Eliza Scott (Katie)
The voice-content changed,	How the hearer related to their voice changed, leading to a change in relationship that reflected the positivity or negativity of the voice content	Iain Lee
The participant changed their appraisal of the voices (voice content did not appear to change greatly),	The participant was able to 'make peace' with the voices and not become so distressed by them.	Sarah Katie (in relation to Edward)

Martin changed how he related to himself, and how he lived his life, this led to a positive change of voice-content for him. Eliza changed how she related to herself and her voices, again leading to improved relationships. Scott's use of voice-profiling and dialoguing led to positive changes in voice-content and improved relationships. Katie's understanding via the timeline, that the voice-content related to external events created "*an epiphany*" that reframed her understanding of her voice-hearing experience. Her voice Rose became less critical and more concerned for Katie's well-being.

For Iain and Lee the voice-content appeared to drive the relationship change. Iain had been friends with his voice as a child, but when it became derogatory about his wife, the relationship became argumentative much of the time. Lee's relationship with his voices appeared to improve over time, with the voices changing from threatening the lives of his children to asking about his shoe choice (Lines 179-180). Lee struggled to articulate what may have precipitated this change.

Sarah's voices still appear to have similar preoccupations to when they first manifested, as does Edward for Katie. However, both seemed able to perceive a protective intention behind their voice-content, enabling them to feel that the voices have a positive purpose.

Consistent with France and Uhlin's research (2006), the results indicate that voice-relationship development does not appear to occur in a vacuum. Whilst the reason for different voice-content is not always clear, voice-relationship development appears to be due to a complex interaction between voice-content, inner appraisals, external influences (how others perceive voice-hearing), and important life changes.

Therapy or group support appears important in facilitating change-promoting events. It seemed to play a key role in the turning points for Martin, Katie, Scott, and Sarah. Although Eliza's relationship with her voices was perhaps always the least problematic of all the participants, she still noted that attending group facilitated her turning point. It is unclear from Lee's narrative how therapy has influenced his voice-hearing relationships, and he did not describe anything that appeared to be a 'turning point'. However, from the change in voice-content described above, it would not seem unreasonable to attribute some of that level of change to the therapy he received. Only Iain had not received psychological support,

which perhaps explains his repeated question, "*am I schizophrenic or am I mad?*" and the lower level of positive relationship-change he has experienced comparative to the other participants.

Consistent with Corstens, et al.'s, (2014) and France and Uhlin's (2006) work it appears that the different opportunities for participants to explore their experiences were important regarding their ability to develop a coherent, positive framework of understanding of their experiences. This seemed important in the development of more positive voice-hearing relationships. It was possible to see therapeutic influences on participants. Martin had re-framed his experiences with the help of his therapist. Katie's therapist introduced to her the idea of the 'well-meaning but not very helpful' character of Edward, which allowed her to reframe her experience of him. Scott, Eliza, and Sarah, all attended a Hearing Voices Network Group, which allowed them a positive framework of engagement with their voices and a meaning-making space that encouraged dialogue and positive relationships with their voices. France and Uhlin, (2006) note that narratives *"[help] people to deconstruct oppressive narratives and generate alternative stories which allow for better function and higher degrees of agency,*" (p54). Therapeutic spaces can potentially be seen as opening access to new cultural narratives, and facilitating narrative changes that allowed positive relationship development for most of the participants in this research.

Strengths and Limitations

Strengths

Using Narrative Analysis (NA) created rich and detailed data with which to work. The use of NA illuminated a link between having the space and audience with which to create and explore a narrative, and the creation of a more positive voice-hearing relationship and sense

of identity as a voice-hearer. The chronological aspect of NA supported the exploration of relationship development over time. However, perhaps the greatest strength of the research was in its collaborative and co-creative philosophy. Returning to participants with initial story-summaries allowed a degree of confidence in the fidelity of the story-summaries, and privileged the participants' voices.

Limitations

Using a single narrative-inducing question meant that there were potential areas of interest that could not be followed up. It was not possible to ask participants what was happening in their external lives during points of voice-hearing change if they did not articulate this. Whilst NA has a chronological aspect to it, the narratives did not tend to give clear timescales. Although the narratives had a sense of time, it was not possible to ascertain accurately how long different participants spent at different 'chapters' in the story-arc.

The range and number of participants is a limitation. A lot of voice-hearers can, for a range of reasons, be very reluctant to discuss their voice-hearing, and thus were self-excluded from the research; their experiences and story-arcs could be very different to the one found here.

Clinical Implications

This study indicates that voice-hearing relationships develop over time. For all the participants the relationships changed and developed over years. Katie, Scott, and Sarah, all explicitly referenced the positive relationship changes occurring over a period of years, not weeks or months. This would suggest that therapeutic interventions may need to follow a client over a period of years. It may, or may not, be necessary for that to be regular contact; however, it appears that clients would benefit from being allowed time and space in which to

explore and develop more positive relationships. This contrasts with NICE guidelines (CG178, 2014), which talk of 10 Family Intervention sessions and 16 Cognitive Behavioural Therapy sessions.

For most participants it appears that the narratives of agency regarding voice-hearing, and the possibility of developing positive relationships with their voices, were not initially available. The participants who appeared most at ease with their current voice-hearing experiences were those who seemed to have discovered, through therapeutic interventions and having positive voice-hearing relationships role-modelled in front of them, that positive voice-hearing relationships were possible. Consistent with Jackson et al.'s (2010) research, this would suggest that introducing narratives of agency regarding voice-hearing, and the possibility of developing more positive voice-hearing relationships would be clinically helpful.

Participants experienced parallel difficulties to those identified by Freeman et al.,'s (2004) research into delusions and the availability of alternative positions. Only highly stigmatised cultural positions (mad, schizophrenic, dangerous, to be "*locked up*", ill, all positions referenced by the participants) seemed initially available to most of the participants. As Baerger and McAdams, (1999) stated, "people rely on the narrative archetype in order to translate their personal histories into meaningful stories and unified identities," (p70). The negative voice-hearing narratives available to most participants potentially cut them off from their families and wider community and may have prevented them from developing relationships with their voices, or even being able to access that possibility as a concept. This appears to have had a potentially profound impact on the initial creation of relationships with voices. This would suggest that the creation of different voice-hearing identities and

narratives would be important clinically and at a public health information campaign strategy level.

Future Research:

The number of ambiguous-to-positive voice-hearing attitudes related by participants does not appear to be a representative experience of voice-hearers. Research into levels of positive attitudes, changes in attitudes over time, and the relationship between changes in attitude, therapy, and availability of alternative cultural positions and social-networks (audiences with shared positive voice-hearing narratives) could help identify therapeutic approaches or social narratives that support these changes.

Further research on how people develop their voice-hearing appraisals when they first started hearing voices, and what led to the formation of those initial appraisals would be helpful. This would help inform early interventions and anti-stigma campaigns.

It would be helpful to repeat this research with participants who have very malevolent voices, to see if their story-arc differs, or if they are 'stuck' at the 'unwanted visitor' stage of the above story-arc. If this were so, how people can be helped to move further along the story-arc would be the next step of that research.

References

Baerger, D. R., & McAdams, D. P. (1999). Life Story Coherence and It's Relation to Psychological Well-being. *Narrative Inquiry*, *9*(1), 69–96.

Banister, P., Cooper, T., Goodley, D., Hastewell, J., Hollway, W., Lawthom, R., Le Voic, M., et al. (2007). *Exploring Psychological Research Methods*. (G. Pike & D. Miell, Eds.). Milton Keynes: The Open University.

Beavan, V., de Jager, A., dos Santos, B., Jager, A. De, & Santos, B. (2017). Do peer-support groups for voice-hearers work ? A small scale study of Hearing Voices Network support groups in Australia

Do peer-support groups for voice-hearers work ? A small scale study of Hearing Voices Network support groups in Australia. *Psychosis*, *9*(1), 57–66. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2016.1216583

Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L., et al. (2014). Cognitive behaviour therapy to prevent harmful compliance with command hallucinations (COMMAND): A randomised controlled trial. *The Lancet Psychiatry*, *1*(1), 23–33. Elsevier Ltd. Retrieved January 7, 2019, from http://dx.doi.org/10.1016/S2215-0366(14)70247-0

Bruner, J. (2004). Jerome Bruner Life as Narrative. *Social Research*, *71*(3), 691–710.

Byrne, S., Trower, P., Birchwood, M., Meaden, A., & Nelson, A. (2003). Command Hallucinations: Cognitive Theory, Therapy, and Research. *Journal of Cognitive Psychotherapy*, *17*, 67–84.

Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness Groups for Distressing Voices and Paranoia: A Replication and Randomized Feasibility Trial. *Behavioural and Cognitive Psychotherapy*, *37*, 403–412. Retrieved January 4, 2019, from https://www-cambridge-org.ezproxy.bangor.ac.uk/core/services/aop-cambridge-core/content/view/3C7536DDEC1E04D57384A2D580DDEF1B/S1352465809990166a.pdf/mindfulness_groups_for_distressing_voices_and_paranoia_a_replication_and_randomized_feasibility_trial.pdf

Chin, J. T., Hayward, M., & Drinnan, A. (2009). "Relating" to voices: Exploring the relevance of this concept to people who hear voices. *Psychology and Psychotherapy: Theory, Research and Practice*, *82*(1), 1–17.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: Implications for research and practice. *Schizophrenia Bulletin*, *40*(SUPPL. 4), 285–294. Retrieved January 7, 2019, from https://academic.oup.com/schizophreniabulletin/article-abstract/40/Suppl_4/S285/1873862

Craig, T. K. J., Rus-Calafell, M., Ward, T., Leff, J. P., Huckvale, M., Howarth, E., Emsley, R., et al. (2018). AVATAR therapy for auditory verbal hallucinations in people with psychosis: a single-blind, randomised controlled trial. *LANCET PSYCHIATRY*, *5*(1), 31–40. Elsevier. Retrieved January 20, 2019, from http://www.ncbi.nlm.nih.gov/pubmed/29175276

Dannahy, L., Hayward, M., Strauss, C., Turton, W., Harding, E., & Chadwick, P. (2011). Group person-based cognitive therapy for distressing voices: Pilot data from nine groups. *Journal of Behavior Therapy and Experimental Psychiatry*, *42*(1), 111–116. Elsevier Ltd. Retrieved from http://dx.doi.org/10.1016/j.jbtep.2010.07.006

Elliott, J. (Barbara J. (2005). *Using narrative in social research : qualitative and quantitative approaches*. London ; Thousand Oaks: SAGE.

England, M. (2008). Significance of cognitive intervention for voice hearers. *Perspectives in Psychiatric Care*, *44*(1), 40–47.

France, C. M., & Uhlin, B. D. (2006). Narrative as an outcome domain in psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*, *79*(1), 53–67.

Freeman, D., Garety, P. A., Kuipers, E., Bebbington, P. E., Fowler, D., & Dunn, G. (2004). Why do people with delusions fail to choose more realistic explanations for their experiences? An empirical investigation. *Journal of Consulting and Clinical Psychology*, *72*(4), 671–680.

Van Der Gaag, M., Van Oosterhout, B., Daalman, K., Sommer, I. E., & Korrelboom, K. (2012). Initial evaluation of the effects of competitive memory training (COMET) on depression in schizophrenia-spectrum patients with persistent auditory verbal hallucinations: A randomized

controlled trial. *British Journal of Clinical Psychology*, *51*(2), 158–171. British Psychological Society. Retrieved January 7, 2019, from www.wileyonlinelibrary.com

Hayward, M., Jones, A.-M. M., Bogen-johnston, L., Thomas, N., & Strauss, C. (2017). Relating Therapy for distressing auditory hallucinations: A pilot randomized controlled trial. *SCHIZOPHRENIA RESEARCH*, *183*, 137–142. Elsevier B.V. Retrieved from http://dx.doi.org/10.1016/j.schres.2016.11.019

Hazell, C. M., Hayward, M., Cavanagh, K., Jones, A. M., & Strauss, C. (2018). Guided self-help cognitive-behaviour Intervention for VoicEs (GiVE): Results from a pilot randomised controlled trial in a transdiagnostic sample. *Schizophrenia Research*, *195*, 441–447. The Authors. Retrieved from https://doi.org/10.1016/j.schres.2017.10.004

Holt, L., & Tickle, A. (2015). "Opening the curtains": How do voice hearers make sense of their voices? *Psychiatric Rehabilitation Journal*, *38*(3), 256–262.

