"NO-ONE'S EVER ASKED ME BEFORE":

ON ANALYSING SUBJECTIVE ACCOUNTS OF

HEARING VOICES AND PERSON-CENTRED THERAPY.

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**A thesis submitted in partial fulfilment of the requirements of the
University of East London for the degree of Doctor of Philosophy**

School of Psychology

May 2017

Abstract

There has been considerable debate about the value of psychological therapies for voice hearers who suffer such distress that they seek psychiatric help. To date, however, the utility of person-centred therapy for this client group has not been investigated.

A convenience sample of ten participants who heard voices and had decided to start person-centred therapy was recruited from the researcher's caseloads at a NHS mental health trust, an independent low-secure psychiatric unit and a counselling agency. On completion of their therapy, participants were interviewed about their experiences of therapy and of hearing voices. Data were analysed using a thematic approach informed by relational existential-phenomenological ideas. Brief consideration was also given to qualitative and quantitative outcomes.

Three themes were identified that referred to how participants recollected their experiences of voices before the therapy: i) An unwelcome intrusion; ii) "Feeling like a freak"; iii) Poignant yearning for things to be different. A fourth theme referred to participants' accounts of their voices once that therapy had concluded: iv) Changing experiences, different views - sometimes.

Four themes related to their subjective experiences of person-centred therapy: i) Being treated like a person; ii) Being offered possibilities; iii) Forging a way through; iv) It's not always just about the voices.

In general, participants gave positive accounts of person-centred therapy suggesting it could be a useful option for this client group. There was, however, some variation in response. Findings demonstrated the importance of engaging with individual voice

hearer perspectives on their unusual experiences, and on what might alleviate their associated distress.

There was some evidence of reliable and clinically significant change which was explored in relation to qualitative findings. Issues around the use of symptom related measures to test effectiveness of therapy are discussed.

Some implications of this analysis for a person-centred understanding of the meaning of voice hearing are offered, with a focus on the potential for growth.

Limitations of the study relating to the dual therapist-researcher relationship and to the homogeneity and size of sample are discussed.

Chapter summary

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Abbreviations used in this thesis

APA	American Psychiatric Association
AVH	Auditory and Verbal Hallucinations
BACP	British Association for Counselling and Psychotherapy
BPS	British Psychological Society
CBT/p	Cognitive Behavioural Therapy/for psychosis
CMHT	Community Mental Health Team
DA	Discourse Analysis
DSM5	Diagnostic and Statistical Manual, fifth version (APA, 2013)
EIS	Early Intervention Service
FDA	Foucauldian discourse analysis
HV	Hearing voices (referring to the experience)
HVM/N	Hearing Voices Movement/Network
ICD – 10	International Classification of Diseases, 10th version (WHO, 1992)
IPA	Interpretative Phenomenological Analysis
MHA	Mental Health Act, latest version 2007
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
RCT	Randomised controlled trial
VH(s)	Voice hearer(s) or person (people) who hear(s) voices
WHO	World Health Organisation

Acknowledgements

There were many people involved with the production of this thesis to whom I owe a great deal. I want to mention some specifically.

Those whose stories form the basis of my analysis showed such courage whilst in therapy with me. Afterwards, they were generous enough to share with me their experiences and stories for my research. Thank you for enriching my life and for helping me fulfil my goals.

Duncan helped me find work with people in a psychiatric setting in the first place and showed interest in my ideas for a PhD. Without his help, I would never have been able either to work in the NHS or access participants for this study. He continued to offer insight and affirmation in supervision which, especially when it was tough, were invaluable.

Julian gave me the chance to work with his patients, constantly championing my work and research. I was privileged to work with a person who was prepared to try different ways of helping people feel better.

Jean's wisdom in clinical supervision helped me cope with what I was hearing, the mistakes I was making, the difficulties I encountered and the successes I could celebrate.

Linda's warmth, guidance, gentle challenges and phenomenal phenomenological expertise kept me going and shifted my stuckness more times than I care to recall. Without her….

Piers helped with the boring and detailed job of formatting and correcting the hundreds of references and then with bringing to pass the layouts I needed for my flowcharts. Worth coming back from 18 months in South America for that darling, eh? Again, remaining errors are nothing to do with Piers.

My precious Mum and Dad always encouraged me, and were proud of what I did, even if they didn't understand why I thought it mattered.

Sebastian, Piers and Brontë have put up with my frequent failures as a mother, as I have borne their justifiable (sometimes) mockery and disparagement. I'm hoping the completion of this may add a tinge of grudging pride to the love they've always given me.

Nicholas, my love. How I could even have started this, let alone finish it, without his love, encouragement, emotional (!) and practical support, I do not know.

Finally, of course, my UEL supervisors:

Dave Harper parachuted in as Director of Studies, took it on and worked so hard trying to make sure I delivered something that approximated an academic study.

Gordon Jinks offered words that always struck home and stay with me still now, none more so than "There comes a time when you just have to sit down and write the bloody thing,"

Rowan Bayne gave me the chance to do this thing in the first place. Even after retirement he has stayed fully involved. He always believed in me and his positive feedback ensured that I came to believe, myself, that I might just be able to do it.

Thank you all.

Dedication

To Rowan, for giving me the chance;

to Nicholas, for loving me;

and to my Dad, who would have been so thrilled.

With love and thanks

NOTE ON TERMINOLOGY

I think it is important to comment on the way I will refer to the topics under discussion in this thesis as their meanings are often contested.

I have used the terms 'schizophrenia', 'psychosis' and 'madness' interchangeably here[1]. It proved impossible to avoid using clinical terms altogether as they are used so widely in research and even in common parlance. I considered placing medically related and other contested terms (such as, 'normal', 'abnormal', 'mad', 'psychopathology,' 'inferior,' 'deficient', 'defective') inside inverted commas to acknowledge they speak only from one perspective. But this seemed to interrupt the flow in reading the thesis so I have decided (apart from where they are used in quotations or extracts from participants' accounts) to use inverted commas only the first time such terms are used to acknowledge they are contestable.

I chose to refer to 'hearing voices' (hereafter, HV) rather than the medical terms 'auditory or verbal hallucinations' whenever possible, as it seems descriptive of the experience under investigation without assuming underlying 'pathology'. I have referred to 'voice hearers' (hereafter, VHs) as 'experts-by-experience', 'service users' or 'survivors', avoiding the term 'patients', whenever possible. Similarly, VHs in this study are 'clients' or 'participants'.

Finally, I have used the terms 'therapy' and 'counselling' interchangeably because, although I use therapy to describe the intervention I offered, it was sometimes described as counselling by participants and in other research.

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[1]Geekie and Read (2009, pp. 12-17) make a useful distinction between terms that have clinical overtones (such as 'schizophrenia', 'psychosis', 'hallucinations') or which are more generally related to clinical understandings (such as 'mental illness', 'mental disorder', 'symptoms', 'mental patient'), and those that describe elements of the human condition (such as 'madness' and 'insanity'), that might or might not include clinical components and which mean different things across time and culture.

Background and overview of study

"But wouldn't you have found it easier to work with him if you'd known about his diagnosis?"

The words of my MA supervisor, about a young male client in the prison I was working in. I can pinpoint those few words as the moment I started to think critically about how people might be helped when they are suffering distress associated with unusual experiences.

I realised that a diagnosis would not have helped me or him address those painful and stressful issues that we discussed and it might have created an obstacle to my attempts at helping.

At that stage, I was not questioning the concepts of 'mental illness' prevalent in our Western culture, nor the usual medical approaches to treatment. I was merely conscious that, in person-centred therapy, the way to help was to accept, respect, and work from within, a client's frame of reference. Sometimes this may have included their descriptions of themselves as suffering from a mental illness. But, if so, it came from the client and not from my own interpretation that any behaviour suggested a diagnostic category.

I started to think about the way psychiatric diagnoses impact on the people that receive them, and on the professionals who work with them. My naïve sense was that such explanations of mental distress might restrict the ways in which distress might be understood and alleviated. I was surprised to find there were many other professionals and 'service users' who were also questioning the nature and value of mental illness as a metaphor for explaining and then helping people to deal with mental distress.

I wondered how working from within such a model might accord with the person-centred approach but, when I looked for evidence of person-centred therapy with people within psychiatric contexts, I found that very little research had been conducted since Rogers' Wisconsin project in the early 1960s (C. R. Rogers et al., 1967). Not only that, but I could find few instances of person-centred therapists even working in psychiatric settings in the UK (Freeth, 2007), although there are more in mainland Europe (Pearce & Sommerbeck, 2014; Prouty, van Werde, & Pörtner, 2002; Sommerbeck, 2003; van Werde, Sommerbeck, & Sanders, 2015).

I decided that I wanted to see how person-centred therapy was received by people who were described and treated as 'mental patients,' and the extent to which person-centred theory might account for experiences that might be considered as unusual according to current mainstream ideas in the UK.

I obtained voluntary work within a NHS mental health trust and, then, paid sessional work within an independent low-secure psychiatric unit. I also worked as a volunteer therapist at a person-centred counselling agency.

For the purposes of this thesis I decided to focus on person-centred therapy with VHs. Psychiatric discourse regards the experience as a 'symptom' of mental illness, yet it has been, and is, understood in a number of other ways and its causes are still contested (Leudar & Thomas, 2000).

I was not looking to test the effectiveness of person-centred therapy or to argue, specifically, against the medical model. Rather, I wanted to explore whether my non-medical approach might help VHs in distress and, if so, how. I was also interested in the ways VHs themselves understand their experiences, and the extent to which they found medical explanations and treatments useful. I wanted to investigate meaning.

The thesis is structured into four parts: Part A: Introduction and context of the study, (Chapters 1- 5); Part B: Methodology and method (Chapters 6-8); Part C: Findings (Chapters 9-12), and Part D: Discussion and Conclusions (Chapters 13-16).

Part A: Introduction and context of the study

Part A: Introduction and context of the study

OVERVIEW OF PART A

This part of the thesis presents literature that informs my research questions, as well as the rationale for the study.

Chapter 1 will explore ways in which HV is understood and explained, and will raise some of the debates surrounding the different explanatory models. I will discuss the different types of help available for VHs if they suffer distress in Chapter 2. An account of person-centred theory and therapy will be offered here. Research relating to subjective accounts of HV and of therapy will be presented in Chapter 3. I will then comment, in Chapter 4, on issues to do with talking therapy as a process, and on how it is researched. Part A concludes with Chapter 5 where I will lay out the rationale behind my study, and the research questions I seek to explore.

Chapter 1

1   HOW CAN WE UNDERSTAND AND EXPLAIN VOICE HEARING?

This chapter will examine debates around the meaning of unusual experiences, specifically HV. Evidence will be reviewed to demonstrate what we already know about the experience in terms of its phenomenology, possible causes and its prevalence. I will discuss the mainstream view that it is a symptom of mental illness, before offering evidence that suggests there may be other ways of conceptualising it, that HV occurs more widely in the general population than might be supposed and that it is not necessarily problematic. Evidence dealing more generally with 'psychosis', which includes HV as well as experiences described as 'delusions' and 'thought disorder', will also be included in this chapter, alongside that dealing more specifically with HV. Research into subjective experiences of HV is of interest given the focus of this study.

1.1   Understanding voice hearing as a symptom of mental illness or disorder

Mental distress and experiences that lie outside commonly accepted societal norms, are often thought of, and represented, as mental illnesses, both in the media (Hunter, 2016; Pilgrim, 2007) and by society generally (Pilgrim, 2005, 2007; Pilgrim & Rogers, 1997). Psychiatrists and psychologists are typically the professionals involved in the care of people who have these experiences and who seek help because of them. In the widely used diagnostic and classification manuals, Diagnostic and Statistical Manual, 5th edition (American Psychiatric Association, 2013) and the International Classification of Diseases, 10th edition, Chapter V, (World Health Organization, 1992), HV is referred to as 'auditory or verbal hallucinations' (hereafter, AVH) and is listed as a primary symptom of various disorders including, especially, Schizophrenia spectrum and other

Psychotic Disorders, Mood Disorders with Psychotic content and some Personality Disorders.

Despite much effort, there has, to date, been no convincing or consistent evidence for either the site or the physiology of so-called mental illnesses and it is argued that diagnosis is often unreliable (Boyle, 2002b, 2007; Insel, 2013; Newnes, Holmes, & Dunn, 1999, 2001; Pilgrim, 2007; P. Thomas, 2014). Typically, and sadly, a diagnosis of mental illness is accompanied by a poor prognosis which, some claim, is unjustifiably pessimistic and, therefore, adds to distress (Read, Bentall, & Fosse, 2009; Repper & Perkins, 2009).

Nevertheless, when the experience of HV causes distress and other problems for people, there can be relief and comfort in being told you are ill by an expert who appears to have had experience of other people with such illnesses (Yalom, 2005). From a place of isolation, people may start to feel supported and that they are not unique in suffering in this way (Barham & Hayward, 1991). They can hope for treatment that will make them feel better and ameliorate their distress or confusion (Barham, 1997; Barham & Hayward, 1991; Barham, Hayward, & Barham, 1995; Yalom, 2005). After all, if you are struggling to cope and are worried or distressed, you might well describe yourself as ill anyway (P. K. Chadwick, 1997b; Liz Pitt, Kilbride, Nothard, Welford, & Morrison, 2007).

The locating of the experience and illness within the person has implications which will be discussed further in 1.8; 1.9; 4.1.4.

1.2   Can voice hearing be explained in a non-medical way?

Part of the problem with a medical understanding of unusual experiences is that it starts from the position of assuming the illness exists as a 'real thing' and then tries to

find evidence of its existence (Boyle, 2002a, 2007, 2011; Linscott & van Os, 2013; van Os, 2010; van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009). In fact, evidence suggests that many people HV and live quite happily with the experience (Romme & Escher, 1989, 1993; Romme, Honig, Noorthoorn, & Escher, 1992). It is not until they seek help from psychiatric services because of associated problems (for example, struggling to cope with everyday life) that they are deemed to 'have schizophrenia'. In this way, schizophrenia erroneously takes on the quality of a real illness that exists (Boyle, 2002a, 2002b, 2011). Some argue that this view accepts as fact the medical model of mental distress when psychiatric diagnoses are not straightforward facts but representations that are conceptually weak and tautological, where symptoms are used *to warrant* a diagnosis and symptoms are then explained *by* the diagnosis (Pilgrim, 2005, pp. 261-262). In discussing 'depression' as an example, Pilgrim notes that psychiatrists give it a non-problematic facticity that separates it from ordinary misery. He warns that not only is this position empirically challengeable, but the social and political implications are enormous (Pilgrim, 2005, p. 262). Furthermore, he argues that the contestable medical codifications of anxiety, depression or schizophrenia add little or nothing to the ordinary language representations of misery and madness. (p. 261).

If the disease model might not adequately account for unusual experiences such as HV, what could be the cause? As Dillon (2011, p. 155) suggests, rather than asking "What is wrong with you?" (with its assumption that HV indicates some deficit in the individual), it might be more appropriate to ask, "What has happened to you?". Then the experience could be accepted as sometimes causing problems for people, but that reasons other than disease or deficit might provide answers about why the voices might arise. Such positions might be described as potentiality models where experiences such as HV might be understood as an individual's struggle to make sense of their world in difficult

circumstances (Dillon, 2012; Laing, 1960; Longden, Corstens, Escher, & Romme, 2012; Longden, Sampson, & Read, 2016; McCarthy-Jones, 2012; Romme & Escher, 2012; Romme, Escher, Dillon, Corstens, & Morris, 2009). A non-pathological understanding has implications for how HV is experienced and how or whether it is acted on, and by whom.

I will briefly outline some factors that suggest we need not always explain HV as pathological. As Jones (2003, p. 2) observes "Being sick is not a *fact*, it is a social definition" [emphasis in original].

1.3 How common is this experience?

It appears that there are many VHs across the world: the proportion is variously reported as 7.2% (Linscott & van Os, 2013), 5.2% (McGrath et al., 2015), and 4-5% (Tien, 1991). Many such individuals are not diagnosed as mentally ill, and seem not to be disturbed by their unusual experiences (Linscott & van Os, 2013; McGrath et al., 2015; Nelson, Yuen, Wood, & et al., 2013; Nuevo et al., 2010; Romme & Escher, 1989, 1993; Romme et al., 1992).

Problems seem to arise when people become distressed, perhaps at the content of the voices, or because they are aware that their experiences are regarded as unusual in mainstream society, or because of how others react to them (Beavan, 2011; Beavan, Read, & Cartwright, 2011; Read & Haslam, 2004; Romme & Escher, 1993, 2012; Romme et al., 2009). In the event of such distress, the usual course of action in Western society is to seek help from a medical professional. It is at that stage that VHs are deemed to be suffering from psychosis and are classified as mentally ill (Cooke, 2014; Newnes, 2004; Newnes et al., 1999, 2001).

Although HV is usually presented as a negative experience that causes distress and interference in people's lives, not all voices heard are problematic. Moritz et al., (2013) present a positive experience of HV as a potential threat to compliance with treatment regimes, and a "'gain from illness'" (p. 917). They accept the necessity for people to take anti-psychotic medication, and seem to agree with the surprise expressed in a previous study (van Putten, Crumpton, & Yale, 1976, p. 1443, cited in Moritz et al., 2013, p. 918) that some people would rather live with psychosis than a "relative drug-induced normality." They also comment (p. 920) that "psychotic patients do have a strong need to give a subjective meaning to their psychosis" (Klapheck, Nordmeyer, Cronjäger, Naber, & Bock, 2012, p. 9) and issue a warning to clinicians to watch out for such tendencies.

Other research takes a more accepting view of cases where HV is regarded positively (Woods, Romme, McCarthy-Jones, Escher, & Dillon, 2013). Faccio et al., (Faccio, Romaioli, Dagani, & Cipolletta, 2013) highlight the adaptive function that voices may play and acknowledge that HV can sometimes be a positive and useful experience that is widely shared within the general population. Jenner et al., (Jenner, Rutten, Beuckens, Boonstra, & Sytema, 2008) and Sanjuan et al., (Sanjuan, Gonzalez, Aguilar, Leal, & van Os, 2004) found that people who value their voices tend to welcome them and feel more in control. Jenner et al., (2008) also suggest that the characteristics and content of positive voices heard by psychotic people were indistinguishable from that heard by non-psychotic people.

1.4   Historical and cultural differences

It is only since the establishment of the discipline of psychiatry in the 18th century that HV has been associated with 'insanity', rather than viewed as an aspect of experience which was acceptable, if bizarre to some (Bentall, 2003, 2009; Boyle, 2002b; Foucault,

1961/2001; Leudar & Thomas, 2000; Read, Mosher, & Bentall, 2004). Thereafter, HV became regarded as symptomatic of an illness that needed treatment to return the afflicted individual to some state of presumed 'normality'. Leudar and Thomas (2000, pp. 2-3) discuss the history of HV, showing that in 5th century BC Athens, HV was a sign of wisdom or virtue. Socrates was revered for being able to engage with reflexive thinking and to engage with his *daemon*, often being guided by it. Plato, Xenophon and Aristophanes all offer contemporaneous accounts of his experiences. In a later era, Plutarch also referred to Socrates in his discussion of HV, which he interpreted as a sign of the divine that addressed men of virtue.

