How Do Individuals Make Sense of Positive Voice Hearing Experiences? An Interpretative Phenomenological Analysis

Holly North
Professional doctorate in Counselling Psychology
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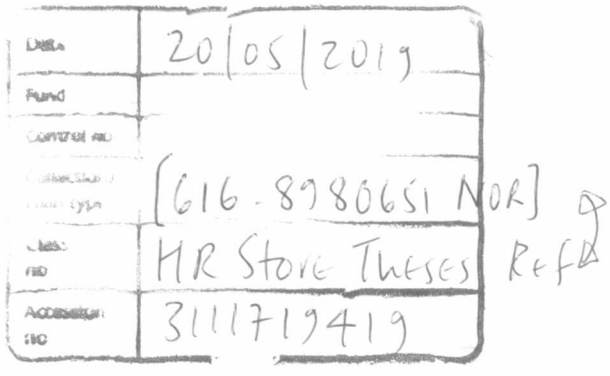
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Abstract

Approaches to voice hearing have primarily and historically been driven by a medical model of psychiatry. Recognition of the limitations of this approach has led to increasing awareness and development of new approaches to understanding voice hearing that Counselling Psychology (CoP) is well placed to address.

The study addressed the lack of research exploring the subjective experience of voice hearing from the voice hearer's perspective, particularly of positive voice hearing experiences.

Five participants, all of whom had positive voice hearing experiences were recruited from hearing voices groups across England.

Interpretative Phenomenological Analysis (IPA) was used to explore how individuals make sense of their positive voice hearing experiences.

There were three superordinate themes identified from the IPA: "Engaging in a complicated world: The voice in repetition or reparation of relational trauma", "Response-ability, in interpretation and action" and "Fracturing identities: The self and society's acceptance of voice hearing".

Three main findings were identified from the analysis: 1) Participants experience a relationship with their voices, which could both compensate for and repeat, experiences of relational difficulties, 2) finding meaning in the voice hearing experience is of fundamental importance for the participants and 3) there is a complex interplay between society and the individual in the acceptance and understanding of voice hearing experiences.

The study supports the argument for a paradigm shift away from the medicalisation of distress towards a focus on the meaning and understanding of human experience from an individual and interpersonal context.

Dedication

This thesis is dedicated to my two children; Mullion and Harlyn, who are yet to know what it is like to have a mother who is not absent, exhausted or in an endless pursuit of recognition and achievement.

I hope the conclusion of this thesis signals the beginning of a new chapter in our lives together.

Acknowledgments

I would like to thank my family for providing a foundation and context in which I could aspire to achieve. I would like to thank my supervisor for providing the belief and support to realise these aspirations.
I would also like to thank the charity that I have worked for during this time who have provided the flexibility and support to enable me to continue my studies.

I am indebted to the participants who provided such open, interesting and detailed accounts of their experiences of voice hearing. I am hugely grateful for their willingness to give up their time and tell their stories.

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Reflexive statement part I

Why do you not wish to take your medication I would ask? The response, "I don't want my voices to be taken away, they keep me company, one of them is my girlfriend". The client, residing in a residential therapeutic community where I work as a psychotherapist ignited my interest in my subsequent questioning of the psychiatric model of hallucinations. I became increasingly interested in the clients subjective and individual approach to their experiences of voice hearing. The client's 'relationship' to their voices was by no means an isolated occurrence and through my experience of working therapeutically with voice hearing clients I have consistently been exposed to the idea that voices can provide a meaning and purpose in an individual's life. Working in a therapeutic community has privileged me with access to clients meaning and understanding of their psychotic experiences. This has highlighted for me the disparity between the client's experience and the prevailing interventions that seek to reduce or eliminate hallucinatory experiences, seemingly ignoring the possibility that the client has a meaningful investment in their voice hearing.

The concept of 'investment' is readily applied to my own position to the topic. I am fundamentally aware of the impact my learning in certain theoretical models has on my approach to the literature.

Due to working for an organisation that provides psychodynamic psychotherapy for individuals with mental health problems, I am particularly influenced by the understanding of voice hearing experiences by psychoanalysts such as Freud (1856-1939), Klein (1882-1960) and Bowlby (1907-1990). Both Freud (1911) and Klein (1946), made use of Schreber's (1903/1955) autobiographical account of a psychotic breakdown who experienced multiple voice hearing experiences during his life, many of which were related to voices from God or supernatural powers. Schreber was a German jurist who wrote '*Memoirs of my Nervous Illness'*, (1903/1955) in part to defend himself against being detained due to mental illness and who became the most frequently quoted patient in psychiatry (Leudar & Thomas, 2000). Both Freud (1911) and Klein (1975) made use of the Schreber case to support their theories about psychosis and voice hearing. Freud

(1911) argued that Shreber's voices and particularly the one of God were a symbolised representation of his father and reflected the conflict with his father (Leudar & Thomas, 2000). Klein (1946) suggested that the voices were internalisations of his therapist (Leudar & Thomas, 2000). Although the specific interpretations of voice hearing vary according to different psychodynamic theories, they share some basic notions that there is meaning in the voices and that they reflect interpersonal experiences. It is these tenants alongside Freud's (1911) assertion that hallucinations can be considered an "attempt at a cure" (Freud, 1911, p.71) that particularly resonates with my experiences with voice hearing individuals and reflects the research focus. It is important to note that I have experienced many years of receiving psychodynamic psychotherapy which has been invaluable in helping me find meaning in my own experiences and this no doubt influences the psychodynamic values embodied in this research.

My background in psychoanalysis has set me on a professional and academic path that is highly questioning of the status quo of the psychiatric model, further enforced by my training as a counselling psychologist. This has played a role in my decision to adopt a literature review weighted towards research that seeks to explore the subjective meaning of voice hearing as oppose to the research that approaches voice hearing from a psychiatric, medical discourse. This presents a paradox, for psychoanalysis has its roots in neurology, and retains a deficit-based discourse. The struggle that remains in the psychoanalytic approaches, between a focus on the subjective meaning of the individual and attempts to be taken seriously by the 'scientific' community, reflects my own personal struggle and developing identity as a counselling psychologist. This personal struggle is considered in my critical literature review, and through engaging in the critical literature review I have become more aware than ever that this is a struggle whereby there is no clear remedy and voice hearing presents a phenomenon whereby this tension is acutely apparent.

I felt particularly frustrated by the positive voice hearing research. I was disappointed by research that stipulated it was interested in positive experiences but still framed experiences in a pathological light. In my experience this is a feeling shared by some voice hearing individuals in the therapeutic communities where I work, we suggest they try make sense of their voice hearing experiences and then encourage clients to take antipsychotic medication that may eliminate their voices.

Perhaps on some level my critical literature review is a way of trying to reconcile my own guilt and that the anger and frustration apparent in my literature review is in fact directed towards myself.

I find my theoretical interests are often met with prejudice in today's evidence driven mental health system. I also witness the narrow-mindedness and discrimination shown towards individuals who experience psychotic symptoms. I am often astounded by the open displays of prejudice, the residents I work with experience. The media I also feel is frequently guilty of biased and inaccurate reporting that fuels society's fear and intolerance for individuals who experience phenomena we cannot relate to or understand.
It does not escape me that my seeming crusade to advocate alternative approaches to voice hearing must reflect something of myself and is unlikely to be completely selfless.

Although I do not share an experience of voice hearing, I feel what I do share is the experience at times of an inability to 'fit in' due to my own experiences of a personality disorder diagnosis which is heavily stigmatised and consequently made me feel very isolated. Receiving a diagnosis led me to feel that I had something wrong with me that I had to fix, psychodynamic psychotherapy helped me understand that what I experienced was an understandable reaction to trauma, the 'problem' then moved from being located in me to the trauma I had experienced. The shift in responsibility had an irrefutably positive and life changing consequence for me.

Completing the literature review has provided me with a valuable learning experience. The review has broadened my views on the different theoretical models that have contributed to contemporary voice hearing understanding and research and countered my beliefs that research has been driven only by neurobiological underpinnings. I have uncovered an active and influential research body concerned with the interpersonal nature of voice hearing and how this has been readily applied to evolving therapeutic approaches to working with individuals who experience difficult voice hearing experiences.

Furthermore, the literature review has necessitated having to learn how to privilege research, critique papers and assimilate the literature whilst acknowledging how my own views and beliefs undeniably influence these processes.

The literature review has been conducted with the overarching aim of producing a meaningful and valuable contribution to research. Coupled with my individual long-term academic and professional goals this piece of work should be considered within this context. I consider myself to be an advocate of valuing the meaning in experiences and the importance of 'talking therapy' in facilitating this. As a trainee-counselling psychologist I have an emotional and professional investment in talking therapy, and my professional identification is immersed within the counselling psychology tradition and principles. My approach to interventions for voice hearing takes an alternative perspective to traditional pharmacological interventions, likely at least in-part borne out of my identification as a counselling psychologist and desire to protect the future of my professional membership and identity.

A significant challenge encountered in my literature review is concerned with balancing my personal and professional ambition with the constraints and boundaries of what is achievable in a doctoral piece of research. I have had to set my own boundaries with this piece of research and still find myself unable to prohibit my curiosity that ventures beyond the boundaries striving to learn everything there is to know in this field of research and beyond. It is profoundly easier for me to consider the ways in which I have influenced the process and outcomes of the literature review with the possibility of neglecting how the research has affected myself. Contesting this is challenging however I feel that I have experienced a change in attitude regarding my prior pessimistic beliefs about the future of research in the counselling psychology field. Previously I felt overly concerned with the practical and methodological constraints and how this limited the ability to explore new horizons in counselling psychology research.

I feel the greatest challenge to my research is in fact my own beliefs and views that create boundaries, negating the free-thinking creativity that was so unbounded in the psychoanalysts and psychologists that I aspire to and draw upon in the following review.

Critical Literature Review

Introduction

The following review embraces a CoP approach, informed by a critique of the statutory clinical guidance and the experiences of the voice hearers described in the reflexive statement, subsequently applying an interpersonal framework to the study of voice hearing. The review focuses on the interpersonal models of understanding that have dominated the research on voice hearing, namely the cognitive and psychodynamic models, with consideration of attempts to find a commonality across the interpersonal field through the recent development of the cognitive-attachment model (Berry, Varese & Bucci, 2017).

The final body of literature reviewed is that of qualitative and positive voice hearing research, and how despite promise to promote a new direction in research, they remain situated in the psychiatric discourse.

Definitions and abbreviations

Auditory hallucinations are the most frequently reported form of hallucination, commonly considered a feature of mental illness (Landmark, Merskey, Cernovsky, & Helmes, 1990) but increasingly recognised in non- clinical populations (Johns, Hemsley & Kuipers, 2002).

Auditory hallucinations (AH) refer to perceptual auditory experiences in the absence of corresponding stimuli in the external world (David, 2004). The phrase auditory hallucination has a psychiatric association and voice hearing is used wherever possible as a preferable alternative, defined by the Hearing Voices Network (2019) as someone hearing something that others around them aren't.

Auditory hallucinations (AH) are often considered a sign of a psychotic disorder. This view is endorsed by the DSM-5s (American Psychiatric Association, 2013) category of Other Specified Schizophrenia Spectrum And Other Psychotic Disorder (OSSSOPD), the diagnostic criteria for which are fulfilled with the sole presence of persistent AH, in the absence of any other psychotic symptoms (Waters, Blom, Jardin, Hugdahl,& Sommer 2018).

The review is concerned with the presence of voice hearing as oppose to specific psychiatric diagnoses, research discussed whereby this is of importance will be acknowledged accordingly

The psychiatric paradigm: Influence on statutory guidance and practice

Psychiatry frames the experience of voice hearing in psychopathology, discourse that binds it to the medical origins of psychiatry. Arguably the most influential figure in British Psychiatry was Henry Maudsley, whose work placed hallucinations as pathological and therefore indicative of mental illness, a view enshrined in currently clinical practice (Leudar & Thomas, 2000).

The belief that hallucinations demonstrate psychopathology means voice hearing is often situated within the frameworks of psychosis or schizophrenia. In 2012, the Schizophrenia Commission (SC) published the report "The abandoned illness" detailing a review of the outcomes of individuals diagnosed with psychosis and schizophrenia. The commission reported that 15% of the population in England experience psychotic symptoms and that "Unless properly treated, psychotic experiences can destroy hopes and ambitions, make other people recoil from you and ultimately cut your life short" (Schizophrenia Commission, 2012, p.4). The report highlights concern about defeatist attitudes towards psychosis despite it arguably depicting the very defeatist attitude it is wishes to alleviate, impacting on the hope that it is possible to live a fulfilling life following a diagnosis of psychosis.

The Schizophrenia Commission go on to state that, "the voice of the mentally ill is still being ignored" (Schizophrenia Commission, 2012, p.68). Remedial recommendations include; valuing service user's experiences, making their preferences central to interventions, tackling individuals and their family's frustration with the one size fits all approach and ensuring individuals are listened to and their experiences validated.

The Schizophrenia Commission report had closely followed the government white paper 'No health without mental health' (Department of Health (DoH), 2011), published with the aim of mainstreaming mental health services in England. The paper set out the objective to give individuals greater control and choice in their lives and tackling stigma and discrimination was considered the heart of this strategy. The recommendations stipulate that individuals need to be given greater choice, control and personalization, in order to respect human rights, dignity and autonomy. Since 2011 several government initiatives have been set out with the aim of addressing

institutional bias against mental health and developing parity of esteem with physical health services e.g. Closing the Gap (DoH, 2014). The most recent attempts to plan how to achieve this is set out in the joint DoH and NHS England paper "Achieving better access to mental health services 2020" (DoH, NHS England 2014). This initiative commits an increase in funding for early intervention in psychosis and young people's crisis care in addition to the introduction of waiting time standards for access to mental health services.

The National Institute of Mental Health in England (NIMHE) developed a national framework of values for mental health, concerned with recognizing the role of values alongside evidence in mental health policy and practice (DoH, 2004). The NIMHE was disbanded in 2011 and evidence from recent government papers suggest that 'value' is now increasingly considered in relation to the savings proposed for society by 'treating' mental health and the use of evidence-based practice to do so. Patient's values can appear at odds with these changing priorities (Petrova, Dale, & Fulford, 2006).

The psychiatric paradigm: Influence on treatment

The 'cost' of mental health problems to society is a frequently debated and increasingly politicised, with figures such as £100 billion disseminated to the public (DoH, NHS England 2014).

It is widely accepted that the aetiology and experience of 'psychosis' involves complex interplay of psychosocial and biological factors (Garety, Bebbington, Fowler, Freeman, & Kuipers, 2007) yet the evidence base of psychosocial interventions is not afforded the same weight in clinical guidance. One reason for this may be the composition of the guideline development groups (GDG), the professionals involved are predominantly from psychiatry, clinical psychology, general practice, nursing and psychiatric pharmacy (Guy, Thomas, Stephenson & Loewenthal, 2012). Professionals not belonging to the medical profession such as psychotherapists and social workers are underrepresented (Guy et al, 2012), despite non-medical factors such as social disadvantage being considered both a cause and consequence of mental illness (Horwitz, 2002).

Anti-psychotic medication is the primary treatment recommended in the seminal clinical guidance (Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (Update) (NICE, 2009). This is despite evidence that up to 40% of individuals show poor response to anti-psychotic medication (Kane et al., 1996), in addition to widespread non-compliance and disabling side-effects (NICE, 2009).

The NICE (2009) guidelines devote 174 of a total 377 pages of clinical guidance to evaluations of pharmacological interventions. Furthermore, the evidence base for the NICE guidelines is solely reliant on randomized clinical trials (RCTs). In RCT's participants are randomly allocated to either a treatment or control condition and the difference in outcome is then evaluated. The approach is founded on a broadly positivist approach to science (Guy et al, 2012) and has been heavily criticised in its appropriateness for evaluating psychological interventions (Concato, Shah & Howitz, 2000). RCT's for psychological interventions rest on the assumption that therapy can be standardised and is criticised for lack of acknowledgment of professional judgment and flexibility in responding to unique individuals (Guy et al, 2012). Further criticisms are that psychotherapy RCT's are not able to mirror clinical reality in the same way as drug trials because clients often present with multiple difficulties (Seligman, 1995), that there is a lack of consistency in what is used as the control therapy (Cooper, 2008) and that the cost of running an RCT is prohibitive for many researchers (Guy et al, 2012).

A recommended solution to the inequality of evidence used in clinical guidance is greater use of practice-based evidence, which is defined as good quality data which has been derived from routine practice (Guy et al 2012). Practice-based evidence enables real world practice such as psychotherapy to be examined and measured, as it occurs with a focus on experiences and process (Guy et al, 2012).

In 2014 an update was made to statutory guidelines with the production of the NICE Psychosis and Schizophrenia in adult's guidelines (NICE, 2014), the guideline stipulates that all individuals presenting with a first episode of psychosis should be offered antipsychotic medication and psychological therapy. The guidance stipulates that the only psychological therapy offered should be Cognitive Behavioural Therapy (CBT) (Beck, 1995) and other therapies such as counselling and psychotherapy have not been found to be helpful (NICE, 2014).

This is reiterated in the NICE Psychosis & Schizophrenia pathway (2017) which specifically recommends that individuals are offered sixteen 1to1 sessions of CBT adhering to a treatment manual that includes targeting symptoms and re-evaluation of people's perceptions and beliefs (NICE, 2017).

A feature of the aforementioned publications is the request for optimism in the treatment of psychosis, personalisation, and more consideration of psychological and psychosocial research and interventions. The hopes have not materialized in subsequent clinical guidance, on the contrary there is an ever-increasing focus on antipsychotic medication alongside manualized and protocol-based CBT (Guy et al, 2012). It is explicitly stated in the guidance that "You should not usually be offered other types of therapy" (NICE, 2014, p.8) and that this combination should be offered at both first- episode and all subsequent episodes of psychosis. This is despite impassioned debate over the efficacy of CBT for psychosis (CBTp) with some arguing that evidence in its favour is 'oversold' (McKenna & Kingdom, 2014).

The language expressed in the guidance continues to focus on 'treating' and 'removing' with antipsychotic medication advocated to "treat the symptoms of psychosis such as hearing voices" (NICE, 2014, pp.3-5). It may be that limiting clinical guidance development to professionals from a medical model with an associated hierarchy of evidence (Concato et al., 2000) restricts the possibility for alternative ways of understanding voice hearing that prioritises experiences and values of voice hearer's to be realised.

Voice hearing and Counselling Psychology

Counselling psychology (CoP) was officially recognized by the British Psychological Society (BPS) as a having a unique identity and philosophy of practice in 1994 (Corrie & Callahan, 2000). CoP is described as seeking to 'challenge the views of people who pathologise' (BPS, 2006, p.7) underpinned by the epistemological positions of the reflective practioner and humanistic value base (Larsson, Loewenthal, & Brooks, 2012). CoP professes to respect the subjective experience of the client over and above issues of diagnosis, whilst pursuing innovative phenomenological methods of understanding human experience (Lane & Corrie, 2006).

Psychosis is largely absent in Counselling Psychology literature and practice (Larsson et al., 2012) however this is likely to change with transformation in the location of counselling psychologists towards working in the NHS and more statutory organisations. Consequently, questions are being asked as to how Counselling Psychologists will be able to retain a humanistic value base when working within frameworks dominated by a medical model of distress (Larsson et al., 2012). It can be argued that applying a Counselling Psychology framework to understanding and working with voice hearing will help contribute to new directions and understanding of voice hearing that clinical guidance so far has failed to provide.

Critique of literature

The history of interpersonal understanding of voice hearing

Sigmund Freud (1911), considered the founder of psychoanalysis, was arguably the first clinician to suggest that there was meaning in psychotic experiences such as voice hearing (Josephs & Josephs, 1986). Freud inaugurated psychoanalytic theories of psychosis through his analysis of the memoirs of Schreber (1903/1988), a German judge who had a psychotic breakdown. It is in this case study that Freud first suggested that experiences such as voice hearing should be considered an attempt at recovery (1911), later elaborating that delusions served to patch a gap that had appeared in the ego relation to the external world (Freud, 1924). Freud provided an example, citing that he believed Schreber's perceived primary conflict with his father was displaced onto a God figure who was one of the main voices Schreber experienced (Freud, 1911). Of significance for the literature review is the suggestion by Freud that voice hearing experiences should be listened to rather than simply dismissed as pathological (Lucas, 2009). Freud's formulation of Schreber's experiences commenced a wealth of psychodynamic ideas and research of voice hearing experiences that are examined in greater detail further in the literature review.

In the 1980's, there was the emergence of a service-user movement promoting the needs and understanding of voice hearing. This began with a collaboration between the Dutch social psychiatrist Marius Romme, researcher Sandra Escher, and voice hearer Patsy Hag and became known as the 'The Hearing

Voices Movement' (HVM) (Corstens, Longden, McCarthy-Jones, Waddingham & Thomas, 2014).

In 1993 Marius Romme and Sandra Escher published 'Accepting Voices', credited with promoting change in perceptions of voice hearing. The book was based on a Dutch experiment asking voice hearers to discuss their experiences. The book became influential in providing a critique for the prevailing psychiatric model at the time, recognising that the psychiatric model failed to pay attention to the meaning of the voices within a person's life history. Marius & Romme (1993) recommended supporting people who experienced difficulties with their voices by helping them to change their relationship with their voices and utilise peer support to decrease social isolation and stigma. (Corstens et al, 2014).

With the support of Romme and Escher the Hearing Voices Network (HVN) was established in the UK in 1990, providing an organizational framework for voice hearing individuals that challenged the psychiatric model (https://www.hearing-voices.org/). Of particular importance has been the development of peer support groups for voice-hearers, known as "hearing voices, there are now over 180 groups hosted in a range of settings in the United Kingdom (Corstens et al, 2014). In subsequent years' networks were established in different countries leading to the development of International Network for Training, Education and Research into hearing Voices (INTERVOICE).

A question remains as to why the widespread and influential HVM approach has not been integrated into contemporary clinical practice, despite there being over 180 HVM based groups hosted in a variety of settings including inpatient units and child and adolescent services (Corstens, Longden, McCarthy-Jones, Waddingham & Thomas 2014). The HVM philosophy bares relevance to the report by the Schizophrenia Commission (2012) and hopes elicited in the 'white paper' (DoH, 2011) particularly of personalisation and choice, yet the current clinical guidance continues to overlook this. This may be a result of the position that the HVM takes, providing an alternative to the medical model that is heavily embedded in the statutory services and therefore associated guidance.

At a similar time to the emergence of the HVM, the possibility that individuals can have a relationship with their voice was reported by Benjamin

(1989), who conducted a seminal study on inpatients with schizophrenia igniting interest in applying cognitive models to voice hearing.

Benjamin (1989) used the Structural Analysis of Social Behaviour Questionnaire (SASB) (Benjamin, 1974) a self-report questionnaire that measures social interactions
around two axes. One, reflecting degree of affiliation (love-hate) and two reflecting interdependence measured through (dominate-submissive). The study was interested in whether relational interactions could be evidenced in the voice hearing relationships. The study concluded that all participants were able to describe interpersonal relationships with their voices using and according to the SASB measure. The relationships also demonstrated that responses to the voices was influenced by the interaction, for example voices that were considering nurturing then they would be trusted (Benjamin, 1989). The findings led Benjamin (1989) to conclude that 'the richness of social interaction can be found in the internal world represented by the voice' (p.308).
The SASB is limited in that it is used to quantify interactive patterns however the excerpts of the participants were provided described aspects of the voices including protective and adaptive functions.

Significant for the current literature review and further research is the introduction by Benjamin (1989) of the relationship with the voices being a possible adaptation and sometimes experienced positively, this was particularly evident in qualitative excerpts of the relationship provided by the participants. Despite its limitations, the study was fundamental in igniting the interest in applying cognitive models of relating to voice hearing experiences, which are explored in further detail below.