Jackson, L. J. ., Hayward, M., & Cooke, A. (2010). Developing positive relationships with voices: A preliminary Grounded Theory. *International Journal of Social psychiatry*, *57*(5), 487–495. Retrieved May 20, 2019, from https://journals-sagepub-com.ezproxy.bangor.ac.uk/doi/pdf/10.1177/0020764010368624

Labov, W., & Waletzky, J. (1967). Narrative Analysis: oral versions of personal experience. In J. Helm (Ed.), *Essays on teh Verbal and Visual Arts* (pp. 12–44). Seattle: University of Washington Press.

Leff, J., Williams, G., Huckvale, M. A., Arbuthnot, M., & Leff, A. P. (2013). Computer-assisted therapy for medication-resistant auditory hallucinations: Proof-of-concept study. *British Journal of Psychiatry*, *202*(6), 428–433.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research : reading, analysis and interpretation*. Applied social research methods series ; v. 47. Thousand Oaks, Calif: Sage Publications.

Longden, E. (2013). The voices in my head. *Ted Talks*. Retrieved February 17, 2019, from https://www.ted.com/talks/eleanor_longden_the_voices_in_my_head

Longden, E., Read, J., & Dillon, J. (2018). Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups. *COMMUNITY MENTAL HEALTH JOURNAL*, *54*(2), 184–188. Institute of Psychology, Health and Society, University of Liverpool, Liverpool, United Kingdom Eleanor.Longden@gmw.nhs.uk; School of Psychology, University of East London, London, United Kingdom ; National Hearing Voices Network, Sheffield, United Kingdo: Springer. Retrieved from https://search.proquest.com/docview/1914295080?accountid=14874

Louise, S., Rossell, S. L., & Thomas, N. (2018). The acceptability, feasibility and potential outcomes of an individual mindfulness-based intervention for hearing voices. *Behavioural and Cognitive Psychotherapy*. Cambridge University Press. Retrieved from https://search.proquest.com/docview/2068607960?accountid=14874

Mawson, A., Berry, K., Murray, C., & Hayward, M. (2011). Voice hearing within the context of hearers' social worlds: An interpretative phenomenological analysis. *PSYCHOLOGY AND PSYCHOTHERAPY-THEORY RESEARCH AND PRACTICE*, *84*(3), 256–272.

Murray, M., & Sargeant, S. (2011). Narrative Psychology. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A guide for students and practitioners*. Chichester: John Wiley & Sons.

National Institute for Health and Care Excellence, (NICE). (2014). *NICE Guidelines CG178 - Psychosis and schizophrenia in adults: choice and schizophrenia in adults: prevention and management*

Clinical guidelines, Reviewed November 2017. Retrieved from https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

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 hallucinations. *Schizophrenia Research*, *109*(1–3), 52–59. Elsevier B.V. Retrieved from http://dx.doi.org/10.1016/j.schres.2008.12.009

Perona-Garcelán, S., Bellido-Zanin, G., Rodríguez-Testal, J. F., López-Jiménez, A. M., García-Montes, J. M., & Ruiz-Veguilla, M. (2016). The relationship of depersonalization and absorption to hallucinations in psychotic and non-clinical participants. *Psychiatry Research*, *244*, 357–362. Elsevier. Retrieved from http://dx.doi.org/10.1016/j.psychres.2016.08.015

Peters, E., Ward, T., Jackson, M., Morgan, C., Charalambides, M., McGuire, P., Woodruff, P., et al. (2016). Clinical, socio-demographic and psychological characteristics in individuals with persistent psychotic experiences with and without a "need for care." *World Psychiatry*, *15*(1), 41–52.

Phoenix, C., Smith, B., & Sparkes, A. C. (2010). Narrative analysis in aging strudies: A typology for consideration. *Journal of Aging Studies*, *24*(1), 1–11.

Riessman, C. K. (1993). *Narrative Analysis*. London: SAGE Publications Ltd.

Schizophrenia Commission, T. (2018). *The Schizophrenia Commission Progress report: Five Years On*. Retrieved April 25, 2019, from https://www.rethink.org/media/3190801/the-schizophrenia-commission-progress-report-five-years-on.pdf

Schnackenberg, J., Fleming, M., & Martin, C. R. (2017). A randomised controlled pilot study of Experience Focused Counselling with voice hearers. *Psychosis*, *9*(1), 12–24. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2016.1185452

Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliff, K., Larner, C., et al. (2012). A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. *Behaviour Research and Therapy*, *50*(2), 110–121. Elsevier Ltd. Retrieved from http://dx.doi.org/10.1016/j.brat.2011.11.007

Skippon, R. H. (2010). *A Narrative Exploration of Being a Parent After Childhood Experience of Being In Care*. Lancaster.

Wengraf, T. (2001). *Qualitative Research Interviewing Biographic Narrative and Semi-Structured Methods.* London: SAGE Publications.

Contribution to Theory and Clinical Practice

Implications for future research and theory development

There are some clear areas for further research following the research discussed in the empirical paper. Overall, the participants in the research had received a lot of therapy, albeit from different sources. It would be interesting to repeat this research with different voice-hearing populations (non-clinical voice-hearers; voice-hearers who have received no, limited, or short-term only psychological interventions; voice-hearers whose voices are powerful and/or malevolent). There would be several key points of comparison:

- What voice-hearing positions and identities had they found?
- What explanations for their experiences had they developed?
- Did their experiences follow the story-arc, or some part of it?
- How coherent were their narratives?

It would be useful to identify how these different voice-hearing populations map onto the story-arc.

When further researching the generalisability and utility of the story-arc there are several different lines of research that would be helpful:

- A longitudinal study following relationship-development in a cohort of participants, starting when they are first identified as having a 'First Episode of Psychosis' or disclose voice-hearing, and continuing over an extended period of years (when looking at the time-frames from the research above, a minimum of ten-years).

- Quantitative research, developing questionnaires or semi-structured interviews to investigate whether voice-hearers would:
    - agree with the relationship-development described in the story-arc;
    - be able to identify their journey through the different 'chapters' of the story-arc;
    - find, or have found, the story-arc helpful in making sense of their experiences;

  How different voice-hearing populations responded would be an important element of this research.

When synthesising information from the literature review and empirical paper, one thing of note from the literature review is that in some studies, some patients reported either significant reduction of voice-hearing experiences (Dellazizzo et al., 2018; Stefaniak et al., 2017) or cessation of voice-hearing following therapy (Cichocki et al., 2016; Leff et al., 2013). Research into identifying what differentiates this voice-hearing population from those whose voices remain, regardless of treatment (therapeutic or pharmacological), would be useful. Different therapeutic approaches may be indicated for these different populations. As there is a link between psychotic or voice-hearing experiences and trauma (Ison et al., 2014; Longden et al., 2012; NICE Guidelines CG178, 2014; Seedat et al., 2003), one hypothesis would be that those whose voices 'disappear' with therapy are experiencing something more akin to PTSD-type trauma memories. When considering *how* to identify these different populations, one consideration might be the 'entity-ness' of the voice: In the empirical paper, one thing that came through strongly was the sense of voices being 'entities' in their own right. They had names, they had clear opinions and 'agendas', in that they often wanted specific behaviours out of their 'hearers'. They had their own 'ideas' and 'attitudes', Katie

and Eliza referenced drawing them. An interesting hypothesis to investigate would be if there is a relationship between the 'entity-ness' of a voice in people whose voices remain with them, and people whose voices cease with therapy.

Taking the two papers together, a second theme that emerged was the differing timescales. Many of the interventions described in the literature review were (relative to the voice-hearing experience) short. The notable exceptions were: the Hearing Voices Network Groups (HVNG), which were open-ended; Carter and Wells', (2018), Attention Training Technique, which was a Single Case Series lasting 80 weeks; and Salvatore, et al.'s, (2016) Meta-cognitive Interpersonal Therapy, a single case study, with an intervention of 18 months. The remaining intervention timescales ranged from a one-off rescripting session, (Ison et al., 2014), to 6 x 30 minute sessions and one follow-up session (Leff et al., 2013), to 44 sessions (Schnackenberg, et al., 2017). Excluding the open-ended interventions, Carter and Wells' Single Case Series, and Salvatore et al.'s single case study, the remaining 28 interventions reviewed had a mean of 13 sessions. This contrasts with participants in the empirical paper, who described relationship changes that took place over years. Further avenues of research stemming from this would be:

- Much longer follow-up periods for research into therapeutic interventions
- Qualitative research asking participants about what they feel have been the important post-therapy changes; how they feel about these changes
- A longitudinal study into voice-hearing relationship development post-intervention
- How different therapies impact on the story-arc and progression timescales. It could be helpful to investigate whether different therapies shorten the length of time spent

at different 'chapters' or, potentially, lengthen it, or divert people into a different 'story-arc'.

Clinically-based Research

Some of the interesting information generated by the empirical study would bear investigating in a clinical research setting.

Naming:

Naming voices often appeared to have some significance for the participants. Names frequently seemed to reflect the character, and/or some element of the function of the voices. Scott, talking about how he named Max, gives insight into naming decisions:

> "I actually used to call him Mad Max, as from the, films, and, over the course of time, … I ditched the Mad, and, Max is like, my internal alarm system, he can suss people out, he's really like, really aware of the surroundings really aware of people, very protective towards me, an, it's like, it's like he's, become me best friend," (Lines 38-42).

In the follow-up discussion with Katie, her voice-naming choices were discussed, including that No Name had not been given a 'name' in the traditional sense. She stated:

> "*With the other two it wasn't really a choice. I can remember asking Edward,*
>
> *'Who are you?'*
>
> *and he said,*
>
> *'I'm Edward-in-the-wall'.*

> *Rose, it was a feeling I got. With No Name I didn't get a feeling for a name at all, and if I ask for a name, he cries. He's like an anonymous child inside me*," (from notes made during follow-up conversation).

Katie stated that she does not even particularly like the name Edward. She stated that she knows that:

> *"The voices are something I create in my own head. That was the answer I got when asked,"* (From notes taken in follow-up conversation).

Interestingly, Sarah did not choose Sherlock's name, another group member suggested it, however, naming the voice appeared to help Sarah to start to interact with Sherlock in a more pro-active manner:

> "*At first I felt really silly about [voice-dialoguing], and I thought how, 'how did you manage to talk to voices? They don't really listen.' But, the more I came, [to group] the more I began to talk about my voices and open up, and David*[1] *… were very very open about his voices, and … he talked to them in front of me, and it just seemed more and more feasible, that I could do this, and the voice that were always, eager about, security and safety, he gave him a name, called Sherlock, because, he'll be quiet if I watched crime thrillers and stuff like that on the telly, … and, I were enjoying the peace and quiet, and then because he were called Sherlock then, started to react, I said,*
>
> *'Do you like, being called Sherlock?'*

[1] Pseudonym

and he said

'Yeah I do, yeah,'

and I were like,

'Oh god, he's spoken back to me,'" (Lines 40-49).

Naming has long been held to have cultural significance, with some cultures holding beliefs regarding the power of name-giving, (Charles, 1951). Exploring the names of voices with clients may be of clinical benefit for the client: How did the voice get its name? What does the name mean to the voice? What does the name mean to the client? If the voice does not have a name, would it be helpful to give it one?

This is where clinical research may be helpful to ascertain whether naming a voice gives a sense of control over the voice, or makes it seem more 'knowable' and less alien? Alternatively, it may give the voice a sense of entity or agency that the hearer does not wish the voice to have. However, Sorrell, et al., (2010), found "distress was significantly associated with perceptions of the voice as dominating and intrusive, and hearers distancing themselves from the voice," (p127), and Romme and Escher (2000), argued that "intimacy is important in the relationship with voices, and that the acceptance and development of intimacy, the very opposite of distancing, is one strategy that may lower distress." (Sorrell, et al., 2010, p136). This suggests that naming, or exploring the name, may be a way of 'moving towards' the voice, and creating a sense of 'intimacy' that supports the development of positive voice-hearing relationships.

Implications for clinical practice

Approaches to the Voices:

Perhaps unsurprisingly, when considering the researcher's reflexive statement, and that three of the participants were from a Hearing Voices Network Group, one of the implications for clinical practice would be to support working with the voices as meaningful constructs. For those voice-hearers for whom voice-hearing appears to be an on-going experience, this may be the most helpful way to help them live alongside, rather than 'at war with', their voices. This is supported by pre-existing research (Corstens et al., 2014; Dillon & Hornstein, 2013; Longden et al., 2018a; Schnackenberg et al., 2018), and the experience of four of the participants of this study. All of the participants of this study, at the time of interview were either positive about wanting the voices to remain in their lives, or ambiguous. None of them were definite in positively wanting a cessation of voice-hearing. It should be noted that this was not the case for most of the participants at certain points in their voice-hearing journey, and that many voice-hearers find their voices highly distressing (Dillon & Hornstein, 2013; Ruddle et al., 2011; Strauss, Thomas, & Hayward, 2015); however, if voices 'are determined to remain' then exploring their 'entity-ness', either through voice-profiling, voice-dialoguing, or other therapeutic approaches such as the Compassion-Focused Therapy approach to voice-hearing (Heriot-Maitland, et al, 2019) may be a helpful clinical approach.