There is evidence that people HV in many different cultures (McCarthy-Jones, 2012; H. B. M. Murphy, Wittkower, Fried, & Ellenberger, 1963), and also that the experience is not always negatively associated with madness (J. M. Murphy, 1976). The negative stereotypical label (Goffman, 1962) attached to a VH in the West may have developed alongside the cultural expectation of autonomy and the existence of an objective, measurable reality, notions not necessarily shared by cultures more open to the possibility of spiritual or religious explanations (McCarthy-Jones, 2012, pp. 165-169).

There have also been suggestions that the form, content and meaning of voices may be shaped by culture (Leudar & Thomas, 2000; McCarthy-Jones, 2012). The Stanford study (Luhrmann, Padmavati, Tharoor, & Osei, 2015), for example, found that participants from USA were more likely to interpret and treat HV as symptomatic of illness and brain disease than those from India or Ghana. American participants also tended to describe their voices as difficult, negative or even 'torturing', and to find the experience distressing. It was unusual for them to talk about knowing who the voices were. In contrast, Indian participants often described the voices as family members and interacted playfully with them; there were few reports of threatening voices. Similarly,

there was less fear associated with HV on the part of participants from Ghana, where connection with disembodied spirits is accepted, as is hearing 'the voice of God'. In Ghana and India few people regarded HV as symptomatic of disease, whereas all participants from the USA did so.

With reference to New Zealand, Bidois (2012, p. 42) notes that experiences that might seem strange in Western culture are "not anomalous for the Maori. The anomaly happens when non-Maori perspective is applied to it…The result from that perspective can only be that it is perceived as abnormal."

That AVH might be a normal part of religious experience in some cultures is accepted by the DSM-5 (American Psychiatric Association, 2013, p. 103). The DSM position does not, however, allow for other, non-religious, types of AVH (Bidois, 2012; Larøi et al., 2014; Luhrmann et al., 2015), although clinicians are advised to take full account of cultural difference and to use the "Cultural Formulation Interview" contained within the DSM section on "Assessment Measures" (American Psychiatric Association, 2013, Section III). Questions might be asked, however, about who formulated the criteria for this interview, how much input was received from people from different cultures and how culture was actually defined (Boyle, 2002b).

This evidence has important implications for how VHs should be treated, and suggests that clinicians should not assume pathology (Larøi et al., 2014, pp. 217-218). In some cases, and contra Szasz, (Szasz, 1996), hearing 'God's voice' would not be considered evidence of disorder (McCarthy-Jones, 2012, p. 149).

1.5   Research into the causes of voice hearing

Much of the research into AVH has failed to study what these experiences might mean, focusing instead on possible causes and how to eliminate them (Suri, 2011), sometimes

from within a pathologising medical framework. It has traditionally been believed that

to engage with patients in a discussion of the meaning of their experiences colludes with

their view of reality and can make their symptoms worse (Boyle, 2002b; Geekie, 2007;

Geekie & Read, 2009; Leudar & Thomas, 2000; Romme et al., 2009).

Such views are increasingly under challenge. Recent studies have demonstrated that, far

from being meaningless experiences, AVH do have meaning and personal significance

for those that hear them (Beavan, 2011; Beavan & Read, 2010; de Jager et al., 2016;

Romme & Escher, 2000; Romme et al., 2009) and that it is sensible to ask VHs for their

views (Beavan & Read, 2010, p. 204).

As important is the acknowledgment that we are all affected by our contexts; that our

physical and mental well-being are affected by the social, economic, political and

personal circumstances in which we find ourselves (e.g. Boyle, 2011; P. Thomas, 2014).

Unless we find out more about the unique situations in which VHs find themselves, we

can develop only an incomplete view on what the experience might mean, where it

might stem from, what relevance it might have and what effects it may be having.

1.5.1   <u>Biological causes?</u>

Twin studies have compared people with and without schizophrenia, assuming the same

environmental influences for identical and non-identical twins (Gottesman, 1991;

Heller, 1996). This does not, however, take account of experiences and relationships

within, and outside, families that differ according to how different individuals act, feel

or are treated. In any case, it could be argued that the interplay between genetics and

environment, unique to every individual, is so vast that it is not (yet) possible to isolate

a definitive genetic profile causally related to the development of a psychotic disease.

Joseph (2004) also revealed methodological flaws and errors in apparently reasonable

claims made by these and other studies.

A recent study (Sekar et al., 2016) published in prestigious journal 'Nature' claimed to have made a 'breakthrough' in finding a biological cause for schizophrenia. This garnered extensive press coverage, despite its demonstrating only correlates (as opposed to causes) in the brains of some people defined as having schizophrenia. Whether such differences could be found across an entire population, and even if a causal relationship could be established, there is no reason to suggest that such differences imply the existence of a pathological disease. Differences in brain chemistry occur in all manner of people in all manner of circumstances. There is no conclusive evidence to suggest we need to pathologise such differences (e.g. Boyle, 2002a; Hunter, 2016).

1.5.2   Chemical causes?

Attempts to isolate neurotransmitter abnormalities might find raised or depleted levels of various chemicals in the brains of people diagnosed with mental disorders like schizophrenia. They do not, however, also take account of an individual's distress or confusion at experiencing something unusual in their culture, or something whose content is distressing. Many feelings or experiences produce chemical effects in the body but it does not necessarily follow that those changes equate to disease or disorder. In any case, no point has been identified that marks the level at which disease or disorder begins. Some studies also have methodological flaws in terms of controls and some also fail to take account of the effects of medication on the brains of those diagnosed with schizophrenia when making claims of causality (Bracken et al., 2012; Moncrieff, 2009, 2013b).

1.5.3   Psychological causes?

Various psychological theories have been advanced in relation to HV. Some have suggested the involvement of cognitive deficits or a failure to process information correctly, especially when a person is vulnerable or under stress. Such deficits include

abnormal monitoring of inner speech (McGuire et al., 1995), errors in neurocognitive pathways that alert an individual to a thought being self-generated (de Weijer et al., 2013), the misattribution of inner speech (Bentall, 1990) and predictive coding errors (Allen et al., 2012).

Garety et al., (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001) propose a model that can predict the development of schizophrenia based on particular cognitive styles that are predisposed to cognitive biases or disruption after "triggering events" (pp. 189-190). Their suggestion is that early childhood adversity creates an enduring cognitive vulnerability characterised by negative schematic models of self and world (pp. 190, 192). It may be reasonable to assume cognitive processes may be affected by events and that unusual experiences may result, and they agree with Peters et al., (1999) that "anomalous experiences" are only experienced as negative if they are externally attributed and personally significant. For instance, they suggest a non-psychotic response would be to say "'I thought I heard God talking to me but it must be my mind playing tricks on me'" (Garety et al., 2001, p. 191).

Whilst these models seem to accept that "triggering events" (Garety et al., 2001, p. 189) can be adverse life events, there is no suggestion that they might be causative of HV in themselves. Instead a tautological explanation is offered that trauma may lead to the development of psychotic symptoms in people who are vulnerable to the development of psychosis (e.g. Bebbington et al., 2004; Spauwen, Krabbendam, Lieb, Wittchen, & van Os, 2006). This is noted by Read et al.,(Read, Fink, Rudegeair, Felitti, & Whitfield, 2008, p. 235) in a discussion of the "stress-vulnerability model" (Zubin & Spring, 1977). Although designed to promote a multi-faceted, multi-layered model of causation for distress involving psychosocial and biogenetic factors, this model ended up being used within a biomedical model to 'demonstrate' the deficits of people who develop

such experiences (Boyle, 2002a, 2002b). Surely the more parsimonious explanation is that "Bad things happen and can drive you crazy" (Read & Haslam, 2004)?

Some psychological hypotheses challenge an exclusively medical model and focus on the problems people experience which are normalised (Bentall, 2003; Larkin & Morrison, 2006; Morrison, Read, & Turkington, 2005), rather than on the diagnostic categories that pathologise the experiences.

Chadwick and Birchwood argue (1994, 1995) that beliefs about voices are as important as the content and that an appraisal of the power or omnipotence attributed to them affects how they are experienced. Those who have a negative sense of self may feel they have less power over their voices. The way people make sense of an anomalous experience, therefore, is argued to provide the main causal pathway to associated affect, for example, distress and depression (Birchwood, 2003). The level of distress is related also to the perceived power and omnipotence of the voices (Birchwood & Chadwick, 1997).

Morrison develops the idea of the importance of 'appraisal', suggesting that HV is normal and it is the misinterpretation that causes distress (Morrison, 1998), with more people diagnosed as psychotic having higher levels of negative beliefs in comparison with non-psychotic people (Morrison, Nothard, Bowe, & Wells, 2004). To that extent, the difference between psychotic and non-psychotic VHs could just be that the former consulted a doctor because of a negative appraisal and distress and then were given such a diagnosis, as implied, perhaps, by Morrison et al., (2000). Indeed, Brett et al., (2007) also found that non-diagnosed people were more likely to attribute their 'anomalous experiences' to being a normal part of the continuum of human experience (p. s29). That negative appraisals of HV result in associated distress (Bak et al., 2005; Morrison et al., 2005), may suggest that trauma predisposes people's cognitive appraisals towards

an interpretation of HV as a psychotic experience. Non-traumatised people are suggested to appraise the experience as more positive and not pathological. Distress is then less likely.

Some of these cognitive models have been used as the basis of developing therapies to help those in distress and will be discussed below at 2.4.

1.5.4   Impact of adverse events

There are suggestions that childhood maltreatment (Read et al., 2008), and trauma of various kinds, especially childhood abuse, (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014; Dillon, 2012; Longden et al., 2016; McCarthy-Jones & Longden, 2013, 2015; Read, Fosse, Moskowitz, & Perry, 2014; Read, Perry, Moskowitz, & Connolly, 2001; Varese et al., 2012) might be sufficient to cause some people to HV. For example, Bentall et al., (2014) found that childhood rape was more frequently associated with AVH[2], whereas being brought up in institutional care was specifically associated with paranoia. Shevlin et al., (2008) reported that people were 193 times more likely to HV if they had been abused.

Traumas relating to poverty and parental loss are also associated with a higher incidence of HV (Read, 2004; Read, Agar, Argyle, & Aderhold, 2003; Read & Argyle, 1999; Read, Rudegeair, & Farrelly, 2006; Ross, Anderson, & Clark, 1994; P. Thomas, 2014; Varese et al., 2012). Furthermore, the more severe the negative events, the more persistent and severe the voices (Bentall, Wickham, Shevlin, & Varese, 2012; Ensink, 1992; Read et al., 2008). The cumulative effect of suffering more than one form of trauma has also been found to be associated with an increase in the number of symptoms experienced (Janssen et al., 2004; Longden et al., 2016; Read et al., 2008).

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[2]A connection also identified elsewhere (Honig et al., 1998)

There appear to be links between HV and ethnicity, class, sexuality and gender (Read, 2004). For instance, various studies have found that people from black ethnic minorities were over three times more likely than white people to be detained under the MHA for psychotic symptomatology, including HV (King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994; Singh, Greenwood, White, & Churchill, 2007; Sproston & Nazroo, 2002). Suggested reasons include the stress of living in a racist society, the stress of trying to assimilate to a different culture and an amalgam of stresses associated with living in an urban environment, relative poverty and family problems and pressures. People from some minority, oppressed or socially disadvantaged groups may feel threatened by, or fail to conform to, ways of behaving that are laid down by those in power at any time. This will add yet another layer of stress to that weighing down an already overloaded and vulnerable person, only adding to their sense of distress, isolation and/or alienation. As with the other difficult or traumatic events discussed, HV can sometimes result.

Related evidence has linked schizophrenia with urban living (Lewis, David, Andréassson, & Allebeck, 1992; Vassos, Pedersen, Murray, Collier, & Lewis, 2012) and poverty (Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001; Read, 2004), circumstances in which a proportionally higher number of BME people might be supposed to live. To use just one illustration, Harrison and colleagues (Harrison et al., 2001) found that British children living in poverty were eight times more likely to develop symptoms of schizophrenia than those who did not, whether or not there was evidence of other family members having similar symptoms (*pace* genetic causes!).

The connection between adverse events and HV is not straightforward; not everyone living in poverty, or who has suffered a traumatic event, develops psychotic symptoms or vice versa. It has been suggested onset of psychosis is mediated by the way in which people view themselves in relation to others (Pickett & Wilkinson, 2009; cited in P.

Thomas, 2014, pp. 74-75). This relates to evidence from Morrison (2004), linking distress at unusual experiences with the way experiences are appraised. If HV is part of the range of human experience, some people living in poverty might be expected to HV. Maybe it is only those who become distressed by it, or who believe it is symptomatic of illness, who come to the attentions of researchers in this field.

The Harrison study mentioned above, for example, used participants who had been referred to mental health services (2001, p. 346), so might not have identified all VHs living in poverty. Brett et al., (2007) also found that non-diagnosed people are more likely to view HV as an aspect of human experience, and also more likely to be white ethnic and to have supportive networks around them.

Similarly, a number of factors have been suggested that might affect whether childhood sexual abuse, a particularly common connection, leads to HV including age of the child, frequency and duration of the abuse, intra-familial versus extra-familial [abuser], whether the child told someone (and was believed), whether there was an effective intervention to render the child safe and whether the children blamed themselves (Barker-Collo & Read, 2003). Again, support networks seem to affect how a child can come to terms with the very real trauma suffered.

There have been attempts to discover the mechanisms behind the development of psychosis. While space does not permit an exploration in depth of these, an example is the attempt by Read et al.,(2001), to find a link between psychological and biological processes. Using models that associate cognitive deficits with psychosis, they searched for specific structural or functional abnormalities in the brains of traumatised individuals and found similarities in the brains of traumatised children and adults diagnosed with schizophrenia. In a 2014 review they claim other evidence supports this traumagenic neurodevelopmental model (Read et al., 2014). They further argue that this

confirms the case for a psychosocial, rather than a brain disease, understanding of experiences such as HV (p. 74) and that integrating knowledge of epigenetic processes[3] with research into cognitive mechanisms (Read et al., 2009) may lead to a greater understanding of the connections between adverse events and the development of psychotic phenomena.

Similarly, Allardyce and Boydell (2006, p. 592) call for more research into "how individuals, their genes, and the neighborhoods *[sic]* they live in, interact with each other" after finding the possibility of a connection between incidence of psychotic disorders and "neighborhood social contextual effect".

For me, the important point is that HV does not need to be expressed as evidence of a biological disease entity such as schizophrenia. Harrop, Trower and Mitchell (1996) and Cromby (2004) argue that any claimed biological differences between VHs and non-VHs, or even clinically diagnosed VHs and non-diagnosed VHs, may be the result of the interplay between social and psychological experiences and circumstance such as trauma or perceived social role. Social disadvantage and psychological well-being are clearly inextricably linked (Boyle, 2011, p. 27, 2013, p. 8).

Sadly, it seems that clinical staff do not always ask about personal history of adverse events when someone seeks help for distress associated with HV, despite all the evidence above. A recent study (Read, Sampson, & Critchley, 2016; Sampson & Read, 2017) comparing records from services in New Zealand with those from 10 years previously (Read, Hammersley, & Rudegeair, 2007), found that there is a move towards staff asking more about adverse events but that it is still not routine. Men are asked less frequently than women, male staff ask less frequently than female staff and older people

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[3] Epigenetic processes appear to 'turn gene transcription on and off' through mechanisms that are highly influenced by the individual's socio-environmental experiences (Read et al., 2009, p. 299).

are asked less often. The most striking finding for this study was that people with a diagnosis of a psychotic disorder are infrequently asked about their history of adverse events. Similar findings have been reported from studies in Ireland (Rossiter et al., 2015b) and in Northern Ireland in relation to trauma caused in the Troubles there (Cunningham et al., 2016).

1.5.5 <u>Spiritual crisis/religiosity</u>

Some studies have found no differentiation between spiritual and psychotic HV experiences (M. Jackson, 1997; McCarthy-Jones et al., 2013) and there are people who regard the experience of HV as a spiritual awakening or prelude to a spiritual emergency (Grof & Grof, 1986; Gunasena, 2007; Hartley, 2008, 11th September; Laing, 1967; McCarthy-Jones, Waegeli, & Watkins, 2013). Even if a crisis is not precipitated, there is often some sort of religious or spiritual element included in HV (P. K. Chadwick, 1997a) that can leave people feeling, variously, vulnerable or uplifted. A spiritual interpretation of HV is associated with experiencing less distress (Cottam et al., 2011; M. F. Davies, Griffin, & Vice, 2001; L. J. Jackson, Hayward, & Cook, 2010; M. Jackson & Fulford, 1997; Miller, 2000), although some people can feel powerless in the face of voices they interpret as coming from spiritual sources (S. Jones, Guy, & Ormrod, 2003).

A spiritual crisis may involve a profound psychological transformation of one's entire being, non-ordinary states of consciousness, intense emotions, visions and other sensory changes, unusual thoughts, or physical manifestations (McCarthy-Jones, 2012; McCarthy-Jones et al., 2013). Episodes often revolve around spiritual themes and may include sequences of psychological death and rebirth, feelings of oneness with the universe or nature, encounters with various mythological beings. Behaviour can be extremely bizarre and unusual and may involve HV.

Those whose HV experiences include such a spiritual component are often quite clear that it is not helpfully called mental illness even though it can feel chaotic and intense (Spiritual Crisis Network, 2010). Whereas some people may appreciate the potential for an alternative understanding of their experience, others may fear the prospect of being under the control of such a supernatural force and miss opportunities for what might be helpful interventions from other sources, including psychiatric help (McCarthy-Jones et al., 2013, p. 247).

1.5.6   Continuum of experience

Various studies have found that significant numbers of VHs do not encounter psychiatric services, (Johns & van Os, 2001; Rössler et al., 2007; Strauss, 1969; van Os et al., 2009; Verdoux & van Os, 2002), suggesting that HV is just part of a continuum of human experience. Nevertheless, some of these researchers also frame their arguments in terms of there being a qualitative difference between 'clinical' and 'non-clinical' HV and advocate a search for what mechanisms or circumstances might lie behind the 'transition' into mental disorder. Undoubtedly, many people are distressed by the content of their voices and by the intrusion into their lives.

The evidence relating to beliefs about voices (Birchwood & Chadwick, 1997; P. Chadwick & Birchwood, 1994, 1995; P. Chadwick, Lees, & Birchwood, 2000; P. Chadwick, Sambrooke, Rasch, & Davies, 2000) and differing appraisals of the experience (Bak et al., 2005; Morrison, 1998; Morrison et al., 2004; Morrison et al., 2000), however, might suggest that part of the distress could come from the fear and anxiety about what it means for them to become a mental patient. Noting the potentially stigmatising and all-encompassing nature of such a possibility, Johns and van Os (2001, p. 1137) acknowledge the helpful trend toward therapeutic interventions that normalise

the experience and take a dimensional stance towards HV as a 'complaint' (Bentall,

2003) rather than as an element of a diagnostic category.

Attitudes of potentiality where voices are viewed as 'messengers' bringing issues to

address (Corstens et al., 2014, p. s291) rather than as evidence of deficit or as

symptomatic of dysfunction or decline into illness, might enable VHs to recover more

quickly than they do at present (or not to suffer in the same way at all) (Rundle, 2017).