The cognitive model

Since the work of Benjamin in 1989, cognitive models of voice hearing have continued to be applied to voice hearing experiences focusing on beliefs and appraisals an individual has on the voices they experience (Mawson, Cohen & Berry, 2010). From a cognitive perspective the appraisals of the voices produce emotional responses such as anxiety which, then influence the reaction to the voices and even facilitate the occurrence (Chadwick & Berry, 1994).

In 2011, Hayward, Berry and Ashton conducted a review of the research on cognitive research of voice hearing. The review examined studies between 1965 and 2010, examining eighteen papers in detail.

The review revealed four main research areas; 1) Papers utilising the SASB model, following on from Benjamin (1989); 2) Studies drawing upon social rank theory (Gilbert, 1989), a cognitive model drawn from evolutionary psychology suggesting that humans, like animals use the mechanisms to either dominate or subordinate others in social environments; 3) Studies utilising Birtchnell's Relating theory (Birtchnell, 1996), and; 4) studies adopting qualitative methodology.

The 2011 study highlights a number of key areas of interest for this review. Firstly that there is a considerable body of research applying interpersonal theories to voice hearing. Furthermore, there is evidence of positive experiences of voices (Honig et al., 1998) with adaptive value (Ashton, Berry, Murray & Hayward, 2011) and that individuals both accept and refute relationships with voices (Chin, Hayward & Drinnan, 2009). The review also highlighted that evidence of relationships with voices has been discovered across clinical and non-clinical populations and is not limited to people with either a diagnosis of schizophrenia or psychosis.

Explored further in this critical review is that the cognitive studies, through desire to prove their own cognitive models of relationships could be applied to voice hearing have often neglected the subjective experience of 'relating' to a voice. The authors suggest that formulation of voice hearing would benefit from consideration of the interpersonal history of the person to develop a more idiosyncratic context of an individual voice hearers past and current relating. Attachment theory is suggested as a possible way of addressing the shortcomings of the cognitive research.
The review also highlights the lack of understanding of the potential adaptive nature of voices and observe and that this needs to be given greater consideration.

The 2011 review highlight Birtchnell's theory of relating (1996, 2002) as the dominant cognitive model in the study of interpersonal relationships with voice hearing. Birtchnell's (1993, 1994) social relating theory posits that relating revolves around two main axes, 'power' (upper/lower) and 'proximity' (close/distant). The theory distinguishes between 'positive' and 'negative' relating with negative relating associated with dominance, submissiveness, clinging and withdrawal.

In 2003 Hayward used the relating theory model to investigate the hypothesis that people relate to their voices in a similar way to how they relate to people in their social environment. The aim was to extend initial evidence obtained from a social rank perspective suggesting that power and rank issues between the hearer and voice-mirrored experiences in the individual's social world (Gilbert & Allan, 1998).

A sample of twenty- seven people were recruited from a community rehabilitation service, all had a diagnosis of schizophrenia and psychosis. Two measures generated from Birtchnell's theory of relating were modified and used in the study, one that assessed interrelating between voice hearer and the dominant voice and a second that assessed 'general relating tendencies' (Hayward, 2003).

A number of measures of voice hearing were also used including: 1) the Psychotic Symptoms Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier & Faragher, 1999), 2) the Auditory Hallucination Scale (AHS), used to assess negative content and intensity of distress and 3) the Revised Beliefs about Voices Questionnaire (BAVQ-R) (Chadwick, Lees & Birchwood, 2000), which measures beliefs about the voices and emotional and behavioural reactions to the voice.
The study looked at bivariate correlations between the measures of relating to others and measures of relating to the dominant voice, identifying significant positive correlations between the scales for upper-ness, lower-ness, closeness but not distance. The authors suggest the results support their hypothesis and signify that the way an individual relates to the voice may be reflective of a pervasive pattern of social relating. The study found that associations between relating to the voice and relating to significant others was independent of beliefs about or emotional responses to the voices (Hayward et al, 2003)

The study's methodology is not withstanding of potential concerns, the studies large number of measures, correlational design and small sample size is highly problematic for the likelihood of type 1 errors. Moreover, the internal consistency of some of the measures was at an unacceptable level and the modified versions of the questionnaires require further testing before they could be considered 'psychometrically sound'. Furthermore, the extent to which the measures may have been examining the same construct is questionable and may be confounded by participants having difficulties distinguishing between relationship with the voices and relationship with others in the social world.

The use of the PSYRATS (Haddock et al, 1999) is contentious because it focuses on the distressing impact and negative content of voice hearing, administrating this questionnaire prior to the other measures may have created a negative context and narrative within which the other measures were administered.

What is demonstrated in this paper and collaborates with the burgeoning research in this area is the idea that theoretical concepts of social relating appear applicable to individual's experience of relating to their voices, and that individuals are able to articulate or describe these experiences in the context of different measures and theoretical frameworks.

Vaughan & Fowler (2004) further extended the research utilizing Birtchnell's (1996, 2002) theory of relating with the aim of exploring the relationship between distress associated with voice hearing and the relationship with the voices. Thirty participants were recruited from community and hospital based mental health teams. Participants were asked to rate the distress they experienced in relation to their predominant voice on a 5-point Likert scale and then completed the same measures of relating to the voice and others in addition to the BAVQ (Chadwick & Birchwood, 1995). Eight of the participant's rated occasional or no unpleasant content and twelve described the voice as wholly negative. Bivariate correlations showed a relationship between distancing from voice and increased distress. In contrast to Hayward (2003) which found no relationship between distance and distress. Voice dominance was also associated with greater reported distress. Birtchnell's (1996, 2002) relating theory proposes that position of relating is determined by early experiences of relationships with others, (Vaughn & Fowler, 2004) consequently the authors hypothesise that individual's relationship with their voices may be influenced by previous relationships and past experiences.

As witnessed in the previous studies the research could be accused of creating a context whereby distressing and negative experiences of voice hearing are more readily accessed. Prior to completing the measures, the participants were asked to rate their distress and negative content of voices, the language used may prime a negative context for considering the experiences.

Recent research has divided cognitive models of voice hearing into two separate categories, the "vulnerability" models and "distress maintenance" models

(Berry, Varese & Bucci, 2017). The "vulnerability" models focus upon the cognitive 'abnormalities' perceived to be responsible for the formation of voice hearing such as self-monitoring abnormalities (Waters, Allen, Aleman, Fennyhough, Woodward, Badcock et al., 2012), dissociation and trauma (Longden, Madill & Waterman, 2012). The research in this area suggests that there is not one factor that is able to account for the 'vulnerability' to voice hearing and that there is likely to be a complex interaction of multiple cognitive factors (Upthegrove, Broome, Caldwell, Ives, Oyebode & Wood, 2016).

The "distress maintenance" model continues the work of Birtchnell (1996) citing evidence that specific cognitive appraisals such as disapproval and rejection of the voice in voice hearing were associated with distress (Mawson, Cohen & Berry 2010). Both the 'vulnerability' and 'distress' models of voice hearing have continued the tradition of a focus on negative and distressing experiences of voice hearing, the language of vulnerability and distress demonstrating this focus eloquently.

The cognitive research has provided a wealth of evidence that models of relating can be applied to voice hearing experiences and conflicting evidence as to which aspects of relating are associated with distress. However, the research has failed to consider the subjective experience of the 'relationship' with the voice and the meaning attributed to this. Psychodynamic models may provide a framework in which, meaning and subjectivity of the experience can be explored.

Psychodynamic models of voice hearing

Since Freud (1911), psychodynamic theories have been applied to the understanding of voice hearing experiences. Freud (1911) believed voice hearing to be symbolised representation of internal or relational conflicts, a view expanded upon by Melanie Klein (1882-1960). Melanie Klein was a psychoanalyst, influenced by Freud who developed 'Object Relations Theory' (1930). Klein suggested that infants internalise the relationships with their early care-givers incorporating two sets of object relations both 'good' and 'bad' which include representations of the self, the object, and the emotion that links the two. The internalised representations of the relationships then unconsciously influence the individuals later relationships (Klein, 1946). Projective identification is a key Kleinian concept whereby parts of the self

and internalised experiences are projected into an object, voice hearing experiences are considered in relation to this as split off parts of internalised experiences-projected outwards (Lucas, 2009).

A further key influence on psychodynamic theories of psychosis and voice hearing was R.D. Laing (1927-1989). Laing was a Scottish psychiatrist and psychoanalyst who wrote a seminal book on psychosis titled *'The Divided Self'* (Laing, 1960). Laing criticised psychiatry's preoccupation with classification, which he argued was invalidating subjective experience of individuals. Laing highlighted the need to understand people's experiences, sentiments that are hugely pertinent when critiquing the literature of voice hearing that fails to value subjective understanding and meaning of these experiences.

The most significant psychodynamic contribution to voice hearing has been the model of attachment theory (Bowlby, 1907-1990), born out of the object relations theory and which has provided extensive research of voice hearing experiences.

Attachment research

A focus on the 'relating' aspect of voice hearing has been largely absent from the research discussed, and attachment research has been posited as having potential to be able to address this.

Since the seminal work of Bowlby (1982) attachment theory has had a significant impact on theories and research concerning the nature of human relationships (Cassidy, 1999), and psychopathology (Platts, Tyson, & Mason, 2002) with limited research investigating its relevance to psychosis (Dozier, Stovall, & Albus, 1999), despite interpersonal difficulties being considered a hallmark of psychosis (Penn et al., 2004).

In 2007, Berry, Barrowclough & Wearden reviewed the literature between 1985 and 2004, that investigated attachment in psychosis. The review found that the majority of studies have been carried out by Dozier and colleagues using the Adult Attachment Interview (e.g. Dozier, Stevenson, Lee, & Velligan, 1991) focused on assessing and demonstrating disproportionate levels of insecure attachment security in individuals with psychosis (e.g. Dozier et al., 1991, Mickelson, Kessler, & Shaver,

1997). The review also found that insecure attachment style in psychosis has been investigated in relation to difficulties with therapeutic alliance (Svensson & Hansen, 1999; Tattan & Tarrier, 2000), interpersonal functioning (Harvey, 2001), coping style (Dozier & Lee, 1995) and poorer rates of recovery (Drayton, Birchwood, & 1998).

Research in this area has examined the relationship between attachment and psychotic phenomena. Berry, Wearden, Barrowclough & Liversidge used their 2006 study investigating the psychometric properties of the Psychosis Attachment Measure (PAM; Berry et al., 2006) to explore the relationship between attachment and non-clinical psychotic phenomena in a sample of university students, finding a positive association between insecure attachment and paranoia and hallucinatory experiences (Berry et al., 2006).

In 2008, Berry, Barrowclough & Wearden used the PAM, Positive Negative Syndrome Scale (PANSS; Kay, Opler, & Fiszbein, 1987) and an inventory of personal problems (Barkham, Hardy, & Startup, 1996) to study a psychiatric sample of patients with psychosis over a period of 6 months. The purpose of the prospective design was to address whether attachment style was confounded by psychotic symptoms. The results showed that attachment avoidance but not anxiety was significantly associated with paranoia and positive and negative symptoms and that there was a significant relationship between change in attachment anxiety and change in hallucinations.

Both studies used the PAM (Berry et al., 2006) which, generates attachment constructs of avoidance and anxiety, thus consistent with voice hearing research across the different theoretical paradigms there is a negative focus on the maladaptive aspects of attachment, as opposed to the core normative constructs of attachment theory such as resilience and adaptation.

Attachment and relationship with voices

The research has shown that individuals often consider voice hearing in terms of a 'relationship' however there is a lack of consideration of the nature of the relationship with the voices. This was addressed in a study that investigated the role of adult attachment and the nature of relationships with voices (Berry, Wearden, Barrowclough, Oakland, & Bradley, 2012). The sample consisted of seventy-three

participants with a diagnosis on the schizophrenia spectrum. The participants completed the PAM (Berry et al., 2008), the PANSS (Kay et al., 1987) and the PSYRATS (Haddock et al., 1999). The nature of the participant's hallucinations were recorded verbatim by the researcher and then used to classify the nature of the participant's relationship with voices. The voices were then classified into either of three categories of 'control', 'rejection/criticism' and 'threat'. The categories were based on the author's clinical experience and previous research investigating thematic associations between trauma and psychotic experiences (Hardy et al., 2005).

Voices were categorized based on *actual* content as oppose to the perceptions or beliefs of the participants. It is unclear why this decision was made and disappointing that the voice hearer's beliefs were not prioritised. From a Counselling psychology perspective, the meaning a person subscribes to a relationship would be considered of value over and above an objective categorisation of the voices content. Furthermore, the categories that participant's voices could be considered within, all share a negative nuance and the paper is focused upon the intensity and 'distress' associated with voice hearing.

The study found A positive correlation between attachment anxiety and severity and distress of voices but no association between attachment avoidance and dimensions of voice hearing. Regression analysis was utilized to explore the voice categories and attachment, distress was the only significant predictor of attachment anxiety, consistent with previous research (e.g. Berry et al., 2006), threat and criticism/ rejection were the only predictors of attachment avoidance.
As with previous research the study was correlational and the direction of relationships between variables cannot be ascertained. Furthermore, many of the participant's had voices that were assigned to more than category, which, compromises the analysis of independent relationships between themes and attachment.

Conclusion

In accordance with the cognitive research, the studies of voice hearing from an attachment perspective can be critiqued for a reliance upon medically framed narratives, neglecting the normative core concepts of attachment theory e.g.

resilience, adaptation and the secure base. There is an overreliance on quantitative methodology despite qualitative approaches to attachment being successfully applied in other research areas including eating disorders (Dallos & Denford 2008) and health settings (Frederickson, Kragstrup, & Denhlholm- Lambersten, 2010).

As with the cognitive literature there has been a significant lack of research concerned with the subjective experience of the 'relationship' with the voice and relational frameworks that could facilitate understanding of this. Furthermore, despite the evidence that individuals develop specific ways of relating to the voices there has been little attempt thus far to conceptualise relationships with voices as attachment relationships despite evidence that of voices providing companionship and an anticipation of loss if voices are not present (Moritz, Favord, Andreou, Morrison, Bohn, Veckenstedt et al., 2013).

The cognitive attachment model (CAV)

A recent perspective has sought to integrate the cognitive and attachment perspectives. The model delineates a proposed relationship between trauma and voice hearing through the mechanisms of disorganized attachment patterns that lead to insecure internal working models in combination with cognitive appraisals affecting emotional and behavioural reactions to voice hearing experiences (Berry, Varese & Bucci, 2017). The CAV model proposes that voices can be understood as dissociated parts of the self or trauma related intrusive memories in a similar vein to the early psychodynamic theories of Freud (1911) and Klein (1946) (Longden, Madill & Waterman, 2012). The model proposes that distressing voice hearing experiences are then maintained by insecure attachment patterns contributing to how voices are appraised and related to (Berry, Varese & Bucci 2017).

The model focuses on distressing experiences and highlights its own reliance upon a construction of voice hearing that's is unitary in focus and fails to acknowledge there may be phenomenologically heterogeneous experiences (Berry et al., 2017). This is despite the CAV model embedding itself within the notion that voice hearing relationships and wider social relationships are similar and possibly overlapping, with therapeutic interventions aimed at the 'relationship' with the voice. There continues to be little appetite to consider the relational experiences that may underpin non-distressing voice hearing experiences and how this may be

beneficial for informing interventions for supporting individuals with less positive experiences.

Qualitative research

The interpersonal research on voice hearing has been criticised for focusing on the researchers account at the expense of the voice hearer's own reports of their experiences. Furthermore, research is predominantly quantitative which, is surprising considering the nature of phenomenon under investigation. To address these issues, Chin et al., (2009) used an IPA methodology to explore voice hearer's relationship to their voices. The study consisted of nine voice hearers who underwent semi-structured interviews comprising of assessment of voices e.g. gender and frequency and then questions on their relationships in the social world and relationships with voices.

The use of a qualitative approach revealed rich and complex descriptions of voices by the voice hearers. Participants both accepted and refuted the idea of relating to their voice, when accepted the frameworks of power and intimacy were deemed intuitive to the hearer.

Unfortunately, the paper remains limited by the biases witnessed in the quantitative research with a focus on participants that reported distressing voice hearing experiences. This was despite acknowledgment that not all voice hearer's report distress and that much could be gained from understanding the meaning generated by people who have positive experiences (Chin et al., 2009). The linguistic and philosophical framework of this paper continues to abide with medical driven discourse despite the paper being informed by opponents of such an approach (e.g. Romme & Esher, 1993).

A further attempt at broadening the qualitative research is derived from a study exploring the wider social relational context of voice hearer's and how this is allied with relating to voices. Mawson, Berry, Murray & Hayward (2011), recruited ten voice -hearing participants via a mental health service. The study offered a sophisticated approach to IPA with participants consulted during the planning and design of the research materials. The reflexive statement acknowledges that the authors all held the belief that voice hearing was distressing and this influenced interviews with a focus on how participant's 'coped' with voices. The analysis

resulted in five interrelated themes, all of which reflected the premise of a 'relationship' with the voice. The hypothesis that the relationship with the voice could mirror social relationships was also supported (Mawson et al, 2011).

The participant's also described experiences in relation to closeness, distance and independence from voices, collaborating the prior research on these concepts that have been identified in previous research e.g. Hayward (2003). The study suggests psychodynamic models such as attachment theory, may be a useful theoretical and clinical framework to explore individual's relationships with their voices. Several of the participant's reported positive relationships with the voices although the study did not elaborate on these.

The authors suggest that understanding individual's attachment styles may be useful when seeking appropriate interventions to support individuals who experience distress from voice hearing. However, the study does not extend research beyond people who experience distress to those that report a positive or sometimes positive relationship and how this can inform therapeutic interventions.

The study, in accordance with previous research recruited participants from a clinical setting, who have been shown to experience greater rates of distressing voice hearing (Birchwood, Iqbal, & Upthegrove, 2005). It is encouraging that despite this, some participants still reported positive relationships with their voices.
The authors recognized that a focus on the 'distressing' aspect of the voices was apparent and likely a product of their professional context (clinical psychology), making attempts to 'bracket' these views. However, the papers central narrative is weighted upon the experience, understanding and interventions for distressing voices, despite being presented with evidence suggesting that even in clinical populations positive experiences are present.

Conclusion

The research examined in this review have a shared aim of identifying interventions to reduce the distress associated with the experience of voice hearing. The studies are often described as extending and developing the seminal work of Romme & Fischer (1993) however during this process the philosophical and epistemological underpinnings have become unrecognizable from the hearing voices

movement. This is to the detriment of an area of study that paradoxically may hold a wealth of interest for developing interventions for individuals who do require support in managing their voice hearing experiences. The cognitive research has failed to stay close to the phenomenon and experience of relating to voice hearing, instead focusing on classification of the content of voice hearing and how this is implicated in participants distress. The attachment research has neglected the normative aspects of attachment theory and again prioritised the researchers account, objective measures and distressing experiences. In several of the studies reviewed, participants have identified positive experiences (e.g. Mawson et al, 2011), however research prioritising positive experiences is very limited.

Positive voice hearing research

Research has shown that up to 60% of voice hearers report pleasant to positive effects of voice hearing (Copolov, Mackinnon, & Trauer, 2004; Nayani & David, 1996; Sanjuan, Gonzalez, Aguilar, Leal, & Van Os, 2004) and other studies have reported the support of positive voices against negative ones (Jenner, Nienhuis, Willige Van De, & Wiersma, 2006). Despite this, there is a significant lack of research concerned with positive experiences of voice hearing and most research has utilised inpatient samples that may over-represent negative experiences associated with voice hearing (Jenner, Rutten, Beuckens, Boonstra, & Sytema, 2008).

The positive voice hearing research is dominated by the use of psychometric measures such as the Positive and Useful Voice Inventory (PUVI) (Jenner et al., 2008) whose study on positive voice hearing in a community sample showed that a diagnosis of a psychotic disorder did not discriminate subjects with positive and/or useful voice hearing experiences. The study highlights the neglect of the subjective experience of the relationship to the voice. Interestingly, the authors discuss concerns that positive voices act as a barrier to treatment seeking, raising the concern that even attempts to study positive experiences are at risk of being framed within a negative and maladaptive context.

This concern can also be evidenced in other research. In a study of one hundred and forty outpatients the PSYRATS (Haddock et al., 1999), was used with an additional question added asking about whether the voices experienced were ever pleasurable (Sanjuan et al., 2004). 26% of participant's reported experiencing

pleasurable voice hearing, despite the PSYRATS being primarily concerned with eliciting information on distressing voice hearing.

More recent voice hearing research has been influenced by the conceptual shift toward a continuum view of anomalous experiences that extends across diagnostic categories and the 'healthy' general population, rejecting the diagnostic categorical models of mental health. The continuum model has gained considerable epidemiological support (Linscott & Van Os, 2013) and is able to situate itself much closer to the values underpinning the HVM, in normalizing experiences and reducing stigma.

In 2016, Baumeister, Sedgwick, Howes & Peters conducted a systematic review of the healthy voice-hearer literature reviewing 36 studies, 27 of which explored the phenomenology of voices. Despite the focus on healthy voice hearing, 23 of the studies still retained a focus on exploring distress and the vast majority relied upon the PSYRATS (Haddock et al., 1999) and other structured measures of assessment.

It is disappointing that despite the influence of the HVM and challenges towards the categorical approach to mental health that there has been little appetite to develop the research interest in positive experiences. Moreover, studies of the 'healthy' voice hearing population are still reliant on measures developed within the psychiatric paradigm to measure distress. It can be argued that the term 'healthy' although may have good intentions, itself colludes with the disease model of framing voice hearing as either healthy or non-healthy.

Clinical applications

Berry et al., (2008) highlight the potential clinical relevance of attachment theory to supporting individuals with psychosis specifically focusing on increasing engagement (Slade, 1999) improving therapeutic interactions (Mallinckrodt, 2000) and application to communication, sensitivity and consistency in clinical practice (Goodwin, 2003).

There is evidence of consistent voice hearing despite treatment (Sanjuan et al., 2004), and that it is the emotional response not the content of the voice hearing that differentiates patients and non-patients (Jenner & Van De Willge, 2001). This suggests that interventions for individuals who want support with voice hearing

should be aimed at the response to voices rather than attempts to eradicate the voices themselves (Jenner & Van De Willge, 2001).

Perez-Alvarex, Garzia-Montes, Perona-Garcelan & Vallina-Fernandez (2008) have called for new perspectives in developing interventions for working with voice hearing, with the cognitive paradigm subsequently developing 'relating therapy' (Hayward, Overton, Dorey, & Denney, 2009). Relating therapy is based on Birtchnell's (1996) theory of relating and aimed at supporting individuals to take an assertive approach to their voices whilst considering the relationship to their voice in the context of their interpersonal history.

Relating therapy highlights the potential importance of individual's interpersonal contexts and histories, in developing understanding and interventions for voice hearer's and there is a clear rationale for exploring this in the context of positive experiences.

Application to counselling psychology

Consideration of the current context and recommendations stipulated in the reform of the mental health system (DoH 2011; Schizophrenia Commission 2012; Nice 2009, Nice 2014) suggest there is a clear obligation for services to develop interventions according to the needs and the experience of individuals. This can only be achieved through prioritising the experience of individuals, concordant with the framework and values advocated by CoP (Lane & Corrie, 2006). The literature review has highlighted limitations in the literature that fail to realise the aspirations of mental health reform. Applying a CoP framework that attempts to refute the pathologising narrative and prioritise the subjective experience of voice hearing, will add a valuable resource to individuals experiencing and working with voice hearing.

In addition, approaching this topic from a CoP perspective offers a unique position that may advance interventions that so far have failed to make real progression away from psychiatric and medical dominance, offering potential alternatives through listening to voice hearer's that are able to manage or find positive experiences in their voice hearing.