Use of narrative:

Taking into consideration the voice-hearing distress reported in the literature, and the original aims of several of the participants from the empirical paper (to "get rid" of the voices), it would seem reasonable to suggest the likelihood that many clients would enter therapy hoping for the cessation of voice-hearing. However, the research indicates that this is a rare

occurrence in terms of outcomes. Clinically, it could be helpful to support clients to consider what their optimal outcomes might be in the absence of voice-cessation. Introducing narratives that create a sense of hope, agency, relationship-change, and the possibility of creation of positive voice-hearing relationships may assist with this. The importance of agency in recovery from psychosis has been noted previously in the literature (Bassman, 2000; Holma & Aaltonen, 1997). This would suggest that agency in voice-hearing recovery would be equally important.

Being able to form a narrative coherently has been associated with positive mental health (Baerger & McAdams, 1999). In the empirical paper, there did appear to be some relationship between participants abilities to narrate their voice-hearing experiences coherently, and their integration of those experiences into their lives. Clinically, a client's ability to narrate their voice-hearing story coherently could be a helpful measure of the client's positive integration of their voice-hearing experiences into their lives. As the client moves towards 'well-ness', their voice-hearing narratives should become more coherent. There has been the development of an assessment tool to support this, the Scale To Assess Narrative Development, (STAND) (Lysaker er al., 2003). STAND allows "raters to assess narrative changes seen over time in the dimensions of social worth, social alienation, personal agency," (France & Uhlin, 2006, p57). Consideration of the use of STAND, or more informal assessment of narrative change over time would be a helpful clinical resource.

Helping the client to create a coherent and meaningful narrative could be helpful as part of a clinical intervention. This is the basis for Narrative Therapy. For most of the participants, their voice-hearing experiences were, at least initially, untold stories. The stigma and fear surrounding voice-hearing means that at least some voice-hearers conceal, at least for a time,

their voice-hearing experiences. When they do share them, the dominant narratives subsequently encountered may well be biologically-based, leading to a diagnosis of schizophrenia, with pharmacological interventions, or social-cultural, the 'mad and dangerous' narrative. This means that there is very little space for different voice-hearing narratives and identities. Stories are social in nature, yet there is very little social space for the safe telling of clients' stories, and stories are part of our sense-making of the world. Therefore, providing that safe-space to explore and create different voice-hearing narratives and identities may be clinically beneficial. NICE guidelines (CG178, 2014) recommend Family interventions for as part of the clinical guidance for psychosis. Introducing more hopeful and empowering narrative into the family setting and close social networks would further strengthen the creation of these narratives for the voice-hearer. Further, the introduction of these narratives into the voice-hearer's family would likely be a source of support and hope for the family themselves, and potentially reduce any sense of hopelessness or helplessness that they may be experiencing.

Using the Story-Arc:

Should further research support the validity of the story-arc, it could be of use to clinicians in different elements of an intervention as discussed below.

Assessment and Formulation

The story-arc could potentially help clinicians assess which 'chapter' their clients are on, where are they in their voice-hearing journey? The story-arc, especially the first four 'chapters', could also be a helpful framework as part of formulating a client's voice-hearing difficulties. What are their unique experiences of each 'chapter'? What are their initial

experiences and what sense did they make of it? What chaos has resulted from voice-hearing? Who are the voices? What are they like? What do they want?

Seeing where a client is on their journey through the story-arc could aid in identifying the best intervention to help the client move onto the next 'chapter'.

Intervention

Participants who had made more sense of their experiences related their stories in a much more temporal manner, moving from past to present in a coherent arc. Participants who had made less sense of their experiences and were less able to 'tell their story', spent a lot more time narrating in the present tense, describing their experiences as they currently were. They did not have a coherent story-arc of their experiences to tell. This is consistent with the previous findings in the literature: "The authors suggest that acute psychosis is accompanied by an inability to order within time and narrate such experiences [which] disrupts one's sense of identity, impairs agency, and leaves the ill person trapped in an unstructured, chaotic present." (France & Uhlin, 2006, p61). The story-arc identified in the empirical paper, may be a useful framework to help clients to create structure and coherence regarding their experiences. It may also help create a sense of 'movement' or journey for clients, rather than a sense of 'stuck-ness'.

Approaches to voice-hearers:

Perhaps one of the most important clinical implications to emerge from the participant interviews comes when thinking about how to relate to voice-hearers:

Some of the participants experienced quite invalidating approaches to voice-hearing. Scott was told not to pay attention to or 'validate' his voices (information from follow-up interview). Katie found the medication did not help in relation to her voices,

> *"[it didn't] matter, what antipsychotic medication they put me on, they were still there, and, for years I had this awful experience with clozapine, every time I saw the psychiatrist it was like,*
>
> *'Are you still hearing voices?'*
>
> *And I'd think,*
>
> *'Yes,'*
>
> *'Right, we're putting the clozapine up.'*
>
> *And in the end I was on 750 milligrams a day, of the stuff, and I'd still [be] hearing voices, it, dampened everything down, it made it impossible to feel any kind of emotion, .. I don't think there's a crueller drug on this earth, you know, it, but it, didn't stop the voices*," (Lines 322-327).

In the follow-up conversation Katie related how a friend with psychosis has found the medication very beneficial, so it is important to find the correct intervention, including pharmacological, for each client.

Voice-hearing can become an 'over-shadowing' experience, as it became for Eliza:

> "*I tried to, get hospitalised, … and I found that, I didn't get, I wasn't take seriously, by, services 'til I told them that I'd heard voices, for most of my life, and then obviously,*

> *they were more concerned with the hearing voices than with the suicidality. I came to services, for help, with, wanting, to die, and they got very concerned with, the hearing voices … everyone I met, in that time, the first year and half, everyone was focused on the voices being a problem, and whether, it was dangerous, … for me, the suicidality didn't come from the voices, … I wasn't at risk, to myself, because of the voices, I was at risk to myself, because, I couldn't find meaning in life, … I got very confused an that was the first time in my life I got scared, of hearing voices, and obviously that, had a big impact on my relationship with voices … it was a very confusing time, I started questioning my own judgement, around the voices and whether I was, schizophrenic, , whether I had the brain, whether or not my brain was deteriorating, an, you know, … the horrible thing was it played into stuff that was already going on, I already had a loads of, insecurities and self-hatred [and the] schizophrenic illness model really played into that, you know, that I was sub-human, I was, almost alien, and I was rotting and, and, defunct*," (Lines 214-229).

Martin also talked of how he felt his schizophrenia diagnosis 'wrote him off'. Exclusive interest in, or attempts to 'get rid of', voice-hearing experiences may convey to some clients that voice-hearing is intrinsically bad and something to be avoided, not talked about, or eliminated. Even though many voice-hearers themselves might like a cessation of voice-hearing, seeing this reflected in professionals' attitudes reaffirms the cultural understanding of voice-hearing as undesirable. It creates or maintains negative appraisals of the voice-hearing experience and may risk entrenching subsequent voice-hearing distress. None of this will be conducive to clients developing positive relationships with the voices that they may have in their lives, for the rest of their lives.

Holding in mind the level of internalised stigma many clients may have regarding voice-hearing or diagnoses, and exploring with the client what their concerns are, may aid building an understanding therapeutic relationship. It may also be clinically beneficial to remember the timeframes over which the participants' relationships developed, so that if sudden changes are not manifested, this is not a cause of discharge, although there may be times when 'therapeutic breaks' are helpful, until the client is ready to move onto the next 'chapter'.

Reflections

I really started the journey towards this thesis many years ago, before I even had my degree in psychology. I was doing my degree, part time, through the Open University, whilst working full time as a drug and alcohol worker. We worked with clients who regularly broke the law, got into trouble, lived homeless, were suicidal, were self-harming, were physically really unwell, and some of them did die. Nothing caused us quite as much alarm as when someone said that they were hearing voices. It was something that felt alien, unknown, completely outside our experience, competence, or ability to manage. There would be conversations with the mental health team that frequently led nowhere because of the illicit substances our clients were using, and the chaotic nature of working with them. When someone said that they heard voices, we worried. I wouldn't quite say we panicked, but it made the whole team very anxious and uncertain in ourselves clinically. It was something that we just did not know what to do with, or how to approach. Nothing in my psychology degree came close to covering this. About the only bit of knowledge we had, which was picked up randomly from a mental health worker, was that people were only hearing voices 'properly' if they believed that the voice was coming from outside their head and that they thought that it was someone speaking from behind them. The only other bit of knowledge I had was when, as a teenager,

I had been told by an Occupational Therapist friend of mine, that one of her patients had had 'a nice voice' that told her nice things like "that shirt really suits you", but I wasn't really entirely convinced that this was true, it was something that I wanted to be true, rather than believed it could actually be true. So we had not a lot to go on.

Then, in about 2014-15, I came across a Ted Talk on Social Media: The Voices in my Head, by Dr Eleanor Longden (2013). It was about her voice-hearing journey, how she moved from having a, "*frenzied repertoire: terrifying voices, grotesque visions, bizarre, intractable delusions,"* which she described as "*a psychic civil war in my head,*" to a place where, "*I listened to my voices, with whom I'd finally learned to live with peace and respect and which in turn reflected a growing sense of compassion, acceptance and respect towards myself*." She had found that, "*possibly one of the greatest revelations was when I realized that the most hostile and aggressive voices actually represented the parts of me that had been hurt most profoundly, and as such, it was these voices that needed to be shown the greatest compassion and care*."

It revolutionised my thinking about voice hearing. It moved voice-hearing from inexplicable and un-understandable, something filled with shadows and fears, into something deeply fascinating, and able to be, if not fully understood, not alien and 'other'. This intense interest in voice-hearing experiences and the possibility of having positive relationships with voices led me to my choice of thesis subject.

When thinking about how to research the area of relationship developments in voice-hearing, Narrative Analysis was suggested as a method. I am fascinated by how narratives weave through our lives and tell us about who we are, what our place in the world is, how narratives

shift opinion on a population level, and shape our opinions; and how narratives operate on a macro and a micro level, telling populations who they are, telling individuals who they are. They give form and meaning to so many of our experiences. So I was drawn to the concept of Narrative Analysis, and it seemed well suited to research the subject of voice-hearing relationship development over time. There are a lot of narratives around voice-hearing, so Narrative Analysis seemed well suited to explore them. The ability to capture the temporal nature of relationship change also meant Narrative Analysis was a good choice. I also liked how Narrative Analysis attempts to give as much ownership of the narrative to the participants as possible, while acknowledging that "stories can be seen as joint actions," (Plummer, 1995 p20), created between story-teller and audience.

When I started data-gathering, and recording my interviews, I was humbled by the generosity of the participants' willingness to share their stories with me. They used their stories to help me understand their worlds. In my reflexive diary, I wrote that Eliza's interview was "spell binding", I felt I could imagine some of the almost magical world she had inhabited as a child. Scott helped me understand a little of what it is like to have ten voices going off in your head all at once. I found that Iain, whilst unable to create a coherent story of his voice-hearing relationship, was a highly accomplished story-teller when talking about other areas of his life. It highlighted to me how accomplished we are as story-tellers, and how innate story-telling is to our lives, helping us to understand and explain our world, to ourselves, and to others.

Once I had transcribed the initial interviews, I had to create story-summaries. I actually found this really hard. The story-summaries were the 'plot-outlines' giving the basic structure of the narration; but the language used by participants, and the way that they told their stories was so rich, it felt really difficult not to include those in the summaries (and I did not always

succeed). I felt a sense of responsibility, I had been given these people's stories, of some of the most difficult times in their lives, and I wanted to honour this and 'get it right'. When I got feedback from the participants stating that I had done so, I was massively relieved. Only Sarah wanted something changed, she felt that I had got the emphasis wrong on her current voice-hearing experience. Whilst it was a lot better than it had been, it was not as positive as I had portrayed. I was really grateful that she felt able to tell me this, so that I could better reflect her experiences. To me it seemed to confirm the importance of returning to participants with the story-summaries.