Some people access HV as a way of coping with difficult circumstances in the way that

some access dissociation to distance themselves from traumatic situations (Morrison,

Frame, & Larkin, 2003; Moskowitz & Corstens, 2007; Moskowitz, Read, Farrelly,

Rudegeair, & Williams, 2009; Romme & Escher, 1989, 2006). Incidentally, it is

interesting to note differing perspectives on dissociation. Romme and Escher, (1989,

2006) consider it to be a normal and understandable way of protecting an individual in

dire straits, a way that might lead to, and thus makes sense of, HV. Morrison et

al.,(2003), however, also cite other evidence that conceives of it as problematic and

pathological. These differences may have implications for attitudes in society generally

as well as for how VHs feel about themselves and the help they are offered if distressed.

But it might be that HV is just more evidence of the infinite range of possibilities

available in what it is to be human.

1.5.7   Hearing Voices Movement: personal meaning, relevant help and living well

The work of Romme and Escher (Romme & Escher, 1989, 1993, 2000, 2006, 2012;

Romme et al., 2009; Romme et al., 1992) is of relevance to this study. Marius Romme,

was prompted, through his work with a client, Patsy Hage, to consider there might be

explanations other than illness for the experience of HV. He and Sandra Escher

discovered that there were many people who heard voices who did not have a

psychiatric diagnosis (Romme & Escher, 1989). Further research started to suggest that elimination of voices was not always necessary, possible – or desired.

They also found that whether distress was experienced was often connected with how the voices were understood, how people around them reacted and whether the hearer had experienced a previous trauma (see also 1.5.4). In a collection of stories from 50 VHs, Romme et al., (2009) provide evidence that voices often emerge after traumatic experiences, and that many people have been able to find ways to negotiate with their voices so that they can re-establish control over their voices and their lives. In addition, many develop positive relationships with their voices; they understand their value or the place their voices have in their lives, often in relation to the trauma they previously suffered. The voices form an important part of how traumatised individuals have come to terms with the dreadful events that damaged them so badly.

To that extent, HV is a normal part of human experience (Corstens, Escher, & Romme, 2008). That some people go on to develop illness or illness behaviours may result from a combination of feeling overwhelmed by an unusual experience (often characterised by negative voice content) and experiencing shame because of current "societal ideology" that associates HV with madness. The force of this "ideology" means that people might not associate their experiences with what has happened to them at all (Corstens et al., 2008, p. 325), even though some claim that "lay understandings" of psychotic experience often invoke psychosocial rather than biological causes (Dietrich et al., 2004; Geekie, 2007; Geekie & Read, 2009; Hayward, Awenat, McCarthy-Jones, Paulik, & Berry, 2015).

The developments from Romme's and Escher's work are discussed in 2.3 and 2.4.6 below.

1.6   Phenomenology of voice hearing

Although the focus of this study is what it is like to HV, rather than what the voices themselves are like, brief mention will be made of some research into the phenomenology of voices because of the connection with how these participants might feel about or view the voices they hear.

Various studies (e.g. Daalman et al., 2011; McCarthy-Jones et al., 2012; Stephane, Thuras, Nasrallah, & Georgopoulos, 2003; Woods, Jones, Alderson-Day, Callard, & Fernyhough, 2015) have tried to identify the components and sub-types of HVs, some building on the study into the phenomenology of voices conducted by Nayani and David (1996). The factors considered have included the location and number of voices heard, their degree of loudness, their identity and frequency, their emotional valence and the degree of control hearers had over them. While many of these studies have yielded similar results, the criteria against which results are measured have often been identified and chosen by researchers, rather than by service users themselves (Fenekou & Georgaca, 2010).

Other studies have made use of the subjective accounts from VHs and on this basis, link the characteristics of voices more closely with the experience of being a voice hearer. Such research seems of greater relevance to this study. For example, on the basis of a thematic analysis of the results of 50 VHs, Beavan (2011), for example, identified five "essential" aspects of HV: i) the voice content is personally meaningful; ii) the voices have a characterised identity; iii) the person has a relationship with their voices; iv) the experience has a significant impact on the voice-hearers life; v) the experience has a compelling sense of reality (pp. 67-68)

Most of the criteria listed in the studies cited above can be subsumed within Beavan's themes. Holt and Tickle (2014) conducted a meta-ethnographical review of seven studies and identified themes similar to those of Beavan: the identity of the voices, the power exerted by them, the impact of HV on relationships, the VH's relationship with the voices and the distinction between thoughts and voices (p. 284).

These studies convey a sense of HV being an intensely personal and meaningful experience, something which has major implications for working with people who are distressed by the experience. Geekie (2007) has also demonstrated the breadth and complexity of the experience of psychosis, proposing three theoretical constructs that can encompass the things his participants discussed, and in which he stressed the overall search for personal significance of these strange parts of people's lives. The constructs were: fragmentation-integration; invalidation-validation; and spirituality. The content of these constructs includes factors identified in other research into subjective accounts of psychosis, and Geekie's acknowledgment of the articulate and lucid ways in which his participants offered their accounts of the possible causes and effects contradicts the frequent dismissive assumption that such participants struggle to communicate in a meaningful way (see 1.7.2). Such a dismissal might be assumed to have an effect on people's feelings of "invalidation" mentioned by Geekie (2007) and others (Barham & Hayward, 1991).

Such phenomenological evidence also contrasts with the traditional medical perspective, which reduces psychotic experience to a meaningless, pathological phenomenon which may be unhelpful and inaccurate for some people (Beavan, 2011; Beavan & Read, 2010; Beavan et al., 2011; Dillon, 2012; Geekie & Read, 2009; Romme et al., 2009).

The non-medical view of HV also has implications for the ways the experience is construed by members of the public, medical professionals and by VHs themselves. The

common association of HV with madness brings with it stigmatising and negative attitudes which mean VHs can be afraid to share their experiences with others (Beavan & Read, 2010; Beavan et al., 2011; Read & Haslam, 2004).

From their studies with VHs, Romme and Escher (2000) proposed that, if a non-pathological approach is adopted, the HV experience can be seen to move through three stages: "startled", where people feel shock or anxiety and are often overwhelmed by HV; "organisation", the phase during which people try to find strategies to manage and negotiate with their voices; and "stabilisation", where VHs integrate their voices into their lives, or even recognise them as parts of themselves and recover a sense of being in control. This can occur within or outside a formal therapy context.

Other research has also investigated the process of positive change (e.g. Milligan, McCarthy-Jones, Winthrop, & Dudley, 2013), with results that broadly confirm these stages. Positive change is found to be brought about by changing appraisals, as suggested in cognitive models (e.g. Morrison & Barratt, 2009), by building relationships with voices (Hayward et al., 2015; Hayward, Overton, Dorey, & Denney, 2009), and by the prioritisation of psychosocial over biological explanations (e.g. Mehta & Farina, 1997).

1.7   The necessity of listening to voice hearers

Subjective accounts are important for several reasons (see also Chapter 3). First, it is ethically and politically appropriate to acknowledge the personhood of people who have these experiences – something that has been lacking for too long (Perkins, 2001; Repper & Perkins, 2009; Rose, 2001; Waddingham, 2015). Service user and survivor groups play a large and important part in campaigning for the recognition and reclaiming of the rights of VHs to be afforded the same respect as non-VHs in terms of having views

worth listening to and being accepted as being able to play an active role in society (Bentall, 2009, p. 287). Second, it is vital to listen to subjective accounts of the experience of VHs to understand what it is like, what it might mean and how those who become distressed by the experience might be most usefully helped. Third, it makes sense to measure the effectiveness of helping methods against criteria that have meaning for those who receive the help. That can only sensibly be achieved by asking VHs what is important or relevant to them.

As has been noted in 1.5.4 we risk missing important information related to previous adverse events that may relate to why someone has started to HV if we do not ask about a person's history when they ask for help with associated distress. They will the not receive appropriate help.

Asking VHs about what they understand voices to mean and listening to what they believe might help alleviate any associated distress allows for a range of idiosyncratic responses. Many researchers argue for the greater involvement of service users in the development and management of research into mental distress and in the delivery of services to those in need (P. K. Chadwick, 1997a; Perkins, 2001; Rose, 2001; Rose, Evans, Sweeney, & Wykes, 2011; Sanders & Tudor, 2001).

1.7.1 Service user/survivor activism

A growing number of service user organisations are arguing for greater recognition of individual perspectives. Such groups, which sometimes challenge psychiatric discourse, have sought in part to reclaim the rights of members to be considered as people with views worthy of consideration, not least when discussing what is to happen to them. Woods (2013) recognises "the voice hearer" as coming into being through user/survivor groups such as Hearing Voices Network (HVN). Reclaiming the term "voice hearer" to describe a person as subject distances these people from their previous positions of

patient as object, that is, as something to be acted upon by 'experts' who know what is best. It then challenges the marginalisation and stigmatisation which positions VHs as separate from, and inferior to, the rest of mainstream society. In regaining a sense of personhood, VHs acquire the possibility of entering the debate around how their experience should be regarded, how they should be related to as people and how (or even whether) they should be offered help or care.

Alongside arguing for the recognition of the right to be heard and for idiosyncratic meaning to be accepted, service user organisations are also active in attempts to challenge the stigmatising attitudes of the public towards unusual experiences and the people who have them. In a survey conducted by the Time to Change campaign with over 2000 service users and carers, a large majority of VHs reported the negative impact that HV had on their lives. For instance, many had stopped doing things because of stigma or the fear of discrimination (Time to Change, 2008).

Some organisations, for instance, Mad Pride and the Mad Hatters of Bath, take a radical perspective on the rights of those who have unusual experiences to be treated in the same way as those without those experiences. This campaign has been described as "the last great civil rights movement" (Dillon, Bullimore, Lampshire, & Chamberlin, 2013, p. 315). Other organisations, while still operating from within the medical model, also argue that mental illness should be regarded without stigma in the same way as physical illness. Examples include Rethink, MIND and SANE.

1.7.2   The importance of considering subjective accounts of hearing voices

Harper (2004) notes the danger of colonising service users' experiences when psychiatric language is used in preference to their own words. Waddingham (2015) remarks on the frequency with which this happens, such that service users' voices are effectively silenced. The richness of the data collected by studies that ask open ended

questions about the experiences of HV (Beavan, 2011; Fenekou & Georgaca, 2010;

Geekie, 2007; Holt & Tickle, 2014; Milligan et al., 2013) contrast with the findings

from other studies that collect answers according to a pre-determined list of criteria (e.g.

Nayani & David, 1996; Stephane et al., 2003). Such criteria, although useful, do not do

justice to the complexity of the experience (Fenekou & Georgaca, 2010; Larøi, 2006).

Our understanding of what the voices are like, what it is like to hear them, along with

the development of a more nuanced view of when, how and why HV is sometimes

problematic, can best be developed based on such personal accounts. The range of

qualitative methods available also offers the possibility of generating different types of

knowledge about the experience: for example, how people talk about it, what it is like to

live as a VH, how VHs construct their life stories, the impact of different discourses

upon VHs, and so on.

When it comes to ways of helping people in distress, it seems even more important to

consider what such individuals might want and how help might best be delivered. Once

again, being asked for their views is not something that many patients are familiar with

(Boyle, 2002a; Fenekou & Georgaca, 2010, p. 10; Wagner & King, 2005, p. 144).

Evidence from a variety of sources confirms that it is a welcome opportunity (e.g.

Corstens et al., 2008, p. 321). Chadwick and Birchwood (1995), for instance, found that

people enjoyed completing their Beliefs About Voices Questionnaire as it gave them a

rare chance to talk about their experiences . During their research into the

phenomenology of HV, Stephane et al., (2003) also noted that patients welcomed the

chance to talk about what HV was like.

Traditional medical approaches tend to resist exploration of voice content in case it

"colludes" with a patient's erroneous sense of reality and "risks increasing

symptomatology" (Boyle, 2002a; Corstens et al., 2008; Leudar & Thomas, 2000; Read

et al., 2009; P. Thomas, 2014). Such approaches not only dismiss or invalidate patients'

experiencing (Beavan & Read, 2010; Beavan et al., 2011; Geekie, 2007; Geekie &

Read, 2009; Wise, 2004; Wise & Rapley, 2009), but also risk missing vital information

that might help alleviate associated distress (Beavan & Read, 2010; Corstens et al.,

2008; Read et al., 2008). Morrison et al.,(2005) argue that finding out whether the

voices themselves were involved in 'real-life' experiences can be a helpful part of that

exploration.

The concept of 'recovery' will be discussed further in 1.9 but subjective accounts that

offer the chance for participants to describe what recovery means for them seem to offer

more valuable insights than assessment against a range of criteria selected from a

researcher's frame of reference. For instance, de Jager et al., (2016) investigated service

user accounts of recovery and, although they noted various idiosyncratic approaches,

found that recovery could be characterised by in one of two ways:

> (a) *turning toward/empowerment*, which involved developing a normalised
> account of voices, building voice-specific skills, integration of voices into daily
> life, and a transformation of identity, and (b) *turning away/protective
> hibernation*, which involved harnessing all available resources to survive the
> experience, with the importance of medication in recovery being emphasised. (p.
> 1).

Davidson and Roe (2007) also found that people tend either to "recover from" or

"recover in", the former implying new ways of being, the latter, an incorporation of an

illness perspective into an existing way of being.

Subjective accounts of criteria important to the success of therapy are discussed below

in 4.2.3 and in Chapter 3.

1.8   The language of deficit

Roberts and Wolfson (2003) draw attention to the differences in concepts, language and

values between recovery and medical models. Such differences highlight some

fundamental tensions between the way people who have unusual experiences will be understood and related to – by themselves, by mental health professionals and by others in society. Drawing on other evidence (Allott, Loganathan, & Fulford, 2002; Rufus May, 2004; Ralph, Lambert, & Kidder, 2002), Robert and Wolfson (2003) suggest the medical model is focused on deficit, control, positioning the patient as different from normal people, and keeping power and decision-making in the hands of professionals. In contrast, the recovery model is characterised by a non-pathologising, context-influenced, potentiality and flexible approach that privileges individual meaning.

The consequences of such different value systems for people who have unusual experiences are profound. This issue goes beyond debates about whether the medical model can adequately or reasonably account for unusual experiences. It affects all VHs[4] whether a medical understanding of what is happening makes sense to them.

The automatic assumption of pathology brings with it a consequent positioning of the person as defective or inferior in some way. If mental health professionals accept this model of deficit they may (consciously or unconsciously) convey a sense of hopelessness about any prospect of recovery or of their patients becoming normal again so that they can fully re-join society (Repper & Perkins, 2009). This has implications for VHs' social, employment, financial and relationship prospects (Repper & Perkins, 2009). That VHs might also see themselves in this way can often add to the negative feelings about self, feelings which can also be exacerbated by what their voices are telling them.

Some of the explanatory models described above set out to normalise experiences. It bears emphasis that practitioners and researchers often evidently value the people they

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[4] And those who have different types of unusual experience

are trying to understand and help. Researchers talk about the importance of individual meaning and context; they discuss psychotic experience as lying along a continuum with normal. Some of the language used, however, is still framed by a deficit model that positions HV at the other end of the scale to normal experiencing. The accepted form of language for inclusion in psychiatric academic journals might account for some of this but it still acts to collude with, and perpetuate, the hegemonic view of HV as a medical problem. Boyle (2002a, 2002b, 2011, 2013) discusses the continuing power exerted by the biological model, arguing that the way the discourse is created allows no space for the possibility of other explanations:

> It is important to emphasise that I am not suggesting that the strategies are consciously or deliberately devised and deployed to serve a particular purpose. They are, rather, part of everyday discursive, theoretical, empirical and clinical practice, whose origins and effects are rarely questioned. Indeed, within the mainstream it is not assumed that these practices *have* origins and effects apart from reflecting reality and furthering scientific progress. (Boyle, 2011, p. 28)

It is disconcerting to read different reports regarding evidence presented above that claim to advocate a continuum model (1.5.6)[5] or which write about how HV can sometimes be a positive experience (1.3)[6] yet which seem to attach quite different values and language to the concepts. Some researchers who discuss the strong associations between adverse events and the development of HV (1.5.4), acknowledge the, often, debilitating effects of the original trauma and the HV experience without implying deficit[7]. Others, however, talk about those who develop psychosis as having some sort of pre-existing biological vulnerability[8]. (There does, however, seem to be some change in tone in papers written over the past 5-10 years).

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[5] E.g. (Johns & van Os, 2001; Strauss, 1969; Verdoux & van Os, 2002) as compared with (Beavan et al., 2011; Larry Davidson & Roe, 2007; Romme & Escher, 1989)
[6] E.g. (Moritz et al., 2013) as compared with (Faccio et al., 2013; Jenner et al., 2008; Sanjuan et al., 2004)
[7] E.g. Read's traumagenic model (Read et al., 2014; Read et al., 2001), (Longden et al., 2016; McCarthy-Jones & Longden, 2015)
[8] E.g. (Bebbington et al., 2004; Garety et al., 2001; Spauwen et al., 2006)

Whilst agreeing that proponents of a medical perspective promise much, despite limited evidence, and their assumptions are unquestionably accepted (Boyle, 2002a), I do not argue against a medical understanding *per se*. Such an understanding holds relevance and meaning for many VHs. In any case, to denigrate medical discourse and privilege alternatives risks those alternatives becoming just as dominant, prescriptive, oppressive and exclusive as the current hegemony (Woods, 2013). That does an ill-service to people in distress (and their loved ones) who are struggling with their unusual experiences and who currently use the medical model in order to access help, or for whom a medical explanation offers relief, clarity and a sense that there are experts available who know what is wrong and who may be able to help them (Hemmings, 2008). My perspective, shared by those within the Hearing Voices Movement (HVM), is that individual understandings are all equally acceptable and that everyone should be supported in finding their own way through any associated difficulties.

1.9   The notion of recovery

Survivor and service user groups have been at the forefront of attempts to bring the possibility of recovery to attention (Deegan, 1996; Repper & Perkins, 2009; Roberts & Wolfson, 2003), following decades in which the general consensus was that a diagnosis of mental illness offered poor prognosis (Repper & Perkins, 2009; Rose, 2001). It is interesting to note the difference in tone between three distinct categories of research: papers which appear imbued with the discourse of deficit (e.g. Anthony, 1993); studies which, while accepting a medical explanation, argue that there is a way forward (e.g. Perkins, 1996; Repper & Perkins, 2009) and sometimes find positive or creative elements within unusual experiences (e.g. P. K. Chadwick, 1997b); and research conducted by (for example) those within the HVM, who advocate accepting and living

well with such experiences, and avoid any attempt to position them as pathological (Corstens et al., 2014; Rapley, Moncrieff, & Dillon, 2011; Romme et al., 2009).