It is regrettable that despite voice hearing being a phenomenon that most practioners and researchers may have little direct experience of themselves, the

research has neglected to consider the value of allowing voice hearers to discuss their experiences free from a discourse that is focused on distress and deficit. Little consideration is given to how this potentially reinforces the stigma and discrimination so widely experienced by the voice hearing population.

CoP professes to prioritise the subjective experience of the client over and above issues of diagnosis, whilst pursuing innovative phenomenological methods of understanding human experience (Lane & Corrie, 2006). Adopting this ethical stance will provide an invaluable opportunity for promoting an alternative avenue of research and practice in an area of psychology and mental health service provision that is so evidently desperately required.

Conclusion and Research Proposal

The review has examined the literature exploring dominant paradigms in the study of interpersonal theories of voice hearing. The research suggests that voice hearing in itself is not a psychopathological disorder, it is the conceptualization of the experience and psychiatric context that situates the experience in the pathological domain (Corstens et al, 2014). The medical model continues to focus on elimination of voices despite a lack of evidence of the benefit of this to the voice hearing population. Moreover, medication is ineffective at reducing voices and rather it is likely to increase stigma and social isolation (Romme & Escher, 2009). The research has suggested that voice hearing should be understood in relation to the hearer's interpersonal context (Rojcewick & Rojcewick, 1997) and yet there has been a significant lack of qualitative research that can support understanding of the subjective experience of hearing voices, with an overreliance upon psychometric measures designed to elicit negative experiences.

Furthermore, despite interpersonal theories of voice hearing attempting to understanding the individuals experience of voice hearing, the research has often neglected to consider the subjective experience of 'relating' and instead has focused on classifying the content of relational voice hearing experiences into categories e.g. distance and how this is related to distress.

Psychodynamic theories such as the attachment model (Bowlby, 1982) provides a context in which the subjective experience of 'relating' could be explored.

However, attachment research has not adequately addressed this and neglected the possibility of normative and adaptive attachment experiences of voice hearing.

The value base and epistemological underpinnings of the research has been primarily concerned with 'distressing' experiences of voice hearing, with a pathologising narrative a feature of much of the research, including the research addressed primarily at positive experiences. This can be understood in the context of the research primarily being carried out in clinical settings. Paradoxically this has negated research that would address the vision and aims of statutory and clinical guidance (Schizophrenia Commission 2012; DoH 2011, NICE 2014).

The research has also failed to incorporate the values and aims of the HVM, who have highlighted the importance of personal narratives, empowerment and normalisation and who have explicitly called for qualitative approaches to research that prioritise the voice hearer's own narrative (Corstens et al, 2014).
Accordingly, the research question propositioned is as follows:

How do individuals make sense of positive voice hearing experiences?

The research question aims to elucidate features of an individual's positive experiences of voice hearing, using an IPA methodology that allows detailed exploration of the meaning participants attribute to their experiences (Smith & Osborn, 2007). The study will utilise a community sample of participants not currently experiencing inpatient treatment, to provide opportunity for the potentially more adaptive and positive function of voice hearing experiences to be explored.

Methodology

Qualitative research

Quantitative research has dominated the psychological inquiry of voice hearing. Likely to be a result of a shared positivist epistemology and values in the medical model, with aims to generalize findings and remain replicable. Positivism is an approach to science based on a belief in universal laws, objectivity and neutrality (Thompson, 1995), investigated by testing hypotheses.

Research using qualitative methods acknowledges the existence and study of a multitude of views and voices, allowing reality to be constructed and knowledge to be mapped out. Yet, this knowledge cannot be understood without understanding the meaning that individuals attribute to that knowledge and their beliefs, feelings and actions (Illingworth, 2006). How knowledge is constructed in qualitative research is framed by the philosophical underpinnings of the method chosen for the qualitative research

Interpretative phenomenology analysis (IPA)

IPA was developed by Jonathan Smith and introduced in his (1996) paper which, argued for a qualitative approach in psychology that could encompass an experiential focus whilst still be compatible with mainstream psychology. IPA is primarily concerned with exploring individual's experiences in detail, from the individual point of view, with small homogenous samples, typically using semi-structured interviews.

Epistemology

IPA has been described as 'an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of philosophy of knowledge: phenomenology, hermeneutics and ideography' (Smith, Flowers and Larkin, 2009, p.11). IPA draws on each of these theoretical approaches to inform its distinctive epistemological framework and research methodology.

Phenomenology

Phenomenology is both a philosophical approach and a range of research methods concerned with how things appear to us in our experience (Shinebourne, 2011). Husserl (1859-1938), an imminent phenomenological philosopher argued that we should go back to the 'things' themselves, with a phenomenological attitude, focusing on how we experience our own psychic life (Husserl, 1927). Husserl developed a method of adopting a phenomenological gaze, whereby through a series of steps, termed reductions we move from assumptions and distractions to reflect upon salient particularity of a phenomenon (Smith et al., 2009). Husserl's influence on IPA has primarily been through the focus of attention, on the systematic examination of conscious experience and the importance of reflection.

Sartre (1905-1980) was another influential phenomenological philosopher whose ideas helped shape IPA. Sartre (1948) stressed the importance of the developmental aspect of the human being, and how we are engaged in a constant process of becoming. Sartre (1948) emphasised the importance of how our place in the world is shaped by the presence and absence of others and how we cannot conceive of our experiences without consideration of others. Through the work of these philosophers and many others, the development of the theoretical underpinnings of IPA with its focus on the complex process in understanding human experience can be witnessed.

Hermeneutics

Hermeneutics is the theory of interpretation. Historically, hermeneutics developed from interpretations of religious texts but was subsequently expanded to become a more general theory of interpretation. Although phenomenology and hermeneutics were developed as two separate philosophical movements, Heidegger (1889-1976) presented hermeneutics as a prerequisite to phenomenology, highlighting how we bring our previous experiences, assumptions and pre-conceptions to an encounter (Heidegger, 1962). Heidegger (1962) said that in 'interpretation' priority should be given to the 'new encounter' which, may then amend the understanding of our initial assumptions and pre-conceptions. Heidegger's (1962) perception of phenomenology as fundamentally an interpretative process is clearly connected to the IPA approach. This helps the researcher consider how their prior assumptions influence interpretation and vice versa, an idea taken up

and expanded upon by Gadamer (1900-2002) and which, became known as the hermeneutic circle or 'double hermeneutics' (Gadamer, 1990).

Idiography

Idiography comprises the third major influence on IPA. Idiography in contrast to psychologies nomothetic approach refers to a focus on a 'particular' (Smith et al., 2009) both in the attention to detail and in the depth of the analysis. This is reflected in IPAs focus on the in-depth understanding of the experiences of individuals. Idiography is predominantly associated with case studies and although IPA uses a number of cases to develop overarching themes, it shares the ability to be able to be able to retrieve the original statements of the individuals, in comparison with nomothetic approaches where data is transformed preventing retrieval.

Conclusion

IPA has been significantly influenced by the three branches of philosophy described. The decision to utilise IPA is the result of identifying the most suitable method to correspond with the research question but also a product of a consistency with the researchers own epistemological position and beliefs. IPA considers itself to represent the 'light' end of social constructionism, particularly in comparison to discourse analysis (Smith et al., 2009). This position relates to Mead's (1934) argument that although individuals are shaped by societal and cultural forces, as developmental individuals we in turn shape and rework these influences.

Alternative qualitative approaches

There are several different methods of researching a phenomenon from a qualitative position that were considered in the process of selecting IPA as the chosen method.

Grounded Theory

Grounded Theory is often employed as a suitable qualitative method for in-depth exploratory investigations (Charmaz, 1995) and therefore considered for the study. Grounded theory is designed to systematically investigate processes from the bottom up, with the hope of an overarching theory evolving from the data analysis (Willig, 2008). Grounded theory is significantly influenced by symbolic

interactionism, the idea of understanding the world by interpreting human interaction through symbols e.g. language (Willig, 2008). The approach is limited in terms of reflexivity and it has been argued that research questions about the nature of experience are more suitably addressed using phenomenological research methods. (Willig, 2008). In consideration for this research, a further discrepancy was that the study was not aimed at developing an overarching explanatory understanding about how positive voice hearing is understood, furthermore grounded theory can struggle with being able to capture the complexities of individuals lived experiences of a phenomenon which was the primary research focus (Smith et al., 2009).

Foucauldian Discourse Analysis (FDA)

FDA (Foucault,1982) subscribes to a stronger form of social constructionism than IPA, with a focus on the structure of the context in comparison with IPAs focus on the individual's experiences as related to the context (Smith et al., 2009). Although the literature review highlights the how voice hearing experiences are influenced by their understanding and framing within society this was not the focus of the research and subsequently FDA was not adopted. Furthermore, a prime distinction between IPA and FDA is that FDA examines the role of language in describing the person's experience, while IPA explores how people ascribe meaning to their experiences in their interactions with the environment (Smith, Jarman & Osborn, 1999) in accordance with the research aims.

Narrative approaches .

Narrative psychology also developed out of social constructionism whilst adopting some phenomenological aspects (Bruner, 1990). Narrative analysis is concerned with exploring the meaning of experiences through individual personal accounts.

A narrative provides an important method for exploring psychological development, the self and people's inter-relatedness with their world (Gergen, 2001b). The framework of narrative approaches bare similarities to IPA, however the focus of IPA is on the meaning of the experience itself. In narrative approaches the focus is not on the experience per se but how the experience is told and why. This refers to how stories are constructed, with a focus on content, process and interpretation (Bruner, 1990).

Research questions and interview schedule

An IPA study requires research questions that are exploratory, with a focus on meaning and sense making for people who share a particular experience (Smith et al., 2009). The research question was concordant with the principles of IPA and designed to address the absence of the 'voice' of the voice hearers in the research.

IPA utilises interviews to collect data, aimed at facilitating a discussion that enables the research question to be answered subsequently via analysis (Smith et al., 2009). In accordance with this the interview schedule questions did not explicitly ask the participants the research question but instead were open ended and exploratory opening- up discussion about different aspects of the experience.

The interview schedule (Appendix A) was drawn up and then reviewed by the thesis supervisor and discussed with peers until the researcher had cultivated a final 9 questions from the initial 17 possible questions. Although some researchers using IPA do not use an interview schedule, preferring to follow an unstructured, participant led approach (Smith et al., 2009), it was felt a semi-structured interview schedule would enable the research question to be kept in mind. Allowing a considered and thoughtful approach to more sensitive topics, as well as moderating any potential anxiety experienced by the researcher that may have been in detriment to the interview.

In practice the interview schedule was used as a guide only, the interviewees were all able to engage in a relatively participant led discussion, demonstrating considerable openness and enthusiasm to discuss their experiences. Further reflection on this process is included in the discussion.

Both the interview schedule and the potential interviews were discussed with an 'expert by experience'. This person was a voice hearer working in psychiatric services who provided feedback on the interview questions, conducting interviews and ideas for recruitment. A pilot interview was conducted with colleagues which helped the researcher become familiar with the questions. This enabled the researcher to focus on engaging with the participants during the interviews as oppose to reading the questions on the schedule.

Participant's and recruitment

Participants were selected purposively (all had positive voice hearing experiences) in accordance with IPA epistemology (Willig, 2008). Five participants were recruited who were interviewed and their data used in the study. The number of participants was chosen in accordance with IPA recommendations (Smith & Osborn, 2007) and to allow significant and detailed focus on a smaller sample of individuals experiences. No interviews were discarded.

The study utilised exclusion criteria (see appendix B) to fulfil risk management and ethical concerns. Participants were not able to participate if they had; 1) received psychiatric in-patient treatment in the past six months, 2) were experiencing significant difficulties or stressful life events, 3) were alcohol dependent or using illicit substances, 4) had experienced a previous negative reaction to talking about voice hearing or 5) if there were difficulties in being able to attend an interview at a place of their choosing.

At the outset of the study it was advised by one of the study supervisors that to seek ethical approval a criterion should be added which requested GP approval for a participant to take part in the study. This was suggested based on managing the potential risk that interviewing people who experience voices could mean that the participants had a greater potential for experiencing mental health problems and becoming disturbed by the experience of taking part in the study.

The suggestion was that the GP would be able to advise on whether they felt the participant would have any negative reactions from taking part. This caveat posed several problems in terms of capacity and stigma which are elaborated upon further in the discussion. No participants were recruited whilst GP approval was required due to the implications and meaning it held for voice hearers. Ethics was resubmitted and approved in 2017 with the removal of the criteria for GP permission. All five participants were recruited following the new ethical approval.

The study was focused upon positive experiences of voice hearing, participants who also experienced negative voice hearing experiences were not excluded but were made aware that the interviews would not be discussing negative experiences.

Participants were recruited from non-medical community settings, information was sent to hearing voices groups, on-line hearing voices groups, community mental health groups, and local mental health or community services

such as MIND. Interviews took place in hired rooms most often used for meetings or community groups in local community services, close to the participant's location and wherever possible and practical of the participant's own choosing.

Table 1.

Participant demographics

Participant	Adam	Lucy	Daniel	Bryony	Jessica
Gender	Male	Female	Male	Female	Female
Age	35-45	55-65	45-55	25-35	45-55

Data collection and analysis

Semi-structured interviews were conducted that lasted roughly 1 hour. The interview schedule was used as a guide rather than to constrain the interview, aimed at providing a context for the participant to describe their experiences, in their own words, in accordance with Smith et al. (2009). The researcher aspired to create an open and empathic, non-judgmental space, avoiding the use of jargon and ensuring the interview setting was comfortable and confidential. Breaks were offered during the interview process and one participant requested a cigarette break during the interview.

Data was analysed in accordance with the procedures described by Smith et al. (2009):

Stage 1: Reading and Re-reading

The interviews were recorded on a Dictaphone and the recordings saved upon a memory stick kept in a safe and on a password protected laptop. The recordings were transcribed using secure translation software due to time and practical constraints (see discussion). The transcripts were read through by the researcher whilst listening to the recording to check for the accuracy. The transcript layout was designed so that they included wide margins on either side to enable the analysis. Transcript one was read and re-read. During the re-reading the left-hand side of the transcript (within the empty margin) was used to note initial observations and feelings. Any judgements or significant observations retained from the interview or

thoughts about personal reflexivity were written down in a 'research' notebook to 'bracket' (Smith et al., 2009) them off for the time being.

Stage 2: Initial noting

The researcher then re-read the transcript, immersing themselves in the data, looking for what is interesting or seems significant about what is said and making initial notes on the left-hand margin of the transcript. The types of noting were divided into descriptive, linguistic comments and conceptual/ interpretative comments which were all written on the left-hand side using different colours to code for the different type of comments. The researchers own initial thoughts and feelings were also placed in the left-hand side of the transcript but in brackets.

The transcripts were rich in data and subsequently this process was repeated several times to ensure that there was a corresponding detail and richness to the analysis. The researcher began by reading through noting only descriptive comments as this felt a good way to engage with the actual content of the participant's account and sense of this. Following this the transcript would be re-read making the other notes and further descriptive comments if required.

The researcher was aware of a tendency to fall back to superficial reading and would correct themselves and return to detailed reading when this was recognised. By using different colours there was a visual aid at a glance of when there appeared a bias to a particular type of comment e.g. if the notes were mostly in the colour indicating descriptive comments.

The descriptive comments were focused on the semantic content and staying close to what the participant said and therefore the explicit meaning. The linguistic comments were focused on the specific way in which the language was used e.g. the use of metaphors. The conceptual comments referred to the interpretative and more abstract suggestions from the transcript.

Following the initial noting, the researcher made one last read through of the transcript focusing only on the interpretation of the transcript, ensuring this was detailed and rich but still evidenced in the transcript. Finally, the researcher would write a short paragraph in the research diary, providing a summary of what the participant seemed to be saying about their experience in the interview. This was done following the advice of an IPA workshop the researcher attended.

Stage 3. Emergent themes

This stage of analysis engaged the right-hand margin of the transcript transforming the initial notes into emerging themes. The researcher utilised the notes on the left-hand side to begin developing phrases and themes that captured a sense of what was found in the text. This stage of the analysis signifies a step away from the text and focus on the initial notes on the left-hand column. See Appendix C for an excerpt of a transcript exhibiting the analysis.

Stage 4. Connecting the themes

This stage involved delineating patterns and connections within the themes. The researcher typed up the themes and began attempting to group them together, experimenting with looking at how the different themes related to each other. The researcher printed these out, spread them out on a large surface in the groups and made further changes. Any themes that were poorly represented or evidenced and/or lacked depth were removed.

When groups of themes were identified, phrases or statements were developed that were able to surmise the theme, thereby denoting a 'super-ordinate' theme. For some themes the super-ordinate 'title' was a short excerpt of the transcript itself. There was not a rigid way of organizing themes, the researcher was open to different ways in which themes could be connected e.g. the function the theme had, chronology and contextual factors.

Stage 5. Representation of the themes

The subordinate themes and different emergent themes were then graphically represented in a table with corresponding quotes from the transcript. Although more time consuming, the researcher included the whole quote from the transcript as oppose to a link or few words and included all the quotes that were appropriate not just a sample. The researcher felt this ensured that the meaning of what the participant wanted to say remained in mind and that themes that were poorly evidenced or rarely represented were able to be identified. Being poorly evidenced did not itself indicate that a theme would be discounted, as it was recognized that at times a very meaningful concept may be referred to quite briefly, particularly when a topic or idea is emotive and difficult to talk about. When themes were poorly evidenced then caution was taken to see whether further evidence could be found in

the transcript particularly whether there was more nuanced representation elsewhere that had previously been missed.

Stage 6: Further transcripts

The same stages of analysis were then completed for the next transcript. In order to try delineate a clear break from the previous transcript, the previous transcript and all work relating to this e.g. the summary, themes and working though were all placed away, out of reach, to represent a symbolic action to remove from being held in mind by the researcher. When completing the analysis for the other transcripts, any apparent links or observations that came to mind that appeared to reflect a prior transcript were written down on a separate page in the book used to document the summary paragraphs. Once all transcripts had a super-ordinate theme table, they were printed out along with the quotes from the transcript.

The task was then to look for connections across the transcripts and develop 'super' super-ordinate themes and sub-themes within them. To do this a quiet room was booked at the researcher's place of work, the researcher then spread out all the printed out super-ordinate themes, using large pieces of paper ordinarily used for a flip chart, the themes were grouped together in different ways until a theme developed that was able to represent something significant and uniting in the participants experience.

The quotes were all printed out and the participant number was written on the quote, they were placed on the flip chart paper which enabled the researcher to see how well the theme was represented for each participant. A different colour was assigned to each participant and a mark placed upon each quote to make this easier. In the initial analysis four major themes were identified, with 3-4 sub themes in each. Following advice from the project supervisor and the suggestion that the themes were too descriptive, this final stage was repeated once more, with careful attention being paid to potential overlap, and overly descriptive themes. Following the further analysis three distinct major themes were identified with between two and three sub-themes for each. These were then typed up into a master theme table (See Appendix D).

Quality assurance

The use of quality, credibility and validity assurance practices in qualitative research is debated and there are concerns that qualitative researchers are under pressure to adopt quality guidelines used in quantitative research (Hoyt & Bhati, 2007). It is argued practices designed for quantitative research can threaten the foundations of the qualitative approach and difference in approach it seeks to advocate (Hoyt & Bhati, 2007).

Accordingly, some researchers e.g. Brocki and Wearden (2006) completely reject the notion that qualitative research should seek to have a generalized set of guidelines, however the general consensus appear to favour the use of quality guidelines specific to qualitative approaches that can still protect the interests and aims of the different qualitative approaches.

Smith et al. (2009) recommends two approaches that adopt a sophisticated, accessible and pluralistic approach to assessing the quality of qualitative research (Elliott et al., 1999 & Yardley, 2000). The current study adopted the use of Yardely's (2000) framework for validity in qualitative research due to the extensive discussion that Smith et al. (2009) has engaged with in respect to its application and value for IPA. Yardley (2000) suggested four main principles for ensuring quality in qualitative research, 1. sensitivity to context, 2. commitment and rigour, 3. transparency and coherence, and 4. impact and importance.

Sensitivity to context

Sensitivity to context refers to whether the analysis and interpretation is sensitive to the data, the social context, and the relationships (between researcher and participants) from which it emerged (Yardley, 2000).

The research subject is a sensitive phenomenon and the participants are more likely to have experienced stigma and exclusion, the choice of IPA as a methodology is itself an attempt to retain sensitivity to the context by valuing the participants idiographic experiences. Furthermore, the research focus on positive experiences may promote a less stigmatising and less judgmental context to the research.

The researcher has worked for a number of years with individuals with severe mental health issues who are extremely marginalised, many of whom have experience of voice hearing. The researcher has utilised this experience and understanding to provide sensitivity to the participant's context and ensure that this was held in mind

in the interviews. The researcher remained mindful of the potential power imbalance and the pertinence for the participant group, the researcher ensured that they adopted an empathic and non-judgmental approach whilst interviewing participants.

To remain sensitive to the data, Yardley's (2000) suggestion was followed to closely ground analysis in the empirical data, as well as pro-actively seeking findings that go against the researcher's own ideas about the topic (Yardley, 2000).

Commitment and Rigor

The researcher has demonstrated commitment to the research in numerous ways. The researcher has worked for the last 12 years in mental health settings with the most disadvantaged and excluded individuals in society, many of whom are voice hearers. The researcher has immersed themselves in the context of voice hearing, both academically and professionally, attending a wide variety of conferences both as a participant and presenter. The researcher has attended multiple trainings on IPA tailored to different stages of the research and analysis, whilst also engaging in CPD related to the subject and teaching on a post-graduate course that provides a psychodynamic approach to understanding voice hearing.

Rigor refers to the thoroughness of the study. To enhance rigor, the researcher practised interviews on colleagues to enhance interview skills. Furthermore, an experienced IPA researcher who taught on one of the attended trainings provided constructive feedback on the initial analysis and emerging themes of the first transcript, the project supervisor also provided feedback on the initial master themes developed. A number of on-line IPA sources were utilised to observe how IPA had been applied in research and to explore examples of the analysis particularly the development of major themes.

Transparency and coherence

The process of recruitment, data collection and stages of analysis are provided in detail to demonstrate transparency in addition example excerpts of the transcript and analysis provided in the appendices (Appendix C & D). To ensure coherence the underlying theoretical assumptions of the IPA approach are consistent with the research conducted and the voice hearing experiences of the individuals remains the focus of the thesis.

Impact and importance

Smith et al. (2009) highlights how the research needs to be considered useful and relevant. This is addressed in both the literature review and discussion, the aspiration throughout the process has been to ensure the outcome of the research is to contribute a piece of research that is unique, interesting and useful. The research has been selected to be discussed at several conferences and has been particularly commended for its unique focus on positive voice hearing experiences.

Ethics and risk management

Risk management

Voice hearing is considered a sensitive area of study, it is often a personal and emotional experience and many voice hearers will avoid discussing their voice hearing experiences for fear of stigma and discrimination.

The study of sensitive topics is considered to generate more than a minimal degree of risk according to the BPS (2010) which, defines risk as the potential physical or psychological harm, discomfort or stress to human participant's that a research project may generate (BPS, 2010).

In addition, the sample of participants were taken from a potentially more vulnerable group in society more potentially likely to have a mental health diagnosis or history of psychiatric care. The BPS (2010) recommends that where an element of risk is unavoidable a thorough risk management protocol should be submitted to the research ethics committee. In accordance with this a risk assessment was included in the research proposal submitted to the ethics committee. As part of the management of risk a distress protocol was utilised for interviews and the screening process (See appendix F).

A number of ways in which risk could be minimized were identified, including the research focus on 'positive experiences' and use of an exclusion criterion (See appendix B).

Risk was further minimised by using an initial screening questionnaire (Appendix B) to screen participants for acute states of emotional distress or difficulties that may have predisposed them to become unsettled by the research.