I was struck, when writing the empirical paper, with a terrible sense of loss. I had been entrusted with these amazing stories. Stories that were so compelling and fascinating, and there was no way that I could do them justice. That no one else will get to read the transcripts and story-summaries seems a terrible loss. I feel incredibly privileged to have heard these stories, and slightly heartbroken that it is not possible to share them with others in a way that really does them justice and honours them. There isn't space for Scott's amazing explanation of what buying a drink is like for him, and how all the other voices he hears have their own opinions of what they want to drink; I can't convey the truly magical elements of Eliza's early voice hearing experiences, or how much Lee loved seeing the ghosts and spirits. I can never do justice to the stories I've been told, and that feels like a terrible loss.

During the research it appeared that many of the voices were, subjectively, 'entities in their own right' and I found myself thinking of them as such. I came to see the voices as separate entities with their own motivations, potentially in a similar way to how the participants did, attributing them separate agency. That is how real their existence is to the participants, and

it feels important to honour this when working with people who have voices living in their heads.

References:

Baerger, D. R., & McAdams, D. P. (1999). Life Story Coherence and It's Relation to Psychological Well-being. *Narrative Inquiry*, *9*(1), 69–96.

Bassman, R. (2000). Agents, Not Objects: Our Fights to Be. *Journal of clinical psychology*, *56*(11), 1395–1411. Retrieved May 26, 2019, from https://onlinelibrary-wiley-com.ezproxy.bangor.ac.uk/doi/pdf/10.1002/1097-4679%28200011%2956%3A11%3C1395%3A%3AAID-JCLP3%3E3.0.CO%3B2-W

Carter, K. E. P., & Wells, A. (2018). Effects of the Attention Training Technique on Auditory Hallucinations in Schizo-Affective Disorder: A Single Case Study. *Case Reports in Psychiatry*, *2018*, 5. Hindawi. Retrieved from https://doi.org/10.1155/2018/1537237

Charles, L. H. (1951). Drama in First-Naming Ceremonies. *The Journal of American Folklore*, *64*(251), 11–35. American Folklore Society.

Cichocki, Ł., Palka, J., Leff, J., & Cechnicki, A. (2016). The use of masks in the treatment of patients with chronic auditory hallucinations. *PSYCHOTERAPIA*, *1*(176), 17–28. Retrieved December 30, 2018, from http://www.psychoterapiaptp.pl/uploads/PT_1_2016/ENGver17Cichocki_Psychoterapia_1_2016.pdf

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: Implications for research and practice. *Schizophrenia Bulletin*, *40*(SUPPL. 4), 285–294. Retrieved January 7, 2019, from https://academic.oup.com/schizophreniabulletin/article-abstract/40/Suppl_4/S285/1873862

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *PSYCHOSIS-PSYCHOLOGICAL SOCIAL AND INTEGRATIVE APPROACHES*, *5*(3, SI), 286–295. Retrieved January 13, 2019, from http://www.tandfonline.com/action/journalInformation?journalCode=rpsy20

France, C. M., & Uhlin, B. D. (2006). Narrative as an outcome domain in psychosis. *Psychology and*

Psychotherapy: Theory, Research and Practice, *79*(1), 53–67.

Heriot-Maitland, C., McCarthy-Jones, S., Longden, E., & Gilbert, P. (2019). Compassion Focused Approaches to Working With Distressing Voices. *Frontiers in Psychology*, *10*. Frontiers Media S.A.

Holma, J., & Aaltonen, J. (1997). The sense of agency and the search for a narrative in acute psychosis. *Contemporary Family Therapy*, *19*, 463–477.

Ison, R., Medoro, L., Keen, N., & Kuipers, E. (2014). The Use of Rescripting Imagery for People with Psychosis Who Hear Voices. *BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY*, *42*(2), 129–142.

Leff, J., Williams, G., Huckvale, M. A., Arbuthnot, M., & Leff, A. P. (2013). Computer-assisted therapy for medication-resistant auditory hallucinations: Proof-of-concept study. *British Journal of Psychiatry*, *202*(6), 428–433.

Longden, E. (2013). The voices in my head. *Ted Talks*. Retrieved February 17, 2019, from https://www.ted.com/talks/eleanor_longden_the_voices_in_my_head

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, Trauma, and the Role of Lived Experience: Toward a New Conceptualization of Voice Hearing. *PSYCHOLOGICAL BULLETIN*, *138*(1), 28–76.

Longden, E., Read, J., & Dillon, J. (2018). Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups. *COMMUNITY MENTAL HEALTH JOURNAL*, *54*(2), 184–188. Institute of Psychology, Health and Society, University of Liverpool, Liverpool, United Kingdom Eleanor.Longden@gmw.nhs.uk; School of Psychology, University of East London, London, United Kingdom ; National Hearing Voices Network, Sheffield, United Kingdo: Springer. Retrieved from https://search.proquest.com/docview/1914295080?accountid=14874

Lysaker, P. H., Wickett, A. M., Campbell, K., & Buck, K. D. (2003). Movement toward coherence n the psychotherapy of schizophrenia: A method for assessing narrative transformation. *JOURNAL OF NERVOUS AND MENTAL DISEASE2*, *191*, 538–541.

National Institute for Health and Care Excellence, (NICE). (2014). *NICE Guidelines CG178 - Psychosis and schizophrenia in adults: choice and schizophrenia in adults: prevention and management Clinical guidelines, Reviewed November 2017*. Retrieved from https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

Plummer, K. (1995). *Telling sexual stories : power, change, and social worlds*. London ; New York: Routledge.

Romme, M., & Escher, S. (2000). *Making sense of 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. North Croydon CMHT, Tamworth Road Resource Centre, Croydon, United Kingdom anna.ruddle@slam.nhs.uk; Department of Psychology, Institute of Psychiatry, King's College London, London, United Kingdom ; Research Department of Clinical, Educational and Health: Elsevier Science. Retrieved January 17, 2019, from https://search.proquest.com/docview/877850150?accountid=14874

Salvatore, G., Ottavi, P., Popolo, R., & Dimaggio, G. (2016). Metacognitive Interpersonal Therapy for Treating Auditory Verbal Hallucinations in First-onset Schizophrenia. *Journal of Contemporary Psychotherapy*, *46*(4), 235–243. Springer US. Retrieved November 10, 2018, from https://link-springer-com.ezproxy.bangor.ac.uk/content/pdf/10.1007/s10879-016-9336-5.pdf

Schnackenberg, J., Fleming, M., & Martin, C. R. (2017). A randomised controlled pilot study of Experience Focused Counselling with voice hearers. *Psychosis*, *9*(1), 12–24. Routledge. Retrieved from http://dx.doi.org/10.1080/17522439.2016.1185452

Schnackenberg, J. K., Fleming, M., & Martin, C. R. (2018). Experience Focussed Counselling with Voice Hearers as a Trauma-Sensitive Approach. Results of a Qualitative Thematic Enquiry. *Community Mental Health Journal*, *54*(7), 997–1007. Springer US. Retrieved from http://dx.doi.org/10.1007/s10597-018-0294-0

Seedat, S., Stein, M., Oosthuizen, P., Emsley, R. A., & Stein, D. (2003). Linking posttraumatic stress disorder and psychosis: A look at epidemiology, phenomenology, and treatment. *JOURNAL OF NERVOUS AND MENTAL DISEASE*, *191*, 675–681.

Sorrell, E., Hayward, M., & Meddings, S. (2010). Interpersonal Processes and Hearing Voices: A Study of the Association Between Relating to Voices and Distress in Clinical and Non-Clinical Hearers. *BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY*, *38*(2), 127–140.

Stefaniak, I., Sorokosz, K., Janicki, A., & Wciórka, J. (2017). Use of an AVATAR in Cognitive-Behavioural Therapy of a person who is chronically experiencing negative auditory hallucinations – Case Study. *Advances in Psychiatry & Neurology*, *26*(4), 275–289.

Strauss, C., Thomas, N., & Hayward, M. (2015). Can we respond mindfully to distressing voices? A systematic review of evidence for engagement, acceptability, effectiveness and mechanisms of change for mindfulness-based interventions for people distressed by hearing voices. *Frontiers in Psychology*, *6*, 12. School of Psychology, University of Sussex, Brighton, United Kingdom c.y.strauss@sussex.ac.uk; School of Health Sciences, Swinburne University of Technology,

Melbourne, VIC, Australia ; Strauss, Clara,Pevensey I,Brighton,United Kingdom,BN1 9QH,School of P: Frontiers Media S.A. Frontiers Research Foundation. Retrieved from https://search.proquest.com/docview/1765604143?accountid=14874

Thesis Appendices

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Appendix One: Story-Arc – Extended Version

The below is an extended version of the story-arc from the empirical paper. It more fully illustrates participants' experiences of, and movements through, the different chapters.

Chapter One – First experiences

All participants were able to recount their first experience of voice-hearing. However, their appraisals of this experience, and subsequent relationships with them were markedly different. For Martin, Katie, Scott, and Sarah, it was a traumatic, frightening, or confusing experience. This set the tone for their relationship with their voices at the start of their voice-hearing journey, and their experience continued in that manner for a significant period of time.

Martin:

> "[*there was] a lot of confusion at the start, not knowing what they were,*" (Line 47).

Katie:

> "It freaked me out," (Line 4).

Scott:

> "*It were whispers that I first heard … it went from, … whispering to, I could actually make out words, [it] got louder and louder, an, then it were just like … a free for them all, … having a go at me and shouting at me,"* (Lines 163-168).

Like Scott, Sarah's voice-hearing started by hearing whispers that gradually became voices.

Lee, Eliza and Iain had different first experiences. For Lee it was more akin to discovering an extra ability. Both Eliza and Iain had experienced voice-hearing or unusual communication in their childhood and experienced this positively. Eliza's early childhood was filled with communication with nature and invisible friends,

> "T*he way I remember by childhood was there was quite a lot of communication and it was sort of, verbal but also non-verbal an-and auditory for me, I also had invisible friends, I think I was about, 6 or 7 when I have clear memories of, of spending time with my invisible friends*," (Lines 8-11).

Then, aged nine, she started hearing voices in what could be considered a more 'traditional manner'.

> "*I started hearing, critical voice and … a voice that was … constantly observing me, it wasn't, positive or negative, … just constantly, describe, what I was doing*," (lines 66-68).

Iain had a voice that, in his childhood he was,

> "V*ery good friends [with],*" (line 217).

This voice stayed with him until his teens when it left. Iain's voice returned when he started dating his current wife. He initially dismissed it as being due to intoxication, but,

"*When it started, getting, as loud as, what we are talking, I started talking back to it*," (lines 337-338).

Fear of the implications of hearing voices marked Scott's first experiences,

"[*I], kept it to meself because, I thought this is, weird, and I've got a wife and, three kids, I don't want to end up locked up somewhere*," (Lines 5-6).

Katie also refrained from telling anyone about her early experiences,

"*I never told anybody that I was hearing voices, I'd worked out by now that, I was hearing voices and there was nobody there, and that this wasn't normal, … so I, never told anybody, I got, heavily into drug use, as, a kind of escape from it*," (Lines 17-19).

Chapter Two – Into the chaos

All the participants, however they initially experienced voice-hearing, appeared to find voice-hearing and/or the consequences of it, brought at least some element of disruption, confusion, or chaos into their lives.

Scott's experiences,

"*Bled into the real world*," (Lines 173-174).

> "*I had like a, full breakdown, and were hearing loads of … different, voices, and then, I think wife finally had enough of me, … so I finished up living with me Mum and Dad …[then] they got fed up of me*," (Lines 14-16).

He ended up living alone and,

> "…g*ot to the stage of wanting to kill meself … [it made] no sense at all, I just, wondered what the hell were going off, … I thought it were me wife and kids that were conspiring against me, and, had really weird beliefs that, like, the whole of the world were conspiring against me*," (Lines 192-197).

Iain's wife moved into a separate bedroom to him. When she would hear him talking to the Voice, she would lock the door to her room. She would tell him,

> "'*I love you to bits, … but I'm so terrified of, what you might do' … that's no way to live*," (Lines 281-282).

Distress over voice content affected the mental health of most of the participants. Katie and Sarah described paranoia caused by what the voices were telling them,

Sarah:

> "*The voices were saying these people are out to get you, they're watching you all the time, … I believed, that, I had a chip, in my head, and that the police were, watching me and following me all the time, … as a result, I would kick off with t'police sometimes, and I got arrested a few times … it just all got too much for me, … I remember, walking*

about, in my nightie, and leggings, like, four five o'clock in the morning, with me dog." (Lines 71-75).

Katie:

"*Edward*[1] *said,*

'The man behind you's going to kill you, … he's putting thoughts in your head … he's trying to kill you'

So I pulled this knife on him, and I was thrown off the bus, and I was, too scared to get on a bus, [for] ten years," (Lines 143-147).