 As regards recovery, it appears that the views of patients, mental health professionals and policy makers diverge considerably (Bonney & Stickley, 2008). Professionals have typically seen recovery as something that can be done to patients, something that involves the removal of symptoms, along with, in some cases, the provision of practical assistance when life feels too hard to manage. Conversely, service users themselves (see 4.2.3) regard recovery as a more creative and wide-ranging process that does not necessarily involve elimination of symptoms, or restoration of some life before psychosis set in (Larry Davidson, 2003; Larry Davidson & Roe, 2007; de Jager et al., 2016; Repper & Perkins, 2009; Roberts & Wolfson, 2003). It appears to be much more about finding personal meaning and living a personally fulfilling life in which psychotic experiences are accepted and managed (Larry Davidson & Roe, 2007; Perkins, 1996; Repper & Perkins, 2009; Romme et al., 2009). Such a view of recovery also requires the presence of hope and the opportunity to take an active role in all aspects of normal society (Repper & Perkins, 2009). Regrettably, such chances are not always available and, even if other aspects of recovery occur, people are very often still defined by their episodes of unusual experiences (Barham & Hayward, 1991; Barham et al., 1995; Bonney & Stickley, 2008; Repper & Perkins, 2009; Roberts & Wolfson, 2003).

Policy makers have had to include within their models of recovery the need to balance risk with responsibility and freedom of choice in order to fulfil their roles of protecting the public (Bonney & Stickley, 2008). Some research, however, has identified the freedom to take risks – whether in managing their lives, or being able to address difficult issues – is an important part of recovery from the perspectives of experts-by-experience (Deegan, 1996; Romme & Escher, 2000). What is required from

professionals is not the elimination of all risk but the offer of a safe environment in which to take the risks that are often part of growth and healing (Roberts & Wolfson, 2003). Of course, one element of 'risk-taking' is coming off medication, which can most successfully be done in a well-managed way to minimise difficult withdrawal effects; there are online service user-led resources to help with that (Coming off medication, 2016). Typically, mental health professionals are risk-averse to the extent that their expectations of patient recovery are low. This may foster dependence (Larry Davidson & Roe, 2007; Repper & Perkins, 2009; Roberts & Wolfson, 2003) and "learned helplessness" (Roberts & Wolfson, 2003, p. 40).

There are fears that the 'recovery model' has been colonised by the medical profession (Coleman, 1999; Rose, 2014), with psychiatric professionals offering their own exhortations to include service user perspectives in the ways they communicate with patients (McCabe, Heath, Burns, & Priebe, 2002; McCabe & Priebe, 2008) and view the potential for recovery (Department of Health, 2001a, 2001b). Rose also notes a "mainstreaming" of the recovery model which, in emphasising normality, permits certain criteria to be included in the notion of recovery but not others (Rose, 2014). As Boyle also argues (2002a), this appropriates recovery into the medical model. Similarly, Perkins and Slade (2012) advocate a shift within health services away from the current emphasis on symptom reduction to a more personalised recovery support process. Although this has been stated in policy directives, they claim it is not currently being delivered in practice.

I want briefly to acknowledge the economic pressures faced by UK mental health services and the effects they may have on people's well-being. There is a drive towards ensuring people suffering mental distress, and who are offered help from psychiatric services, are restored to full health as quickly as possible (Pilgrim, 2008a), thereby

lessening pressure on caseloads and cutting service costs. Indeed, there is a similar emphasis on minimising costs to business and employers of employee absence due to mental health problems (Pilgrim, 2008a, p. 267). It may also be that economic pressures at times lead to the impact of difficult circumstances and oppression being downplayed (Moloney & Kelly, 2008, p. 288; Smail, 2005). The outcome of these economic constraints can be that, if superficial issues can be rectified sufficiently to enable clients to go back to work and be discharged from psychiatric services, the opportunity to address difficult or painful issues that are at the root of their problems may be resisted (Rundle, 2009a, p. 289). This is of relevance with HV which, as discussed, is often associated with previous trauma, the resolution of which, conceivably, might take a considerable length of time.

Harper and Speed (2012) problematise the notion of recovery, arguing that it implies there is something to *recover from*. This perpetuates the deficit model of unusual experiences, whilst allowing that deficit to reside in the individual and placing all the responsibility for said recovery on that individual. If they do not get better, it must then be because they did not try hard enough, or engage well enough with therapy, or were 'non-compliant' with their medication. Or it could even be because their symptoms are 'treatment resistant'[9]. This also absolves us in society from the need to address possible social or economic causes for mental distress, as debated by Smail (2005).

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[9] Somehow, even the responsibility for this can successfully be placed on the 'patient'.

Chapter 2

2 HOW CAN DISTRESS OCCURRING ALONGSIDE VOICE HEARING BE ALLEVIATED?

HV is not always a distressing experience. Notwithstanding issues connected with trauma, social hardship and stigma (mentioned above), it may be that distress is associated with something else entirely. Undoubtedly, however, some people are distressed at the idea that they HV, because it might suggest they are mad and they fear the consequences of stigma or challenges to their identity as a voice hearer. The practical ramifications of stigmatising attitudes are likely only to add further to VHs' distress. Others suffer because of the hurtful, threatening or aggressive things their voices say to them. Attempts to help alleviate any distress seem to be informed by the position taken in relation to understanding the experience, whether that is an approach to therapy, medical help or practical assistance with managing everyday life.

There are various ways in which people in distress can be offered help. These will be discussed in the sections below. Section 2.5 will discuss person-centred therapy in detail.

2.1 Medication

The usual aim of interventions offered to VHs under the medical model is the elimination of symptoms, or at least their masking or reduction. This usually involves the prescription of antipsychotic drugs (Bentall, 2009; Moncrieff, 2009, 2013b; NICE, 2014). Rogers and Pilgrim (1993) surveyed 516 service users who had had at least one hospital admission and reported that 98.6% had been given psychiatric drugs of some sort. But medication is not always effective; Roth and Fonagy cite studies that reported

between 23% and 66% of patients who were prescribed "appropriate levels of medication" showed residual symptoms (2005, p. 266). In these cases, different or stronger 'cocktails' (combinations of the same type of medication) may be prescribed (Moncrieff, 2009, 2013b). Such prescription is commonly over the limits set by the British National Formulary (BNF) and contravenes NICE (2014) guidelines, which recommend that patients take only one type of antipsychotic medication at any time. Reporting on an audit by the Royal College of Psychiatrists Prescribing Observatory for Mental Health (POMH-UK), the Healthcare Commission revealed that 36% of people were prescribed more than 100% of the maximum recommended daily dose of antipsychotics, with 43% taking more than one antipsychotic medication (Healthcare Commission, 2007).

Medication can give respite from the voices. In some cases, the voices disappear for good, or the VH has only one episode of psychosis (Morrison, Hutton, Shiers, & Turkington, 2012; Perera & Taylor, 2014; M. Taylor & Perera, 2015). Others develop a sense of when they are likely to experience an episode and learn the triggers so that they can seek help or increased medication to deal with it (Morrison et al., 2012). There is a suggestion, however, that these powerful chemicals have a general effect on the body so that all manner of bodily responses are dulled or masked (Boyle, 2002b; Healy, 2002; Moncrieff, 2009, 2013b; P. Thomas, 2014). This is not the same as 'curing' the symptoms (Mizrahi, Bagby, Zipursky, & Kapur, 2005), although the relief from intense or overwhelming emotion can be welcome (P. K. Chadwick, 1997b). Unfortunately, side effects can be unpleasant (Moncrieff, 2013b; Morrison et al., 2012; P. Thomas, 2014), or even dangerous, (Bracken et al., 2012; Double, 2002; Healy, 2002; Moncrieff, 2013b; Rapley et al., 2011) so any relief comes at a cost (Moncrieff, 2013a, p. 160).

The list of physical adverse effects from early antipsychotics (first generation) includes dry mouth, tachycardia, weight gain, constipation, urinary retention, delirium, akathisia, tremor, rigidity, dystonia and tardive dyskinesia. Those are also found with later (second generation) antipsychotics but there is an additional risk of glucose intolerance, diabetes hypertension and cardiovascular disease and sexual dysfunction (Read & Bentall, 2013, p. 276). Such side effects might be expected to affect a person's ability or desire to live their everyday lives as they would wish.

There are also frequent (Barbui et al., 2005; Hofer et al., 2007) and unpleasant (Awad, 1993; Van Putten, 1974) cognitive and emotional effects which have been reported as being more "unpleasant and impairing than the physical effects" (Moncrieff, Cohen, & Porter, 2013, p. 412). The early antipsychotics were demonstrated (Deniker, 1956; Lehmann & Hanrahan, 1954) to elicit a subjective state of "mental slowing, apathy and emotional indifference" (Moncrieff, Cohen, & Mason, 2009, p. 103). Later drugs caused emotional detachment, reduced initiative, dysphoria and akathisia (Belmaker & Wald, 1977; Healy & Farquhar, 1998; Ramaekers et al., 1999; Wallace, 1994).

In their study of subjective accounts of the effects of antipsychotic medication, Moncrieff and colleagues (2009) identified sedative effects that were "profound and disabling"; cognitive effects such as "reduced or slowed mental processes, mental clouding and feelings of reduced intelligence"; and "flattened or numbed emotions, loss of interest and motivation, reduced creativity and changes in personality". Conversely, some people reported a decrease in the intensity of their symptoms and reduced agitation, which also helped them feel more in contact with reality (Moncrieff, 2013a, p. 160; Moncrieff & Cohen, 2009; Moncrieff et al., 2009).

Antidepressant and mood-stabilising medication can also be prescribed for people experiencing psychosis and significant physical side-effects that are similar to those for

antipsychotic medication have been shown to affect large numbers of patients (Moret, Isaac, & Briley, 2008). Interpersonal and emotional effects have also been identified (Gibson, Cartwright, & Read, 2014). In a survey of 1829 people prescribed antidepressants in New Zealand, adverse emotional and interpersonal effects were found in many participants. These effects were related to the type of antidepressant and personal circumstances but not to the level of depression experienced before taking the drugs. The effects noted included those that might be expected to exacerbate feelings of depression such as "sexual difficulties", "feeling emotionally numb", "reduction in positive feelings", "suicidality", "caring less about others" and "not feeling like myself".

These interpersonal and emotional effects may have a significant impact on people's lives, especially if they also experience physical side effects mentioned above.

2.2   Soteria

The Soteria approach is mentioned here although it currently has little influence on mental health services in the UK (P. Thomas, 2014, p. 238), despite positive evaluations of its short term (Mosher, Vallone, & Menn, 1995) and long-term effects (Bola & Mosher, 2003). It is included because its values and approach are like those of the HVM (1.5.7; 2.4.6) and Open dialogue (2.4.4), models which are currently advocated to help VHs, and to person-centred therapy, the focus of this study.

Soteria was originally a residential project in California developed by Lauren Mosher to help people diagnosed with schizophrenia move towards recovery with minimal use of medication. In an explicit rejection of disease explanations, people were encouraged to engage with their own perspectives on the causes and meanings of what Mosher called "personal or developmental crises" (Mosher, 2004, pp. 350-351). Staff in residential

units were typically not medically trained and were often ex-residents. They sought to 'be with' residents in order to offer a "non-intrusive, gradual way" of empathically and non-judgementally developing a shared understanding of what it was like to be going through those crises and what they might mean (pp. 351-352). The parallels with the HVM and person-centred relating are clear. An empirical evaluation showed outcomes to be at least as effective as typical psychiatric treatment (Bola & Mosher, 2003; Mosher et al., 1995).

Soteria houses were set up in Switzerland, Hungary and Alaska, US, though funding was withdrawn from the US in 1982. In the UK the Soteria network continues to promote the values of the approach through local networks (Soteria Network, 2016). Thomas argues that the approach is not more widely incorporated in the UK partly because of the challenge it poses to the current technological paradigm and the risks that paradigm attaches to a failure to medicate those diagnosed with schizophrenia (P. Thomas, 2014, pp. 242-243). There may also be a risk to the continued status of clinical professionals were such a non-medical approach to gain purchase (Boyle, 2002a, 2002b).

2.3 Self-help and help from family and peers

Various mental health support organisations (for example, Rethink, MIND, SANE) have found that VHs and those who have other unusual experiences can often feel marginalised or even ostracised in society. Anything that can ease those feelings of isolation or alienation might therefore be welcome and offer opportunities to be in relationship. Families can play a large part in making someone feel part of things and accepted, despite their difference – or, in the best case, because of their difference. Friends and the wider community are also helpful if they can accept VHs without judgement and show some understanding of the struggles they may be having.

Some psychiatric services employ service users to offer peer support groups. Whilst these have been found to be helpful in many ways (e.g. Mental Health Foundation, 2012), the organised nature of such groups has resulted in some service users and organisations fearing the colonisation of the recovery movement by professionals (Coleman, 1999; Coleman & Smith, 2002; Laurie Davidson, 2005; Larry Davidson, Bellamy, Guy, & Miller, 2012; Pilgrim, 2008b). Such professionalisation also perpetuates the idea of unusual experience such as HV being symptomatic of illness or disorder, and places the peer support group as a form of treatment, a notion vehemently opposed by many user groups.

Apart from lobbying activities, the consumer or service user movement is active in trying to help people in distress through peer support. An example is the HVN in the UK and its international counterpart, Intervoice. These run a series of user led support groups that give VHs the chance to share their experiences and understanding of the voices they hear. No assumptions are made about the meaning that someone's voices might have and all explanations are equally valued, whether voices are interpreted as spiritual occurrences, a symptom of madness, or aspects of self (Longden, Corstens, & Dillon, 2013). Apart from a refusal unquestioningly to interpret HV as a sign of pathology or deficit, this approach affirms and supports VHs in struggles to deal with their voices and be regarded without stigma by others. For more than ten years now such peer support groups have demonstrated success in helping VHs live more satisfactory lives and to make sense of their experiences (Dillon & Hornstein, 2013; Gail A. Hornstein, 2009, 2011, September; Romme et al., 2009).

2.4   Talking therapy

This section will consider various models of talking or psychological therapy that attempt to help those in distress through HV.

The current government advice regarding talking therapy is to

> Offer cognitive behavioural therapy to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.

> Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings. NICE (2014)

The Schizophrenia Commission reported in 2013 that only one in ten people have access to the talking therapy support recommended by NICE (2014). (Schizophrenia Commission, 2013). While other reports suggest the figure is 39% (Royal College of Psychiatrists, 2014), this still means that many people are not receiving the help they could.

2.4.1 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT), specifically Cognitive Behavioural Therapy for Psychosis (CBTp), is the most widely researched approach to talking therapy for people who have experiences such as HV. The original format of the method was developed by Aaron Beck as a way of helping people diagnosed with depression (Beck, Rush, Shaw, & Emery, 1979). He posited a series of faulty cognitions as the reason for psychological disturbance, suggesting that thoughts, beliefs and behaviour could be returned to normality through testing against reality and offering ways of reframing cognitions.

It was further developed as CBTp for people who were diagnosed as psychotic. Early approaches challenged and dismissed individual realities as evidence of the fault within, and distraction techniques were widely used as a way of teaching the patient not to engage with the voices they heard or unusual thoughts (Tarrier, 2010).

More recent forms attempt to explore clients' own understandings of their experiences (Bentall, 2009; Turkington, Dudley, Warman, & Beck, 2004; Turkington, Kingdon, &

Weiden, 2006) and involve clients in developing their own formulation of problems (P.

Chadwick, 2006; Johnstone, 2012; Johnstone & Dallos, 2014). This leads Bentall to

conclude that a well-trained CBTp therapist will make

> every effort to treat the patient's beliefs, no matter how implausible, as if they
> might just be true. Not surprisingly, ….it often becomes obvious that there is a
> nugget of truth in even the most paranoid systems. (2009, p. 253).

The centrality of the therapeutic alliance and the importance of working from the

patient's (client's) framework, are noted as vital aspects of talking therapy (Bentall,

2009; Cooke, 2014; Johnstone, 2012). An active, collaborative process of person-

centred exploration has been shown to be valued by clients (Kilbride et al., 2013; Wood,

Burke, & Morrison, 2015). Paul Chadwick (P. Chadwick, 2006) explicitly cites the

influence of Rogers (C. R. Rogers, 1961) when he calls for "radical collaboration" in his

approach to CBT. He also notes that it is not just a warm and understanding alliance that

is important but also the active collaboration between therapist and client to find

personal solutions.

The current perspective on CBTp is summarised by Turkington et al., (2006) thus:

> The goal of cognitive behavior *[sic]* therapy is not to try to persuade or force the
> patient to agree that he or she has symptoms of a mental illness. Rather, the goal
> is to reduce the severity of, or distress from, the symptom regardless of whether
> the patient accepts a diagnostic label (p. 368)

By focusing on work with individual symptoms, therapy does not get drawn in to

debates about what Geekie has called the "essentially contested concept" of

schizophrenia (Geekie, 2007, pp. 65-76; Geekie & Read, 2009, pp. 141-148). CBTp

advocates go further in their overall strategy to present a therapy somewhat distant from

the medical model (Wise, 2004), claiming,

> cognitive behavior *[sic]* therapy is not compatible with any kind of biomedically
> based intervention that requires using the diagnostic label "schizophrenia,"
> forbids any exploration of a personal meaning (formulation) of psychotic

symptoms, or precludes the possibility of meaningful recovery (Turkington et al., 2006, p. 370)

This approach is concerned with normalising psychotic experience and collaboratively setting treatment goals, suggesting such CBTp practitioners are prepared to encourage the patient's formulation. The emphasis on personal meaning (Kingdon, 2012) contrasts with situations where coping strategies suggested by VHs from their own perspectives have been discounted, dismissed or not explored – their voices effectively silenced as 'irrelevant' or 'wrong' because they are deemed mad (Wise & Rapley, 2009, p. 194).

The normalising technique is used especially in the early stages of treatment, for alleviating distress, when an acutely ill person may be unable to understand they have a mental illness . (Turkington et al., 2006). Alongside widespread support for the success of CBTp for people experiencing psychosis (Wykes, Steel, Everitt, & Tarrier, 2008), researchers have made clear statements about when the approach may not be as effective. For instance, Turkington et al., warn that,

> Some are simply too thought disordered or agitated to use cognitive behavior *[sic]* therapy, although the effect of medication may lead them to become more amenable to treatment. Some may be too paranoid and unable to form a viable therapeutic alliance. There is no evidence at the current time that cognitive behavior *[sic]* therapy is of benefit for patients who consistently refuse antipsychotic medication. (2006, p. 369)

Other studies have reported on the hard work and commitment involved in undertaking CBTp (Göstas et al., 2013; Kilbride et al., 2013; Wood et al., 2015). If a person is struggling in the ways Turkington discusses above, it might be that they find such effort too difficult, at least for a time.

It has been suggested that the success of CBTp has been overstated (e.g. Jauhar et al., 2014). Questions have been raised about the methodological rigour and the extent of the claims put forward by researchers. It should be noted, however, that many of these critical reports are written by those critical of talking therapy and in favour of a medical

approach and medication for psychosis. As (N. Thomas, 2015) notes, in any case, the approach is developing and so too is its focus. This may mean that existing measures do not always adequately capture features of relevance to its effectiveness. Furthermore, he claims there is an unmet need for CBTp, and for qualified therapists, so that some clients, especially with complex needs, may receive treatment from someone not sufficiently qualified or experienced, if they receive therapy at all. Nevertheless, the continuing commitment to further research might add to the already substantial evidence base that demonstrates many people having found the approach helpful.