The study was approved by the London Metropolitan Research Ethics Committee (July 2017) and complied with the universities research code of conduct.

Following the interview, the participants were provided a debrief (Appendix G) that provided information and contact details for support services local to the individual if required.

Informed consent

In accordance with the BPS (2010) Code of Ethics and Conduct, written informed consent was sought from the participants, and participants were provided an information sheet (See appendix J) with the necessary information to enable the participants to make an informed decision. All participants were informed that during the data-gathering phase, they could freely withdraw or modify their consent and to ask for the destruction of all or part of the data that they have contributed. Participants were given a two- week window of opportunity after which they were informed that the audio recordings would be transcribed and analysed. Participants were informed that the audio-recordings would be destroyed following submission of the thesis and an estimated date given.

Proportionality

The research adhered to the BPS (2010) principle of proportionality, whereby procedures for consent need to be proportional to the nature of participation and the risks involved. Information was provided prior to the interview (given out in voice hearing groups) and again at the time of the interview. This enabled the participants to have multiple opportunities to consider taking part in the study. Participant's signed to say they understood the information, consented to take part in the study, and have the interview recorded and transcribed.

Confidentiality

The principles of confidentiality were explained to the participants and the data gathered was anonymised, identifying information relayed during the interview were removed from the tape. The tapes were stored safely and securely and will be destroyed following completion of the doctoral programme.

Participants were informed of the exception to confidentiality as part of the informed consent form, which stipulated that if the researcher was concerned about the participant's risk to themselves or others then appropriate services will be contacted. Participant's and their voices were given a pseudonym.

Reflexivity

Reflexivity is considered imperative in qualitative research (Shaw, 2010). Reflexivity presides around the argument that it is necessary for researchers to reflect on how they may impact upon the research when gathering and analysing data (Shaw, 2010). There has been considerable debate on the specific definition and meaning of reflexivity in qualitative research which is considered largely defined by the philosophical approach of the researcher.

Woolgar (1988) postulated a continuum of reflexivity, at one end '*benign introspection*' where the researcher maintains a positivist stance, attempting to provide an 'accurate' representation of the participant's account. At the other end of the continuum is '*radical constitutive reflexivity*' which takes a postmodern stance that reality is constructed contemporaneously (Shaw, 2010) and the researcher must ensure the gaze is turned back onto themselves consider the dyadic nature of how reality is construed.

The position of the researcher is more closely aligned with the radical constitutive reflexivity end of the continuum drawing upon the work of Heidegger (1962), who argued that when new things are encountered, they are experienced as already interpreted and that meaning-making is a core part of the human experience, but takes place within the constraints of the world in which we live (Heidegger, 1962).

Accordingly, it is perceived that the researcher's beliefs about the world, themselves and understanding of their own experiences influenced the methodological processes. The researcher shares the epistemological position of IPA undoubtedly influencing the choice of research method. Furthermore, the researchers professional background in psychodynamic approaches contributes to the valuing of interpretation, although care had to be taken not to make interpretations beyond what was introduced by the participants.

The researcher's sense of their own individuality also influenced the decision to use a qualitative approach and IPA. Nomothetic approaches, and the desire for society to generalize human experience challenges the researcher's identity as someone who has sought to accept their own individuality and uniqueness.

During the analysis reflection was made upon the concept of 'fore-structure' (Gadamer, 1990) in the theory of interpretation. The concept of 'fore-structure' refers to the importance of situating the meaning of the 'other' with sensitivity to the individual who is making the interpretations own meaning, referred to as the 'fore-meaning' (Gadamer, 1990).

In the current study this refers to the researchers own experiences and assumptions related to voice hearing and potential identification or discordance with the participants. The shared experience of experiences that are considered outside of societal norms engineered a desire to find positive meaning in the voice hearing experiences that had to be kept in check, to ensure that this hadn't become a cathartic exercise to heal personal trauma. The IPA approach provides a framework to safeguard against this potential influence by providing explicit structures and space to reflect on the researcher's personal relationship and feeling towards the participants experiences.

Analysis

The analysis produced three super-ordinate themes;

1. 'Engaging in a complicated world': The voice in repetition or reparation of relational trauma.
2. 'Response-ability', in interpretation and action
3. 'Fracturing identities': The self and society's acceptance of voice hearing

Each theme has between two and four sub themes, the exhaustive list of superordinate themes, sub- themes with example quotes are presented in Appendix E. The table below presents the super-ordinate themes and sub-themes.

Table 2

Super-ordinate and sub-themes

Super-ordinate theme	**Sub- themes**
'Engaging in a complicated world': The voice in repetition or reparation of relational trauma	1. The individual interpersonal context 2. Managing the relationship with the voice 3. The voices influence in interpersonal experiences
'Response-ability', in interpretation and action	1. Finding the meaning in the message 2. Trying to save the world is not where I'm at
'Fracturing identities': The self and society's acceptance of voice hearing	1. The self and voice hearing 2. Sharing the experience 3. Alienation and acceptance by society 4. The medical model: conflicting or co-existing realities?

'Engaging in a complicated world': The voice in repetition or reparation of relational trauma

This theme considers the interpersonal context of the individuals and the similarities in the childhood experiences of the participants. The theme considers the role of voice hearing in the context of the participant's interpersonal experiences in addition to how the participant's experience and manage the relationship with the voices.

The individual interpersonal context

An individual's interpersonal context refers to their experience of relationships with others. The participants in the study described challenging childhood experiences and often the experience of relational trauma.

Lucy describes how:

"A lot of my childhood was spent on my own and I found it difficult to make friends".

This experience was echoed by Bryony:

"I was struggling. I always found it difficult to get on with people. I was being made fun of at school at the time because they found out I was adopted"

Daniel also described the challenges he faced at school:

"I went to boarding school...and I got incredibly independent at a young age and relationship are hard for me to commit because I had to be independent so young".

Jessica described a feeling of not fitting in and shame due to the experience of abuse during her childhood:

"*So I felt ashamed because I didn't fit into that model"*

Adam was the only individual who described a happy childhood with stable family dynamics. However, Adam did allude to experiences of potential difficulties at school when providing a metaphor of the way in which school does not provide for everyone:

"We are all taught to drive the same vehicle when we go through school. What happens if the vehicle you're driving is completely different from the one your taught, how do you know how to pilot, if you imagine the school teaches you to drive a mini metro, what happens if it turns out you've got a harrier jump jet"

The suggestion of others driving a mini metro and himself a harrier jump jet provides an enlightening image of how different he felt in comparison to his peers and a sense of being ill equipped to manage a completely different type of vehicle. The mini-metro and jump jet as a comparison are different in innumerable ways and the concept of 'piloting' is seen throughout the Adams narrative when describing his experience of life and voice hearing.

All participants volunteered information regarding their childhood relationships and context without being specifically. This appears to form an important part of participants understanding of the aetiology or understanding of their voice hearing experiences.

The experience of 'not fitting in' is particularly salient and present in all the participant's accounts of their experiences. As a child 'fitting in' is often concentrated on the school setting. Unsurprisingly school is evidenced in many of the participants accounts as a context in which the difficulties in engaging with the social world were often presented however in some cases this appears directly related to and exacerbated by challenging family dynamics.

Bryony described experiencing an abusive family environment which then translated into difficulties with the school environment; *"That put a lot of stress on me. I was struggling with my school work as well",* and of being bullied because the other children found out that she was adopted.

For many of the participants there appeared a multitude of stressors during childhood and compounding relational trauma. For three of the five participants the experience of alienation continued and was evident in their current experiences.

Managing the relationship with the voice

Participants differed in the extent to which they perceived a relationship with the voices and the identity of the voices appeared to influence this. Bryony described very specific relationships with her voices:

"I have another voice called 'Mother'; she's called Mary to everyone else" (and that the relationship with the voices were), *"like any person really"*

Bryony described a constant engagement with two voices who were described as 'Emily' and 'Mother'. The interactions involved support between both the participant and the voices:

"I usually ask her "what's causing you to be negative" she might call me a name and I'll say why did you call me that, she'll say because I'm worried about something"

There is also evidence of the interaction between the two main voices and how this supports Bryony:

(Talking about mother) *"She hasn't been around these last few weeks, but because I have been under lots of stress. It is nice when she's there because she kind of sticks up for me if Emily is being nasty"*

The excerpt provides insight into the complexities of the relationship with the voices. Despite initially describing the voices as providing reassurance and support, Bryony reports the absence of the 'Mother' voice is due to her being under a lot of stress. Bryony also refers to 'Emily' being nasty.

The specifics of the relationship Bryony has with the voices may reflect the distinct identities of the voices and how they are considered in relation to her e.g.

"She's a bit like a sister". Bryony 's voice identities are framed within a domestic context and reflect a closeness in accordance with this.

Adam also experiences voices that have distinct identities that influence the relationship with them, he makes reference to a voice called Spider and a Hebrew prophet who refuses to be named:

"What is that people think of when they think of spiders? They think in terms of flies being wrapped up, and eaten, and consumed, but what do flies represent? Flies represent corruption. They represent dirty, disease-ridden. So, you have something which is terrifying, but which eats corruption. So, my relationship with something, which people think of as being terrifying, is terrifying, but also really positive"

There is an awareness that others find the experience of a spider terrifying however Adam highlights the positive function of the spider, and how this relates to the overall experience of hearing voices. The consumption by the spider is also important, the participant describes feeling spun on a web at times which, may reflect an identification with the fly, and links to the context in which voice hearing is considered by society as a 'disease':

"I thought, "Was I being spun? Was I being spun onto the web?" So, there's the sense that this thing, which was actually really, really positive, is terrifying, and was actually treating me like I was a fly on the web"

The importance of the identity of the voice in the participant's relationship with the voice is observed with Jessica who in comparison with the other participants does not know the identity of the voices she experiences nor does she wish to, stating; "*I don't need to know who it is*". The nature of the support in the relationship is also different with Jessica frequently supporting the voices "*I can help them with words*". It is hypothesised that when the participant is being supported by the voices, the identity of the voices and how they relate to the individual is very important. When the participant is supporting the voices, the identity may be less important or the responsibility of helping the voice may create a reluctance to want to know the identity as suggested by Jessica below:

"If it is telepathy, and this person could be in a very difficult situation, then you don't want to try and work out anything"

Some of the participants were able to identify times whereby voices provided a source of support, advice or reassurance at other times the voices influence extended beyond this to taking control of the individual's life. An illuminating example of this was provided by Adam, describing his experiencing using the analogy of long and short reins:

"So I have the concept of short-reins and long-reins. So long reins I have the illusion of free will. I get to feel like I'm the person...like I'm in control of my life. Short reins are when they are directly telling me what to do and how to do it, and that's at times of real stress"

Adam describes how at times of real stress the voices take direct control, the presence of voices at significant times of need is present for all the participants and explored later in the chapter. The concept of free will, is described by Adan as an 'illusion', suggesting that even at times when he is not under duress or being directly told what to do, the voices still retain the control over his life. This is supported by a further analogy he makes in not being the captain of his own ship:

"There is the sense that I am the pilot of my life, but I'm not the captain...a startling realisation...'Actually I'm not the captain of my ship, I am just the pilot, but I have to be a good pilot or else I'll get told off by the captain"

This builds on the notion of the voices being an authority in their relationship. The distinguishing in roles between a pilot and captain is important. Although captains are in charge, pilots navigate the ship, a function sometimes considered of equal importance to that of the captain. It is unlikely Adam experiences this equality though because he describes himself as 'just' the pilot and in terms of the ships roles he would be working for the captain. The analogy suggests that he has some agency in where his life goes but ultimately it is his voices that hold responsibility for his life particularly when things go wrong, and this is supported when Adam says:

"the captain is the one who takes control if everything else goes wrong"

Lucy also experiences a need to follow orders stating; *"whatever the voice tells you, you must do it"* and describing the voice as "authoritative but not scary".

Bryony describes several ways in which the voices help in everyday life to remind her to do things such as lock the door, this could also be considered a form of control however Bryony reports a sense of reassurance, with the voices saying things like *"We'll be okay, don't worry"*. Bryony goes on to describe this in relation to her experience of anxiety and that the voices would reassure her for example if she was worried about going out. However, Bryony also describes how *"Sometimes, it would be nice to just have a bit of quiet"* and that "*The more I say, 'can we just have some quiet time?' the more she talks"*.

Bryony's dynamic with her voices has a more affectionate tone in comparison to the experience of a 'captain' (Adam) or higher power (Lucy & Daniel) and this is congruent with the domestic context of her voice hearing experiences.

The concept of equality as oppose to control is also present with Jessica who when asked who was being supported herself or the voices described it as; "*both, it's an equality"*.

The voices influence on interpersonal experiences

There is evidence features of relationships outside of voice hearing are evident in the participants relationship with the voices.

Bryony described experiences of bullying, an abusive family situation, being adopted and a mother who "doesn't talk to me", this appears mirrored in her description of Emily as 'nasty' and the Mother voice as being absent at times. Bryony 's relationship with the voices has an evident familial quality as indicated by one of her voices being called 'Mother' but Mary to everyone else and the description of Emily as *"She's a bit like a sister"*. Bryony goes on to describe the link between the voices and her interpersonal context outside of voice hearing:

"Well you see, I had a difficult relationship, I mean she's still alive but with my mother, it's as if she's taken over. My mother doesn't talk to me" ...."She's kind of taken over that role" (discussing the mother voice) and *"Yes we're a bit of a family really"*

The evidence suggests Bryony has found a family with her voices that she is lacking in her external interpersonal world, the voices are providing a 'relationship' that is missing or inadequate e.g. a mother. The idea of the voices providing a relationship that is lacking is a feature from the very beginning of her voice hearing experience when the Emily voice first appeared behind the wall at school when she had no friends that she could confide in:

"My home was just quite bad. It was somewhere I could go that was safe" ... "I think maybe she was just the only one I could go to talk about it....I used to go and speak to her every day"

Bryony described a very difficult childhood and that her voices had supported her through this:

"I mean I had a very difficult childhood and Emily has probably kept me going".

Furthermore, the voice 'Emily' appeared at a time she was needed; *"sometimes she would appear at home, after I had been abused at home".*

The voices appearing following an experience of abuse was also shared by Jessica:

"When I was being abused as a child and I say this in the voices, I get a voice saying they feel ashamed and they'll like validate and normalise"

Jessica described a prevailing experience of feeling ashamed as a child due to the abuse and the voices provided something that was missing, through being unable to disclose the abuse to anyone, they provided her with validation of how she was feeling.

Lucy 's relationship with the voices are also considered in light of their interpersonal context. Lucy was adopted, expressing, "*I definitely had a problem with my identity*". For Lucy the voices provided a way of connecting to her biological mother:

"I heard someone call out...oh it was such a call, it felt like someone desperate to make contact but who couldn't somehow...deep down I felt it might be my natural mother"

The voices also served to provide an answer to her problem with identity by providing a connection with her biological family:

"It's not that I'm special... I just have something that's been given to me....maybe it's been passed through family genes and that each family has its own particular way of identifying itself"... "it may have been a thread running all the way through the family"

The voice experience provided a way for Lucy to feel a sense of identity which had been missing, in addition to the specific experience of her natural mother's voice. The description of the experience as a 'thread' provides a sense of something being tied together in a reparative way, a 'stitching together' where there was previously a hole.
The experience of Lucy, echoes that of Bryony and Jessica in the voices providing something missing from and compensating for, difficult early family relationships.

For Adam and Daniel the relationship with the voices is best understood within the social context, for Adam he described struggling with the social world:

"You know I've often found myself at odds with the world, the social world...it's like how do people make friends"

This appeared to stem from childhood, feeling different at school and the experience of a school system not designed to support people that are different. For Adam the voices have become a way to manage this difficulty:

"I think they've helped me navigate some of the stresses...So there are times I just don't get it socially and because of that they come to the fore..it's like a stress response...some people go for a run. I become psychotic"

The use of the term 'psychotic' is interesting as Adam is critical of the medicalised approach to voice hearing, the description of the experience as a "stress response" also eludes to a more medicalised conceptualisation. Adam presents the experience as unfavourable with the comparison of how others would "go for a run", which has a healthy and socially acceptable connotation.

How exactly the voices enable social stress to be navigated is unclear, there is some evidence that again this is by compensating for the difficulty e.g. by providing a friendship;

"So I was frantically trying to build this family and friends network in my head"

However, this is unsuccessful with the participant describing the voices as saying to him:

"I am not your friend, I am certainly not your family. I am a harbinger"

For Adam the relationship with the voices helps navigate the social difficulties. This is not seen in the same way to Lucy, Jessica and Bryony, there is no direct compensation through providing a friend in the same way that the other participants experienced in relation to their family context. Instead the nature of the relationship takes on a more formal and authoritative function;

"So, there was a lot of social stuff going on, and I didn't know what was going on. I was confused and I was upset, and they (the voices) just, you know, took me for a drive"... "they sat me down and counselled me"

The notion of "being taken for a drive" in comparison to others who "go for a run" further elucidates a sense of relating to the social world differently from others, and a lack of agency in managing these experiences e.g. not being able to stand on

his own feet but instead being driven by others. This, and the notion of being counselled places the agency and knowledge with the voices, although the participant describes the voices as helpful, he has also described the difficulty with this:

"So they will come around when it is important..but will not respond if I'm asking and begging for advice"

There appears a lack of reciprocity in the relationship, suggesting further distinction from the participants who experience voices embodying a friendship/familial quality, however Adam does describe the relationship in terms of an "attachment".

Despite experiencing a sense of being different, Adam experienced positive relationships with his family and has long-term friendships, this may indicate why in comparison to the participant's with very different familial experiences the voices do not embody a familial or friendship identity.

Daniel also described difficulties in his early relationships:

"I went to boarding school...and I got incredibly independent at a young age and relationships are hard for me to commit because I had to be independent so young"

Daniel described the voice hearing experience as:

"I'm not saying that every voice that I see has some prophetic quality, but I think they are part for me of kind of engaging in the world that is complicated, confusing and not going to work out as expected"

The function of the voices in coping with the social world is similar to Adam, with 'prophetic' and 'harbinger' describing a forewarning/prediction, that helps them to manage a difficult social world. The experience of going to boarding school at a young age was conceivable difficult, Daniel has described how it has made it difficult for him to commit to relationships, possibly because of the unexpected separation with his own family. The voices potentially provide a way of trying to

compensate for this experience of unpredictability. Daniel also shares the difficulty in elucidating a framework that describes the nature of the relationships:

"The truth is what it is, it's your imagination working for you. It's your imagination gone a bit wild. You're not really friends with your brain"

This suggests despite the voices providing a function, compensating for the Daniel's loneliness and difficulties with other relationships, the nature of the relationship with the voice is 'imaginary'. The extent to which the voices provide comfort does not seem affected by this:

"I thought there was a psychic plane and people could have Extrasensory Perception kind of experiences on that...it was comforting and I kind of liked the escape".

The connection between the voice hearing experiences and potential reparative/ compensating function in relationships is evident in the accounts described above, however there is also evidence of the voice hearing experiences repeating and enacting the maladaptive relational experiences of the participants. Adam described experiences whereby the voices would tell him "*Would you please leave us alone"* and responding in a rejecting way when he needed them:

"So I was really clingy, and it's like any time I was stressed or anxious I would turn to them for advice, and they'd say 'we don't want to be doing this"

Furthermore, Bryony described several examples whereby her voice Emily could be negative towards her:

"She calls me racist words, sometimes when she's really upset" and *"Sometimes she would say, "Well you deserved it."*(in relation to being abused).

The experience described demonstrates a repetition of her experiences of being bullied, inconsistencies in her relationships and the experience of people

disappearing from her life. Bryony's own mother disappeared from her life and was not in contact and the voices at times had disappeared, signalling a repetition of loss:

"I think I kind of lost her for a while"

Response-ability; In interpretation and action

A unifying feature of all voice hearing experiences described were that participants found meaning in the experience. What differed was the extent to which they felt compelled to interpret the meaning of the experience and whether they would act upon the meaning they had derived.

Finding meaning in the message

For Adam interpretation of the voices was important so as not to have the experience interpreted by others:

"I have a responsibility to interpret my experience, and I have a responsibility to interpret for other people, because if I don't then they are going to"

Adam describes the difficulty in this process:

"I look back at it now as, like, there's an awful lot of rubbish in the experience...., but it's like panning for gold. So there's these little bits of gold, and I've clung on to those".

Adam presents as almost forced to interpret his experience for fear of the meaning or meaningless interpretation that others will give. It is the interpretation by others of the experience as meaningless that is particularly difficult:

"rather than just going, 'Oh it's a sound effect of a disease which we've already decided.... And its meaningless. There is no meaning there its rubbish"

Adam must determine what is being communicated by the voices and whether this is important, this is irrespective of the nature of the messenger:

"Is this communication important.....and actively having to think about it"...."rather than responding to something just because its friendly or because it's frightening, actually going 'well what is being communicated here"

For Adam the voices have provided a form of forewarning and keeping him away from danger:

"They were pointing at this taproot...It was this hint that if I'm not careful I might break the taproot, and If I break the taproot then I won't come back"..."They were being very clear, it was like, "Be very careful right now. You're in a very dangerous place".

A taproot is the main root of a plant or tree system providing the source for all the other roots to grow, inferring from this, the role of the voices appears to be associated with keeping him alive, maintaining the life source but also in keeping him grounded. The idea of remaining rooted is also supported by his description of the voices as keeping him on track:

"There have been other points where they have actively intervened to get me back on track"

Bryony also described the voices in helping her to keep safe and 'on track':

"She reminds me to do things, like lock the door and things like that"

For Bryony there is an everyday companionship with the voice, when referring to Emily, she reports; *"Everywhere I go she comes with me" and describes how "it (voices) can help people's lives".* Emily describes her voices helping in her life with the different anxieties she has for example going out or using public toilets and that the voices will accompany her and provide reassurance. Bryony's experiences are different to Adam's in that the communication is explicit and does not require deciphering, however the aim is the same, being kept away from danger.

Daniel's experience resonates with Adam's in describing the voices as having a *"Prophetic quality"* and that they (the voices) *"have often been related to things that have later happened in the news and things".*

This quality also appears to extend to knowledge about the 'self':

"They are part of your psyche, the needing a bit of 'TLC'.... they're trying to tell you things about yourself or your past...and you need to know these things, so you don't feel bad about yourself"

Daniel's description highlights the function the voices have in helping to *"not feel bad about yourself",* the voices take on a therapeutic purpose helping Daniel to identify past events and aspects of himself that may have had a negative impact on him. There is a disparity highlighted here in the voices being considered part of the psyche as oppose to some 'outside', creative higher power. When Daniel is in touch with the voices that provide support they are internalised, when they are discussed in light of being creative and prophetic then they are externalised, and this may reflect his own way of seeing himself.

Lucy and Jessica also express the importance of finding meaning in the voice hearing experience with Lucy stating;

"The experiences of hearing a voice seem to have occurred at a point of importance, something very important was happening"

The notion that voices happen at a time of importance is intrinsically linked to the meaning that the participants then subscribe to the experience. The importance for some of the participants relates to the association of voices occurring at difficult times e.g. at times of abuse and loneliness. The meaning of the voices is also described in relation to the importance of resolving the voices distress as seen with Lucy and Jessica.

'Trying to save the world is not where I'm at'

Participants varied in the extent to which, they acted upon the meaning obtained from the voices. Lucy expressed that *"whatever the voice tells you, you must do it"* and this is related to the meaning and identity of the voice for her. Lucy attributes the voices to a higher power who is imparting a message in which, she appears to feel a sense of duty to act upon:

"and if he's got a message, he's got a message to give to someone, and if it's that specific, one ought to work on it, a message that is positive, why not do it and see what happens"

For Lucy, the messages she receives provide an opportunity to do something good and important:

"The experiences of hearing a voice seem to have occurred at a point of importance, something very important was happening ....That I have to act on it, or if I don't physically act on it I must consider it deeply...I might miss something important"

In one example provided by Lucy, she described receiving a message about someone she had not seen for some time but whom she reported to have been 'troubled'.