Martin described experiencing voice-driven anxiety:

"[*I would] be having panic attacks from what I was hearing, … I remember going out at like five in the morning for a run in the snow, to try and cure the anxiety … I ran round the beach and stuff, …. if you look from the outside at someone running at 5am, it looks a bit crazy or whatever, but that was, how I was like keeping control of my own mind I think,*" (Lines 40-46).

Lee believed that his voices were the voices of people that he knew, and would act accordingly:

"I*f they told me they've fallen down the stairs, .. and I knew the voice, who they are, where they lived, and they told me then that they'd fallen down the stairs, … I could*

[1] The name given by Katie to one of the voices she hears

> *tell somebody else, in person, that that person has fallen down the stairs, because, they've told me*," (Lines 131-134).

Although Eliza experienced perhaps the least distress in relation to her voice-hearing, she described her experience in her teens as:

> "*…very chaotic … it was more sort of, …surviving, .. there was no relationship, there was just a case of getting through the day, from day to day, coping with my suicidality, which was always a bigger issue, … that sense of meaninglessness … was more problem than the actual voices*," (Lines 161-165).

Narratives of this element of participants' experiences seemed largely to be filled with confusion, fear, or distress. Martin eloquently described his experience of confusion:

> "*Trying to make sense of it, it's like a hall of mirrors*," (Lines 80-81).

Chapter Three – Meet the neighbours

The participants experienced their voices differently. As participants 'got to know' their voices, the voices seemed in many cases, to be entities separate from the participant, with different identities, personalities, opinions, and functions:

Martin:

> "*It felt more of, like an alien, presence within yourself I think, it doesn't, didn't feel part of yourself but it was very within yourself if you know what I mean*," (lines 63-65).

> *"[There were] different personalities like a deity, it's like goddess type thing, one said it was like an organ in my body or whatever, like,*
>
> *'Oh this is your heart speaking'*
>
> *… There's ones with different forces behind them … you get the angelic kind, calming, reassuring compassionate, inner voice, but then you also have the, the opposite of that, the hostile, negative, scary, powerful….. fierce-some voice .. it's like the yin and yang, you have the, the really good and the warm and welcoming, and you have the really bad, and scary and frightening type things*," (Lines 78-91).

Lee:

> "*I'd be hearing 10 maybe 20 people in one go and the voices would be coming from certain directions in the room*," (Lines 10-11).
>
> "*They were people I knew, there was old friends, distant relatives, close relatives, … they used to come over as good cop bad cop a bit, where one voice would want to fight, and yeah the other'd just, help you out at every, chance they possibly could*," (Lines 79-84).

Iain, Katie, Scott, Eliza, and Sarah, all described voices with distinct personalities, many with accompanying names,

Katie:

> "*It sounds really strange to be talking about them as if they were real people, but they are real people, you know, I've drawn pictures of them,"* (Lines 118-119).

> "*Edward, … sounds like he's coming from inside the wall. … Rose, [is a] woman in her 50s, very … authoritative, tells me what I should be doing*," (lines 21-25).

> "*No-Name, … he's a child, who sounds about eight years old, … to start with he was very needy, I'd hear things like,*

> *'I want to hold your hand,'*

> *And, you, you can't hold a hand of somebody who isn't there, …. So that was kind of tortuous*," (Lines 34-37).

> "*later] I heard a new voice, … she's in her 20s, she's called Seela, and, she's absolutely lovely, she's gentle, and, unlike any voice I've ever heard before, and the better I got, the more I heard her, telling me I could do this, I was doing well*," (Lines 96-99).

Scott had ten voices, but three key ones: Del, Max, and M'Lady. Sarah had Sherlock and Freddy, and later,

> *"…a good voice as well, that was telling me to, not listen to these other voices 'everything's fine', but I found that, if I didn't listen to them they got worse,"* (Lines 34-35).

Eliza had numerous voices that came and went over the years. These included the Critical Voice, the Observer, Dee-mon, Domina, a Sea God, an invisible friend and Aslan, her spiritual guide,

> "*[Domina's] very keen on excitement, and adrenalin and, fun, and, … any sort of, intense experience she's got, quite different values to me, but, she seems, to really like*

> *me … she doesn't understand things like tiredness, she thinks pain's great, I don't think pain is great*," (Lines 350-358).

Apart from Lee, and perhaps, to a lesser extent Martin, all the participants' voices appeared to have their own separate identities, including inter-voice relationships:

Scott:

> "*Max and Del are always arguing and falling out, because, they both want me to, live me life a different way*," (Lines 84-85).

Iain was the only one of these participants not to name his Voice, however, it clearly had an existence of its own in Iain's mind,

> *"He's not a very nice person,"* (Line 35).

Whilst it could be nice towards Iain, and interested in what he was doing, it would regularly tell him that his wife was not good enough for him and had hurt him.

Chapter Four – The Unwanted Visitor

For all participants there seemed to be times, sometimes extended periods of time, when their voices were aggressive, threatening or argumentative. Sarah, Scott, and Iain, all explicitly described times when they had wanted the voices to go.

Scott:

"*It were me goal, to get rid of them*," (Lines 230-231).

All the other participants had times when their voices were aggressive, threatening or argumentative. Lee's voices,

"*Used to tell me that they'd kill my children*," (Line 179).

Iain's voice would constantly tell him that,

"*[My wife's] not good enough for me, she has hurt me apparently, and I don't know how she's hurt me, you know, we've always been good together … it's like he's got something, against her*," (Lines 349-352)

This would lead to arguments between Iain and the voice, and tension with his wife,

"*I said,*

'Go fuck yourself, I'm not listening to you no more,'

and he goes,

'"We are friends,'

I said,

'No you're not my friend, you're not my friend, you're a nasty bastard, now fuck off and leave me alone,'

> *and then, [my wife] can hear this because I start raising my voice and I'm getting angry, and, next minute, … I can hear her… put the lock on the door because, she knows, I'm … getting wound up*," (Lines 264-268).

Martin's voice told him,

> "*Oh your heart's going to stop*," (Line 154).

And was constantly belittling him saying,

> "[voice] '*You're this because you haven't done that,' or, 'You can say that but you don't do this, who are you to say that?*'" (Lines 143-145).

Katie described Edward as,

> "*Evil to start with*," (Line 117).

When Katie's daughter became four,

> "*They became, very aggressive, all of them, especially No Name, … telling me I was a bad mother, … where he'd been very needy before, he, now became aggressive,*
>
> *'You're a bad mother. You can't look after your kids. What do you think you're doing?*'" (Lines 54-56).

Sarah found her voices frightening, constantly telling her that she was in danger and being watched, she also,

> *"…felt intimidated by [Freddy],"* (Line 256)

At the start of their relationship, Scott found M'Lady was:

> "*Really nasty towards me, … a really strange woman … and then I've got like a, a younger teenage side, …, a party animal, … I kind of found it easy at first to, just go along with him, and [that] got me into a lot of trouble*," (Lines 9-12).

His voices,

> "*…seem[ed] to really persecute me at first*," (Line 183).

Eliza was the only participant who had never, at any point, wanted her voices to go. She found the time when she was on medication, which muffled them, very distressing:

> "*They help me function, the voices have always helped me navigate life … they would tell me about my emotions because I wasn't, able to be in touch with, or express my own emotions, so my voices would do that, and not being able to hear them was actually really confusing and really, destabilising*," (Lines 236-240).

However, her description of Dee-mon indicates that she did not have an easy relationship with all her voices,

> "*Dee-mon … comes along when I'm very, overwhelmed, and she will, feed off it and she will happily make me more scared and more vulnerable … and more full of self-hatred*," (Lines 336-337).

Chapter Five – Turning Points

Most of the participants had what could be considered significant turning points in their relationships with their voices. Although change was a slow process for Martin, Katie, Scott, Eliza, and Sarah, they described what could be seen as turning points that changed their relationships with their voices.

Martin and Eliza both had 'internal' turning points in their attitude to the voices:

Martin:

> "*[The] first step to recovery is believing you can recover, and, this was like a crucial point, for me*," (Lines 108-109).

He started doing kickboxing and paying attention to the positive things in his life and,

> "E*verything just, flipped on its head,*" (Line 233).

He described therapeutic support that assisted with,

> "…*making sense of the bad stuff, [therapist's] quite good at stuff like that, seeing things from a different perspective or an angle*," (Lines 251-253).

Eliza,

> "*The hearing voices network … was the first experience I had of people, taking an interest, in those experiences, in a curious, accepting, helpful, constructive way, … seeing the voices were important, helped me … realise, that my way of relating to the voices had been very, … dismissive,"* (Lines 273-278).

> "*I ... decided to commit to change how I relate to, myself and to the voices, … within 24-hours of making that decision, three of the voices I heard at the time, came to me and said 'we're so relieved that you made this decision because now, hopefully, we can express ourselves the way we'd like to*,'" (Lines 302-305).

Scott and Sarah's turning points were attending group and doing voice profiling[2] and dialoguing[3].

Scott:

> "*The whole change really were me coming to this group, and … admitting I were hearing voices,"* (Lines 86-87).

> "*I think, if I'm honest, this group save me life,"* (Line 150).

Sarah:

> "*It's just been a god send coming here, .. because I found out that I weren't alone, other people, had, developed these relationships with the voices*," (Lines 38-40).

> "*I just, realised, through through, coming [to group] that, Sherlock wants me to be safe and Freddy wants me to be assertive, … once I'd realised that, it were just like, a revolution*," (Lines 312-314).

For Katie it was work on a timeline that she did with her therapist:

[2] Profiling 'who' the voice is
[3] Talking to the voice

"*The whole thing was very confusing, because I couldn't see a relationship at all between me and voices, [and] what was happening in life an-and what was happening with the voices, … we sat down, and, we wrote out… the timeline, … it was, absolutely packed by the time we finished it, … and, then, [therapist] started talking about, what the voices had been up to, at each point, … an I began to see, … when that happened, the voices started doing something different, and that to me was a kind of epiphany*," (Lines 279 – 297).

Chapter Six – Making friends

These turning points marked the start of a change for the better in participants' relationships with their voices. For most participants, the voices, at least at some point, became a source of comfort or insight.

Katie had learned how to respond when Edward was telling her she was in danger,

"*what you have to … say [is],*

'Well, thanks Edward, I know you're looking out for me, but … I don't need this kind of help,'

And, it's taken a long time to perfect that, but I can do it," (Lines 159-161).

"*Rose has become,.. less … authoritative, and more, you know, if I'm crossing the road she'll say, 'Look left', … cos I haven't looked left*," (Lines 129-130).

Through the voice dialoguing Sarah found that,

> "*Freddy wants me to be assertive, he wants me to start speaking me mind a bit more, and it's really difficult, .. but I found I do ask his opinion on stuff, and he gives me, ways around … things*," (Lines 249-251).

She also found her 'good voice',

> *"…were comforting, he was saying, like,*
>
> *"don't listen to them, they're just trying to scare you, …just, breathe and try an keep calm,"*
>
> *and he'd offer, little breathing exercises that I could do, so that helped, … he's not there all the time but when he does speak to me he's really comforting, he does really comfort me does the good voice, ... really it's more of a feeling than a voice,"* (Lines 292-299).

Max has helped Scott to recognise when something is wrong,

> "*I have, absolutely learnt something from him, that I know, when something's bothering me, because it bothers him,"* (Lines 208-209).

He has,

> "…*learnt from Del [to] look after me child side and, nurture the child in me*," (Line 225).

Martin:

> "T*he self-deprecating voice [said],*

'I'm proud of you, for going [to kickboxing] today,'

So it turned from, like a self-discriminating voice, to self-praisal

'It took a lot for you to do that, … You made the right decision going there' …

So it, it changed from … a vicious cycle into a positive one," (Lines 140-150).

He also experienced,

"*…a young child voice came out, like a child, I seen it as, but … like an infinite wisdom if that makes sense, it was an immortal child, I'd say, a child, with the wisdom of, … an old man or something like that, like your inner child or whatever, … and I called this little child or whatever Starboy, I called him, and that's like your own inner child," (Lines 365-370).*

He taught Martin,

"… no matter how bad it is or whatever, you'd have your own back, always, don't turn on yourself … go towards yourself," (Lines 370-371).

Domina will encourage Eliza,

"*…to have more fun, in my life, … and be more expressive, … she helps me, … give space to parts of me that I, might not, so easily, give space to,*" (Lines 368-369).