2.4.2   ‘Third wave’ therapies

Recent developments from the CBT model have been influenced by Buddhist or Eastern religious thinking and include mindfulness, acceptance and commitment therapy (ACT) (Bach, Gaudiano, Pankey, Herbert, & Hayes, 2006; Bach, Gaudiano, Hayes, & Herbert, 2013; P. Chadwick, Hughes, Russell, Russell, & Dagnan, 2009; Gaudiano & Herbert, 2006; E. M. J. Morris, Johns, & Oliver, 2013) and compassion focused therapy (CFT) (Gilbert, 2010; Gumley, Braehler, Laithwaite, MacBeth, & Gilbert, 2010). These methods take a welcoming approach to voices or other experiences, staying with the distressing experience such that people can learn to understand where it might fit in to their lives. In this way, the experience itself has been found to be less frightening, threatening or confusing. CFT might be particularly helpful for people suffering from distress associated with HV, given its focus on dealing with feelings of shame which might be assumed to form part of the distress associated with having unusual experiences (Gilbert, 2010; Gumley et al., 2010).

2.4.3   Family interventions

Unusual experiences can influence, and be affected by, the circle of people around VHs. Approaches that involve the whole family have been useful to try and work out what is

perpetuating the experience and what others in the family can do to help the person in distress, or what behaviours or 'systems' might be worth adapting to being about changes in the abnormal experiences. (Meddings, Gordon, Inger, & Owen, 2010; Pharoah, Mari, Rathbone, & Wong, 2010). NICE recommend the use of family interventions and it seems logical that such a practical intervention might be found useful, not least because of the potential help offered to counter any detrimental effects on all members of a family if they find unusual behaviours and experiences difficult to cope with.

2.4.4   Open Dialogue

Open Dialogue (Aaltonen, Seikkula, & Lehtinen, 2011; Seikkula et al., 2006; Seikkula, Alakare, & Aaltonen, 2011; Seikkula & Arnkil, 2006) has yielded highly successful results in a small area of Finland. Some NHS trusts are starting to train staff in its use in the UK (Open Dialogue UK, 2016). Rooted in systemic theory (as are the family interventions in 2.4.3), Open Dialogue takes a non-medical, non-directive and collaborative approach. Family members and others involved in a client's life are invited to attend meetings with the client and a professional who acts as facilitator, in discussing what is causing problems and what might be needed to help the client. It can be challenging for some people to take part in, at least initially, and people are free to withdraw at any time. But all treatment decisions are made in those meetings where the client is present.

People who have taken part in this approach have been shown to need significantly less medication and to manifest greater levels of successful social functioning. There has also been a dramatic drop in the number of hospital admissions (Aaltonen et al., 2011). The success appears to stem from the ways in which the person having the unusual experiences is respected and treated as an equal with other people who do not. They are

involved in decisions and plans for their futures according to their needs and no assumption of illness is made so that they are not segregated from others or regarded as 'less than' in any way.

2.4.5 <u>Trauma focused therapy</u>

Given the strong associations between childhood trauma and the development of psychotic experience (see 1.5.4), trauma focused therapy that works with flashbacks, dissociation and other aspects of behaviour related to trauma, has been adapted specifically to help with psychotic experiences. Some success has been demonstrated (Herman, 1992; Larkin & Morrison, 2006; Ross & Halpern, 2009)[10].

2.4.6 <u>Approaches derived and developed from the work of Romme and Escher</u>

The values of the HVM have been employed in the Maastricht approach to therapy in addition to the peer support/recovery networks within HVN groups mentioned at 2.3 above.

The Maastricht Interview was originally developed for research purposes (Romme & Escher, 2000) but was found to have therapeutic benefits. It is a structured set of questions that helps users explore the characteristics of their voices, what they might mean and the effects that voices have on hearers lives (Corstens et al., 2008). The Maastricht approach involves therapy where VHs are helped to develop strategies for dealing with difficult voices and emotions, and to work through historical anxiety, guilt and shame.

Voice dialoguing (Corstens, Longden, & May, 2012; Corstens, May, & Longden, 2012) is one method used here. It is based on the work of Stone & Stone (2011), who advocate dialoguing with different parts of our selves (or different 'voices' within us) to

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[10] (See also 2.5.4.2)

understand ourselves better and help overcome difficulties. Corstens et al., (2012a; 2012b) assume that voices can be related to in the same way as with other parts of the self and that this form of relating can uncover meaning and decrease distress.

For VHs who might not wish to engage with therapy, Longden et al., (2012) have proposed the formulation of a construct linking voices to life history. They argue that simply to recognise links between adverse events and previously incomprehensible symptoms, can provide a framework within which traumatic, unassimilated experiences can be integrated and made sense of. A structured format is offered to VHs to enable them to build a picture of how exactly the voices fit into their individual biographies.

2.4.7   Other approaches

The 'formulation' approach to working with a client to find out what is wrong and what could be done to help emerged from functional analysis in behavioural work (Johnstone & Dallos, 2006). As Johnstone and Dallos (2014) demonstrate, it can be a useful tool within therapeutic modalities which are found helpful by people diagnosed with psychotic disorders. Examples of its use within psychodynamic, systemic (family), narrative and integrative work highlight its advantages over a narrow approach to treatment based on diagnostic category (Johnstone & Dallos, 2014).

Interpersonal relating therapy (Hayward, Berry, & Ashton, 2011; Hayward et al., 2009) starts from a cognitive understanding of HV and suggests that people relate to their voices in the same way as to other people. If VHs can be encouraged to develop relationships with their voices, this model expects associated distress to diminish and an understanding of what the voices signify to be developed. This involves comparable assumptions to voice dialoguing, without necessarily talking directly with voices.

Davies et al.,(1999) report a similar approach in a single case study that proved useful to 'Peg', the voice hearer, relating to HV as a form of inner speech. In this study, a new positive voice mediated between Peg and the distressing voices she heard, leading to a lessening of distress and a consequent increase in self-esteem.

These and other models of therapy that address the experience of HV specifically have been shown to help some people. But the limited amount of research means that such approaches have not yet been included in the list of treatments recommended by NICE (2014).

2.4.8   Person-centred therapy

Until very recently, little research involving this approach had been done since the work of Rogers' and his colleagues in the mid-20ᵗʰ century (1951, 1957, 1959, 1961; 1967). It is not included in the NICE guideline (2014) and is rarely offered to VHs in the UK. It is, however, the therapy under investigation here and will now be discussed further.

2.5   Person-centred theory and therapy

2.5.1   Introduction to the person-centred approach

Carl Rogers' theories of personality, personality change and the causes of distress (C. R. Rogers, 1951, 1961), and how best to help people suffering that distress (C. R. Rogers, 1957, 1959) were generated through his observations of therapy with clients in a number of settings from the 1940s onwards. His practice based research did not, therefore, entirely fit with the "if-then" linear scientific thinking of the modern paradigm. His thinking emerged from within the "swampy lowlands" of clinical practice with all the ambiguity and inconclusiveness of client experiences (Schön, 1987) rather than the "high, hard ground" of a conventional experimental approach which takes a "straightforward linear process with a coherent and logical plot" (Freshwater & Rolfe, 2001, pp. 526-527). Nevertheless, he and his colleagues and students were the

first researchers to record and then analyse therapy sessions in the 1950s, striving to find out what happened in therapy sessions in order to develop theory.

His research led him to propose a theory of relationship based on change and process rather than a fixed state. He argued that people are pro-social and growth-oriented and that they try to make the best of whatever situation they find themselves in (C. R. Rogers, 1980, p. 118).

2.5.1.1   *Person-centred theory of personality development and the origin of distress*

Rogers presented his theory of personality as a series of nineteen propositions (C. R. Rogers, 1951, pp. 483-524) which contained within them a number of the theoretical concepts that form the basis for his thinking on personality development and therapy and for subsequent developments by others (most recently summarised by Cooper, O'Hara, Schmid, & Bohart, 2013b). They are contained in full in Appendix Ai but the fundamental aspect of the approach is a belief in the 'actualising tendency'. This is conceptualised as a universal, amoral, directional force, always in operation to optimise the potential of the organism. It is theorised also that a person's idea about themselves ('the self-concept') develops according to the actions and values of those with whom they are in significant relationship. All other concepts about personality development and therapy flow from this.

2.5.1.2   *Theory of person-centred therapy*

Rogers' theory of effective therapy was distilled into six "necessary and sufficient conditions" (C. R. Rogers, 1957, 1959) which would facilitate constructive personality change in any model of therapy (see Box 2.1). The values are often incorporated in other approaches (which then add their own techniques).

He theorised that client distress can be ameliorated by re-starting the process of positive self-regard through the successful experiencing of unconditional positive regard (UPR), conveyed through the empathic understanding of the therapist as a genuine person.

Box 2.1: *The Necessary and Sufficient Conditions of Therapeutic Personality Change. (C. R. Rogers, 1957, pp. 95-96)*

For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

• Two persons are in psychological contact.

• The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.

• The second person, whom we shall term the therapist, is congruent or integrated in the relationship.

• The therapist experiences unconditional positive regard for the client.

• The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors *[sic]* to communicate this experience to the client.

• The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow.

The three 'therapist conditions' of UPR (or acceptance), empathy and congruence (genuineness) are usually the qualities incorporated into other models discussed earlier. UPR is not the same as 'liking' (it does not require acceptance of evil or hurtful behaviour) but does require acceptance of the client as a unique Other who might make bad choices but is actualising as best they can. Rogers defined being empathic as sensing "the client's private world as if it were your own, but without ever losing the "as if" quality" (C. R. Rogers, 1957, p. 101). This means to understand the Other whilst retaining an awareness of one's separateness from her. Congruence is often misinterpreted as being able to say anything, however brutal, in order to be genuine, but actually means that the therapist is present to the client as she is, without artifice. It is

not an action but involves the therapist's being aware of the flow of her experiencing; of what is coming from the client as well as what is part of the therapist's own process. In this way, the process of the session can be monitored to ensure it remains focused on the client's frame of reference.

According to Rogers' first proposition (C. R. Rogers, 1951) we live at the centre of our own continually changing world of experience, in which case the only understanding that can possibly be meaningful, and therefore helpful, is an empathic one (Tudor & Worrall, 2006, p. 28). Anything else assumes a shared reality or asserts a reality and insists it be shared. This is a phenomenological stance where, although we try to "take the phenomena as given" (Rollo May, 1961, p. 26), or follow Husserl's call to go "back to the things themselves" (1910/1970, p. 258), we also acknowledge that we each see the world through our own lens (Heidegger, 1962; Merleau-Ponty, 2002). This allows a therapist to take account of specific individual context and circumstance, especially important perhaps when a sense of reality is not shared.

Tudor (2000) recognised that a superficial knowledge of person-centred theory often concentrates just on the three therapist conditions. Such arguments misunderstand the approach and may position the conditions as techniques for 'doing' person-centred therapy, rather than as attitudes or ways of 'being' person-centred (Kovel, 1976; Masson, 1989; Smail, 2005). He talks of the three other "lost conditions" (Tudor, 2000, p. 33) that are also necessary for the theory to operate as Rogers suggests (1957, 1959). The first condition states that two people need to be "in psychological contact". If, for instance, a client is heavily medicated, or is experiencing a different reality, so that they are not able to engage with the therapist in any meaningful way, there can be no "psychological contact". The second condition is that one of the people "must be in a vulnerable or anxious state" so that there is a point to the encounter; that the client has

issues she wants to explore in a therapeutic environment. Rogers' final condition was that of the necessity for the three therapist qualities to be experienced by the client. The therapist can be fully genuine, accepting and empathic but, if those attitudes are not communicated to, and received by, the client, the environment necessary to facilitate a reappraisal of the self-concept cannot exist.

This holistic approach to employing all conditions in a principled, rather than instrumental way (Grant, 1990) should embrace the full social, cultural and personal contexts within which a client lives (Bohart, 2013; Wilkins, 2016). Person-centred theorists argue that this answers criticisms that the approach is Western-centric (Masson, 1989; Smail, 2001b, 2005) and takes no account of the social or material pressures under which a particular client may labour (Smail, 2005).

When working with people who experience a different reality, specifically, it is worth noting that it can be affirming and, possibly, unusual for a client to have her reality and situation accepted and understood without it being denied, distorted or altered in any way. To dispute the existence of voices or to be fearful of engaging with them denies the client's reality which can add to feelings of isolation and even more uncertainty about whether they can trust their experiencing. A willingness to try to experience the client's world as if it were our own, and the consequent empathic understanding, must be communicated to the client (the sixth of Rogers' therapeutic conditions).

These attitudes of acceptance, empathic responding and non-directivity need not mean a person-centred therapist avoids difficult issues or fails to reflect inconsistencies. Neither do they mean that a client's reality is adopted by a therapist. Indeed, owning the fact that things are different for the therapist adds to her reliability, and her very presence as a separate person can act as an anchor to a person who feels she is losing her sense of self or contact with reality (van Werde, 1998).

2.5.1.3   Process conception of psychotherapy

Rogers outlined seven stages over which he had observed the change process happening during therapy (C. R. Rogers, 1961, pp. 125-259). These are contained in Appendix Aiii. Although he described 'stages', he was clear that this was not a rigid path along which every client would move in order. He believed that each person would progress idiosyncratically, but noted a broadly similar process that happened much of the time. In accordance with the era in which he was working, he was attempting to symbolise subjective data in a scientific manner, data that he expressed elsewhere in perhaps more human terms – claiming, after Kierkegaard (1941, p. 29), that the typical aim of each client was "To be that self which one truly is" (C. R. Rogers, 1961, p. 163).

2.5.2   <u>Wisconsin project</u>

Rogers' five year (1958-1963) study with hospitalised patients (known as the Wisconsin Project) is an illustration of his attempts to explore his hypotheses about the process and outcome of therapy with people said to be suffering from severe and enduring mental illness (C. R. Rogers et al., 1967). Although it was conducted some fifty years ago and results have been regarded as equivocal, it is included here as it is the only large scale project that has researched person-centred therapy with people diagnosed with schizophrenia.

Three groups of 16 participants were selected – "more chronic schizophrenics" "more acute schizophrenics" and "normals" *[sic]*[11]. Participants in each group were paired for gender, age and socio-educational level and one member of each pair was then

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[11] The distinction between 'acute' and 'chronic' schizophrenics was disregarded in the subsequent analysis as a decision was made that the sample "did *not* represent the end-points of the acute-chronic continuum but was, rather, a quite homogenous sample from the mid-range of this continuum…" (Rogers et al., 1967, pp. 222, emphasis in original).

randomly selected for the experimental group (n=24). Eight therapists then worked with three participants across a range of the variables.

The random allocation meant participants in the experimental group were scheduled to attend therapy sessions even if they had not given meaningful consent to therapy. This seems to contradict Rogers' own theory (1961) which proposes that voluntary engagement is necessary for the therapeutic process to start taking effect because the participant must be able to perceive and receive the therapeutic attitudes – the sixth of his necessary and sufficient conditions (1957, 1959). Not only that, but it did not offer any prospect of release for reluctant participants. Rogers had given an undertaking that the researchers would not act as advocates for patients in their attempts to achieve release from the hospital or in terms of their ongoing 'care plans'. Being forced into therapy without giving consent and with no prospect of change in one's situation could be supposed to appear both threatening and to militate against any prospect of change.

Although disquieted by the ethics of this (C. R. Rogers et al., 1967, p. 69), Rogers justified it on the basis of prior assurances given to management of the hospital that his team would not intrude upon management or administration decisions – assurances that, perhaps, were given in order to ensure the research study was allowed to take place and the ethics of which, Masson maintains, were questionable (1989, pp. 243-246).

The hypotheses and summarised findings are contained in Box 2.2. where it is seen that the hypotheses about the presence and degree of the therapeutic conditions affecting change, were not supported to any great degree, even though associations were found in some cases. It was evident, however, that level of process was enhanced if there was evidence of higher degrees of therapeutic conditions, even if process movement could not be found. This offered confirmation to Rogers' theory of process (see 2.5.1.3) that people who were more open to the flow of their experiencing were more likely to

evidence constructive personality development. Higher degrees of the therapeutic

conditions were also shown to enhance the level of process that people operated at, and

was associated with more positive outcomes, although it did not cause movement to a

significant degree.

Box 2.2:   *Summary of hypotheses and findings from Wisconsin study.*
(C. R. Rogers et al., 1967)

Hypothesis I: The greater the degree to which the conditions of therapy exist in the relationship, the greater will be the evidences of therapeutic process or movement in the client.

Comment: The more the clients experienced the therapeutic conditions, the more likely they would be to experience positive change.

Findings: No evidence of positive correlation between conditions and process movement although empathy and congruence were associated with process level. Revised theory to posit an association between conditions and process level, though not process movement.

Hypothesis II: The same variables of process movement will characterise the in-therapy behaviour of more acute schizophrenics, more chronic schizophrenics, normals and neurotics.

Comment: Therapeutic process should be the same for all clients although the degree of change may not be the same will all client groups.

Findings: Confirmed the same variables of process movement in all groups. Schizophrenic clients focused more on relationship formation than self-exploration, at least initially.

Hypothesis III: The process of therapy will occur to a significantly greater degree in a group of individuals to whom therapy has been offered than in a control group, paired and matched to the therapy group, to whom therapy has not been offered.

Comment: More evidence of therapeutic change was expected from the group offered therapy than from the controls who received treatment as usual.

Findings: Not confirmed. Little process movement found in either group. Differences in process level were not significant. Researchers argued that therapeutic input already included in TAU meant that the impact of an extra two hours of individual therapy had to be highly significant to show even more improvement.

Hypothesis III-A: Those individuals receiving a higher degree of the conditions of therapy will exhibit a greater degree of the process of therapy than will those receiving a lower degree of therapeutic conditions, or those individuals constituting the paired and matched control group.

Comment: This offered the chance to compare individuals within the experimental group according to the degree of conditions perceived.

Findings: The association of therapeutic conditions with process movement was not confirmed. An association with process level was confirmed: those exposed to higher conditions showed highest process level; the control group showed the lowest level of process.

Hypothesis IV: Evidences of positive outcome will be greater in the group of individuals to whom therapy has been offered than in a control group, paired and matched to the therapy group, to whom therapy has not been offered.

Comment: In positing process movement, the researchers rationalised that it was meaningless unless it was also related to constructive therapeutic outcomes.

Findings: Both groups showed positive change but the experimental group showed more constructive personality change and a better record of hospital release (cf. findings for *Hypothesis III* above).

Hypothesis IV-A: the greater the degree to which the conditions of therapy exist within the relationship, the greater will be the evidences of constructive outcome.

Comment: Those experiencing more of the conditions of therapy should show more improvement.

Findings: Definitely confirmed. Those experiencing higher conditions showed more positive change. Furthermore, those experiencing lower conditions sometimes showed a worsening of their conditions.

Hypothesis V: The greater the evidences of process movement in the client in therapy, the greater will be the evidences of constructive outcome.

Comment: If process change is indicative of positive change, this change should be reflected in measures of outcome.

Findings: Partially confirmed in relation to process movement. But there was a "striking" relationship between process level and measures of outcome.