"and as I was walking along the voice spoke to me as clear as your voice just spoke to me then, 'xxx is in xxx prison. Go and visit him"

Lucy makes the distinction of a 'positive' message, and that the voices provide an opportunity to do positive things, through this they provide an extension of a way of relating to the world that is already significant to her. As discussed previously Lucy describes the voice hearing experiences as providing a sense of identity and place in the world, the messages she receives and actions she takes as a result are intrinsically linked to the place in the world she experiences as a consequence. The voices provide an opportunity to affirm a sense of herself as someone who may do good in the world.

Adam also describes the role of the voices in providing a prediction or forewarning:

"all I'm saying is sometimes, to be forewarned about something is to be forewarned and be prepared...They were being very clear, it was like be careful right now, you're in a very dangerous place"

Adam describes how the voices themselves take- action:

"There have been other points where they have actively intervened to get me back on track"

Adam frequently uses the metaphor of vehicles and journeys when describing the experience of voice hearing and reflects a type of action e.g. being taken for a drive. For Adam the action associated with the voices is attributed to the voices themselves and reflects the location of power and control in the relationship.

The voices taking- action is also reflected in Bryony's experience:

"she reminds me to do things. Like lock the door and things like that"

The action takes a more day to day practical form, however, the act of reminding her to lock the door is very meaningful, it is a way of keeping her safe and protecting her from the outside world. Bryony goes onto elaborate that she struggled to remember to do things like this; *"I would forget things; I would then be constantly looking at the door to see if I'd locked it"*.

Daniel describes the voices as having a *"prophetic quality"* demonstrating a similarity to the experience of Adam and Lucy. For Daniel the forewarning or predictions are related to tragedies in the outside world not necessarily himself:

"For a long time, for 20 years have often been related to things that then later happened in the news and things..."

Paradoxically, Daniel also describes scepticism in respect of the reality of the experience:

"but nothing has ever convinced me that these things have really any reality to them"

For Daniel there is no evidence of any acting upon the information received:

"I'm not saying you're going to do anything with that information"

Daniel's 'inaction' may reflect the distrust in the reality of the experience but also the nature of the information received and the difficulty in receiving information about a potential impending disaster.

Jessica described a unique form of action in response to the voices. Jessica describes talking through the voices, a process whereby voice hearers communicate with each other and entails her being contacted through the voices by others who are struggling

"I wish people well. I give information and I say 'it may or may not be of use to you...so at the moment there is the voice saying 'help me' so I would often say..Mrs X will be honoured to support you and the voices in any way that I can"

The form of action is talking, providing support and information, however like with Daniel there is a sense of concern regarding the responsibility, e.g. not knowing if the information will be of use, highlighting another possible difficulty with 'knowing'.

For those participants whose voice hearing provides information or concerns related to others there is the difficulty in how the responsibility for others is managed.
Daniel describes his thoughts about responsibility and the complexity of this:

"I don't think you're obliged to hold onto things as if they're your responsibility to do something about them. I think it's partly a problem shared is a problem halved and it's your problem, as it is a problem is still a problem...Things like 9/11, I knew

before it was going to happen, it was going to happen, but I couldn't talk about that to people"

Daniel describes the difficulty in managing the dilemma between disclosing information and 'halving' the problem with the challenge of being able to talk about these things with others. Daniel introduces the idea that it is not his obligation or responsibility at the same time as stating that even if the problem is shared it is still 'your problem'. The nature of the information that Daniel receives has serious consequences, and likely to be disbelieved by others placing Daniel in a position without a clear solution which his description reflections. The challenge of this position is evident when Daniel says:

"before the 9/11 thing I was very worried, but I didn't...foolishly now, I should have spoken to somebody about what I was experiencing even for my own sake"

Furthermore, Daniel describes the direct impact on his own well-being:

"I get more disturbances, hallucinations, confusion when the terror rating was about to go up"

This may reflect the difficulty in managing the anxiety and responsibility for the potential impending disaster the voices are predicting. The challenge of feeling responsible for others and how to respond to this is also described by Lucy and she describes her position as:

"Trying to save the world is not where I am at right now"

The reference to saving the world highlights significant the sense of responsibility and importance. Lucy goes on to introduce the question of whether she is 'deserving':

"It felt overwhelming because it felt that somehow I'd been given some kind of insight or gift, that I didn't necessarily deserve to have"

The excerpts by Lucy reflect the conflict between the overwhelming sense of responsibility to be deserving of the gift that has been bestowed in combination with the reluctance or difficulty in the perceived expectations that accompany this. The depiction of the experience as a gift suggests Lucy has received something of value. For Lucy this may reflect being given the link to her family and sense of identity described earlier. A gift also describes something that a recipient may have little possibility of refusing and requires appreciation.

Jessica also experiences the responsibility of being 'honoured' by her experience of voice hearing:

" I sometimes say in the voices, I feel honoured to be able to listen and talk in the voices because I do...I just wish I was, sort of....I apologise sometimes because I'm not sure whether the techniques I use are helpful or not"

The description highlights, in a similar way to Lucy's experience the insecurity in respect to whether she can respond in a helpful way to the voices. Both Lucy and Jessica use an apologetic tone despite the experience not necessarily sought out and instead 'gifted'.

Jessica, unlike the other participants does not wish to learn the identity of the voices:

"It's quite complicated, because I don't know who it is, and I don't want to.... then what could you do apart from say 'Get help' and 'you're loved and respected"

For Jessica, the voices usually express a difficulty and need for support and she reports that the voices say to her "*help me*". The distressing nature of the voice's experience may impact on her reluctance to learn the identity of the voices:

"There's things that are said that if someone said that to you it would make you weep, and it sometimes makes me weep. You don't know whose saying it to you and you don't know what the outcome will be"

Jessica describes the uncertainty accompanying the experience, not knowing what the outcome will be and whether there is a positive ending. The avoidance of unearthing the identity of the voices may help to protect Jessica from learning whether her intervention has been helpful. A distant approach may prevent Jessica becoming overwhelmed in the same way that some of the other participants have experienced as a result of the responsibility. This may also be a way of avoiding becoming overly identified with the encounters. Jessica has described her experiences of trauma and abuse and supports voices of individuals who are experiencing abuse. Jessica describes the experience of weeping in response, highlighting the emotional toil of this role and the potential impact of being reminded of her own experiences.

The complexity Jessica's feelings related to the experience are highlighted in the following description:

"It's beautiful, its bittersweet, because if you have the belief system I do then its most likely someone in a difficult situation"

Fracturing identities: The self and society's acceptance of voice hearing

The final master theme is concerned with individuals and society's framing of the voice hearing experience. The theme includes the potential compatibility or conflict in different ways of understanding the experience and how this influences the voice hearing individual's own sense of self and identity.

The self and voice hearing

For many of the participants, accepting voice hearing had been part of a process and the ease of this varied. Bryony described the initial difficulty when she started hearing voices at junior school:

"I didn't want to hear voices"

For Bryony, one of the problems of hearing voices was that it contributed to her feeling of being 'different'. This was magnified by Bryony's childhood context

of being adopted and enduring pervasive bullying, she reported (about that voices); *"not telling anyone else about it".*

Daniel also shared the sentiment of initially rejecting the experience:

"I don't really want to say it but for a long time I desired not to, I aspired not to hallucinate, but you just have to accept that you see things differently"

The use of the term 'hallucinate' is rarely present in Daniel's account of voice hearing experiences and reflects a medicalised framework and may illuminate the language used to describe his experience at the time. When individuals first experience voice hearing their first encounters as a result of this are likely to be with their GP, a medical practioner. It also suggests that the medical framework is associated with a rejection of the experience and that *'seeing things differently'* may refer to seeing the experience of voice hearing differently which, facilitates acceptance of the experience.

There is a contrast between the idea of *'hallucinating'* which suggests something that doesn't exist, to seeing '*things differently'* and therefore accepting the phenomena as different but existing. The use of term 'aspired' suggests an active choice, and the question of making a choice is raised again by the Daniel when he asks; "*is hearing voices a problem?"* and then responds to the question:

"If you choose to see it as a problem, at the moment I find it quite debilitating, it stops me getting on with my life"

Daniel suggests that he is in some way to blame for the debilitating aspects of the experience through his choice to see the experience as a problem. This empathises the complicated nature of acceptance and that it is not a linear process. The idea of 'acceptance' appears to relate more to the acknowledgment of being different and is also considered by Lucy;

"This is the truth for me, it might not be the truth for the next-door neighbour but it is for me, it's my truth"

Acceptance may also be influenced by the extent to which the experience is internalised. Both Adam and Jessica present with the experience of voice hearing as being very much a part of them. Jessica describes the experience as 'organic':

"It's been part of me for such a long time, this thing (voices), you know it's like an organic thing"

There is marked difference between the language of the experience as *'organic'* in comparison to '*hallucinate'*, something that is organic suggests a natural context associated with growth and 'wholeness'. Acceptance may therefore depend on the extent to which the experience is considered a part of the self.
The question of what is considered natural or normal is also raised by Lucy:

"I just feel that what we do not see in this world, there are things that we can see visibly and every day, and they're natural, they're normal. But there are other things that we can't see with the naked eye but are still there, and they are physical things".

The complexity of visibility is highlighted, specifically whether something being visible influences the phenomenon being considered 'natural'. Lucy also states that things that cannot be seen, such as the voice she hears, are still there and have a physical quality. Acceptance appears facilitated by the perception of something being natural and physical.

Identity refers to the notion of who we are and what we value (Chryssochoou, 2003). All individuals in the study shared a particular identity of being a 'voice hearer' by very nature of their participation in the study, furthermore all participants were recruited from 'hearing voices' group. All participants shared the experience of hearing voices that were identifiable in some way. Bryony had a clearly defined and identified set of voices:

"Well, I have a few voices. Emily is my main voice that I hear, she's the same age as me... I have another voice called 'Mother'; she's called Mary to everyone else"

For Bryony the voices have human characteristics which may be because Bryony can see as well as hear her voices. For Bryony there appears to be a clear delineation of the voices as being external to herself, evidenced by her voices aside from the devil often being described in relation to herself:

"She's a bit taller than me and we both want to go on a diet"

Adam also experiences his voices as having identifiable characteristics which, can be considered 'human' and non- 'human':

"Well, there are two main support voices, now. I've had other communications from other places, but it's mostly... They used to be two, separate, but they've actually become, kind of, amalgamated over time. One aspect is Spider.....The other one is a male Hebrew patriarch, so Hebrew prophet, who refuses to be named"

Although Adam can experience the voices as being external and separate from himself this has not always been the case. Adam describes the way in which his own identity and sense of self is influenced by whether the voices appear internal or external in origin:

"The experience of hearing voices inside tends towards fracturing the identity"

However, Adam then goes on to describe how external voices can also reflect an aspect of who he is:

"There are voices which are me, and these are the voices which are only me, then they're the voices which are me but not me. So these are the voices which have come from outside, but are actually part of who I am"

The use of the term 'fracturing' suggests a painful and damaging influence of the voices upon his identity, the idea of 'fracturing' is also suggested in the paragraph above, with the description of confusion around voices e.g. 'are me/ but not me'.

Identity is often understood in relation to other persons, Adam describes how the voices that refer to him in a certain way undermine his sense of self:

"When they're referring to me as an input, output device that undermines my sense of personality. That undermines my sense of self"

An input/output device suggests something mechanical and without personality, the voices appear to take on the identity and use Adam as a device to process, he receives the voices and then outputs information.

Lucy provides an alternative experience of her identity being influenced by voice hearing. Lucy described her childhood whereby; *"I definitely had a problem with my identity"* which, she attributed to the experience of being adopted by older parents and then experiencing a quite lonely childhood; "*A lot of my childhood was spent on my own, and I found it difficult to make friends".* Lucy experienced voice hearing as providing an identity:

"I was given this as, in a sense a way of helping me to establish who I was and what helped my identity"

For Lucy, voice hearing became a way of her developing a sense of identity and connection with her biological family.

"It's not that I'm special... I just have something that's been given to me.... maybe it's been passed through family genes.....each family has its own particular way of identifying itself"

The differences described by Adam and Lucy may reflect the differences in their sense of identity prior to experiencing voice hearing. Lucy described having a problem with her identity which, she attributed to being adopted, whereas Adam described a stable and happy childhood with no voice hearing experiences until he went away to university in early adulthood. There is a clear divergence between the experience of the voices providing a way of connecting with an identity and the voices fracturing and undermining identity.

The identity of the voices for Lucy are less circumscribed and she attributes them to be an unnamed religious or creative *"higher power"*, this in part she attributes to her religious beliefs:

"As I was growing up, I just took this all on board and just assumed that all these things.... they must be coming from this great creative power whatever people call it"

The experience of the voices as a higher power, without a specific identity and name may contribute to having less detrimental impact on her sense of identity. This is supported by Jessica's experience whose voices are also without a clear sense of identity. Jessica describes the voices as being any one of the 250 million voice hearers who talk through telepathy when needing support:

"So I will, like, talk in voices without speaking out loud. I'll cover my mouth and I'll talk without speaking out loud, because of my belief systems, because I've always thought it was telepathy...and you don't know who you're speaking to"

Jessica describes the experience as being part of her and *'organic'*, suggesting a consolidated or 'whole' sense of identity in contrast to Adam's experience of *'fracturing'*. Jessica describes the voices as being part of her, thus more closely aligned to Lucy 's experience of the voices supporting her to develop a sense of identity and providing connection with others:

"I separate it because that is-because it's been part of me for such a long time, this thing, you know it's like an organic thing"

Jessica's description of the voices hearing experience as being 'organic' also suggests an experience of assimilating the voice hearing, organic also suggests something internal that has grown within. Conversely, Jessica also describes separating of *"it"* and there seems a conflict between being a part of it and being separate from it. Being able to separate from it may reflect the ability for Jessica to

separate her own identity from that of the voices unlike Adam who describes the difficulty in determining what is him and not him.

Jessica was the only participant who did not at some point attribute a religious identity to one or some of their voices. For Lucy, Daniel and Bryony the attribution of a religious identity appears to be influenced by their own Christian belief systems and identity as a Christian:

"As a Christian I know that when you have these experiences from above, (Religion) It's been how I make sense of them" (Daniel)

Adam rejects a religious interpretation of his experience; he described a Christian up-bringing and how it influenced his early attempts at making sense of his voice hearing experiences:

"and I layered over the top of it a Christian interpretation of it, because that's the only interpretation of the experience I had.... oh, it was bullshit"

Paradoxically, Adam also describes an experience of a voice who he perceives to be a religious figure. Rejection of a Christian religious interpretation of the experience does not therefore exclude the experience of voices having religious identities. Lucy and Daniel both experienced voices they identified as god and Bryony experienced a voice identified as the devil which, had a profoundly negative influence.

Alienation and acceptance by society

All participants reflected on the experience of society's perceptions of voice hearing and the influence of this on their experiences and identity as a voice hearer. Adam highlights the experience of feeling stigmatised:

"If somebody sees me in the street and I'm mumbling to myself, they're going to have a stock set of thoughts about what this person is, its stigmatised"

The stigma is around the '*thoughts*' about '*what'* he is. The reference to himself as *'what'* reflects an experience of feeling depersonalised and that society does not see him as human. Adam also raises the notion of visibility, describing being *'seen'* mumbling on the street, there is the sense of being exposed in some way and that the mumbling should be hidden. The visibility of the experience is also considered by Jessica:

"On a day to day basis, people around me more or less accept it, and if I'm out in the community on a bus, I wouldn't cover my mouth"

Jessica suggests that she would not go out of her way to hide her interaction with the voices and initially describes some acceptance of this, however she also raises the concern that she may be ridiculed or frighten others:

"but I'm also aware of conservations that I've had with people, non-voice hearers, how it can be ridiculed, or it can frighten people. So I don't want to frighten people and I don't want to ridicule anyone"

Fear of voice hearing and how voice hearing is portrayed in the media is also considered by Bryony:

"they do exaggerate, there was a programme and it was a murder and he was being told to kill through his voices, and I thought well they're not all like that ... there was a lot about negative voices, you hear more about that than positive, I think if it's like ever on TV, it's always hearing people do bad things"

Jessica considers the reasons why voice hearing is portrayed so negatively:

"It's convenient to think of voice hearing as a negative and dangerous thing and that people must be locked away, that suits the status quo"

The idea of 'convenience' and 'status quo' reflects her belief that there is little motivation for society to challenge their view of hearing. Jessica's view is that

perceiving voice hearing as an illness allows a continuation of a set of ideas that in her experience maintains an unequal and unfair psychiatric system.

In addition to being experienced as dangerous, participants were also familiar with society's perceptions of voice hearing being associated with 'madness' as described by Daniel:

"That's a mad person doing insane crazy things"

and Lucy:

"Other people think you're barmy"

The participants accounts reflect stereotypical words used to describe mental health problems such as, '*crazy*', '*barmy'* and '*insane*'. Despite different terms the experience is considered within a dominant narrative of being out of the ordinary and not 'normal'. The use of the term '*barmy'* is more dated and may reflect Lucy being older. Daniel who is younger uses terms that are more in-line with current language trends. It is therefore evident that in time the language used by society to discuss these experiences changes, but the meaning does not.

Adam highlights the potential for society to have a positive contribution to voice hearing:

"What is actually needed is, we need a society which accepts that, as a phenomena, that is an acceptable phenomena and actively build a good foundation for it"

The notion of 'acceptance' is repeated here and can be linked to the participants own acceptance of their voice hearing. The participants have undergone a journey from rejection to acceptance and as Adam points out the hope appears to be that society will also embark on such a journey.

The medical model: conflicting or co-existing realities?

Participants differed in the extent to which their experience of voice hearing had been influenced by the psychiatric system, however all participants shared and expressed a rejection of the medicalisation of voice hearing.

For Adam the experience of receiving a psychiatric diagnostic label related to voice hearing was extremely damaging:

"It's not a nice identity to have. I consider that to be a festering wound for me. The diagnostic procedure is actually part of the damage"

The identity Adam is referring to is that of schizophrenia, the experience of this as a festering wound illuminate how Adam feels harmed by this diagnostic label, the festering aspect suggests something on-going that is unable to heal. The description of diagnosis as a 'procedure' suggests that the experience feels like something is being done to him, something structured, official and impersonal. This is reiterated further:

"What leads me to be sat in a psychiatrist's office, being told by somebody who I am by somebody who doesn't know who I am"

and echoed by Jessica:

"I don't need psychology or psychiatry to tell me what I'm experiencing. I don't need to put a framework on it, or make money from it"

The experience of having an identity imposed is highlighted, an identity is given of a mental health condition, a framework that places voice hearing as an auditory hallucination is imposed on Jessica and Adam whose meaning of the experience is not listened to. Being *'sat in the psychiatrist's office'* highlights an important power dynamic, the space belongs to the psychiatrist, the psychiatrist has an *'office'* which is a symbol of power and status. There is also a question about what leads the participant to be there, suggesting that Adam is not there of his own accord, the idea of 'being told' is also reflective of the power dynamic and the experience of not being listened to.

For Adam, part of the difficulty with the psychiatric label appears to be the prognosis that then accompanies this:

"The hope, you know the hope gets extracted in the diagnostic process...In terms of the prognosis they gave, it was very negative prognosis. They don't give out much hope of me recovering at all"

The diagnostic label has negative connotations, for prognosis and for meaning, it removes the meaning from the experience. Adam describes how it becomes a; *"sound effect of a biological disease"* and then *'extracts'* hope. The language becomes medical and surgical, the discussion of *'procedures'* and '*extractions'* contrasts with the language used to describe meaning.

Adam also introduces the idea that '*recovery'* is something that may be desired, the introduction of the term recovery appears at odds with the rejection of the medical model. This highlights the complexity in that at times Adam's experience of voice hearing has been difficult, there may have been hope of help with this but instead the response of medical professionals is to *'extract'* hope.

Daniel also described negative experiences of psychiatric care:

"but the problem is a soon as you get sectioned and get ill, you get these messages that your part of that and that is so destructive, they plug you up with drugs and make you violently ill and then they isolate you"

Corresponding to Adam's experience, the description of psychiatric input involves language that evokes a sense of violence and something being done to the person against their will. For Daniel it is the process of being sectioned that creates an illness, there is imagery evoked of being 'plugged' up with drugs with a then involuntary sickness because of this:

Bryony also referred to the threat of being sectioned:

"I thought if I spoke to anyone they would think I was crazy...if you say you hear a voice, they want to take you straight to the section room...rather than talking to you, seeing if it's a good voice...they don't realise there are two different types"

In accordance with the experience described by Adam and Daniel, the language reflects a sense of something being done to Bryony, in this case being taken away somewhere. There is also a link with Adam's experience of power in certain spaces, in Bryony's case the '*section room*', a section room is sometimes referred to a place of safety but is commonly situated in either a hospital or police station. Again this there is the idea of being taken and placed in someone of authority's space. This also reflects the participants being forced to move in respect to the framework of their own experience, from their own meaning to a place and meaning belonging to a biological or psychiatric system and a loss of agency and freedom.

Authority and equality were a feature in participants accounts of their relationship with their voices and appeared in relation to experiences with mental health services. Jessica raised the question of inequality in the mental health system:

"There's that inequality thing, and you know vested interests...a system in place it's a system
I don't understand, why would you want power over someone else?"

Jessica refers directly to the concept of power and inequality that dominates the participants discourse when describing the medical framework. Jessica describes finding it difficult to understand why someone would want to have power and may reflect Jessica's experience of abuse and attempts to answer questions of her own childhood experiences that resurface when experiencing the system as unequal or an abuse of power. The intensity of feelings is emphasised when Jessica describes taking part in a conference about mental health:

"it was lovely to sit in a room of psychiatrists... and say what you thought, but they couldn't section you"

The *'room'* again conveys meaning, unlike in the psychiatry and section '*rooms*' described by Adam and Bryony with a clear delineation of ownership and power, this is a conference room and a conference aimed towards service users. The transition in where the 'power' is held in in this space allows Jessica to say what she feels without the threat of being '*sectioned*':

The medical model as perceived by the participants as a system that fails to acknowledge the meaning of their experiences, they do not feel listened to and an alienating meaning feels imposed upon them. Jessica argues for an alternative to the medical approach that rejects the notion of illness:

"There's an alternative to the reality of mental illness. I'm a voice hearer and I have been since childhood. I'm not ill and I don't take any psychiatric drugs"

Jessica empathises her identity as a voice hearer and not as someone who is *"ill"*. Jessica presents evidence that she is not taking medication as though she feels the need to prove that she is not "*ill*". This is significant when considering the usual diagnostic process of looking for evidence that someone is '*ill*'. The role of the medical model in influencing identity as a voice hearer is present in all the participants accounts of their experiences, Lucy highlights this:

"We are not a sum total of ticked boxes"

and Adam reflects on the influence on meaning:

"In terms of an experience, it is much maligned, it is only ever seen as being a symptom of a disease. Its only ever thought of as being a sound effect, you know and a meaningless one at that"

All participants are engaged in a struggle to prioritise the meaning of their experiences whilst experiencing the medical model and society as signifying a threat to this by adopting a framework that renders their experiences meaningless.