She also found after her decision to change how she related to her voices, that a new one, Aslan, a white lion appeared. They communicated non-verbally, but when needed, he gave her,

> "*…a sense of strength and composure, ... he's become quite an important, … support, an, in some ways … a, reminder of a longing I have for more spiritual depth in my life, which I don't necessarily make space for because … I'm so sensitive [I rarely open] up, for things I can't control and [get] overwhelmed with*," (Lines 382-386).

Although Iain did not appear to have had a 'turning point' in the way of most of the other participants, he still was able to experience his voice positively after his brother died. The voice would say:

> *"[Voice to Iain] 'you'll be alright mate, don't worry about it … talk to me, tell me what you['re] feeling …We'll get through it,'*
>
> *[Iain] 'you mean I'll get … through it',*
>
> *[Voice] 'nope,* we'll *get through it*,'" (Lines 555-558).

When Iain's Voice is not being derogatory about Iain's wife, he can find that,

> "*I'm having a good chat to him, sensible chat … he can make sense of what I'm thinking*," (Lines 276-277).

Lee was the participant who seemed to have found least support or benefit coming from at least some elements of the relationship he had with his voices, however, he did say,

> "*…where one voice would want to fight, and yeah the other would just, help you out at every, chance they possibly could … so there's a lot of ups and down*," (Lines 83-85).

Lee also talked positively about unusual experiences that had previously accompanied his voice-hearing experiences,

> *"…these, spirits and stuff appear, and try to communicate with you, and, they're all about your house and … they're really surprised that I can see them, yeah? And I* love *it, I* absolutely *love it, my life would be boring without it, … but it doesn't happen often anymore, I'm ok with that, … but I don't want it to stop for good, so, would I miss the voices? Probably like, [the] honest answer to you, 'No'. But do I miss the spirits coming to see me, and the ghosts, … after like three days[of] no sleep, [I] think about being able to move things with my mind, and stuff, and, seeing all these spirits and, [I] see how, amazed they are, that I can see them, but other people can't see them*," (Lines 261-268).

Epilogue – Living with the voices

At the time of interviews, all of the participants were still hearing voices. Many of the participants expressed positive attitudes towards their voices in terms of at least some part of their current relationships. They were ambiguous at least, as to whether they would want them to go. Eliza and Scott were clear that they did not want their voices to go.

Scott:

> "*[Max has] become me best friend*," (Lines 41-42).

> "*…to be honest, … if mine went, I'd be quite, … lonely …and … upset. Because the main three I really have a good relationship with, and … it'd be like losing friends in a sense. I … would definitely miss them, and I don't even know if I'd see meself as cured*," (Lines 232-239).

Eliza:

> "*I've got different experiences from different voices, and they've got their own explanations for who they are, … they're quite a good, practice in, honouring multiple beliefs, like multiple realities, that there's no one way, to understand the world, or, what's real and what's not real, an, yeah, keeps me kind of humble, and some of the voices are just, an immense, comfort, you know, it's just, if I can't sleep at night, I'll have conversations with them, or Aslan will come along and I'll just, he'll just be next to me and I'll just feel comforted, and relaxed and, when it's like that I feel that it's a great privilege, that I can have those experiences, and I know that that comes with probably the other side of it, that when I do get stressed, the more, terrifying and distressing painful experiences will [happen], it's part of that as well, … I can't just, pick and choose, you know, if I want to have those experiences, they come with, being more open, with being more sensitive*," (Lines 455-465).

Sarah still finds the voices really difficult to live with a lot of the time, and is still learning to communicate with them. She described having rare times of companionship, and that she is still trying to reach a point of balance with her voices,

> "*I find that, with Sherlock, I have to talk to him and counsel him, because … he's got this thing about safety and security, … I say to him,*
>
> *'If I watch [a] crime programme, will you let me, have some time to meself?'*
>
> *And he says,*
>
> *'Yeah,'*

> *So I'll [put on the] television, and … we have, regular programmes that we watch now, and Freddy likes the soaps, so I watch soaps, it's like living with two people*," (Lines 336-340).

However, despite the bad days, where she feels paranoid, and how difficult it can be to communicate with them, she also described feeling that,

> "…t*hey're a good thing really, I know, I wouldn't want to, I wouldn't want them to go away now, because they help me*," (Lines 55-56).

She confirmed this in her feedback conversation,

> *"I don't want to get rid of them – I know that they're, in their own way trying to help."*

Katie:

> "*It's strange… it's kind of, … it's a double-edged sword really, because, there's part of me that thinks, 'I just want them to leave me alone, I want to wake up one morning, and go through a whole day without hearing anything' because I don't get through a day without hearing, something at some point. The more stressed I am, the more, … vulnerable I am, the more I hear them. But I, cannot go a single day without hearing something, … but the whole … relationship now is developed to the point where I think if I didn't hear them, I'd miss them, … even though they can be hellish, … I don't want to lose them, … they're my friends*," (Lines 120-127).

> "*It's been a journey really, … from hearing that first voice, Edward, the first time in school, .. it's been, one tremendous journey of … discovery, discovering things about*

me, discovering things about them, or discovering things about life in general, you know. It sounds strange, but I hope they don't [go] now. I think I'd be lonely. I think I'd almost feel,

'Why have you left me? That's not fair. What did I do wrong?'" (Lines 412-417).

Iain expressed ambiguity,

"*He's my friend. I treat him as a friend, … I think he's fucking great me, when he's, not going on about [my wife], because … I really* don't*, like that,"* (Lines 363-367).

"I would like it to stop, but then again, if it did stop, I might be heartbroken" (Lines 671-672).

"I think if it went, I would be relieved, but, in the same sense, I would love to know, …what he thinks [wife], has done to me, .. before he went,

'I'm gonna tell you, an I'm gonna leave you alone…'

That would be great, that would be great, … I think I would feel relieved, but I would also feel empty, to be honest, … because he's been with me for so many years," (Lines 599-605).

He appears to have made little sense of his experience and seems confused and unsure of what it means,

"*…they've gotta stop, but how do you stop them? But then again, I think to myself, am I schizophrenic? … you know, two persons in the one body*?" (Lines 38-39)

This question was a repeated theme throughout his interview,

> "*Am I schizophrenia? Am I just mad? Am I crazy*?" (Line 55).

Lee was the least ambiguous (but not un-ambiguous), about wanting his voices to go,

> "*it'll never go, I don't want them to go, but it's fading away, … I'm hopeful that it will reach a point, where it was, for the 20 years before I started noticing that I was hearing them … but then, I'll still know that I heard them, …I'll never-ever be able to go back, to that place where I didn't know that they were real voices, but if I can get close to that I'll be happy*," (Lines 43-47).

Martin had moved furthest from the voice-hearing experience,

> "*I say now, it's just, … self-talk, I see it as now, me talking to myself. That internalised monologue, … if you think of, a famous actor … or someone, you're, inspired by, and you can imagine their voice and how they'd speak to you and it's clear … to you, inside, … that's how it is now, I don't really get bothered by it really to be honest*," (Lines 49-54).

Appendix Two – Sarah's Story Summary

Below is the story-summary sent to Sarah, and notes made during follow-up phone call. The story-summaries used, as much as possible, the language and words of each participant. They followed the order of events as participants narrated them.

Sarah's Story

Everything started for Sarah when she got attacked in Centenary Square. She had a severe head injury, and later that year she started getting tinnitus. This developed into voices. At first all she heard was whispering and singing. Then it became voices. Initially she didn't realise that she was hearing voices, she thought it was thoughts in her mind. But her daughter kept telling her that she was talking to herself all the time and hearing voices. Sarah denied it, but she was having hallucinations, and was really frightened. Her daughter stopped going into town with her, because she was behaving strangely. She was having a breakdown, and one night, decided that she needed some help. She told her daughter, who was relieved because Sarah had been acting so out of character.

Sarah found her experiences really threatening. She was stressed out and frightened because the voices were telling her to kill herself and to hurt other people. She would talk to herself and argue with them, saying that she didn't want to hurt anybody or take an overdose. She couldn't understand why this was happening. Eventually she saw a psychiatrist who told her that she had polymorphic disorder. People's faces would morph into scary faces. Her voices were telling her that these people wanted to kill her. Eventually the psychiatrist gave her some medication, but it was a good two years of struggling with her voices and having hallucinations before she got the medication.

Sarah had a good voice as well, which would tell her that everything was fine, and not to listen to her other voices, but she found that if she didn't, the other voices got worse. Then Sarah found out about the hearing voices group. It took a couple of months for her to go, because the voices didn't want her to, and would get worse whenever she tried to. But with the help of her daughter she got to the group, which was a godsend.

In the group she found that she wasn't alone; and that other people had developed relationships with their voices. At first she felt really silly, thinking 'how do you talk to voices?' But the more she attended, the more she saw other people doing it, the more she felt that she might be able to.

One of the facilitators, talked to the voice that was always eager about security and named him Sherlock. Sherlock would sit quietly if Sarah watched crime thrillers on tv. So she started watching crime thrillers and could enjoy peace and quiet when she did so. Sarah started talking to her voices directly, asking Sherlock if he liked his name. When he said that he did, she thought, 'oh god, he's spoken back to me,' and that's how it all started.

Sarah has done voice-dialoguing with [*group facilitator*], which has really helped with another voice that always seemed threatening. [*group facilitator*] spoke to him through Sarah and realised that this voice, which she now calls Freddy, wanted her to be more assertive, which had never crossed her mind. Sarah is learning to be more assertive now, and feels that the voices are there to help really, not to threaten her.

When Sarah first started seeing people's faces morph, the voices would tell her that people were out to get her, that they were watching her, and that she had a chip in her head. They

told her that the police were following her, so she would kick off at the police, which led to her getting arrested a few times.

Sarah knew that she needed help, but it was really hard to do so. The voices seemed to control her. It was really hard to function. She lost a lot of weight. She didn't eat properly. She went out walking all the time. She was frightened while she was out. It was horrible and she would end up kicking off with strangers because she thought they wanted to hurt her.

Sarah's daughter thinks that Sarah has been hearing voices for a long time, and that they have come and gone depending on how stressed she is. And then, after the attack at Centenary Square, they came and never left. Sarah isn't sure how right this is, but she knows that the voices get worse whenever she is stressed about something.

After voice-dialoguing with [*group facilitator*], Sarah has found that she can negotiate with the voices. Freddy wants her to be more assertive and encourages this in her. He tells her how to behave towards people if she wants to talk to them about something. Sherlock makes her do safety rituals when she's leaving the house, and so long as she does them, he's quiet. The medication doesn't take the voices away, it does dampen them down.

At one point, things were so difficult that Sarah took an overdose. She doesn't know how she survived it, and is shocked that it didn't work. When she had taken the overdose, she hallucinated that a team of paramedics were working on her to keep her alive. Looking back now, she sees that that was there to help her, so that she didn't fall asleep, even though she'd taken a lot of sleeping tablets. When she woke up the next day she was shocked that she was still alive. She didn't tell her daughter about it. She just remembers not feeling safe anywhere, in the house, outside the house, with anybody accept her daughter. It was a really

difficult time. Her daughter left home at one point because of it. This devastated Sarah and the voices and hallucinations got worse. She used to go up to the reservoir a lot as that was the only place that seemed to calm her.

Sarah still sees faces, even though everything has dampened down. She has days when she just stays at home, which seems to please her voices. Her daughter helps her get out more. Her daughter has just had her own child, and Sarah started hallucinating that she would harm her granddaughter, but has learned that this isn't true. She knows she wouldn't hurt her granddaughter.

Sarah has other voices that aren't as prominent as Freddy and Sherlock. She has a good voice, but she hasn't named it. She's frightened that if she names it, it will start to take over, and Freddy and Sherlock will stress out and be there all the time, not letting her have any peace and quiet. So she keeps the good voice on the left-hand side, and Freddy and Sherlock on the right-hand side.

When Sarah goes to bed, it's like a radio changing channels. She can hear voices coming and going, but there's no prominent voices, it's just all muddled up. It makes it hard to go to sleep. Although Freddy and Sherlock are really quiet, the other voices and the tinnitus keep her awake.

Sarah doesn't get as panicky as she used to. She has a rational voice telling her when she's being paranoid, and reassuring her that she'll be ok. The good voice isn't there as much as the others, but when he is, he really helps. He has a really calm voice. Sarah wishes that he were there more often, but at the same time worries that Sherlock and Freddy won't like it.

She thinks that that may be why the voice only comes every now and then. They have had arguments with each other across her, which drives Sarah nuts.