An additional finding that had implications for Rogers' theories of personality development (1951) and process of personality change (1961) was the Ward Availability Project (1967, p. 57ff). Here, therapists in the study were available on the ward at various times in the day and patients were informed that they could approach them as and when they wished to. Many patients approached the therapists informally; their visits became more frequent and less tentative and they started to engage in a form of therapeutic process. It seems that this confirmed Rogers' process theory of change but also, indirectly, his notion that everyone has within themselves the resources they need to actualise in the way that works best for them and – in contrast to the coercion used on his experimental group - that it is best to let the client direct the process of therapy. Although unplanned initially, this project delivered additional data that enabled the researchers to compare findings from encounters between a client and different therapists, as well as with different clients and the same therapists. They found that

therapists are generally consistent across participants and that clients had a smaller

effect on the ways of being of the therapists. It was discontinued due to time limitations

but was found to be a useful way of starting, if not continuing therapy. The findings

were incorporated into the overall results and offered insights on a group of participants

initially unmotivated to begin therapy.

In summary, Rogers felt that this project had been one of the most difficult periods in

his career and he was disappointed in the overall results. I wonder though, whether the

research methods and design were, in fact, those best suited to answer his questions (as

discussed in 1.7 and 4.2.3) or whether various practical and other issues that have been

identified later (Sommerbeck, 2002) may have affected the operation of the study, the

results and their interpretation.

2.5.3   <u>Learning from the Wisconsin study about person-centred work with clients
who have unusual experiences</u>

An abridged form of a paper Rogers published in 1962 is included in the book he

produced (first published in 1967) with Barry Stevens (C. R. Rogers, 1973). In it he

offers reflections on what he learned from the Wisconsin project which, as mentioned

above, had been a difficult experience for him. Some of those reflections will be

discussed in this section.

He discovered that the clients available to him were often reluctant to take part in

therapy, did not think it would make any difference and were "unmotivated to change"

anyway (pp. 182-184). This provided a different challenge from the start for the

therapists involved in carrying out the sessions, who were usually working with self-

referred clients who wanted to bring about change in their lives.

He commented that the lack of motivation was more difficult to work with than the

psychosis and that such work did not, perhaps, constitute psychotherapy according to

his more familiar experience of clients seeking self-exploration and change. He

suggested, however, that there was still merit in finding ways to offer relationship of

some form to these people, saying:

> We should not be misled by the fact that a relationship with such an individual
> may become psychotherapy when he chooses to seek help. (C. R. Rogers, 1973,
> p. 184)

This seems to suggest that establishing contact with an individual, to whatever degree,

gives them experience of being in relationship which, Rogers assumed, was a universal

desire. A sense of that experience may remain with the person who may then find it

easier to enter therapy when the time is right. This statement perhaps presages Prouty's

later work on pre-therapy (see 2.5.4.1) with those clients who struggle to be in

relationship or are described as "contact-impaired".

When he said that psychotic content was "unimportant" (pp. 188-189), Rogers did not

suggest it lacked meaning. Rather, he accepted that it was a form of communication that

might be difficult for the therapist to understand in the same way as when working with

a client, perhaps from another country, who was not fully fluent in the language of the

therapist. This has also been referred to by Warner more recently in her

conceptualisation of metaphact process, where clients conceptualise and understand in a

very literal way and may be described as psychotic (Warner, 2007). Indeed, she goes

further, arguing that it behoves the therapist to find a way of understanding the client's

language, instead of placing the client under the (additional) pressure of struggling to

communicate in the language of the therapist.

In his reflections on working with the participants in the Wisconsin study, Gendlin

suggested that lack of overt communication need not indicate lack of motivation or lack

of activity (1973). Maybe, then, these participants were open to being in relationship at

some level, but their forms of communication, motivation and wishes were operating differently from those normally encountered by the therapists involved.

Indeed, it might also be that they were unable to perceive the therapeutic conditions being offered by the therapist, in which case it might be difficult to feel motivated. (Perhaps the side effects of antipsychotic medication may have played a part here). One of the findings from the study was that participants who perceived consistently high levels of sensitive empathy were those who made most positive progress (p. 189). But they also found that people diagnosed as psychotic typically perceive the therapeutic conditions to a lesser degree anyway (p. 190). Again, this may have been due to the 'numbing' effects of medication.

If we accept that the actualising tendency is always in operation and that we are essentially relational, we surely also must accept that these participants were taking part in what they needed and could manage to the best of their abilities. That is not the same as being "unmotivated" – another problem of different language perhaps.

An interesting finding related to motivation and therapy process was the degree and frequency with which psychotic participants embarked on a process of self-exploration (pp. 184-185). Whilst most appeared uninterested in developing self-awareness as compared with other client populations, those that did embark on the process evidenced the most significant increases in depth of self-exploration over the course of therapy. Rogers understood this to mean that they had "entered into "therapy" as we have customarily understood it" (1973, p. 185). So many of these people had never been offered the opportunity for self-exploration and had only ever been receivers of other people's judgements, opinions and actions – often negative or hurtful. The dawning realisation that they had a right to affirm themselves in this way, and to assert their entitlement *to be*, was significant and exciting for Rogers (1973, p. 188).

Rogers' perspective on the importance of the relationship was enhanced because of his work in Wisconsin. His belief that it was the "realness of the therapist in the relationship which is the most important element" (C. R. Rogers, 1973, p. 186) that contributed most to effective therapy was reinforced from his observations of the many different characteristics of those therapists who were successful. He concluded that those who were prepared to be most themselves were likely to work most successfully with their clients.

This point was developed by Gendlin who explored the notion of congruence in relation to his work with the withdrawn and reluctant patients in the Wisconsin study (Gendlin, 1973). He concluded that three aspects of therapist expressivity were an important part of conveying congruence with this client group (pp. 121-124). "Non-imposition" was especially important with these very defensive individuals. Gendlin argued that, although it was important for the therapists to express what was going on for them, they would be best served by trying to limit their remarks to what was going on for them rather than what they were experiencing in relation to the client. This links with the finding that the participants found it difficult sometimes to receive empathy. Secondly, "therapist self-attention" was important to enable the therapists to assess exactly what they were experiencing in any moment and select which aspects of it were important to express, again owning it as theirs, without imposing on the client's process. The third aspect of therapist expressivity was "unmuddied simplicity". When people were struggling to communicate, complex thoughts or concepts could feel overwhelming. Gendlin suggested that, in a session with a withdrawn client, it was best to keep statements brief and clear, whether they were responses to expressions of their own or the client's experience. In this way, he argued, a therapist could initiate and develop a helpful therapeutic encounter.

Gendlin also noted that there can be rich "sub-verbal interaction" that forms part of a developing relationship (1973, pp. 124-128). He gave an example (pp. 127-128) of a patient with whom he would stand in silence for an hour twice a week, saying nothing. If Gendlin tried to initiate conversation, the patient would leave; if not, he would stand for an hour, only rarely offering brief observations about generalities. Eventually, the client started to offer more conversation and Gendlin would wait while he spoke, perhaps responding after a further period of silence. But he made the point that much happens during periods of silence and a client can experience the empathic presence of a therapist without words.

These learnings are not specific techniques for work with this client group. But they may seem to be adaptations of the ways in which a person-centred therapist tries to be with any client. Such an attitude of flexibility has also been argued by Cooper and McLeod in their pluralistic approach (see 2.5.4.1). It does, perhaps, seem reasonable to consider the possibility of adapting what is required when working with particular clients. This might involve a move away from classical client-centred therapy but, as Wilkins has pointed out in a personal communication (July 2016), there is an argument to be made for a range of approaches still to be 'person-centred'.

The promotion of flexibility might extend to the place of theory in therapy. Rogers was always open to the development of theory in the light of changing evidence – "the facts are *always* friendly" (Rogers, 1961, pp. 24, emphasis in original). If, as he argued, therapy is encounter, the theoretical orientation of the therapist is unimportant in the encounter itself. In fact it might even be an encumbrance to the therapist who is trying to remain present (C. R. Rogers, 1973, p. 186). Whilst this is not to argue against the usefulness of holding to a set of values of a particular theory, or of understanding the processes of change in a particular way, it may be advisable to follow Rogers and to

hold theory "tentatively, lightly, flexibly, in a way that is freely open to change…" (C. R. Rogers, 1973, p. 187).

2.5.4 Some recent developments in person-centred theory of relevance to work with people experiencing different realities

2.5.4.1 Pre-therapy – working with "contact-impaired" clients

Prouty and his colleagues understood that, if the first of Rogers' (1957, 1959) conditions was not fulfilled, therapy could not even begin (Prouty et al., 2002). For some people who experience a different reality, have been institutionalised or who are medicated following a diagnosis of mental illness, contact may be problematic. In her description of person-centred work in a psychiatric context, Lisbeth Sommerbeck characterises "psychotic" and "near psychotic" clients as often being withdrawn and out of contact with the world around them (Sommerbeck, 2003, pp. 68-69). She argues that a "non-acknowledgement of the other" is a defining feature of such people who do not want to be understood in the same way as other clients (p. 69). This then has implications for how a therapist can try to learn about, and empathise with, the client's inner frame of reference. In such situations, it is argued that re-establishing contact can be achieved through "contact reflections" of various sorts (Prouty, 1994). For instance, just to state that a client is looking out of the window – a concrete reflection – can be a way of establishing contact that can then be built upon. Turkington et al., (2006) make a similar claim when describing participants who are not able to engage in CBTp.

If clients have been isolated from social contact and relationships for some time, or have deep-rooted traumatic issues they are too fearful to address, deep forms of relating may also be inappropriate, certainly at early stages of therapy. Again, "ordinary" accurate empathic reflections are preferable to "additive" empathy (Sommerbeck, 2014, pp. 163-

164)[12]. Mearns has described similar ideas when he wrote of the difference between "encounter and invasion" in his work with a war veteran, Rick (Mearns & Cooper, 2005, pp. 103-105). Here too, Mearns argued that, particularly when clients appear unable or unwilling to communicate, a therapist must try to assess a client's inner frame of reference accurately to ensure she is offering appropriate levels of empathy while remaining congruent.

Given my own view that effective therapists gauge their empathy appropriately with all clients, I am not sure it needs to be separated off as an additional technique. Nevertheless, some practitioners find it helps them develop relationships with clients who are difficult to reach.

2.5.4.2   *Person-centred work with victims of trauma*

Although the research questions of this study did not seek to explore the relationship between trauma and HV and I did not specifically ask participants about their experiences of it, the strong association found elsewhere between adverse events (see 1.5.4), trauma and HV warrants a brief mention of the person-centred theoretical position here. It also became apparent over the course of therapy that several participants had, indeed, suffered such events in their lives, even if they did not, at least initially, associate them with their HV experiences.

Stephen Joseph and his colleagues have carried out extensive study on person-centred ways of working with victims of trauma (Carrick & Joseph, 2013; S. Joseph, 2004; Joseph, 2005, 2015; Joseph & Linley, 2006; Joseph & Murphy, 2013), arguing that person-centred therapists have often worked with such clients and Rogers, in fact, wrote of his work with traumatised combat veterans (C. R. Rogers, 1942). Person-centred

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[12] This may, perhaps, have been an issue in the Wisconsin study (C. R. Rogers et al., 1967) as Gendlin reported in 2.5.3.

therapy is not, however, commonly considered for use with people diagnosed with post-traumatic stress disorder (PTSD), the commonly accepted diagnosis given to people suffering in this way (Carrick & Joseph, 2013; S. Joseph, 2004; Joseph, 2005).

In line with Rogers' theory (1951), ideas about self-structure are threatened when something happens that does not 'fit' with a person's ideas about herself and her world. This may cause person to hold ever more tightly to that self-structure. When the circumstances become too extreme, the self-structure is broken down and distress is experienced. An example of this would be a child who is abused by a loved family member who, the child would reasonably expect, should protect her from harm. Apart from the obvious distress caused by the events themselves, such trauma and confusion challenge utterly the child's view of herself and her world, and the resulting effects can often be shattering, as also noted by Janoff-Bulman (1989). Afterwards, according to Rogers' theory, the person oscillates between trying to avoid thoughts of such terrifying and confusing events, and trying to make sense of it so that it can be integrated into future ideas about self, others and the world.

Such avoidance-approach behaviours are similar to those often described in other models of post-traumatic stress (Horowitz, 1986) and commonly used therapeutic approaches attempt to help people by gradually exposing them to the traumatic experiences so they can come to terms with, and integrate them (e.g. Herman, 1992).

Joseph claims two differences from other approaches which suggest person-centred therapy might offer benefits to traumatised individuals. First, that the client sets the pace of therapy, which relieves any pressure they may feel to address difficult issues before they are truly ready. Second, that the theorised operation of the actualising tendency means that recovery can involve "post-traumatic growth" (PTG) (Tedeschi & Calhoun, 1995), where a person becomes more fully functioning than they were before (S.

Joseph, 2004; Joseph, 2005, 2015; Joseph & Linley, 2006). It is important to note, however, that such a position does not imply that the occurrence of the trauma was a 'good thing'. But, if, because of such a trauma, a person needs to reassess their self-concept so fundamentally, it may enable them to 'rebuild' in a way that facilitates reflection on previously held conditions of worth and to decide what holds relevance for them going forward. Movement towards a more internal locus of evaluation may result through a closer match between self and experiencing. CBT work on schema also focuses on this (Janoff-Bulman, 1989).

Joseph makes the point that such PTG does not always occur and that some people recover to the point at which they were before. This reflects themes in research discussed earlier (1.7; 1.9) such as "turning towards/empowerment" or "turning away/protective hibernation" (de Jager et al., 2016); and "recover from" or "recover in" (Larry Davidson & Roe, 2007) which suggest that recovery can take different forms.

2.5.4.3   *Pluralistic perspective*

Cooper and McLeod propose that "the person-centred world view" assumes that "each individual is distinct" so that a therapist must try to facilitate each client's unique actualisation "in the way that best suits the individual client" (2011a, p. 213). Different clients are likely, therefore, to want and need different things from their therapy, as suggested by Bohart and Tallman (2010a, p. 121). McLeod also notes that "aptitudes" for different therapies vary across clients (2013, p. 52).

Such a perspective creates the opportunities to offer techniques, such as Socratic questioning as used in CBT (Cooper & McLeod, 2011a, p. 214), as required by the client, as long as they are operating from within the client's frame of reference. To achieve an understanding of what is required from each client, the strategies of goal

setting and collaboration are suggested, in common with other therapeutic approaches discussed here (see 2.4).

This flexibility might, logically, be of relevance when working with clients who experience a different reality or who have unusual experiences, where vulnerabilities may be idiosyncratic. This is noted in research into subjective accounts of the experiences of therapy explored in 3.2 (Levitt, Pomerville, & Surace, 2016).

2.5.4.4   *Schmid – alienation and inauthenticity*

Schmid contends that distress is related to alienation from self through the tension of living inauthentically, but in such a way that it complies with prevalent societal mores. In current Western society where HV is considered so negatively and as a disorder, it makes sense that a person would find it difficult to accept the experience without negative judgement – and hence, alienation from themselves. To comply with the force of social mediation and their self-concept, they might try to deny, distort, or externalise the experience. When this inauthenticity becomes too difficult to sustain, distress might occur. Further distress may be present due to alienation from those who do not share the voice hearer's reality. The problem lies in internalised societal ideas about what is acceptable. A dilemma is faced about whether to live authentically and accept that aspect of experience, but run the risk of becoming isolated and ostracised, or to live inauthentically and deny self or experiencing. As Schmid points out, inauthenticity

> differs qualitatively from the common meaning of illness or disorder. What is experienced from an internal frame of reference as 'psychological suffering' is seen from an external point of view as alienation or maladjustment. If it is called 'disorder', one must permanently keep in mind that the order is also a cultural norm. (2004, p. 34)

The notion that disorders are historically and culturally specific is supported by evidence discussed in 1.4.

2.5.4.5   Warner – the drive to continue processing

Warner proposes that trying to make sense of things and trying to find meaning in experience are universal qualities of what it is to be human (Warner, 2005, 2013, 2014) and that this is an embodied, contextualised experience (Gendlin, 1964, 1968, 1995) that changes the nature and meaning of experience. These writers agree with Dennett (1987) and Baron-Cohen (1995) that human beings seek to discover meaning in all situations through attributing intention, wishes, beliefs and emotions to even the simplest of events. Warner adopts the term "processing" to encapsulate this. When things happen to people that mean they find it difficult to understand their experience, perhaps because it is unusual for their culture or because it is reminiscent of previous trauma or struggle, it is understandable that distress and/or confusion is the result. When other people around them are also disconcerted by what is regarded as odd behaviour, that distress and confusion is exacerbated and people can end up feeling alienated from the world they live in and the people they come across (see 2.5.4.1). This process conception fits with Rogers' ideas about self as a process of becoming rather than as a fixed entity, and with the notion of actualisation as a mechanism for optimisation of the organism (C. R. Rogers, 1961).

Ideas about difficulties in processing offer a framework of understanding for the reasons why things that happen to us affect the ways we are and what our potential for change might be. The notion of processing also reinforces ideas about agency through its reliance on the actualising process which proposes that the client finds the optimal way of coping all the time. Even if a VH is struggling to cope and wants someone to help make her better, person-centred therapy still follows her lead about how best to help or understand such that she remains at the centre of decisions. To that extent then, the VH is respected as someone still trying to exert control over, or make sense of, their

difficulties and as someone who needs support not management. She is still using her potential despite her dis-ease and she retains her sense of agency.

Although Warner proposes reasons for the development of different forms of what she calls "difficult process"[13] (2007, 2014), she does not mention but those specifically responsible for HV and they are, perhaps, not necessary to know. As therapists, we might find theoretical information – at whatever level we choose to seek it – enables us to be more aware of what a client is likely to be going through. This, in turn, should free us up to be more fully present. In theory, we should then be able respond more accurately to each client's likely situation. In a personal communication (September 2008), Margaret Warner stressed that such theory is meant only as an aid to empathy and that, if a therapist feels it hinders the process of therapy, she is best advised to dispense with it.

There is an argument that a lack of familiarity with background literature (for instance, about the relationship between trauma and psychosis) may mean a therapist could miss relevant clues for help or warning signs that a client is becoming even more vulnerable. My fear, however, is that such 'technical' or 'academic' knowledge may act as a hindrance to being present for any individual client (who is, indeed, unique). Just because 'many' people tend to behave in a certain way, or have certain ways of being, or might have had certain things happening to them in their lives, does not mean that any individual client at that moment will be that way or have had those experiences. Such knowledge can only take us away from trying to grasp that client's unique way of being, and what they may want from therapy. We then run the risk of starting to classify

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[13] Space does not permit examination of these ideas but they include 'fragile', 'dissociated', psychotic, 'metaphact' process and are discussed in (Warner, 2013, 2014).

behaviour and accepting the "specificity myth" (Shanks Glauser & Bozarth, 2001) of assuming there are specific treatments for specific problems.

We might also fall into the trap of believing that there are behaviours or ways of being that are normal and abnormal. If we can, instead, accept that experience lies along a continuum and is not, necessarily problematic, (Johns & van Os, 2001; Van Os, Hanssen, Bijl, & Ravelli, 2000; Verdoux & van Os, 2002), any incidence of distress need not be attributed to a problem in the individual; it is perhaps more likely to have been internalised from public attitudes because the particular behaviour – e.g. HV - is unacceptable or inconsistent with the culture or society the person lives in.

2.5.4.6 *Summary of new developments*

In the current study, these concepts have relevance in two ways. First, they acknowledge the impact and importance of listening to VHs' own accounts of their own experiences, recounted in their own ways. Second, there is an explicit acknowledgement of the open attitude of the therapist who does not need to place herself in the role of expert in the VHs' experiences. It offers the potential for a respectful, emancipatory and participatory encounter.