Sharing the experience

All participants were recruited from hearing voices groups and accordingly there was reflection of the role of sharing voice hearing experiences in this setting. Bryony discussed the value in finding others with similar experiences:

"I think this group has brought me along a long way with my voices. Understanding and hearing you're not the only one....Sometimes you feel like you're a bit of a freak, but you realise you're not the only one"

Bryony places emphasis on not being the only one and this is particularly salient considering the experience of feeling ostracised and excluded by society. Bryony refers to feeling like a '*freak*' and that it is not being the only '*freak'* that is helpful. For Lucy, sharing helps to normalise the experience:

"We're all unique but that somebody else might think 'it's nice to know that what I'm thinking isn't completely out of the world, out on a tree. It's actually more ordinary that I imagined'

This is supported by Jessica who finds that sharing the experience supports the 'reality' of the phenomena:

"I thought well perhaps this is a real occurrence because it happens to lots of people"

For Lucy, knowing there are others helps to make the experience feel more '*ordinary'* and accordingly feels less '*out on a tree'*. There is an experience of her thinking being validated, however also a need to retain the importance of experiences being '*unique'*. This introduces a tension between being able to embrace the uniqueness of individuals whilst also wanting to feel part of the '*world*'. This tension is elucidated in some form in all the participants experiences of voice hearing and is eloquently explicated by Lucy:

"and this is where we go wrong today, we're more interested in highlighting people's differences, instead of saying let's encompass this...the joy of being human"

Discussion

Summary of results

The aim of the study was to explore how voice hearing individuals understand and make sense of positive voice hearing experiences. There were three main superordinate themes identified from the IPA: 1. 'Engaging in a complicated world': The voice in repetition or reparation of relational trauma, 2. 'Response-ability', in interpretation and action and 3. 'Fracturing identities': The self and society's acceptance of voice hearing.

Three main findings were identified from the analysis and are explored in greater detail in the discussion. The first main finding was concerned with the participants connection with the voices. The participants experience what can be considered a relationship with their voices, with participants ascribing relational features to the experience, such as closeness and availability. Related to this is that all the participants shared an experience of interpersonal difficulties, the relationship with the voices was able to compensate for difficulties in relationships but also demonstrated at times features that indicated a repetition of relational difficulties.

Furthermore, a uniting feature of the participants accounts was importance of finding meaning in the voice hearing experience, what differed was the extent to which the individual would invest in discovering the meaning and then act upon this. Participants also varied in how they responded to and felt about the responsibility of receiving messages or warnings about themselves or others.

The results of the study also highlighted the influence of voice hearing on the participants sense of identity. For some participants, there is evidence that voice hearing facilitates an identity, for others the experience of voices fracture and undermine their sense of identity. The experience of being a voice hearer in society was also discussed by participants in relation to their sense of identity. Society plays a role in how individuals experience the label of voice hearer. Participants experienced difficulty in feeling accepted in society and the frameworks of meaning others applied to voice hearing impacted upon this. The medicalisation of voice hearing was unanimously rejected and considered to have

pervasively negative consequences for individuals and society's understanding of voice hearing.

The discussion explores the key findings identified in light of the current literature and considers the implications for clinical guidance and practice with specific reflection on CoP practice. The limitations of the study are discussed alongside consideration for further research.

Comparison with existing theory and indications for further research

The literature review highlighted that understanding of voice hearing would benefit from consideration of the interpersonal history of the person to be able to understand how past and current relationships may influence the voice hearing relationship. The study addressed the paucity of interpersonal focused voice hearing research, the in-depth interviews provided rich accounts of individual past and present relational contexts in which the voice hearing experiences could be considered.

Relating to the voices

One of the first studies to consider whether features of relating could be applied to voice hearing relationships was reported by Benjamin (1989) who found that hearers appeared to have integrated and coherent relationships with their voice's and that these relationships seemed to be similar to relationships in the 'real world'.

Since then various models of relating have been used to investigate features of the relationship with the voice and how this contributes to positive or negative ways of relating to the voice. Birtchnell's (2002) social relating theory suggests that relating is the result of two intersecting dimensions of power and proximity, represented at their two poles by `upper/lower' and `distant/close', respectively. These four positions represent innate goals towards closeness, distance (escaping from threats from others) upper-ness (experiencing an advantage over others); and lowness (seeking protection from others) and it has been demonstrated that these features are present in the voice hearing relationships e.g. Chin et al., (2009).

This study supported the notion that individuals have what can be considered a relationship with their voices and replicated research demonstrating that dynamics

of power and intimacy were key components in these relationships. Prior studies had focused on quantitative data using structured interviews and assessments (e.g. Hayward, Strauss & Bogen-Johnston, 2014). The study provides valuable evidence that participants describe characteristics of closeness and power in the relationships despite these concepts not being explicitly introduced.

Bryony described her voices as like '*any other person* 'and depicted a domestic context in which she lived with her voices and that they would go everywhere together. The voices provided her with a consistent source of reassurance and advice, e.g. reminding her to lock the door and helping her to go out. Despite the supportive nature of the relationship there were times when they would appear to abuse this position, by calling her names or disappearing. This was also evident for Lucy whose voices were ascribed a position of power. Lucy described the voices as authoritative, but not scary and that wherever possible she must do what the voices tell her.

For Adam issues of control were also a key feature of the relationship with his voices. Adam described a notion of long versus short- reins which illustrates the extent to which the voices are in control of his life. Adam describes how at times of real stress the voices take '*direct control'*, making use of a further metaphor of being the pilot and the voices the captain. Adam reports that the voices are helping him to stay on track and safe, which is comparable with Bryony's experiences. However Adam also describes the experience of free will during periods of long-reins as 'illusionary' suggesting a struggle to retain a sense of agency over his own life.

Prior studies, focused on negative experiences highlighted that distress was positively correlated with voice dominance and distance, participants who reported being closer to their voices reported more positive experiences (Vaughn & Fowler, 2004).

This study suggests distance from the voice has different meaning and impact for different people which the qualitative design may have helped revealed. For Bryony in particular, closeness with the voice was important and mostly helpful, the voices occupied positions of close family roles and Bryony was also able to physically see the voices.

Jessica was the most distant from her voices, experiencing voices from all over the world and little sense of identity or physical closeness. Jessica described the voices as distressing at times because they would often be asking for help with problems, it was the experience of helping them was positive. The other participants experienced clear attributions of power and authority to the voices, in comparison Jessica described the relationship with the voices as demonstrating '*equality*'.

It could be hypothesised that the distance from the voices promoted the experience of equality in the relationship. Many of the participants had experienced trauma in close relationships and attributions of power to voices close to the participants may have reflected this which would be consistent with Freud's (1911) and Klein's (1946) psychodynamic theories of voice hearing which is explored further below.

The previous research from a cognitive perspective (e.g. Vaughn & Fowler, 2004) is partially supported, closeness and power were important features of the experience identified by the participants however this study highlights the complexities of these relational factors and the limited function of quantitative research in recognising the complexity.

It may be that individuals given time to reflect in an interview setting are drawing upon wider aspects of the experience and therefore considering multiple factors such as the sense of safety and support provided by the voice when concluding the experience as positive.

In 2003, Hayward utilised Birtchnell's (2002) social relating model to investigate the hypothesis that people relate to their voices in a similar way to how they relate to people in their social environment. Although the focus of Hayward's (2003) study was on negative experiences the results nevertheless indicated that the way an individual relates to the voice may be reflective of a pervasive pattern of social relating.

The findings of this study also evidence some consistency in how individuals relate to their voices and their experiences with others. This supports the Birchwood et al., (2000) study which, using social rank theory (Gilbert & Allan, 1998), found that power and rank dynamics between the voice hearer and the voice were mirrored in their social relationships.

Both Lucy and Jessica described helping the voices to be a feature of their experience, and this was concordant with how they would relate to others outside of voice hearing, often being in positions whereby they would be helping or support others.

It has been suggested that voice hearing relationships may be indicative of an individual's past relationships and experiences (Vaughn & Fowler, 2004), and this would benefit from further research (Hayward et al., 2011). Despite not being the specific focus of the current study this aspect of voice hearing emerged as a key feature in the analysis.

The participants in the study often described difficult childhood experiences or a key childhood event that had a detrimental impact, for some of the participants there was a continuation of relational difficulties into adult life. Despite no specific question being asked about past experiences in the interview, all participants voluntarily provided information about their historical and current relational context. This suggests that the relational context is an important feature of how individuals make sense of their voice hearing experiences.

Several participant's described isolation during childhood and many experienced bullying or interpersonal trauma, supporting the wealth of research that has demonstrated links between childhood trauma, such as childhood sexual abuse and voice hearing (e.g. Longden, Madill & Waterman, 2012).

A recent innovation in voice hearing research has endeavoured to combine the cognitive model of voice hearing with an attachment perspective, to consider the possibility that insecure attachment patterns may mediate the link between trauma and voice hearing (Berry, Varese & Bucci (2017). The model proposes that distressing voice hearing experiences are maintained by insecure attachment patterns contributing to how voices are appraised and related to.

The study supported and refuted the idea that childhood interpersonal difficulties may be reflected in the voice hearing relationships. In some circumstances the voices appeared to provide a reparative and compensating experiences. Bryony described a childhood marked by persistent bullying and an abusive home environment, she said that the voices provided someone to talk to and somewhere to go where was safe. She described her main voice who was '*like a*

sister' as the person who had kept her going. Furthermore Bryony had a voice called *'Mother'* who was called *'Mary'* to everyone else, she described how this voice had taken over the role of her own mother who she has a difficult relationship with and who doesn't talk to her. In this case the voices could be seen to compensate for difficult relationships and provide a relationship that is missing. Bryony's experience could also be considered in terms of Klein's (1946) object relations theory. Klein suggested early relationships were internalised by children and would then unconsciously influence the individuals later relationships (Klein, 1946). Bryony's 'Mother' voice could be considered an example of projective identification (Klein, 1946), whereby internalised aspects of the relationship with the mother are split off and projected outwards, onto the voices.

Bryony's voices can be considered to demonstrate both 'good' and 'bad' object representations (Klein, 1946), at times they provide support and reassurance and maternal aspects such as help running a bath, at other times they call her nasty names and say that she deserved the abuse.

Lucy also described an isolated childhood, with few friends and attributed this to being adopted and struggling with a sense of identity and place in the world. For Lucy the voices provided a connection with her biological family, not only through the possibility that she once heard her biological mother call out but also by perceiving the voice hearing experience to be a thread running through her family and therefore connecting her to a family and a sense of identity that she was missing.

Lucy described how the voices helped her to engage in the social world, Daniel described how the voices helped him to engage in a world that was "*complicated, confusing and not going to work out as expected*" and Adam described how the voices also helped him navigate social stressors.

It is hypothesised that a positive voice hearing relationship may provide a helpful attachment relationship, compensating for historical and current interpersonal difficulties. From an attachment perspective it could be argued that in some cases the voices have functioned in the provision of a secure base (Bowlby, 1988). A secure base is considered to be a platform from which the child seeks refuge when under threat but ventures from for exploring and learning when threat is

reduced (Bowlby, 1988). If the child's care giver is available and supportive when the child seeks refuge then the child experiences a sense of relief as a result of the proximity to this person (Bowlby, 1988). It is through these positive experiences of care that secure attachment is perceived to develop (Bowlby, 1988). Both Adam and Bryony reported that they would seek advice or reassurance from the voices when experiencing distress and Bryony experiences consistent physical proximity to the voice. From this perspective we could consider the voice hearing relationships to incorporate some of the elements of a secure base. A secure base is perceived to have significant benefits in terms developing a positive sense of self and others as well as ability to regulate emotions (Bowlby's 1973). Further research could look at whether features of a 'secure base' can be evidenced in voice hearing and whether this facilitates positive experiences, which could suggest value of therapeutic interventions that attempt to facilitate a secure attachment with voices.

This study highlights the complexities of the relationship individuals have with their voices and refutes the idea that there is a clear unilateral mirroring of the voice-hearing and social relationships. Further research would benefit at looking at how an individual is able to develop an adaptive and positively experienced relationship with a voice in the context of significant interpersonal difficulty. It would be helpful to explore further the idea that voices compensate for relational difficulties and the potential adaptive function of this.

Finding meaning

A key feature in participants experiences of voice hearing was the importance of finding meaning in the voices and in the experience.

Voice hearing research from the survivor and hearing voices movement have in accordance with this study highlighted the importance of the meaning in the voice hearing experience (e.g. Holt & Tickle, 2013) and the positive effects voice hearers experience from interpreting their experience (Romme & Escher, 2000). Adam described the importance of needing to actively consider the information that was being communicated and likened the experience to panning for gold suggesting it can be challenging. For some participants the voices had a prophetic quality or forewarning of something happening to either the participant or in some cases the

wider world.

Finding meaning in voice hearing is considered a valuable intervention for those experiencing distress associated with voice hearing. This does not appear to be solely related to positive voice hearing, with negative voices also seen as useful messengers, providing advice and communicating important information (Romme & Escher, 2000). The study supports research demonstrating that some people experience negative content, but it is the interpretation of this content that enables a voice hearing experience to be considered positive (e.g. Romme et al., 2009). Adam describes how as oppose to responding to something either because its friendly or frightening, he considers what it is being communicated.

The extent to which individuals felt responsibility to act upon the communication from the voices varied. Lucy described the experiences as overwhelming because she felt like she had been given a type of insight or gift and questioned whether she was deserving of this. Jessica, experiences voices requesting her help and support and explained she felt honoured but also apologetic because she did not know whether the support and advice she provided to the voices was helpful or not. The difficulty in receiving potential troubling or disturbing messages was described by some of the participants and the challenge in managing the uncertainty in respect to what the outcome would be.

Research has shown that it is the emotional response not the content of the voice hearing that differentiates patients and non-patients in voice hearing (Jenner & Van De Willke, 2001). This study suggests that it is the way in which individuals find meaning and make decisions about whether to respond or not that enables them to modulate potential distress associated with the negative content. The participants in the study had been voice hearers for many years and had well developed understanding of the meaning of their voices and had been helped by voice hearing groups to explore their emotional responses to voice hearing.

It has been shown that people who attempt to suppress or avoid their voices experience more distress associated with voice hearing (Romme & Escher, 2000). The participant's in this study who framed their experience in positive terms also all actively engaged with the voices most of the time. What did differ was the extent to

which the meaning or message was acted upon and this could also vary at different times for the same participant.

The influence of the identity of the voice and the relationship with the voice on the response to finding meaning and whether messages are acted upon requires further elaboration.

Jessica described investment in supporting voices who approach her for advice and support, whilst highlighting a desire not to learn the identity of the voices, nor to place any interpretation on their message. In this context not developing a sense of who the person is may help her to manage the difficult messages and information she is receiving.

For others the desire to act upon a message is facilitated by the identity of the voices being attributed to a religious figure or '*creative, higher power"* and may be influenced by the individuals own belief system and set of expectations that they themselves live by. How individuals manage meaning or messages that are not in accordance with their own belief system or identity and whether this is indicative of less positive experiences would benefit from further research. This would be helpful in developing ideas about the importance of congruence with the voices and whether this facilitates positive experiences.

Identity and voice hearing

Frequently referred to in the participants experiences was the importance of their own identity. Participants were united in their identification of being a 'voice hearer' by the very nature of their participation in the study. For some participants who struggled with a sense of identity, identity as a voice hearer was an important way in which they could develop a sense of who they were. This was particularly salient for Lucy who struggled with a sense of identity due to being adopted. Being a voice hearer enabled a way of threading together a connection with her biological family.

For others the experience of voice hearing was described as having an undermining influence on their sense of self, Adam described the experience of voices as *"fracturing"* his identity and described this in relation to the confusion at times between voices that were part of who he was and voices from the "*outside"*. Adam, who described the most destructive impact on his sense of self was also the only participant who described the voices as sometimes coming from within. The

lack of reflection on the 'self' and identity in voice hearing in the literature review was likely a result of the focus on the interpersonal aspects of voice hearing however it was clearly a key concern for how individual made sense of their experience.

Most of the research on identity in voice hearing has focused on the identity of the voices themselves as oppose to how the experience of the voices influences the individual's own identity and sense of self. The neglect of this is mirrored in the current studies literature review and attention on this aspect of voice hearing is greatly needed.

An important influence on how participants experienced an identity as a voice hearer was related to their experiences of this within society.
Participants were united in an experience of feeling stigmatised and excluded by society. There was concern that society's view was that people who heard voices were dangerous or crazy and some identified the medias role in maintaining negative perceptions.
Research continues to demonstrate that voice hearing in the media is consistently portrayed as a symptom of mental illness and associated with criminal behaviour and suicide (Vilhauer, 2015).

Related to experiences in society were participant's rejection of the medical model of voice hearing and concerns in respect to the influence the medicalisation of voice hearing has on the acceptance of voice hearing in society. The medical model of voice hearing posits that hearing voices is a manifestation of brain pathology (e.g. Gaser et al., 2004) and Adam described this framing as positing the experience as a meaningless symptom of disease, echoing the words of Deacon (2013).

Participants described the experience of receiving a psychiatric diagnosis associated with their voice hearing as particularly damaging, and there were frequent references to the differential power dynamics involved in their experiences with mental health professionals. There was concern that situating voice hearing within a biological framework, as "*a meaningless symptom of disease*" was incompatible with the participant's own understanding of their experience and the meaning they had derived. There appeared a lack of collaborative understanding with participants feeling like they were being told *"what they were experiencing"* by people that did not know them. Furthermore, participants indicated that the medicalisation of voice

hearing extracted hope, by rendering them subject to a poor prognosis and possibility of recovery.

The participant's in the study advocated for an alternative model, rejecting the notion that they are "ill", calling instead for acceptance of an alternative that prioritises their own meaning and understanding that contribute to the potential for positive experiences.

The importance of meaning reflects the sentiments of Laing (1960), who argued that by focusing on trying to classify 'psychosis', the meaning in 'madness' was lost and that we should seek to try to make sense of the experiences people have (Laing, 1960).

This approach corresponds to the model of 'Psychological Formulation' (Johnstone, 2017) as an alternative to psychiatric diagnosis. Johnstone (2017) reports that the most damaging aspect of a psychiatric diagnosis is in the loss of meaning for an individual. This experience is evident in the majority of participants accounts of psychiatric care. The aim of a formulation- based approach is to restore the meaning in experiences (Johnston, 2017) through understanding experiences such as voice hearing in an individual context, including the social, cultural and biological influences on peoples lives. Research examining the application of formulation-based approaches to voice hearing would be helpful to determine whether the relationship between meaning and positive experiences can be replicated.

Further research could also continue to explore the relationship between individual frameworks of meaning for voice hearing and the impact on positive experiences, particularly whether acceptance of a psychiatric framework and identity as being "ill" may render more negative outcomes.

It has been argued that labelling individuals as mentally ill only accentuates any burden of the experience by situating the problem within the person, rather than to engage in the difficult task of addressing the contextual elements that may be at the source of distress (Jacob, Gagnon & Mccabe, 2014). The study has shown that for individuals experiencing voice hearing there is often demonstrable difficult interpersonal contexts, by labelling these individuals with a mental illness the interpersonal context becomes invalidated and the 'problem' placed within the voice hearing person. Rejection of this model appears to be a protective factor in the

participant's experience of distress associated with their experiences and would benefit from further research.

Sharing experiences: The hearing voices group

All participants were recruited from hearing voices groups, further research could explore whether the sharing of voice hearing experiences may support the development of positive voice hearing experiences. As described in the literature review the hearing voices movement provides an alternative to the medicalisation of voice hearing, with voice hearing considered a natural part of the human experiences (Corstens et al, 2014).

The hearing voices movement developed an international social movement whereby experts by experience (voice-hearers, family members) worked to challenge, critique, and reframe traditional biomedical understandings of voice-hearing (Corstens et al., 2014). The outstanding result of this has been in the extensive development of a recovery network and peer -focused 'hearing voices groups' (Longden, Carstens & Dillon, 2013). There has been an attempt to shift the power from the bio-medical framework to the 'experts' of their own voice hearing experience. The hearing voices group are considered an unprecedented success and consistently associated with beneficial outcomes (Longden, Carstens & Dillon, 2013). Of particular significance is the role of the groups in helping people to develop understanding and meaning (Longden et al., 2013). The experience of hearing voices groups may have been a contributary factor in the participants development of understanding and meaning although this can only be speculated as the role of the hearing voices group was not directly addressed.

Woods (2013) argues that through the hearing voices movement, 'the voice-hearer' has become an identity people can embrace promoting a view of voice-hearing as meaningful in the context of people's lives but that the challenge now lay with mental health professions in fully recognising this claim.

The participant's in the study were subject to pervasive alienation and stigma in society and research has shown that hearing voices groups result in less isolation and greater social skills (Beaven, Jager & Santos, 2016). Participation in the hearing voices group may have formed a protective factor in moderating the negative effects of social isolation and interpersonal difficulties. This was supported by Bryony's

account of the positive benefits of the hearing voices group as helping her feel less alone, further research could explore this potential.

Applications for clinical practice and guidance

Despite evidence of the numerous positive effects associated with the hearing voices group, e.g. reducing social isolation ((Beaven, Jager & Santos 2016) and facilitating understanding (Woods, 2013), recent clinical guidance that forms the basis of statutory services approach to supporting individuals who want help with voice hearing makes no reference to hearing voices groups (NICE, 2014). Clinical guidance remains firmly situated within the bio-medical model stipulating that hearing voices is a 'psychotic symptom' and that treatment should consist of antipsychotic medication in addition to individual CBT. The study supports the assertion that alternative approaches focusing on normalising and sharing experiences in addition to accepting and finding meaning in the phenomena are more likely to facilitate positive experiences of voice hearing.

The study has also highlighted the importance of understanding voice hearing within a personal interpersonal context, which can only be derived from listening to the individual and valuing their interpretation of the experience, not rendering the experience meaningless from the imposition of a framework of understanding that is incongruent with their understanding. This supports the argument for a the 'formulation-based' approach (Johnstone, 2017) discussed prior.

In 2013 the Division of Clinical Psychology (DCP, 2013) released a position statement advocating for a paradigm shift towards understanding of human distress within an interpersonal context, utilising a formulation approach allowing exploration of the meaning of individual experiences and relationships in contributing to current difficulties (DCP, 2013). This has since been followed up by the DCP (2018) publication "Power, threat, meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis".

The publication supports the continuum model of human experience suggesting that behaviours are coping and survival responses to current circumstances, history, belief systems, culture, and bodily capacities (DCP, 2018).

The framework is concerned with four interrelated aspects of the origins of human distress; 1) the operation of 'power', 2) the 'threat' this power may pose to the individual or group, 3) the role of 'meaning' in shaping power and threat and 4) the 'threat response' which an individual or group may need to draw upon for emotional, physical or relational survival (DCP, 2018).

Power mechanisms are understood in terms of legal, social, economic and ideological aspects and threat is considered the experience someone may have from the negative operation of such power. Meaning is understood in terms of social and cultural discourse which, shape the expression of power and threat. The threat response is considered the way an individual, group or community develops ways of responding to and coping with the experiences of power and threat (DCP, 2018).

The participants experiences can be understood in relation to the framework. Some of the participants described the experience of psychiatric services as providing a negative operation of power, examples included the imposition of diagnosis, being 'sectioned' and having psychiatrists imposing a meaning without knowing the person. Some participants also experienced a sense of threat from the how the meaning of voice hearing was understood by society, experiencing stigma, exclusion and expressing concern with the media portrayal of voice hearing as dangerous.

Within this publication the hearing voices network (https://www.hearing-voices.org/) is acknowledged as an example of a non-diagnostic successful approach that embraces the principles suggested by the DCP (2018) framework. It is unclear how future clinical guidance will respond and whether there is appetite amongst the biomedical community for a change in how voice hearing and other phenomena are considered.

The study demonstrated the importance of finding meaning and understanding in the voice hearing experience and how the interpersonal context and history of an individual in influences. A formulation or meaning based approach to understanding voice hearing can be at the forefront of innovation and change in psychology as per the recommendations of the DCP (2018). Further guidance should begin to consider application to other experiences that are pathologised and

marginalised by society for example self-harm.

It is disappointing that in mental health CBT and pharmacology remain prioritised. None of the participants wished to remove voice hearing from their lives although some felt that voice hearing could be difficult at times. Interventions that continue to focus on reduction or elimination of voices may discourage individuals from seeking support when they feel they need help. Counselling and Psychotherapy may provide a therapeutic intervention that enables individuals to develop understanding and meaning of their voices and facilitate more positive experiences.