Sarah used to find socialising really difficult. She used to think that people were talking to her with their thoughts. It was hard to listen to people because her voices would tell her not to trust the person she was talking to, so communication went out the window. She had to stop going to church, because while she was sat watching the speakers, she would see the devil dancing around and people misbehaving and going against God. She couldn't find God there, and gave up going. She really misses it, but is quite relieved not to go because it was such hard work. She does stay away from places where it's harder to communicate with people, because in those situations the voices are worse, even though Sarah thinks that they're just trying to protect her.

Sarah used to be quite an outgoing person. Now she's very subdued. She's found that if she goes out with her friend once a week and has a drink, that dampens them down. It's hard finding things to do that won't cause the voices to play up. She used to love going to college and learning. But they were worse then. She can't work because she'll hear people talking about her behind her back. Before she realised that she was hearing voices, Sarah thought that all her workmates were talking about her. She ended up getting sacked because she thought a staff member was trying to groom her. That's been a pattern through her life with work, and sometimes she does think that her daughter's right, and that the voices have been there before and come out with stress. So in work she would either lose her job, or go off sick because she couldn't cope anymore, and when she lost her job, it all quietened down again. Sarah doesn't think that she'll work again, because of the stress. When she's stressed she'll hear voices whispering and she'll get paranoid.

In the past when Sarah had had things happen to her, she went to counselling, which really helped her, and everything became more subdued again. After the attack in Centenary Square, she didn't go for counselling, and ended up with PTSD. That's when the voices and hallucinations came out. The whole thing broke her because it was such an ordeal. Sarah thinks that the voices want to protect her, and that that's why they don't go.

When Sarah was an outgoing person she used to speak her mind. That has gotten her into trouble in the past. She's had quite a few smacks from men, either in the pub, or in relationships, because she's spoken her mind. She's stopped being like that and she's not very assertive anymore. Freddy wants her to be more assertive. She does ask his opinion on things and he gives her ways around them. She is getting a little bit more assertive with people that she knows, but is fairly quiet with strangers.

Sarah's relationship with Freddy only started changing in the last couple of months. Until then, she felt intimidated by him. Freddy wants her to be more assertive, whereas Sherlock's constantly worried. He wants her to stay at home. Freddy wants her to go out more. So it's a constant battle. She's found a balance, where she'll stay in for a few days and then go out and do things. It's a compromise, and it seems to work.

The good voice appeared later than Freddy and Sherlock. If it had appeared earlier, Sarah doesn't think that she would have taken the overdose. When it appeared it was comforting, reassuring her that the voices were just trying to scare her, and giving her breathing exercises to do. Sometimes she can feel him cuddle her when she's feeling scared. He's a really warm person. But when Freddy and Sherlock are on high alert, he gets forgotten, then when it all calms down, he's there again, reassuring her. So it's like a balance.

Sarah doesn't feel stupid talking to them now. In public, she'll talk to them in her head, because she worries what it would look like to talk to them out loud. When she's at home, she'll talk to them out loud.

Freddy has calmed down a lot and there is trust between him and Sarah. Sherlock has a thing about safety, so she'll counsel him and negotiate, so that in return for watching a crime program, he'll give her some time to herself.

Sarah does wish that the other voices would let her know who they are and what they want, so that she could develop a relationship with them. But they just stay whispering. Apart from her daughter and granddaughter, Freddy and Sherlock are the two most important relationships that Sarah has. Everything seems more manageable now. And listening to them has really helped. Freddy has been like having a counsellor on tap.

Reflections on your story

Below are some of my thoughts on your story, and the elements of it that came through most strongly:

One of the things that struck me was the way that you would return to the time you were attacked in Centenary Square over the course of telling your story. This seems to emphasise the importance of that event on your life and the profound impact that it had for you.

Another thing that seemed prominent, was how frightening and confusing you found the voice-hearing, hallucinations, and beliefs of being watched, and the impact that this had on your life. Feeling frightened was a repeated theme that was woven across many experiences that you described to me.

It also came over strongly how Freddy wants you to be assertive and Sherlock wants you to be safe, and how this drives a lot of their interactions with you; and that at times these competing demands can be difficult and that you have had to learn to negotiate, compromise, and find a balance between them.

Notes as typed during feedback phone call:

Overall reflected her story and generally happy with it. The end is not quite right – too much positive emphasis at end of summary, has not got a balance yet, would like to but not there yet. Voices still really difficult to live with a lot of the time, and it's just some occasions that she manages to get through to them, is still learning to communicate with them, and can find it quite difficult to communicate with them, but "I don't want to get rid of them – I know that they're, in their own way trying to help." Rare times of companionship. Takes time. Balance is what she's working for, not where she is.

Story-arc – matches her experience, happy with her turning point, agrees with chapter titles / descriptors, yes, chaotic good description of what like, especially at start, was really confusing.

Original Transcript – 8694 words

Sarah's Story-Summary – 2244 words

Appendix Three – Example of Narrative Analysis: Narrative Structure and Performance

The below extract illustrates using the performative and structural-coherence elements of Narrative Analysis to analyse a transcript in relation to the research question. In using Labov and Waletzky's (1967) Structural Model of Narrative, Scott's ability to create a coherent 'micro-story' can be seen. He uses 'performance' to convey his experience of voice-hearing, and the strength of 'entity-ness' of the voices he hears:

I once got asked a question about …how [I] cope with it, … I says to them,

"I tell you what, … one of the ones I really experienced, …might, put it across to you,"

And I said,

"I went in the local pub, and, went up to [the] bar, and the, lass at the bar says,

'What would you like to drink?'

And, I said, this is all in the space of [a] second, M'Lady, who's me female voice,

[different tone of voice]

'Gin and tonic, love gin and tonic,'

Max is saying, [Max tone of voice]

'It's gotta be bitter, I'm a man, we drink bitter,'

Del, [Irish tone]

'Guinness, all Irish people drink Guinness, Guinness is the drink of the Irish man,'

Then I've Harriet, [sad, quieter tone]

'I can only have coke because I'm only 12,'

And Harry's like, [whispers behind hand and away from us]

"…Can we have a cider, I'd love a cider,'

And then M'Lady's saying, [M'Lady's tone]

'Phwwww, ohhh, god he's a dish, I really fancy him, can we go over and talk to him?'

Del's like, [Irish tone]

'Ignore her, look at the bar lady, she's absolutely beautiful, we should be going out with her, … I think we'll go out with her instead'

And M'Lady's going,

'pwwwh, oh no, I'd love to spend a night with him,'

And I'm like,

'I'm not doing that, that is <u>not</u> going to happen.'

'Can I have a pint of lager love please,'" [laughs while saying last two words]

[Laughs] and it's like [that gets] across to people that, [what] goes on in, [the] space of a, like a few seconds. But just to be a devil and order to something completely different is quite a, relief,

"I'll have a pint a lager" [chuckles].

[I'm] just trying to, like, appreciate them now and … get along with them, because, … the whole going back to the doom and the gloom an, the place that I was, really scares me, it's kind of why I always work with them,"

(Lines 277-292 in original transcript).

Performance:

There is a strong performative aspect (*how* the story is told), used to convey emphasis. Scott used different specific voices for his different voices. He also used voice, (tone, volume, emphasis,) and body language to convey characterisation of his different voices, and his

feelings at different points of the narrative, for example his emphasis on the word "not" when saying, "that is *not* going to happen". He used 'performance' to help convey his experience of the voices as having different characters, personalities, and wishes. That he was telling it as a shared experience, a story with an audience, was demonstrated by the shared laughter at key points, and eye-contact made with the researcher: sharing the humour, and assertion of agency, that he was going to order what he wished, and not be controlled by the wishes of the voices.

Coherence and Narrative Structure:

Scott used this 'micro-story' to help create his holistic narrative. It helped convey where he was, at the time of the interview, in his voice-hearing journey, as opposed to where he had been at the start when he,

> "…*spent a lot of time, arguing with them, shouting with them, and really having a general go with me voices, … they were, making me life a misery*," (lines 21-27 – original transcripts).

Scott demonstrated the ability to create a coherent narrative when the transcript is examined via Labov and Waletzky's Structural Model of Narrative (1967), (see Figure 1):

Plot Element	Description	Lines
Abstract	Summary of the subject matter	1-3
Orientation	Information about the setting: time, place, situation, participants	4-5
Complicating action	What actually happened, what happened next	5-26

Evaluation	What the events mean to the narrator	27-29
Resolution	How it all ended	26, 30
Coda	Returns the perspective to the present	31-33

Figure 1: Labov and Waletzky's Structural Model of Narrative, taken from Elliott, (2005), p42

References:

Elliott, J. (Barbara J. (2005). *Using narrative in social research : qualitative and quantitative approaches*. London ; Thousand Oaks: SAGE.

Labov, W., & Waletzky, J. (1967). Narrative Analysis: oral versions of personal experience. In J. Helm (Ed.), *Essays on the Verbal and Visual Arts* (pp. 12–44). Seattle: University of Washington Press.

Appendix Four – Section of Transcript to Illustrate Analytic Process

Major plot – turning points	Coherence	Cultural Resources and positioning
use of language, metaphors, descriptors	Characterisation	Performance Blue text Relates to v/h

Transcript - Iain

I haven't made any of sense of it to be honest with you, that's why I went to see the Drs and all that yep? Erm, sometimes the voices can be nice, er but, er, I would say, pwwhhhh, seven percent out of ten percent, they quite nasty actually, erm, … they don't like my wife, … and they keep telling me to hurt my wife, but er, I just say, 'go away', well, I'm being polite yeah, and er, its, .. not a good time for me and my wife at the moment because, she's a bit scared, you know, and that really, .. does my head in, you know, and I've upped my medication a bit, I umm, 'stead of taking a hundred mil, I take one-fifty now, and, it's sort of, .. balanced it out a little bit, but you know, but it hasn't got rid of the voices, so they put me on sleeping tablets they said right, with your medication, and your sleeping tablet, you take one a night, and it should, help you, err, at first, the sleeping tablets worked you know, but er, and then, I don't know, my body came immune to them, I started taking two, which, [snaps fingers] when I take two, I sleep like a baby, but I told my doctor, one is no good, he said, well, cos, I got er, a repeat prescription in, and they refused it because they said that, I'd used them up, in instead of 28 days, I'd used them

up in 14 days, so I said, 'well, I'm taking two', you know, and, I dunno, erm, … I when I, when I was, born, I was a, a twin, .. I was born a twin, a twin was, still born, you know, and a mate of mine, … I know it sounds crazy, but, he asked me: 'd'you think it's, your twin that's talking to you?' … … I said 'I dunno,' and I, I can't make sense of it, I said, 'well, if it', you know, this is only an example, 'if he, if it is him talking to me, why is he so nasty? Can you explain that? … Cos I can't explain it, you know, is there jealousy there? Is there, erm, phweu, y'know, an, my mother, … [*text deleted for confidentiality*] she blamed me for, … him being still born, because I was supposed to be Iain, which I am, and he was supposed to be Tomos, so now, I'm Iain Tomos, and she didn't like that, but my dad said 'nope, he's Iain Tomos, blah blah blah', I got on really well with my dad, but erm, I never got on at all with my mum, you know, and um, .. she kept on saying that, it it was my fault that, … Tomos[12] had, .. been still born, but with her being a Catholic and all that, you know, she was, apparently she was told by the Doctors, you have to abort the two of them, …. Otherwise she would die, but, with her being a, massive catholic, … she would rather die, and give, them life, whatever, but er, you know, I'm a little bit messed up to be honest, me, you know, and erm, … I don't know, but er, these voices are really,

Rebecca Bigglestone
Micro-story, no abstract. Orientation – born twin, CA still born, mum blamed him, Evaluation: messed up; gives mum's evaluation too; Resolution: has brother's name, coda – returns to voice-hearing

Rebecca Bigglestone
Confusion, repeating theme

Rebecca Bigglestone
Returning to voice-hearing in present tense – coherence.