Members of this client group have typically been treated as patients, with many assumptions made about their conditions, what they 'must' be feeling or what they 'must' want to happen if they are to 'feel better'. In person-centred therapy those assumptions are non-existent or, at least, "bridled" (Dahlberg, 2006, p. 16) in a respectful attempt to facilitate dialogue and depth of relating (if required by the client).

Such attitudes are redolent of the more emancipatory methods of helping such as those advanced by the HVM and more recent forms of CBTp, as well as participatory

approaches to research advocated by service user and experts-by experience

organisations (see 1.5.7; 1.7; 2.4.1; 2.4.4; 2.4.6; 4.2.3).

2.5.5   Recent research into person-centred therapy

There is evidence to support person-centred principles being applicable to therapeutic

work with VHs (see 2.4), but person-centred therapy itself is rarely offered; lacking an

'approved' evidence base (Cooper, 2008; Cooper, Watson, & Hölldampf, 2010), it is

not a recommended intervention (NICE, 2014).

Until very recently, person-centred practitioners appeared wary of conducting the type

of research on person-centred therapy as required by policy and funding bodies: that is,

randomised controlled trials (RCTs) (Cooper, 2008, 2011; Cooper et al., 2010; Lietaer,

1990). Ironically, the person-centred approach was first developed by Carl Rogers who

embraced positivist research and attempted himself to isolate the elements of successful

(and unsuccessful) therapy using mechanistic and quantitative methods. Not only that,

but much of his early work was with clients with a psychiatric diagnosis.

There is evidence, however, of an increase in attempts to measure the effectiveness of

person-centred therapy (Cooper, 2008; Cooper et al., 2010; Elliott, 2013; Wilkins, 2016,

pp. 271-280). There are also calls for more such research to be done (Cooper, 2011;

Cooper, O'Hara, Schmid, & Bohart, 2013a, pp. 6-12; Cooper et al., 2010, p. 240; Elliott,

2013). Robert Elliott and colleagues have conducted a series of meta-analyses to

evaluate the effectiveness of person-centred and other related therapies (most recently,

Elliott, Watson, Greenberg, Timulák, & Freire, 2013), looking at practice with a variety

of client groups. Person-centred therapy specifically is not reviewed, is often used in

manualised form as a control and is classified together with other

humanistic/experiential therapies.

This feels problematic in some ways. First, it highlights the lack of research into person-centred therapy and implies hesitancy to test the approach itself, even though some of its principles and practices are used by others. Second, the assessment of results from studies that use 'person-centred therapy' in a manualised form does not, I would argue, offer a realistic representation of its practice[14] which relies on moment-to-moment responses in the encounter. In some trials, it may also be the case that the practitioners are not trained in, and do not have an affinity with, the person-centred approach. Third, whilst acknowledging the claim that there are a number of different "tribes" within the "person-centred nation" (Sanders, 2004), all of which conform to person-centred principles, even though their practice might not be client-centred therapy in the 'classical' sense (Wilkins, 2016, p. 8), the differences sometimes seem so great that I wonder if a meta-analysis can deliver meaningful answers about what constitutes 'effective person-centred therapy'. Process-experiential therapy, for example, contains within it an explicit element of directing the process of therapy, though not the content (Sachse, 1990, 2004), which is claimed to be consistent with one of the principles of therapeutic change suggested by Castonguay and Beutler (2006, p. 361). That is very different from the approach I adopt in my own practice (discussed in 6.1.1)

Elliott (2013) offers suggestions for further research claiming there is a need to "render unto Caesar" (p. 475) the studies required in order to ensure person-centred approaches are considered by policy-makers (see 4.2).

Timulák and Creaner (2010) conducted a meta-analysis of outcome studies using qualitative methods to investigate participants' qualitative self-reports of the effects and changes experienced after taking part in humanistic therapies. Rather than seeking to measure effectiveness, this analysis yielded a series of categories that can be

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[14] This would be true also of any manualised therapy tested under experimental conditions.

incorporated under the broad headings of i) appreciating experiences of self; ii) appreciating experiences of self in relation to others; iii) changed view of self/others; and iv) negative findings. Timulák and Creaner note that, although some of the findings might appear "negative", growth may also be suggested in some ways. For instance, finding the process of exploring painful issues difficult was also reported by participants to be part of what needed to happen for change to take place.

There have also been systematic attempts to identify helpful and "hindering" (Grafanaki & McLeod, 1999) aspects of person-centred and experiential therapy, using analysis of transcripts of the therapy sessions combined with the recall of client and therapist (Elliott, 1985), or questionnaires asking clients to identify the most helpful events of their sessions (Timulák & Lietaer, 2001).

Helpful aspects identified by Timulák and Lietaer as most frequently reported, "were associated with empowerment, safety and insight" (2001, p. 62) and themes included aspects of the therapeutic relationship as well as the value of exploring personal meaning in a non-judgemental setting where clients felt understood. These findings were supported in a meta-analysis (Timulák, 2007) which suggested nine key categories of helpful events –

> (a) awareness/insight/self-understanding; (b) behavioral *[sic]* change/problem solution; (c) empowerment; (d) relief; (e) exploring feelings/emotional experiencing; (f) feeling understood; (g) client involvement; (h) reassurance/support/safety; and (i) personal contact. (p. 314)

These categories reflect the findings discussed in 1.7; 3.1; 3.2 and 4.2.3, from subjective accounts from experts-by-experience about what helps them manage their distress.

The general findings from the analyses reported in this section also link to other research into experiences of HV and therapy discussed in 1.7;1.9; 3.1; 3.2 and 4.2.3, where the opportunity to explore personal meaning and make sense of confusing

experiences have similar outcomes. They add support to the premise that person-centred

therapy might be a useful option for VHs.

Although there appears to be a variety of research taking place into the person-centred

approach, little is from within psychiatric settings in the UK and none is specifically

with HV.

Chapter 3

3 SUBJECTIVE ACCOUNTS OF HEARING VOICES AND OF DOING PSYCHOTHERAPY

3.1 Qualitative research on the experience of hearing voices

Subjective accounts from VHs can tell us what it is like to be a VH as well as reporting on the voices themselves. Sources include the bibliography compiled and maintained by Hornstein (2005) which contains over 300 first person accounts of madness dating back to the 15th century, books that tell individual stories, and articles in journals such as Schizophrenia Bulletin (Geekie, 2007).

I will focus here on peer reviewed research that has asked VH to describe their experiences of HV in the same way as I have done in this study.

Geekie (2007) studied the experiences of psychosis as expressed in therapy sessions by 15 clients of a First episode of Psychosis service in New Zealand. He demonstrated the breadth and complexity of the experience of psychosis, and proposed that it could be encapsulated within three constructs, the first two of which imply a continuum of experience. The constructs were: "fragmentation-integration" - at the negative "fragmentation" end there was a loosening and disintegrating, suggesting disorder and "fragmentation"; the more positive "integration" implied order and greater well-being through integration of experience; "invalidation-validation" - negative "invalidation" related to an inability to trust or convey the meaning of experience and an undermining of personal interpretation or judgement by others; more positive "validation" implied support or confirmation of one's perspective by others and by self; "spirituality" - this was not a continuum but incorporated a broad range of meanings depending on the

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individual's worldview; it included spiritual matters but also related to how individuals positioned themselves within their lifeworlds.

Geekie acknowledged the articulate and lucid ways in which his participants offered their accounts (2007) which, he suggested, indicated a search for the personal significance of these strange parts of people's lives. He argued that this contradicted the assumption that such participants struggle to communicate in a meaningful way (see 1.7.2) and that such dismissive attitudes might contribute to feelings of "invalidation", an effect found in other studies (e.g. Barham & Hayward, 1991; Beavan & Read, 2010).

The perspective advocated by the HVM (Corstens et al., 2014) also stresses the importance of considering individual frames of reference and implies that it is not a homogeneous experience. Holt and Tickle (2014, p. 292) noted the diversity of perceptions of the experience in their meta-synthesis of seven studies of subjective experiences of HV. They identified five themes: identity of the voice(s), power of the voice(s), impact of hearing voices on relationships, relationship with the voice(s), and the distinction between thoughts and voices. These themes support the view that the experience has meaning (Romme & Escher, 2000), which varies according to how the voices are interpreted by the hearer as much as by the content (Birchwood et al., 2004; Morrison et al., 2004). VH are very often in some sort of relationship with their voices – positive or distressing (e.g. Chin, Hayward, & Drinnan, 2009), which vary across VH and sometimes across time (e.g. Milligan et al., 2013).

The voices that people hear were perceived as powerful to varying degrees (Holt & Tickle, 2014). Often the extent of the power was closely linked to the ways VH felt about their own power or self-worth (Chin et al., 2009; Fenekou & Georgaca, 2010; Karlsson, 2008; Mawson, Berry, Murray, & Hayward, 2011), with those who explained voices in a biomedical or spiritual way feeling passive in the face of the power of those

forces (S. Jones et al., 2003). Sometimes VH experienced a "'battle' for control" (Mawson et al., 2011, p. 264) or that it was "Me vs. the voices" (Chin et al., 2009, p. 8), a struggle from which there was often no escape. In these cases, voices retained their power over participants with critical, commanding, demeaning or abusive content (Beavan & Read, 2010; Holt & Tickle, 2014, pp. 288-289). This may have added to VHs' senses of invalidation or fragmentation (Geekie, 2007). If voices were regarded more positively, VH were more likely to interact with them which reinforced their own senses of power and agency (L. J. Jackson et al., 2010).

Many VH do not come into contact with psychiatric services and have positive experiences of HV or cope well with it (Beavan et al., 2011; Holt & Tickle, 2014). Even when VH sought medical help, they have had positive experiences. For instance, some of Geekie's participants described an increased understanding of themselves and the world through HV (2007). Voices have been regarded as offering guidance, encouragement and advice (Beavan & Read, 2010) and Jackson et al., (2010) found that VH who believed their voices had a spiritual component compatible with their own, were more likely to regard it as a life enhancing experience. When voices were perceived negatively and as powerful, however, there was a loss of faith in self and judgement, lack of confidence, a sense of discontinuity with the world (Geekie, 2007, p. 248; Mawson et al., 2011). This was often compounded by negative voice content and negative reactions from other people (Geekie, 2007, pp. 252-253) which had an impact on VHs' abilities to live a normal life and maintain relationships (Karlsson, 2008; Mawson et al., 2011).

Even though VH 'knew' their voices were not real, they very often felt that they were (Beavan, 2011). Most studies in the Holt and Tickle (2014) meta-analysis reported that voices had particular identities and were perceived as those of people participants knew

and who had significance in their lives (Chin et al., 2009; L. J. Jackson et al., 2010; Mawson et al., 2011), but not always (Beavan, 2011). The strong association between HV and childhood sexual abuse, with the consequent frequency of VH hearing the voices of their abusers, is an example of this (Read et al., 2016; Sampson & Read, 2017).

Several studies mentioned that participants used creative strategies to cope with or manage their voices, with some success (Chin et al., 2009; Fenekou & Georgaca, 2010; L. J. Jackson et al., 2010; Mawson et al., 2011). These strategies included negotiating boundaries with voices, self-assertion and distraction (Holt & Tickle, 2014, p. 289). Relating with voices was found to increase the potential for integration and positive relationships, sometimes even resulting in VH becoming 'friendly' with their voices (Chin et al., 2009), especially where voices were perceived to represent a compatible spiritual force (L. J. Jackson et al., 2010). This could alleviate the loneliness many voice hearers experienced (Chin et al., 2009), sometimes because of the rejection or avoidance they experienced from other people (Karlsson, 2008; Mawson et al., 2011).

Romme and Escher (2000) proposed that, if a non-pathological approach was adopted, the HV experience moved through three stages: "startled", where people felt shock or anxiety and were often overwhelmed by HV; "organisation", when people tried to find strategies to manage and negotiate with their voices; and "stabilisation", where VHs integrated their voices into their lives, or even recognised them as parts of themselves and recovered a sense of being in control. This could occur within or outside a formal therapy context.

Milligan et al., also suggested that VH was "an experiential journey" (2013, p. 107) which often began with "negative triggers" which were rejected by the VH. They found that "crisis-induced change" resulted in VH trying to find ways of managing and

understanding the experience drawing on resources from self, others and services. If

voice content had become negative this process would be difficult and unsuccesful,

sometimes meaning continued attempts to reject the voices. When the experience was

understood or regarded positively, new understandings were usually also positive,

although integration and acceptance were still difficult.

Considering HV as an intensely personal and meaningful experience, has implications

for working with people who are so distressed or disturbed by the experience that they

seek medical help. This contrasts with a medical perspective, which reduces psychotic

experience to a meaningless, pathological phenomenon. Apart from such dismissal

being inaccurate, unhelpful and distressing, (Beavan, 2011; Beavan & Read, 2010;

Beavan et al., 2011; Dillon, 2012; Geekie & Read, 2009; Romme et al., 2009), the

failure to explore an individual's perspective may mean that information which may

help alleviate distress is ignored or missed (Beavan & Read, 2010; Read et al., 2008).

A non-medical view of HV also has implications for the ways the experience is

construed by members of the public, medical professionals and by VHs themselves. The

common association of HV with madness brings with it stigmatising and negative

attitudes which mean VHs can be afraid to share their experiences with others (Beavan

& Read, 2010; Beavan et al., 2011; Read & Haslam, 2004). (see also 1.7).

3.2 Qualitative research on client experiences of psychotherapy

Qualitative research that investigates client accounts of experience can offer useful

insights into what helps or hinders successful therapy. Therapists can use this

knowledge to refine their practice and help determine whether different processes or

therapies are of relevance to specific client groups (Roth & Fonagy, 2005), whether

various common factors (Duncan, Miller, Wampold, & Hubble, 2010) operate in the

same way in different therapeutic modalities (Levitt & Williams, 2010) or even the extent to which therapy plays a part in any change (Stiles, 2013, p. 39). This may offer additional understandings of findings from quantitative therapy research which, in turn, may influence how those studies are designed and carried out.

Despite evidence suggesting that client factors account for most of the change in therapy (40%, Asay & Lambert, 1999; 87%, Wampold, 2001), it is only in recent years that there has been more direct exploration of what clients tell us about their subjective experiences of therapy (Bohart & Tallman, 2010b) as opposed to measuring the success or otherwise of different therapeutic approaches, often according to criteria set by researchers rather than by service users.

Levitt et al., (Levitt et al., 2016) conducted a meta-analysis of over 100 peer-reviewed articles that explored subjective experiences of therapy across a range of therapeutic modalities, humanistic/experiential, psychodynamic and cognitive/behavioural being researched most frequently. Studies originated from a range of countries within Europe and elsewhere, with most from the UK and US. Diagnoses and severity of problems were not typically reported across individual articles so Levitt et al., presume findings represented a range of issues and concerns. Although they mention inclusion of two studies that focus on "more severe mental illness" (p. 822), these were eating disorders and self-harm; they also report that three studies were excluded as they focused on "treatments for psychosis" (p. 804) but do not explain what those treatments were or why they were excluded. The only study, therefore, that is connected with psychosis is a discourse analysis of the experiences of CBT in five participants experiencing psychosis by Messari and Hallam (2003).

There is, however, a recent meta-synthesis of six qualitative studies[15] that researched participants' accounts of undertaking CBTp (Wood et al., 2015), and which identified themes within three areas: therapeutic alliance; facilitating change; and challenges of applying CBTp. It is interesting to note that the factors important to participants in these studies resemble those identified by participants in Levitt et al., (2016) and other research (e.g. B. Morris, 2005).

Using a combination of grounded theory and content analysis, Levitt et al., identified five clusters of experience that were encapsulated under one core category that stated:

> Being Known and Cared for Supports Clients' Ability to Agentically Recognize Obstructive Experiential Patterns and Address Unmet Vulnerable Needs (*sic*) (Levitt et al., 2016, p. 817)

The therapeutic alliance seemed to have a major influence on the process of therapy in all studies, Levitt et al., (2016) reporting the importance of a caring, understanding and accepting therapist. These qualities were also noted by participants experiencing psychosis but, additionally, they stressed a need for therapists to be able to tolerate the client's distress, perhaps acknowledging the extreme nature of some of their experiences (Wood et al., 2015). These qualities translated into establishing a relationship based on trust, partnership and collaboration, where control was shared (Kilbride et al., 2013) and which enabled participants to internalise positive messages and undertake joint exploration (Göstas, Wiberg, Neander, & Kjellin, 2013, p. 351; Lilliengren & Werbart, 2005, p. 331), thus developing self-esteem in a safe environment (Wood et al., 2015).

A negative therapeutic alliance was regarded as a significant hindrance (Levitt et al., 2016; Lilliengren & Werbart, 2005; B. Morris, 2005; Nilsson, Svensson, Sandell, & Clinton, 2007). For instance, with participants experiencing psychosis, it could restrict the exploration of difficult personal issues (Wood et al., 2015). Messari and Hallam

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[15] Including the Messari and Hallam (2003) study mentioned above

(2003) refer to Padesky (1993) who argued for genuine openness and the spirit of exploration on the part of a therapist, and that guided discovery should not constitute a therapist asking questions with the aim of changing a client's mind. This may be a particularly important aspect of the therapeutic alliance for those clients who have unusual experiences, as it can offer a respectful acknowledgement of their different perceptions of reality.

The active process of shared learning in CBTp (Kilbride et al., 2013) offered a structure within which personal understanding could be improved, taking into account individual circumstances and needs (Wood et al., 2015). This is similar to the initiating factor of the curiosity of an agentic client identified by Levitt et al., (2016) which led to participants identifying the issues, vulnerabilities and unmet needs that were causing problems in their lives. The active process of exploration and shared learning which then often followed (Lilliengren & Werbart, 2005, p. 331) resulted in their making discoveries (Levitt et al., 2016; B. Morris, 2005) and being able to increase their participation in their "life contexts" (Göstas, Wiberg, & Kjellin, 2012).

The opportunity to attend to and talk about oneself was often a new or unusual experience for many participants in several studies, as was the realisation that another person was fully attending to them for the duration of the session (Göstas et al., 2013; Levitt et al., 2016; Lilliengren & Werbart, 2005; B. Morris, 2005). The credibility and clarity of the boundaried therapeutic relationship and sessions could enhance feelings of security; but were sometimes perceived as signifying a lack of personal caring on the part of the therapist. (Levitt et al., 2016, p. 821). These factors were not mentioned explicitly in the studies of CBTp.

The work of therapy was often described as hard, with participants experiencing psychosis (e.g. Kilbride et al., 2013) and other issues (e.g. Göstas et al., 2013), and the

unique context that enabled it to happen was noted (Göstas et al., 2013; Lilliengren & Werbart, 2005; B. Morris, 2005). Often participants who were satisfied with therapy overall believed that the pain and struggle had been worth it (Timulák & Creaner, 2010). But sometimes it was felt to be too difficult, the results not regarded as helpful (Lilliengren & Werbart, 2005, p. 332; B. Morris, 2005, pp. 38-39), or clients were left feeling vulnerable because issues had been unresolved (B. Morris, 2005). This was a particular feature of undertaking CBTp for people experiencing psychosis, where the process was described as unexpectedly active, emotionally challenging and hard work (Kilbride et al., 2013; Wood et al., 2015). Participants stressed it could only be done when the time was right (Wood et al., 2015).