The participant's in the study described both positive and negative experiences of voice hearing and the beginning of voice hearing was a time associated with more difficult and at times distressing experiences. Consequently there is a rationale for developing thoughtful interventions that can support people who are first presenting with voice hearing who are experiencing distress. The study highlights the importance of therapeutic interventions that consider the relational aspects of the voice hearing experience, an example of this is 'relating therapy' (Hayward, Overton, Dorey, & Denney, 2009) based on Birtchnell's (1996) theory of relating and aimed at supporting individuals to take an assertive approach to their voices and exploring relationship to their voice in the context of their interpersonal history.

This study demonstrated that a history of trauma and experience of social difficulties did not always lead to maladaptive relating to voices and professionals should be mindful not to make assumptions regarding distress associated with voice hearing.

Attachment theory is considered an important framework to consider voice hearing relationships (Berry & Danquah, 2016). This study demonstrated that individuals have relationships with voices that could be considered attachment relationships and may have a reparative or adaptive function. Thus caution should be taken at attempts to 'remove' voices from individuals. Further research could look at whether there are beneficial effects from targeting therapeutic interventions at fostering healthy attachment relationships with voices and whether this promotes positive experiences.

Despite CoP finding itself in discord with the psychiatric discourse and advocating a position valuing meaning, subjectivity and, mutually constructed realities, CoP has continued to occupy a position of co-habitation with the medical model due to concerns of the impact on the profession if it were not to do so (Chwalisz, 2003). The findings of this study demonstrate the important place CoP could have in developing clinical guidance and services that embrace a meaning and understanding based approach to human experience. This is simply not going to occur whilst CoP remains a silent partner to the medical model, CoP needs to develop its own position in respect to the medicalisation of distress and advocate the advancement of collaborative and non-pathologising based approaches.

Limitations

The study utilised an IPA approach with five participants, all of whom had been recruited from hearing voices groups, therefore caution should be made when considering the extent to which the findings may relate to others who have positive voice hearing experiences.

The study positioned itself as wanting to advocate a non-pathologising narrative, enabling voice hearers to be given a voice, however there are key hypocrisies within this study; the literature review focuses in part on research into psychosis as a way of illuminating voice hearing research, however this may have led to a prioritising of research that embraced a biomedical framework. Furthermore, the study itself imposed its own meaning through the dichotomy of positive/negative voice hearing experiences. The participants that took part in the study had to some degree positive and negative experiences of voice hearing, and Daniel raised the difficulty in the imposition of the positive/negative dichotomy.

A further concern of this nature is from the initial recruitment strategy, whereby it was requested that participation was dependent on GP consent. In retrospect this was an abhorrent request that would have only sought to make individuals feel discriminated against. It is an indication of the anxiety and prejudice that was produced by the subject content and the difficulty the researcher felt in being able to challenge this. Unfortunately, this led to initial recruitment requests being poorly received prior to the GP caveat being challenged and removed, there

was likely to have been some distrust in the research that persevered and may have impacted upon the recruitment process.

The recruitment process proved challenging with many hearing voices groups, from all over the country visited and people talked to and invited to take part. Individuals who have voice hearing experiences, as seen from the study have often had difficult experiences with psychiatry and allied professions and there was often reluctance verbalised to take part in something that was associated with psychology.

The researcher's association with psychology may have provoked the discussions that occurred around rejection of the medical model and the prevalence of this in the findings. Jessica stated during her interview when discussing the medicalisation of distress that she didn't need psychology or psychiatry to tell her what she is experiencing, and she does not need a framework placed on it or make money from it. This may illuminate the dynamics in the relationship between the researcher and the participant but also led to more cautious interpretation during the analysis.

Adam also described the sense of a responsibility to interpret his own experience so that others did not and made references to psychiatrists telling him what he was thinking despite not knowing him. The researcher was therefore under considerable pressure to ensure any interpretation of experience was well evidenced and the accounts of the participants was not misrepresented, this ensured a high degree of care in the analytic process but may have facilitated a more cautious and descriptive approach.

The analysis was limited by the use of transcription software, although the transcription was then thoroughly checked whilst listening to the recordings, this process may have negated some of the depth to which the researcher was fully immersed in the data. Unfortunately, personal and practical constraints on the researcher's time negated the option of transcribing without technological support.

The psychological background of the researcher may have also influenced the extent to which the participant's felt willing and compelled to discuss their childhood experiences. There may have been an expectation by the participants through their contact with psychology professionals that this is the type of

information requested and valued. The background of the researcher as a psychotherapist may have influenced the interviewing technique, interviews were predominantly unstructured with participants experiencing relative freedom over the dialogue, this may have led to association with a more therapeutic type space and again encouraged a discussion about the relational and historical aspects of their experience.

As discussed, all participants had at some point had both positive and negative experiences of voice hearing and some felt that it was difficult to distinguish such a dichotomy. Therefore, the study cannot reliably state that the findings are indicative of positive voice hearing experiences only.

Conclusion

It is suggested that throughout history voice hearers have followed a similar historical trajectory to women, children, the disabled and people of a non-white skin colour, in that their voices and opinions have been dismissed as unreliable, and those in a position of power have spoken for them and over them (Mccarthy-Jones, 2012). The study aimed to address the lack of research of both positive experiences of voice hearing and the lack of research documenting the 'voice' of the voice hearer. The research has produced five rich and detailed accounts of how individuals make sense of positive voice hearing experiences, illuminating the importance of relationships, meaning and the frameworks in which people find themselves in. It is hoped that this research contributes to the movement towards 'reclaiming experiences' (Dillon & May 2002) and the request for a paradigm shift away from psychiatric diagnoses that is finding increasing support in psychology.

The participants in the study did not consider themselves to be 'ill' and yet continued to experience an abundance of negative attitudes, alienation and stigma. Counselling Psychology's vision is to promote fairness, equality and social justice (CoP, 2017). Counselling Psychology should be engaging with voice hearers and other stigmatised individuals and groups in society, particularly if the organisation is to realise its vision of working collaboratively to meet the psychological needs of people (DCoP, 2017).

"and this is where we go wrong today is we're more interested in highlighting people's differences, instead of saying let's encompass this.... the joy of being human" (Lucy)

Reflexive statement part two

In writing my second reflexive statement at the close of my research I took time to read my first reflexive statement that had concluded my literature review. Several years has passed, and my first reflexive statement exudes a naivety and wariness, a recognition that I was attempting a piece of research that was considered relatively unorthodox for a CoP trainee and an accompanying anxious enthusiasm to be doing so. The completion of this thesis reflects a personal and professional journey over a period of immense change.

Shortly after starting the doctorate in counselling psychology I found myself pregnant, upon informing the department it was suggested I should consider leaving the course, subsequent tears were interpreted as an indication that somehow I had made a terrible mistake, actually they were tears of absolute fear that two such significant dreams and aspirations were being posited somehow as incompatible.

The vulnerability I felt in that moment, the lack of control, feeling insignificant, rejected by a world I was desperate to be part of, provides a momentary and diminutive glimpse of the daily struggles individuals can experience as a result of prejudice and judgement when they are looking for support and understanding. This was overwhelmingly evident in the experiences of the participant's in my study and it was disappointing that despite decades of attempts to challenge the stigma around experiences such as voice hearing, individuals still found themselves being defined by terms such as 'crazy' and 'dangerous'.

In my first reflexive statement I reflected on my own experiences of feeling different and not being able to 'fit in' as part of the context that precluded my chosen subject.

I remember a distinct occasion in my final year, walking with other students from my class when someone said to me "You look like someone who has had a difficult life", I remember walking to the bathroom and looking at myself in the mirror and wondering how it was that I had been exposed and subsequent anger at not doing better to literally keep up appearances. The evidence was that despite years of studying and working on the front-line of mental health for a charity that seeks to challenge stigma I still felt shamed.

My own experiences and beliefs are intrinsically woven into the fabric of this thesis. However it has only been through listening to and learning from the participants that I have begun to challenge my own hypocrisy. My own experiences of trauma, abuse and diagnosis of personality disorder as a teenager was something I felt compelled to hide yet these were important features for my journey both into counselling psychology and the subject of the thesis. The openness and willingness of the participants to discuss their experiences challenged the way in which I hide my own experiences behind a professional role.

I have experience of receiving a stigmatising diagnosis and negative judgments about myself and behaviour and awareness of the negative impact this had. This has led to an unwavering devotion of both my professional and academic life to challenging society's assumptions about human experience. I chose voice hearing as the topic of study because I have never experienced voice hearing and wanted to manage my own personal motivations that may have surfaced should I have chosen a topic of study with which I had a direct relationship to.

Approaching my first interview I had been so focused on recruiting participants I had given little in the way of thought about the final piece of work and particularly how the experiences of these individuals was going to be represented by myself.

During the interview with the first participant I was overcome by a huge wave of indebtedness to the individual who was sat in front of me, giving up their time, to come and tell me about their experiences of something so significant and personal so that I could do 'research'. With this sense of indebtedness also came an overwhelming sense of responsibility to 'do a good job' and fairly reflect and attempt to understand the individual experiences. This helped me to really set aside some of my own presumptions about the experience and hopes that certain relational models would be present in the participant's narratives about their experience.

It has taken a long time to complete my thesis, I have worked full- time throughout to manage the financial implications of studying and have given birth to two wonderful children. I hope that this thesis will contribute to challenging the

stigma surrounds voice hearing and 'difference' but will also challenge the lack of financial accessibility to Counselling Psychology.

More could be done to provide a context in which individuals such as myself who come from poor socioeconomic backgrounds can be supported, as oppose to discouraged and ostracised as was my experience. I was frequently told that my working hours was not compatible with the course which led me to hide the struggles I had in balancing my commitments when really I needed support and guidance of how to manage this. Consideration of this would also enable more diversity within the profession.

There have been several occasions whereby I felt that I was not capable of completing my thesis, this was in part exacerbated by a poor early recruitment strategy that involved requesting GP consent. As can be expected upon advertising for participants with such criteria I was met with a barrage of negativity and subsequent humiliation that a study that preached a challenge to stigma and medicalisation was advocating that a voice hearing individual had to get their GPs 'permission' to take part in what I hoped was an innocuous study. This led to over 18 months of not being able to recruit a single participant for the study. Fortunately, upon returning from maternity leave and with the support of a new supervisor this was removed as a criterion and I was able to recruit 5 participants within 6 months, finally I felt that completing my thesis was possible.

I believe this issue was exacerbated by the challenge of having several supervisors, some of whom were only around for a matter of weeks. I was never really able to develop a close relationship with a supervisor until my most recent and last supervisor. This meant that I didn't feel able to challenge decisions like the GP consent and perhaps supervisors were not able to develop trust in me, to be able to manage potential risk and ethical concerns.

I have learned a huge amount from the participants of this study about the uniqueness and challenges of the human experience, most of all I have learned how to embrace and accept my own.

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Appendix A

Interview schedule

1) Could you tell me about your experience of positive voice hearing?

2) Are you able to describe what makes a particular voice hearing experience positive?

3) How would you describe your experience of positive voice hearing?

4) How has your experiences of positive voice hearing changed over time?

5) Are you able to describe the particular features of the relationship with the voice that can lead to positive experiences?

6) What does your experience of positive voice hearing mean to you?

7) Can you describe how it feels to be a positive voice hearer?

8) Can you describe how you interact with your voice?

9) Is there anything you would like to tell me about your experience of positive voice hearing that we have not already discussed?

10) Any clarifications I have.

Appendix B

"How do individuals make sense of positive voice hearing experiences?"

Unique identifier .....

Initial screening sheet
Thank you for expressing interest in taking part in the research. Due to the sensitive nature of the topic and the possibility that for some individual it may provoke difficult or challenging feelings we are asking individuals who have expressed an interest in taking part some questions that may help us decide whether it would be appropriate for you to participate.

First please read the accompanied information sheet.

Please confirm your name and contact details.
Name.....
Telephone Number .....
Email .....
Preferred method of contact .....

Is it okay if we can ask you some questions to that will help us to make a decision about whether it is advisable to participate?

1) *Have you received any inpatient psychiatric treatment in the past 6 months?*
2) *Are you experiencing any significant difficulties or stressful life events, e.g. family problems, illness?*
3) *Are you alcohol dependent or using illicit substances?*
4) *Have you ever had a negative reaction to talking about voice hearing?*
5) *Would you have any difficulties in meeting the researcher at a particular location and time for example at a room in a university to take part in the research.*

If the answer to any of the questions is yes:
Answering yes to Q1
Unfortunately individuals that have experienced inpatient treatment in the past 6 months are not permitted to take part in the research due to ethical reasons. Talking about voice hearing can elicit significant emotions and may be a stressful experience. Whilst you are currently receiving support or have recently received support for issues related to mental health it would be unwise to take part in research that may have an impact on current or previous psychiatric or psychological treatment.

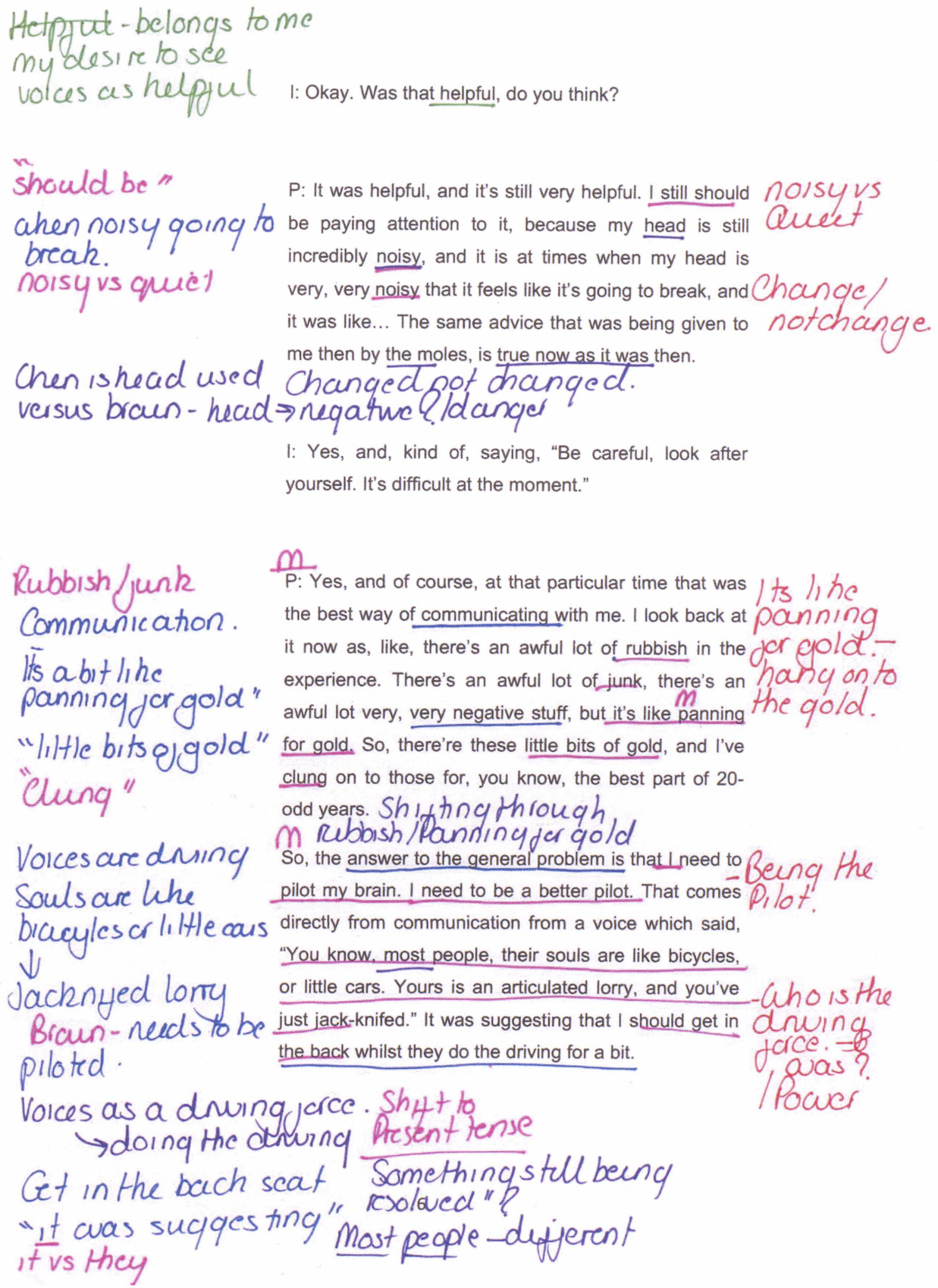
Answering yes to Q2/3/4:
Unfortunately it is not advisable for individuals experiencing high levels of stress to take part in the research. Talking about voice hearing may be a stressful experience and therefore individuals that are experiencing additional stressors in their life may find this particularly challenging. Using alcohol or drugs may influence voice hearing experiences and affect the results of the study and individuals using alcohol or drugs are therefore unable to participate.

Answering yes to Q5:
The research will require participants to meet at a particular location at a particular time e.g. a room in a local library, university etc. Do you have any specific requirements that could make this feasible?

Notes:

Appendix C

Example transcript analysis



Communication. Importana.

Answer to the problem is in the communication

Animals.

"taproot"

"knowing something // using language P doesnt know"

think, at that particular time. It was at that time that I was having- there was some communication which was really, really important. So, the answer to my problems was actually contained within that.

Important communication

So, we're talking about a time period where I saw moles in my head, and they kept on saying, "Shh, shh," and telling me to be quiet, in my head. They kept on pointing at something which was a taproot. At that point I didn't know what a taproot was. I had to go and look up what a taproot was.

looking in.

I: I'm not sure what it is, either.

Imagry - taproot in head.

"Hint"

Need to be careful

Head/Brain - changes

Psychotic/death

"You wont come back, lost forever"

lost to psychosis

P: A taproot is something where, if the taproot gets broken, the whole plant dies. They were pointing at this taproot. So, you know, they were in my head, but they were pointing at this taproot. It was this hint that if I'm not careful I might break the taproot, and if I break the taproot then I won't come back. "You won't come back, and you'll be lost forever, and you'll never stop being psychotic."

Forewarning "Be careful"

Responsibility over life

Being lost to the experiences, needing to be careful

I: That sounds very daunting.

me finding it daunting

noise vs quiet

Very dangerous place.

"Be careful"

Use of "very"

Voices providing clarity about dangerous. Be quiet - who is allowed to speak

P: Very daunting, but at the same time, it was like they were being very clear. It was like, "Be very careful right now. You're in a very dangerous place. Be quiet."

Forewarning

Forewarning

Control

Silenced by the voices.

Physical

amount of times I, like, nodded my head and shook my head around.

I: In response?

Painful moving head to communicate.
tactile language
communication by brain activation

P: It wasn't response. That was them talking. They were actively moving my head to communicate. In some ways, that was actually kind of painful. I still have the same sensation when they're talking now, so bits of my brain feel like they're being activated, and that's where the communication comes from.

Active versus passive

I: So, at the time, it didn't feel like a positive experience?

something about fragmentation when describing initial experience.
Animals / Religion

P: No. Well, at the time I wouldn't have known what ___(short pause) was because, like, I was just talking to, you know, a spider, and I was talking to… and the whole experience was… and my brother is definitely the antichrist, and all that kind of… So, it was like-

I: Lots going on at the time.

What is/isn't a voice

lots going on
were other people experiencing same…

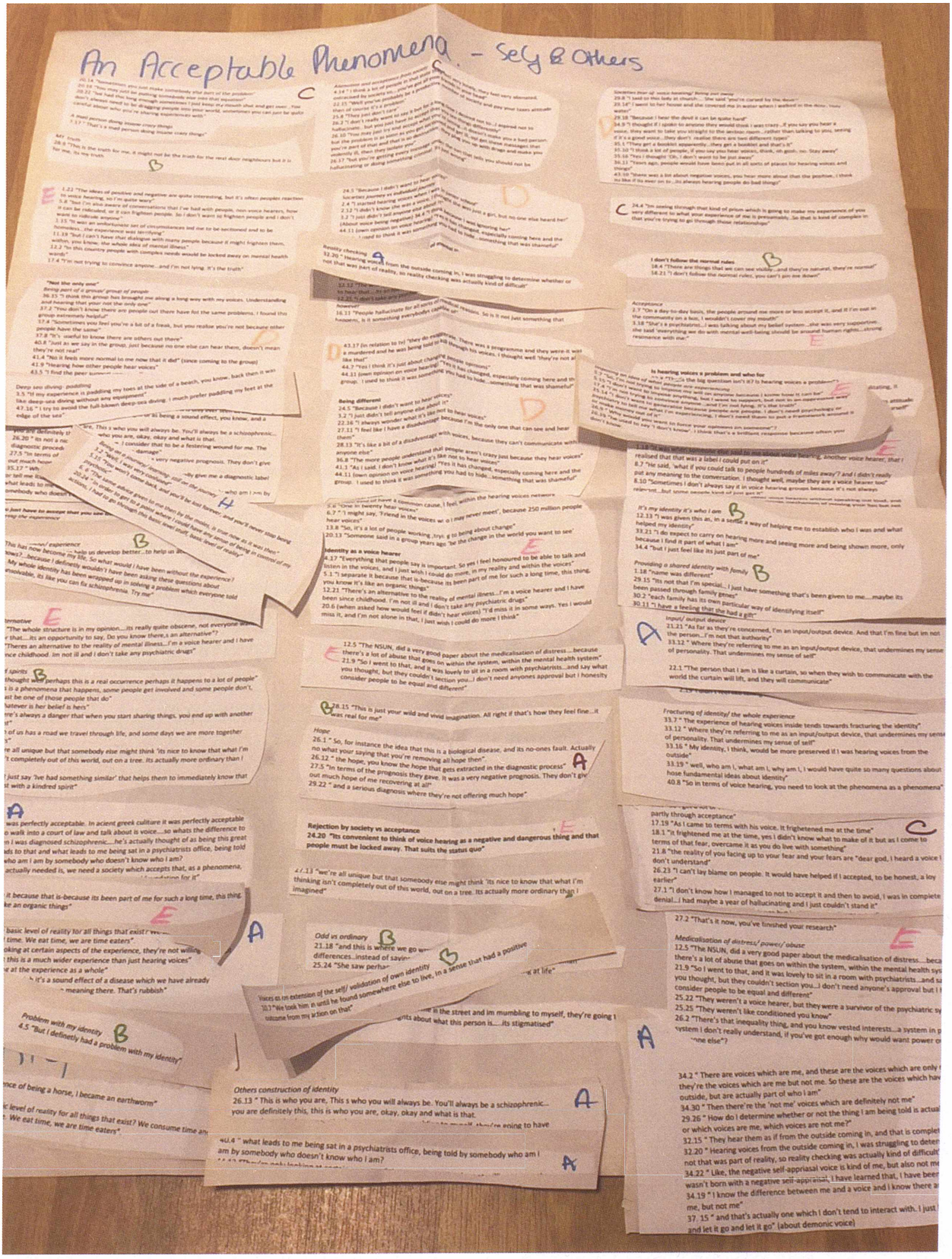
P: There was an awful lot going. So, being able to recognise what was a voice and what wasn't a voice, and, you know, what was an experience which other people were having, and what was an experience that other people weren't having, was not possible, I don't

whether others do/dont share experience

What was a voice and what wasn't - Confusion
Are other people having experience - isolation/difference.

Appendix D

Developing initial master themes



Appendix E

Master themes and example quotes

Table 3.

Table of quotes for super-ordinate theme one: "Engaging in a complicated world": The voice in repetition or reparation of relational trauma.