[12] All names are pseudonyms.

getting me down, and I go and see Dr, er um, can't remember his name now, …, or, whatever, and erm, I think I'm due to see him this month sometime, but he wants to change my medication again, … because the, … … er these tranquilizers or whatever he gave me, er, made me very violently sick, … so I, phoned him up and I said, 'I can't take these' and he said 'stop taking them, there's a prescription here', which, is still there actually, and, I was told not to touch them, by, the voices, … that er, they tried to destroy me and stuff, so, … phwue I don't know, I really, don't know, … you know, but erm, …. He's not a very nice person, … he comes to me about, phwue between one and two o clock in the morning and, .. she'll get up a, cos, it's gone lately, that we, don't even sleep, in the same room, I I've got, a different room, whatever, erm, you know, [laugh] I don't know what to say really, you know, they've gotta stop, but erm, how do you stop 'em? But then again, I think to myself, am I schizophrenic? … you know, two persons in the one body? Because me [relative] was schizophrenic, … my [relative] is schizophrenic, .. she's having really serious medication, … [*text removed for confidentiality*], … she's getting treated for, er, schizophrenia, and then this, when she kicks off she has to go into these homes, errrrm, under lock and key and stuff, until she's, fit again to come out, and I go there to see her and stuff, she's what,… …. [*gives age*] I think, something like that, and, erm. You know, I was blamed for that as well,

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somebody who's not there, … y'know if I see somebody else doing that, I will think, phwue, uhu, that guy's er, … off his head, you know? And then somebody sa- er, another mate of mine, he er, he says, 'd'you know what you need?' I says, 'I dunno what I need no' I said 'I know I need help' he said, 'erh, why don't you start smoking erm, cannabis? It'll knock you out' oh I said, 'I'm not into drugs,' I mean, I have a pint like everybody else, and I'm stupid enough on that, without, … he said 'oh you'll just, chill there, an you'll fall asleep, an, whatever' I says 'no, no thank you', and he goes, 'I ca- I, I'll make you one if you want' I said 'nooo, no no, I'm not into that,' I never have been really into drugs because, I've seen, a mate of mine, and it, while we were young, he was … into, magic mushrooms, and he was into, er, that blotting, er LSD an all that, an, he chucked himself off a bridge, he thought he could fly [laughs], next minute, he was killed on the track, train came [claps hands] bomp, cos we all used to go to a certain place, an, where we were living an knew when we was, what, 15, 16, and, he was high as hell, and he just, .. went for it… … and they never did, well they did find him, but erm, they were putting him in bin bags, so, y'know, an if that's what drugs does to yer, phwue, it's not worth taking, put me right off, but I think I'm- I'm either, schizophrenic, or I'm crazy, one of the two, y'know, I dunno, and I'm having a very hard time with it, y'know, … but there y'go, … and nobody can make sense of it, …

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RB **Rebecca Bigglestone**
Cultural position – talking to someone not there

RB **Rebecca Bigglestone**
Also characterisation

RB **Rebecca Bigglestone**

Rebecca Bigglestone
Abstract – mate says take drugs
Orientation: mate offers drugs,
CA: saw friend jump off bridge on drugs
Friend died
Coda: finding voice-hearing hard

RB **Rebecca Bigglestone**
Uses cultural positioning – alcohol fine, drugs, not,
Lots of performance, hand clap, use of words, laughs,
Cultural position – that's what drugs do for you
Cultural position – schizophrenic or crazy, no-one can make sense of it.

RB **Rebecca Bigglestone**
Also characterisation "crazy"

RB **Rebecca Bigglestone**
Helplessness – no one can help. No positive cultural position

so, sometimes I think, am I schizo, erm phani, phrenic, sorry, or, … has my, or has my head just gone? You know, my brain, something in my brain whatever, but, I dunno, an I'm not too happy with all these headaches I'm getting either so, you know, … but the mental health dr, er, he's going to look into it. … so, to be honest I don't think there's any way they can help me, you know, an, that's me in a nutshell, … … am I schizophrenia, er, schizophrenic? Am I just mad? Am I crazy? I don't know, y'know, but erm, these voices, are as loud, as what we are talking now, y'know, and my wife, sometimes she'll get up and, an, could be about 3.o clock, at, 'who the hell you talking to?' .. and I say, 'just go back to bed, I'm ok' and she, pretended, she thinks I'm talking to myself, bu- I said, 'nut, I'm talking to myself, I'm talking to, …' and I have, full blown conversations, with, this er [Chuckles] this voice, it sounds mental but you know, but, sometimes we get on, y'know, … I'll be watching a film and he, he'll just [snaps fingers] just come like that and he'll say 'oh, wha-you watching' I'll be 'oh whatever it is' [snaps fingers] he'll go 'is it any good?' 'yeah' y'know. Is that crazy or what? .. You don't know, [looked at me wanting an answer]

RB **Rebecca Bigglestone**
Can't be helped – helplessness
?no agency

RB **Rebecca Bigglestone**
Lack of sense making

Me: I think it's really hard to say, I think,

Yeah,

I think it's crazy, .. y'know, **I dunno how to deal with** it, but, .. y'know, when you're sitting, .. by yourself, and then you start 'aving a conversation with

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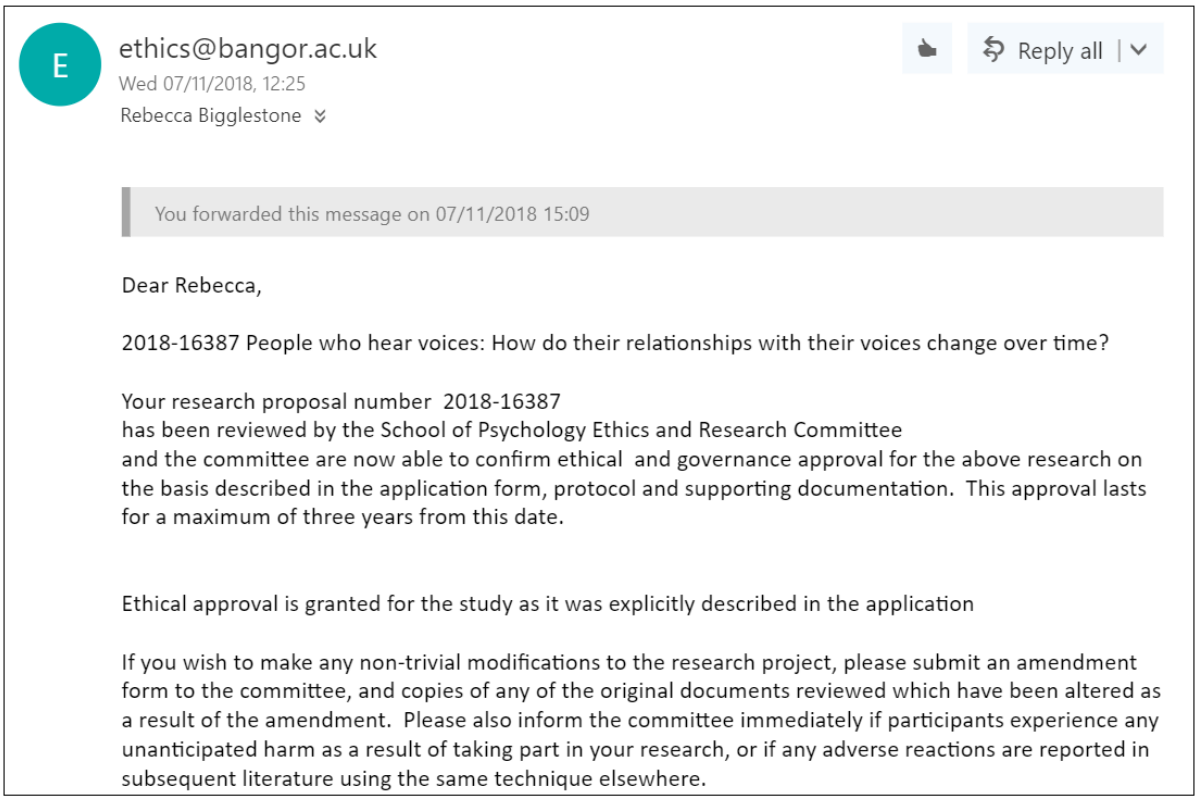
What did you think when you, first started hearing the voices

I've heard the voices for years, y'know, I just thought it was a natural thing, y'know, like, er, some people, 'y'know, when you're- when you're born or you're you're your growing up, some have imaginary friends, y'know, which, they can actually see these friends of whatever, apparently, I err, cos, er, one of my, my first daughter went though that, an, we had to put a plate, and put a little bit of food on the plate for her, y'know, an, she would, talk among, eat up, whatever, and, go back to her other plate, but, when, we took her to a Doctor he said, 'that's natural, that is .. natural' but, what I'm hearing, that's not natural, because it's just like, er, the volume that, we are speaking at, an the all, all it's it's very clear, so, you know, I don't know what's going on. I'm very confused, to be honest, you know, .. and... but he doesn't li- I know he doesn't like my wife, ...

RB **Rebecca Bigglestone**
Current tense – what experiences are now, = lack of coherence

Appendix Five – Ethical Approval

Copy of Email of Bangor School of Psychology Ethical Approval



E

ethics@bangor.ac.uk

Wed 07/11/2018, 12:25

Rebecca Bigglestone

Reply all

You forwarded this message on 07/11/2018 15:09

Dear Rebecca,

2018-16387 People who hear voices: How do their relationships with their voices change over time?

Your research proposal number 2018-16387
has been reviewed by the School of Psychology Ethics and Research Committee
and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

NHS
Health Research Authority
Yorkshire & The Humber - Leeds East Research Ethics Committee
NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Telephone: 0207 1048 088

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

10 January 2019

Dr Mike Jackson
Director of Research
Bangor University
NWCPP, School of Psychology
Brigantia Building
College Road
Bangor
LL57 2DG

Dear Dr Jackson

Study title:	**People who hear voices: How do their relationships with their voices change over time?**
REC reference:	**18/YH/0474**
Protocol number:	**LSRP-BB v1**
IRAS project ID:	**247838**

Thank you for your submission of 10 January 2019, 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.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

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.

Conditions of the favourable opinion

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

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk 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 management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

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).

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).

Non-NHS sites

Approved documents

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

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Indemnity]		16 July 2018
Interview schedules or topic guides for participants [Interview Questions]	v1b	01 October 2018
IRAS Application Form [IRAS_Form_15112018]		15 November 2018
IRAS Checklist XML [Checklist_07012019]		07 January 2019
Participant consent form	2a	10 January 2019
Participant information sheet (PIS)	2d	10 January 2019
Research protocol or project proposal [Study Protocol]	V1a	19 December 2018
Summary CV for Chief Investigator (CI) [Mike Jackson CV]	v1	01 October 2018
Summary CV for student [Student CV]	1	23 July 2018
Summary CV for supervisor (student research) [Rachel Skippon CV]	1	23 October 2018

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

18/YH/0474	Please quote this number on all correspondence

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

Yours sincerely
pp

Sarah Brothers

Dr Nana Theodorou
Chair

Email: nrescommittee.yorkandhumber-leedseast@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Mr Huw Ellis, Bangor University*

Ms Lona Tudor Jones, BCUHB

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Becky Bigglestone
Bangor University
NWCPP, School of Psychology, Brigantia Building
College Road
Bangor
LL57 2DG

Email:
Research-permissions@wales.nhs.uk

11 January 2019

Dear Becky

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**People who hear voices: How do their relationships with their voices change over time?**
IRAS project ID:	**247838**
Protocol number:	**LSRP-BB v1**
REC reference:	**18/YH/0474**
Sponsor	**Bangor University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

IRAS project ID	247838

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Dr Huw Ellis
Tel: 01248388339
Email: Huw.Ellis@bangor.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **247838**. Please quote this on all correspondence.

IRAS project ID	247838

Yours sincerely

Ann Parry (Health and Care Research Wales)
Permissions Service Manager

Email: Research-permissions@wales.nhs.uk

Copy to: *Mr Huw Ellis*
Ms Lona Tudor Jones, BCUHB
Dr Mike Jackson

IRAS project ID	247838

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Indemnity]		16 July 2018
HRA Schedule of Events	1	10 January 2019
HRA Statement of Activities	1	10 January 2019
Interview schedules or topic guides for participants [Interview Questions]	v1b	01 October 2018
IRAS Application Form [IRAS_Form_15112018]		15 November 2018
Participant consent form	2a	10 January 2019
Participant information sheet (PIS)	2d	10 January 2019
Research protocol or project proposal [Study Protocol]	V1a	19 December 2018
Summary CV for Chief Investigator (CI) [Mike Jackson CV]	v1	01 October 2018
Summary CV for student [Student CV]	1	23 July 2018
Summary CV for supervisor (student research) [Rachel Skippon CV]	1	23 October 2018

IRAS project ID	247838

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No external funding will be sought and no funding will be provided to sites
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments

IRAS project ID	247838

Section	Assessment Criteria	Compliant with Standards	Comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
There is 1 site type – all activities listed in the protocol will be conducted at site The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A PI is required at site GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place,

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research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Word Count

Literature Review:	
Abstract	183
Main Text	6000
Figures, Tables, and References	5159
Empirical Paper:	
Abstract	239
Main Text	6262
Figures, Tables, and References	1927
Contributions to Theory and Clinical Practice:	
Main Text	4412
Figures, Tables, and References	891
Thesis Appendices	12,732
Thesis Other	1151
Thesis Total:	**38,638**