"Engaging in a complicated world": The voice in repetition or reparation of relational trauma	
Sub-theme: The individual interpersonal context	
Daniel	*"I think it's quite lonely is any psychotic illness"*
Bryony	*I was struggling. I always found it difficult to get on with people. I was being made fun of at school at the time because they found out I was adopted*
Adam	*"We are all taught to drive the same vehicle when we go through school. What happens if the vehicle your driving is completely different from the one your taught, how do you know how to pilot, if you imagine the school teaches you to drive a mini metro, what happens if it turns out you've got a harrier jump jet"*
Daniel	*"I was unhappy, I wasn't part of the community, I was homeless. I didn't really have any community"*
Lucy	*"I spent many hours on my own as a child"*
Daniel	*"I went to boarding school...and I got incredibly independent at a young age and relationship are hard for me to commit because I had to be independent so young*
Lucy	*I definitely had a problem with my identity"*
Jessica	*"I'm a little bit dyslexic*
Jessica	*"I'm a survivor of incest"*
Lucy	*"A lot of my childhood was spent on my own and I found it difficult to make friends"*
Jessica	*"So I felt ashamed because I didn't fit into that model"*
Adam	*"I've often found myself at odds with the social world, it's like how people make friends"*
Lucy	*"I had elderly parents; I was odd for all sorts of reasons"*
Sub-theme 2: The voices influence on interpersonal experiences	
Adam	*"This is how I deal with social stress...you know I've often found myself at odds with the world, the social world...it's like how do people make friends"*
Bryony	*"My home was just quite bad; it was somewhere I could go that I felt safe"*
Bryony	*"I have another voice called 'mother', she's called Mary to everyone else...she the opposite of what my mother was like, she's really nice"*
Bryony	*"It's a bit like having a twin I think"*
Daniel	*"They helped me survive"*
Adam	*"So, I was frantically trying to build this friends and family network in my head"*
Bryony	*"It's nice that she's there because it can be quite lonely on your own"*
Bryony	*"I mean I had a very difficult childhood and Emily has probably kept me going"*

Bryony	*"I think, maybe because she's the only one I could go to talk to about it"*
Bryony	*"It's safer than it was with my brother"*
Adam	*"They've helped me navigate some of the stresses. So, there are times when I just don't get it socially and because of that they come into the fore…it's like a stress response…some people go for a run, I become psychotic*
Daniel	*"It's a habit that developed while I was ill because it was comforting…. presumably it does still provide some comfort"*
Bryony	*"It's like having a child in a way" (P4)*
Bryony	*"she just says things like, 'We'll be okay. Don't worry"'*
Jessica	*"When I was abused as a child and I say this in the voices I get a voice saying they feel ashamed and like they'll validate and normalise"*
Lucy	*"I heard someone call out…oh it was such a call; it was like someone desperate to make contact but who couldn't somehow…deep down I felt it might be my natural mother"*
Bryony	*"I have another voice called 'mother', she's called Mary to everyone else...she the opposite of what my mother was like, she's really nice"*
Adam	*"I am not your friend; I am certainly not your family. I am a harbinger"*
Bryony	*"yes, we're a bit of a family really"*
Adam	*"It's like an authority figure"*
Bryony	*"Everywhere I go she comes with me"*
Adam	*"the captain is the one who takes control if everything else goes wrong"*
Sub-theme 3: Managing the relationship with the voice	
Daniel	*"The truth is what it is, it's just your imagination working for you…you're not really friends with your brain"*
Bryony	*"I think it's like any person really"*
Adam	*"So, I have the concept of short-reins and long-reins. So long reins I have the illusion of free will. I get to feel like I'm the person…like I'm in control of my life. Short reins is when they are directly telling me what to do and how to do it, and that's at times of real stress"*
Jessica	*"It's quite complicated, because I don't know who it is, and I don't want to"*
Bryony	*"Sometimes it would be nice to just have a bit of quiet*
Adam	*"There is the sense that I am the pilot of my life, but I'm not the captain…a startling realisation…. 'Actually I'm not the captain of my ship, I am just the pilot, but I have to be a good pilot or else I'll get told off by the captain"*
Bryony	*"The more I say can we just have some quiet time? the more she talks"*
Adam	*"This had been going on for years, my clingy attachment"*
Adam	*"It's like an authority figure"*
Adam	*"the time they were riding me like a horse…. they were literally saying right now you are a horse and taking me for a ride*
Adam	*"After that they said don't call us, we'll call you. So, my relationship has shifted after that"*
Jessica	*"Both its an equality"*
Bryony	*"Compromising with your voice is a good way of dealing with it*

Bryony	*"She used to be quite negative, but since I've been asking her what's causing it when she's negative, she's been more positive*
Adam	*"So, the answer to the general problem is that I need to pilot my brain. I need to be a better pilot*
Daniel	*"You know surrender"*
Adam	*"There's a certain amount of negotiation that goes on, so for instance I've had a really unhealthy relationship with positive voices. So, I was really clingy, and it's like any time I was stressed or anxious I would turn to them for advice, and they'd say 'we don't want to be doing this"*
Adam	*"Having a good relationship with voices is important, but it doesn't need to be buddy-buddy"*
Adam	*"You have to avoid developing an unhealthy attachment*
Bryony	*"I've tried to talk to him...he doesn't get any better with talking to him, so I try and ignore him"*
Adam	*"And that's actually one I which I don't tend to interact with, I just like try and let it go and let it go and let it go"*

Note. The table is divided into the three sub-themes that make up the super-ordinate theme. The quotes are attributed to each participant using their allocated pseudonym.

Table 4.

Table of quotes for super-ordinate theme two: "Response-ability; In interpretation and action"

"Response-ability; In interpretation and action"	
Sub-theme 1: Finding the meaning in the message	
Daniel	*"A voice can become a positive experience in your life, extremely valuable although initially it may be confusing"*
Lucy	*"and as I was walking along the voice spoke to me as clear as your voice just spoke to me then, 'xxx is in xxx prison. Go and visit him"*
Adam	*"So, it can take a long time to figure out, what was that communication all about"*
Adam	*"'decided'...and its meaningless. There is no meaning there. That's rubbish"*
Daniel	*"For me hallucinations have a prophetic quality"*
Adam	*"this has led me to all kinds of thoughts about the nature of the message and the messenger"*
Jessica	*"I don't try and work out what people think or why they do things"*
Adam	*"rather than responding to something just because its friendly or because it's frightening, actually going 'well what is being communicated here"*
Daniel	*"I pay attention to them...until I actually sit down and say 'okay let's give you some time now'"*
Lucy	*"The connection to the otherworldliness....it just seems that it's a wonderful thing to have, and if you've got it it's a joy*
Adam	*"they were being very clear, it was like, 'be careful right now. You're in a very dangerous place"*

Daniel	*"I work hard at trying not to interpret, you know trying not to manipulate"*
Adam	*"it's after the fact, its once I have a little bit of distance from it, then I can have a little bit of a think about it, what was that about?"*
Bryony	*"Sometimes she would appear at home, after I had been abused at home"*
Lucy	*"The experiences of hearing a voice seem to have occurred at a point of importance, something very important was happening"*
Adam	*"There were some communications which, was really, really important, so the answer to my problems was actually contained within that"*
Daniel	*"Getting a good interpretation"*
Adam	*"I look back as it now as, like, there's an awful lot of rubbish in the experience...but it's like panning for gold. So, there's little bits of gold and I've clung onto those"*
Lucy	*"The experiences of hearing a voice seem to have occurred at a point of importance, something very important was happening "*
Lucy	*"It kind of gives me preparation for something"*
Lucy	*"all I'm saying is sometimes, to be forewarned about something is to be forewarned and be prepared"*
Jessica	*"So that's it, it's a person somewhere...well I can hear them and they can hear me...So at the moment there's a voice saying 'help me'"*
Lucy	*"Always accept it and listen with respect, because there may be essence of truth in it, even if the whole thing isn't true"*
Jessica	*"I don't need to know who it is"*
Sub-theme 2: "Trying to save the world is not where I'm at"	
Jessica	*"If it is telepathy, and this person could be in a very difficult situation, then you don't want to try and work out anything"*
Daniel	*"have often been related to things that then later happened in the news and things, in terms of seeing things, has been lightening in the sense it's been quite disturbing"*
Adam	*"I was interpreting and I didn't want to hear what was being said"*
Jessica	*"but I don't necessarily want to know their business"*
Jessica	*"It's beautiful, its bittersweet, because if you have the belief system that I have then its most likely someone in a difficult situation"*
Jessica	*"I just wish I could do more*
Lucy	*"It felt overwhelming because it felt that somehow I'd been given some kind of insight or gift, that I didn't necessarily deserve to have"*
Daniel	*"I'm not saying you're going to do anything with that information"*
Daniel	*"I don't think you're obliged to hold onto things as if they're your responsibility to do something about them. I think it's partly a problem shared is a problem halved and its your problem, as it is a problem is still a problem"*
Jessica	*"there's things that are said that if someone said to you it would make you weep, and it sometimes makes me weep. You don't know whose saying it you and you don't know what the outcome will be"*
Lucy	*"When this voice called out I knew I had to act on it"*
Lucy	*"Trying to save the world is not where I'm at"*

Jessica	*"wish people well. I give information and I say 'it may or may not be of use to you"*
Daniel	*"It's being communicated to you, you don't have to dwell on it"*
Lucy	*"and if he's got a message, he's got a message to give to someone, and if its that specific, one ought to work on it, a message that is positive, why not do it and see what happens"*
Jessica	*"so, at the moment there is the voice saying 'help me' so I would often say...Mrs X will be honoured to support you and the voices in any way that I can"*
Daniel	*"I get more disturbances, hallucinations, confusion where the terror rating was about to go up"*
Lucy	*"whatever the voice tells you, you must do it"*
Jessica	*"It's quite complicated, because I don't know who it is and I don't want to...then what could you do apart from say 'get help' and 'you're loved and respected'*
Adam	*"They were being very clear, it was like be careful right now, you're in a very dangerous place"*
Jessica	*"I can help them with words, and I can you know say who I am, which I do, and say I'm not rich or famous or more important than them. I can say the ChildLine number*
Jessica	*"Everything people say is important. So yes, I feel honoured to be able to talk and listen in the voices...I apologise sometimes because I'm not sure whether the techniques I use are helpful or not"*

Table 5.

Table of quotes for super-ordinate theme three: "Fracturing identities: The self & society's acceptance of voice hearing"

"Fracturing identities: The self & society's acceptance of voice hearing"	
Sub-theme 1: "The self & voice hearing"	
Lucy	*"This is the truth for me, it might not be the truth for the next door neighbours but it is for me, it's my truth"*
Jessica	*"It's been part of me for such a long time, this thing, you know it's like an organic thing"*
Lucy	*"Because I didn't want to hear voices"*
Daniel	*"I don't really want to say it but for a long time I desired not to, I aspired not to hallucinate, but you just have to accept that you see things differently"*
Daniel	*"You may just try and accept what you're seeing, it doesn't make you a bad person"*
Lucy	*"There are things that we can see visibly and they're natural, there normal"*
Daniel	*"If you choose to see it as a problem, at the moment I find it quite debilitating, it stops me getting on with my life"*
Lucy	*"But I definitely had a problem with my identity"*
Lucy	*"I was given this as in a sense a way of helping me to establish who I was and that helped my identity (*

Adam	*"When they're referring to me as an input/output device that undermines my sense of personality. That undermines my sense of self"*
Adam	*"The experience of hearing voices tends towards fracturing the identity"*
Lucy	*"Some days we wonder what the heck we're doing here at all"*
Daniel	*"As a Christian I know that when you have these experiences from above"*
Lucy	*"But I just feel like it's part of me"*
Daniel	*"Hearing voices from the outside coming in, I was struggling to determine whether or not that was part of reality"*
Jessica	*"I separate it because it's part of me for such a long time, this thing, you know it's an organic thing"*
Lucy	*"it's not that that I'm special...I just have something that's been given to me...maybe it's been passed through family genes.... each family has its own particular way of identifying itself"*
Daniel	*(Religion) "It's been how I make sense of them"*
Lucy	*"As I was growing up, I just took this all on board and just assumed that all these things.... they must be coming from this great creative power whatever people call it"*
Adam	*"It's not a nice identity to have"*
Adam	*"This has now become my life...my whole identity has been wrapped up solving a problem which everyone told me was unsolvable "*
Adam	*"There are voices which are me, and there are the voices that are only me, then they're voices which are me but not me"*
Sub-theme 2: Alienation & acceptance by society	
Jessica	*"It's convenient to think of voice hearing as a negative and dangerous thing and that people must be locked away, that suits the status quo*
Daniel	*"That's a mad person doing insane crazy things"*
Jessica	*The idea of positive and negative are quite interesting but it's often people's reactions to voice hearing so I'm quite wary"*
Bryony	*"I just didn't tell anyone else about it*
Jessica	*"but I'm also aware of conservations that I've had with people, non-voice hearers, how it can be ridiculed, or it can frighten people. So, I don't want to frighten people and I don't want to ridicule anyone"*
Adam	*"If somebody sees me in the street and I'm mumbling to myself, they're going to have a stock set of thoughts about what this person is, its stigmatised"*
Daniel	*"I think a lot of people in that state feel very lonely, they feel very alienated, ostracised by society"*
Adam	*What is actually needed is, we need a society which accepts that, as a phenomena, that is an acceptable phenomena and actively build a good foundation for it*
Jessica	*"but I can't have that dialogue with many people because it might frighten them within, you know, the whole idea of mental illness"*
Jessica	*"I'm not trying to convince anyone, and I'm not lying, it's the truth"*
Bryony	*"The more people that understand that people aren't crazy just because they hear voices"*
Lucy	*"Other people think you're barmy"*

Bryony	*"they do exaggerate, there was a program and it was a murder and he was being told to kill through his voices, and I thought well they're not all like that"*
Lucy	*"The important thing is to never negate somebody else's reality simply because you haven't felt it or understood"*
Daniel	*"You're getting every message under the sun that tells you should not be hallucinating, or doing something criminal, it's just wrong"*
Bryony	*"Yes, it has changed, especially coming here and the group, I used to think it was something you had to hide, something that was shameful"*
Daniel	*"Well you've probably be a productive member of society and pay your taxes attitude then of course it's a problem"*
Bryony	*"I said to this lady at church.... she said 'you're cursed by the devil"*
Bryony	*"I thought if I spoke to anyone they would think I was crazy, if you say you hear a voice they take you straight to the section room, rather than talking to you, seeing if it's a good voice, they don't realise there are two different types*
Bryony	*"Yes, I think it's about changing other people's opinions*
Bryony	*"I think a lot of people if you say you hear voices, think 'oh gosh, stay away'"*
Bryony	*"there was a lot about negative voices, you hear more about that than positive, I think if it's like ever on tv, it's always hearing people do bad things"*
Adam	*and it was perfectly acceptable. In ancient Greek culture it was perfectly acceptable for Socrates to walk into a court of law and talk about his voice... so what's the difference with me being diagnosed with schizophrenia"*
Bryony	*"they get a booklet apparently; they get a booklet and that's it"*
Jessica	*"On a day to day basis, people around me more or less accept it, and if I'm out in the community on a bus, I wouldn't cover my mouth"*
Sub-theme 3: Sharing the experience	
Bryony	*"I think this group has brought me along a long way with my voices. Understanding and hearing you're not the only one"*
Lucy	*"I might just say 'I've had something similar' that helps them to immediately know that they're at least with a kindred spirit"*
Jessica	*"We kind of have a common cause, I feel, within the hearing voices network"*
Bryony	*"Sometimes you feel like you're a bit of a freak, but you realise you're not the only one"*
Lucy	*"We're all unique but that somebody else might think 'it's nice to know that what I'm thinking isn't completely out of the world, out on a tree. It's actually more ordinary that I imagined'"*
Jessica	*"I might say. 'Friend in the voices who I may never meet', because 250 million people hear voices"*
Bryony	*"It's a bit of a disadvantage with voices, because they can't communicate with anyone else"*
Bryony	*"It's useful to know there are others out there"*
Lucy	*"and this is where we go wrong today is, we're more interested in highlighting people's differences, instead of saying let's encompass this...the joy of being human"*

Jessica	*"It was when someone else said to me about voice hearing, another voice hearer, that I realised that was a label I could put on it*
Lucy	*"I could have a difference way of looking at life"*
Jessica	*"I thought well perhaps this a real occurrence because it happens to a lot of people"*
Daniel	*"I've had this long enough sometimes I just keep my mouth shut and get over, you don't always need to be dragging people into your world, sometimes you can just ne quite careful about who you're sharing experiences with"*
Jessica	*"Sometimes I may hear that voice in what I called our shared mind*
Sub-theme 4: The medical model: Conflicting or co-existing realities?	
Adam	*"In terms of an experience, it is much maligned, it is only ever seen as being a symptom of a disease. Its only ever thought of as being a sound effect, you know and a meaningless one at that"*
Lucy	*"We are not a sum total of ticked boxes"*
Adam	*"It's not a nice identity to have. I consider that to be a festering wound for me. The diagnostic procedure is actually part of the damage"*
Jessica	*"The whole structure is in my opinion.... it's really obscene, not everyone wants to hear that, it's an opportunity to say. 'Do you know there's an alternative'?*
Adam	*"What leads me to be sat in a psychiatrists office, being told by somebody who I am by somebody who doesn't know who I am"*
Jessica	*"There's an alternative to the reality of mental illness. I'm a voice hearer and I have been since childhood. I'm not ill and I don't take any psychiatric drugs*
Adam	*"When other people interpret my experience, they usually give me a diagnostic label or tell me it's something which, it definitely isn't"*
Adam	*"so, for instance the idea that this is a biological disease, and its no-one's fault. Actually, no you're saying that you're removing all hope then"*
Jessica	*"There's that inequality thing, and you know vested interests...a system in place it's a system I don't understand, why would you want power over someone else?*
Daniel	*"People hallucinate for all sorts of medical reasons. It's not just something that happens, it's something that everyone is capable of"*
Adam	*"In terms of the prognosis they gave, it was very negative prognosis. They don't give out much hope of me recovering at all"*
Adam	*"The hope, you know the hope gets extracted in the diagnostic process*
Adam	*"This is who you are, this is who you will always be. You'll always be. You'll always be a schizophrenic, you are definitely this, this is who you are, okay, okay and what is that"*
Jessica	*"it was lovely to sit in a room of psychiatrists... and say what you thought, but they couldn't section you"*

Note. The table is divided into the three sub-themes that make up the super-ordinate theme. The quotes are attributed to each participant using their allocated pseudonym.

Appendix F

Distress protocol for interview

Client identifier……..
Date……

1. If participant expresses emotional distress in line with what may be expected e.g. crying when talking about something difficult

- Offer support
- Offer a break
- Offer to end interview
- If continues then monitor for any further concerns and check how the client is feeling during and after interview.

2. If participant presents with emotional distress beyond what is to be expected but there is no immediate danger or concern e.g. becomes incoherent, expresses paranoia, anxiety

- Stop interview
- Offer support and reassurance
- Ask for them to contact an appropriate provider of care/ support e.g. GP
- Provide contact sheet with support links

3. If participant's behaviour or thoughts reflect imminent danger then:

- Contact emergency services
- Reassure participant
- Inform a member of staff at location of room.

Indications of concern during interview	Follow-up questions/ initial action	Response	Emotional distress/ safety concern Y/N	Imminent danger Y/N	Action taken
Indications of emotional distress Crying Confusion Incoherent speech Increased response to hallucinations	• Offer support • Assess distress • Ask if wish to continue • Offer break • Ask how feeling				
Indications of discomfort Tiredness Moving around Loss of concentration	• Offer break • Assess distress • Offer support and reassurance				
Indications of safety concern Disruptive behaviour Aggressivity Threats (to self or others)	• Stop interview • Assess distress • Contact emergency services				

Appendix G

Participant Debrief

Thank you for taking part in the study "How to individuals make sense of positive voice hearing experiences"

If you have any questions regarding this study please contact the researcher on:

Mobile:

Email:

Please be aware that the contact details are to be used for the purpose of questions regarding the research only and will not be consistently monitored.

In the event that you feel distressed by participation in the study then please contact your GP (during working hours) or mental health crisis line (out of hours) on (Insert local number)

If you are concerned about your immediate safety or wellbeing, go to your nearest accident & emergency (A&E) department or call 999.

If you would like to withdraw your participation from the study please contact the researcher by the .....(date).....

Thank you again for your participation.

Appendix H

Informed consent for research participation

"How do individuals make sense of positive voice hearing experiences"

I have read the information sheet, or it has been read to me. I have had the opportunity to ask questions about it. Any questions I have asked, have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant_____

Signature of Participant _____

Date _____

Once completed please send to:

Appendix I

Informed consent for audio-taping and transcribing interviews

"How do individuals make sense of positive voice hearing experiences"

This study involves the audio taping of your interview with the researcher. Neither your name nor any other identifying information will be associated with the audiotape or the transcript. Only the research team will be able to listen to the tapes. The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice) will be used in presentations or in written products resulting from the study.

Following the interview, you will have two weeks to request the interview is deleted if you wish to withdraw your consent to taping or participation in this study. Following this the interview will be transcribed.

By signing this form you are consenting to:

- Having your interview taped
- To having the tape transcribed
- Use of the written transcript in presentations and written products

The recording for the tape will be destroyed following successful completion of the doctorate. An estimated date is September 2018.

Participant's Name _____

Participant's Signature _____

Date_____

Appendix J

Information sheet
"How do individuals make sense of positive voice hearing experiences"

Introduction
I am a student at London Metropolitan University studying for a professional Doctorate in Counselling Psychology. I am inviting you to participate in research that will be exploring how individuals understand their experiences of positive voice hearing.
The research is primarily focused upon how individuals experience positive voice/s, this does not mean that individuals who also have negative experiences of voice hearing cannot take part however this will not be discussed in the research.

Purpose of the research
Many people have positive experiences of voice hearing however there is a significant lack of research on this, most research is focused on negative experiences of voice hearing. I wish to learn more about how people experience positive voice hearing as this may provide valuable insight into ways in which people who may have difficulties managing voice hearing can be supported.

Participant requirements
The research requires that participant's;

- Have experienced voices at some point in the past 5 years.
- Are not currently using illicit substances or dependent on alcohol.
- Have experienced voices for over a year i.e. not only for a few weeks
- Have not received inpatient psychiatric treatment in the past 6 months.
- Feel comfortable talking about their voice hearing experiences.
- Consent to being interviewed and this interview being recorded.
- Experience at least one voice that can sometimes be considered a positive experience or has in the past had a positive experience with a voice.
- Are able to travel locally to attend an interview.

What the research involves

- Prior to the research taking place you will be asked a few questions that will help us determine whether it would be appropriate for you to participate in the research.
- A date and time will be arranged for the research interview.
- The research will involve a semi- structured interview, whereby you will be asked questions about your experiences of voice hearing. The interview will likely last about 1 hour.
- The interview will be transcribed, and the interview material may be used as part of a doctoral level thesis.

Potential risks

Talking about voice hearing experiences can provoke emotions. Whilst every possible step is taken to ensure that individuals do not have a negative reaction to taking part in the research, sometimes unexpected difficulties can occur as a result of talking about issues of a sensitive nature.

Right to refuse and withdraw
You do not have to take part in this research if you do not wish to do so. You may stop participating in the interview at any time and following the interview can ask for your information to be withdrawn from the research. You will have two weeks following the interview to withdraw your data, after this the interview will be transcribed and analysed.

Reimbursement
You will be reimbursed your travel costs to attend the interview upon production of a valid receipt.

Ethics
The research abides by the BPS (2009) Code of practice and has ethical approval granted by London Metropolitan University.

Confidentiality
We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is, and that information will be confidential. The information you provide in the interview may be used in presentations or written products however no identifying information including your name will ever be used.

Who to contact
Name of researcher.....
Email .....
Contact number .....