Sometimes participants were dissatisfied or disappointed with therapy because they experienced 'a mis-match' with the type of therapy offered. Lilliengren and Werbart found that people who were disappointed with psychoanalytic therapy would have preferred more active help or direction in solving their problems (2005, p. 332). Nilsson et al., (2007) found that those dissatisfied with CBT would have welcomed more opportunity for self-exploration and those dissatisfied with psychodynamic therapy would have welcomed more guidance or practical help in managing their problems.

Morris pointed out, however, that the experience of being disappointed or dissatisfied with therapy could be more nuanced with some participants feeling dissatisfied overall although they had experienced some benefits (B. Morris, 2005).

This may support Levitt et al.'s contention (2016) that therapists should offer flexibility of approach within the boundaried therapeutic setting so that individual needs can be recognised and attended to. A lack of sufficient flexibility or attunement also resulted in some participants feeling vulnerable if issues had been left unresolved after they had

taken the risk of exploring painful events or problems (Lilliengren & Werbart, 2005; B. Morris, 2005; A. Rogers & Pilgrim, 1993, p. 625).

Wood et al., highlighted the personal and idiosyncratic nature of change, especially in relation to coping strategies necessary for specific social contexts. In the case of those experiencing psychosis, this included accepting that recovery may involve a continuation of their unusual experiences (Kilbride et al., 2013; Wood et al., 2015). The personal nature of post-therapy change was not stressed to the same degree by Levitt et al., although personal and inter-personal goals, needs and a sense of agency were mentioned in several of their thematic clusters which possibly relate to individual circumstances.

These consistent qualitative findings from various therapeutic approaches with a broad range of clients, including those experiencing psychosis, are in accordance with the notion of client as active self-healer and Rogers' understanding of the relationship in person-centred theory (Bohart, 2008; Bohart & Tallman, 1996, 1999; C. R. Rogers, 1961). Other qualitative meta-analyses into person-centred and experiential therapies reported similar findings as discussed in 2.5.4 (see Timulák, 2007; Timulák & Creaner, 2010; Timulák & McElvaney, 2013).

This research will be discussed in relation to findings from this study in chapter 13.

Chapter 4

4 ISSUES CONCERNING TALKING THERAPY

The literature above generates questions about the process of therapy and about how it is researched. This chapter will discuss some of these questions in the light of the current study. Issues concerning the process of therapy include the therapeutic alliance and the place of the client within that. I will also consider the extent to which therapy can cause harm or perpetuates the problems it sets out to help.

I will then turn to issues around the way therapy is researched. I will consider the extent to which RCTs can answer questions of importance about therapy, and what success criteria might have meaning. I will also note the increasing impact and involvement of experts-by-experience in researching unusual experiences and what may help people manage them.

4.1 Issues concerning process of therapy

4.1.1 Therapeutic alliance

Hornstein (2011, September, pp. 4-5) has identified four elements that she says are crucial in helping people recover from debilitating distress.

> Being listened to
> Being believed
> Having an empathic witness to their suffering
> Being seen by at least one key person as capable of becoming fully well

Her work with HVN peer support groups and her studies of first person testimony are supported elsewhere (Bentall, 2009; Dillon & Hornstein, 2013; Romme et al., 2009). Her approach is also in line with Common Factors theory (Duncan et al., 2010), other research into therapy (Norcross, 2011) and person-centred therapy (Cooper et al., 2013a). This evidence suggests that tools and techniques play a much smaller part in

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clients' perceptions of therapeutic effectiveness than anticipated (Asay & Lambert,

1999; Lambert, 1992; Lambert & Barley, 2001).

While this might suggest that specific techniques may be unnecessary, evidence from

subjective accounts of therapy ((Kilbride et al., 2013; Levitt et al., 2016; Wood et al.,

2015) shows that techniques and structure will be found useful by some (see 2.4 and

Pluralistic perspective, 2.5.4.3). The important thing is that they are used from an

empathic position in full collaboration with the client (P. Chadwick, 2006; Cooper &

McLeod, 2007, 2011b; Johnstone & Dallos, 2014; Kilbride et al., 2013; McLeod, 2013;

Wood et al., 2015). More work needs to be done to define the exact features and

qualities of a 'good' therapeutic alliance and the impact they have on the therapy

process, for different clients with different issues.

4.1.2   Client as active self-healer

The role of the client as knowing best has been a fundamental element of the person-

centred approach to therapy. Other research has also identified the client as the

singlemost important predictor of therapeutic change (Asay & Lambert, 1999; Duncan

et al., 2010; Lambert, 1992; Lambert & Barley, 2001; Lambert & Bergin, 1992;

Norcross, 2011). Bohart describes this process as "the client as active self-healer"

(Bohart, 2013; Bohart & Tallman, 2010a, 2010b), arguing that a therapist's techniques

and qualities are of limited effectiveness if the client is not actively engaged in the

process of wanting change and being able to do the work necessary to bring it about. He

also argues that the therapeutic alliance is the primary facilitator of the client feeling

able to play this part in what goes on in therapy sessions, and outside of them (Bohart,

2013; Bohart & Tallman, 2010a, 2010b).

For Rogers, an addition to the common acknowledgement of the importance of

understanding and a non-judgemental attitude, was the need for a therapist to remain

genuine as a person in the relationship as well. Other modalities might not place the same emphasis on such transparency. In the person-centred approach, however, it is assumed that the client heals themselves through the therapeutic relationship that the therapist helps to facilitate. As Rogers notes (1961, p. 32),

> In my early professional years, I was asking the question: "How can I treat, or cure, or change this person?" Now I would phrase the question in this way: "How can I provide a relationship which this person may use for his own personal growth?"

Considering evidence implicating the client as agent, and from a Common factors perspective, Duncan goes so far as to say

> Clients are the true heroes and heroines of the therapeutic stage. Miscasting therapists as the stars has only served to disconnect them from the local knowledge, strengths, and expertise of their clients, factors that far outweigh any model or technique…. When cases are discussed without clients' voices, when supervision occurs from the supervisor's perspective, when the DSM is read without eye contact with the person being described, the client is depersonalised—becomes a cardboard cut-out—and only suits the purposes of the therapist/supervisor/author. With the addition of the client's voice, the client emerges as a thinking, deciding agent whose deliberations about his or her life and the best course of action are reasonable and well executed, a part of a never-ending story with many possible conclusions. (Duncan, 2002, p. 50)

The "depersonalisation" of which Duncan speaks has been found in evidence discussed in 1.7 and 4.2.3 that explores personal accounts of people who suffer mental distress. It might contribute to the ways experts, and clients themselves, position the latter as inferior and unable to contribute meaningful input to their recovery plans.

4.1.3   Evidence of harm

Although Bentall (2009) concludes that most evidence suggests that therapy is helpful, it must be acknowledged that it can also cause harm (Goldsmith, Lewis, Dunn, & Bentall, 2015; Jarrett, 2008).

Most worryingly, is that therapists can be perceived as powerful by clients and do indeed control the rules of engagement in respect of timing, location, frequency and so

on (Proctor, 2002, 2010). There is therefore the potential for therapists to abuse that power, in the process harming their clients unwittingly (or even intentionally). Issues of power in therapy are addressed further in 8.5 but the power of the process of therapy must not be underestimated and therapists have a duty of care to the vulnerable clients they engage with.

Some people in florid or acute psychotic states may feel distracted or overwhelmed by the voices they hear, or by other intense emotions. If they have been institutionalised they may also be unused to making decisions or exercising agency. In these cases, there is an argument that people are unable to cope with therapy (Turkington et al., 2006, p. 370). A non-directive therapy may be particularly frightening in a world that is already lacking in boundaries or structure. A directive or task driven approach may be more manageable and also help anchor clients (van Werde, 1998) to a consensual reality. A different view is held by Warner (2013, pp. 344-345), whose experience with clients who experience difficult process leads her to conclude that such clients prefer the freedom to engage as they choose in a safe environment without needing to adhere to a structure.

Thirdly, Jones, (2002) describes how, in the 20th century, searches for the cause of schizophrenia were much informed by psychoanalytic and behavioural thinking that had an idealised view of families, such that failures to attain that ideal might lead to members developing mental illness (Hatfield & Lefley, 1987). Despite a lack of evidence (Hirsch & Leff, 1975), such assumptions were widely taken up, including by Laing from an anti-psychiatry stance (Laing, 1960; Laing & Esterson, 1970).

4.1.4   Part of the problem?

Masson (1989) critiques therapy as an exercise in power on the part of 'Therapy', while Smail (2005) views therapies as blaming and pathologising, arguing that this leads to

people's voices being effectively silenced as unworthy and of no value. This then perpetuates the positioning of vulnerable people as inferior or deficient and, in individualising distress, the onus for change rests with the individual with no consideration of social context or circumstances (see 1.9). This attitude could be viewed as Western- centric (Pilgrim, 2008b), which may be at odds with cultures that have a more communitarian approach such that therapy has no relevance to people from those cultures.

Individualising distress may also mean that society can abdicate its responsibility for mental health because it will not need to take account of poverty, racism or other forms of oppression (Smail, 2005), all of which have been shown to be associated with psychotic experiences (e.g. S. Hansen, McHoul, & Rapley, 2003; Lewis et al., 1992; Read, 2004; Read & Haslam, 2004; Singh et al., 2007; P. Thomas, 2014; Varese et al., 2012) (see also 1.5.4 and 1.9).

The changes advocated by the BPS report (Cooke, 2014) regarding service user perspectives (e.g. Repper & Perkins, 2009) and by more inclusive approaches to therapy (e.g. Longden et al., 2013), do not fully address the implicit power differential in a therapy relationship (Proctor, 2002) and the potential harm posed by 'Big-Psy'[16] (S. Hansen et al., 2003; Masson, 1989; Proctor, 2006; Smail, 2001b). But seeking a voice hearer's perspective, rather than making automatic assumptions about what is wrong and what needs to be done to correct the deficit, might go some way towards mitigating that harm. What is important is that therapists acknowledge they are in a position of power within the relationship and are vigilant about ensuring they use their power collaboratively and constructively (Natiello, 2001; Proctor, 2002, 2010).

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[16] The potential threats posed by 'Big-Pharma' (see S. Hansen et al., 2003) are also acknowledged but space does not permit discussion here

4.2   Issues concerning research into therapy

Smail argues that it is not appropriate for psychology to attempt research into what

might be ineffable (of which therapy might be an example):

> As psychologists trying to say something in public about the causes and cures of human distress, we have to stick to the effable, even though the effable never tells the whole story (Smail, 2001a, p. 50)

Nevertheless, when people are in distress and need help to cope it is important that

appropriate and well evidenced methods are available.

4.2.1   RCTs as the gold standard?

NICE guidelines rely on evidence from randomised controlled trials (RCTs) (the so-

called Gold Standard of research) for physical and mental health issues. The importance

attached to the method warrants a brief discussion here.

The RCT is an experimental method, used when two or more treatment procedures are

to be compared. It claims to control for bias so that it can offer an objective result that

may demonstrate a causal relationship. These controls include running a non-

experimental control group alongside the intervention being tested. Groups are matched

as far as possible to remove selection bias, for instance, across gender, age and so on.

Researchers seek to remove as many features of the intervention as possible from that

control group so that any change can be assumed to be caused by the intervention. The

method is claimed to deliver objective, measurable results. There are many debates

around the extent to which these claims hold up (see Elliott, 1998 for a review.), not

least because assumptions are not made explicit in the same way as required in

qualitative research.

In therapy research, attempts would be made to remove any active therapeutic input so

that any changes could reasonably be associated with the therapy model being tested

(Baskin, Tierney, Minami, & Wampold, 2003), over and above any placebo effect (Wampold, 2001). This might be using a type of intervention that is assumed to hold no active therapeutic element or to operate in a different way; or controls might receive no treatment and be held on a waiting list or they may receive treatment as usual which usually means no therapy but continued medication (Barker, Pistrang, & Elliott, 2002, pp. 155-156).

4.2.1.1   Blinding?

An important feature of RCTs is blinding where attempts are made to control for expectations of participants (single blind trials) or participants and researchers (double blind trials). Double blind trials are, obviously, impossible in therapy research as the researchers cannot be blinded as to the condition they are offering. Single blinded trials where participants do not know whether they are in the treatment or control groups are also problematic. Participants must deduce some inkling of whether they are in the treatment or the control group, especially if attempts are made to control for any active therapeutic input (Budge, Baardseth, Wampold, & Flückiger, 2010, p. 25).

This may well have some effect, but what that might be is often neither hypothesised or discussed. It is also likely that participants in therapy research would suspect which group they would be in because, ethically, they must give informed consent to join the study, which involves agreeing to undertake a form of therapy if selected.

People might feel better because they have embarked on something connected with therapy. Alternatively, it is reasonable to suggest that they might feel disappointed or cheated if they realise they are in the control group so are not getting the help they feel they need – especially so, perhaps, if they are allocated to a waiting list control or to 'treatment-as-usual'.

Another ethical issue is raised by attempts to blind. If people are in distress and seeking therapy, it could be considered unethical to withhold treatment from them if they are allocated to the control group. Conversely, it could be argued that there is a risk of harm through exposing patients to unverified treatments. The limited choice in types of therapy offered to people who have unusual experiences, and the consequent need for further research into different methods raises the potential dilemma of risking methods with this client group that are, to date, unverified according to the criteria set by policymakers.

4.2.1.2   *Objectivity of results*

All studies make assumptions and all investigators will have biases and preferences which will affect the investigations, results and reporting in some ways. If RCT researchers' assumptions of objectivity and their broader epistemological positions are not acknowledged, discussed or evaluated, no account will be taken of their possible effects on the study design, questions asked and criteria for success. Questions will then remain over the trustworthiness of results.

One risk with not making assumptions clear is that results may be overstated, as well as biases under-reported. This matters in two ways in respect of therapy for HV: inappropriate treatments may be offered and helpful ones withheld.

Jones et al., (C. Jones, Hacker, Cormac, Meaden, & Irving, 2012, pp. 29-30) conducted a meta-analysis of 31 papers describing 20 trials and argued that CBT did not, after all, deliver significantly better success rates as compared with other therapies, some of which they described as 'less sophisticated'. Relapse and hospitalisation rates were not improved, nor were global mental state measures, or specific measures of mental state in positive or negative symptoms of schizophrenia.

Those findings have been robustly challenged (e.g. N. Thomas, 2015), but if Jones et al., were correct, it may mean that continued support is given to one intervention at the expense of others that might be as helpful, but not recognised as such. It therefore behoves researchers in other approaches to ensure they test their interventions thoroughly so that reasoned comparisons can be made.

Furthermore, researchers are often aligned through funding or practice or are in favour of the therapy model under investigation. This may affect the ways results are analysed or the ways the interventions themselves are carried out in the study (Luborsky, Singer, & Luborsky, 1975; Wampold, 2001). Such allegiance effects might also affect treatment outcomes and also comparisons between different therapies (Smith, Glass, & Miller, 1980) and it has been suggested that this allegiance is under-reported (Dragioti, Dimoliatis, & Evangelou, 2015). This means that readers might question the trustworthiness of results because of potential biases (Dragioti, Dimoliatis, Fountoulakis, & Evangelou, 2015).

4.2.1.3   *Standardising procedures*

In attempting to ensure objectivity and control, interventions are sometimes manualised to ensure consistency across investigator or practitioner. With an exercise as personal and unpredictable as personal therapy, there is a possibility that the treatment being tested is significantly changed from the one at the centre of the study. The study will then be reporting on something other than the intervention usually practiced.

Person-centred therapy, supportive counselling, or befriending are the least likely approaches to be practiced out of a structured manual but are often used as controls. Budge et al., comment on the way a form of supportive counselling is used as a control but that manualisation means it rarely operates as a bona fide form of the therapy (2010,

pp. 29-30). Furthermore, such controls are deemed to be non-therapeutic interventions despite evidence that suggests the alliance is an important factor in therapeutic change (Asay & Lambert, 1999; Duncan et al., 2010; Lambert & Barley, 2001). With some evidence suggesting that even just having the chance to talk and be listened to can be therapeutic (Budge et al., 2010; C. R. Rogers, 1980), it might be that even a modified version of other counselling could account for some change. This would affect the differences noted between any active therapy tested and its controls.

This has implications for claims that no differences can be found between therapy models – the so-called dodo bird effect (Duncan, 2002; Duncan et al., 2010; Rosenzweig, 1936). Rather than all treatments being equal, it might mean that methodological flaws in RCTs account for some of the flattening of difference. This does not necessarily negate the contention that client and relationship variables are the biggest predictors of therapeutic change, but it might affect the balance. It may also account for some of the effects found in the meta-analysis mentioned here (C. Jones et al., 2012) that questioned whether positive results for CBT had been overstated. In several of those studies supportive counselling was used as a control intervention although it was also acknowledged as an active intervention.

4.2.2 Meaning AND measurement

RCTs are designed to test whether an intervention has an effect in a controlled environment and are described as efficacy studies. To see whether a therapy 'works' in practice – that is, whether it is effective - would require testing in a more naturalistic setting. But, even then, the research context means it cannot be an exact enactment of a therapeutic encounter. Attempts to standardise and control for bias will affect the quality of the encounter in various ways. For example, there might be a requirement to operate from a manual; therapist researchers might be trained and briefed to operate in

formulaic ways; and, participants know they are in a research study. But it is difficult either to quantify or to understand the nature of what those differences might be.

There are reasons for measuring and assessing different therapies, particularly when decisions must be made about where to place limited public funds. To date, no methods have been suggested that seem to improve upon RCTs, for all their failings. Qualitative studies that take account of in-depth accounts from service users are often small scale and difficult to replicate or compare against each other. Such studies, do however, contribute to our understanding of what experiences or interventions mean to participants and can suggest areas for further large scale study. They also often offer an in-depth analysis that suggests commonalities across wider populations.

When an experience is as complex as HV and where there is dispute over how it arises, the breadth and depth offered by an exploration of subjective accounts may add something to the understanding of its causes, mechanisms and meanings.

4.2.3   Meaningful success criteria – following the lead set by experts-by-experience

Subjective accounts from experts-by-experience inform explanatory models of why experiences might occur and suggest ways of helping those in distress (also discussed in 1.7.2; 3.1 and 3.2). Only by listening to those that have the experiences can we be sure that the criteria under investigation, and how they are measured or analysed, are relevant to their frames of reference. With a group of people who are so often dismissed and marginalised, this offers an important way of discovering those 'lost' perspectives, as well as taking steps towards more inclusive attitudes in society more generally (Waddingham, 2015). If experts-by-experience (whether or not they are service users) are not fully included at all stages of research projects into their very own experiences we lose "a unique and significant perspective on the data" (Sweeney, Greenwood,

Williams, Wykes, & Rose, 2013, p. e89). Trujols et al., (2013, p. 555) caution against the use of patient reported outcome measures that are not generated by, or do not reflect the values of, service-users. They recommend new measures incorporate findings from "qualitative and participatory methods to capture and incorporate patient perspectives and values". Cooper (2011, 2013, October) has also suggested use be made of qualitative research that explores expert-by-experience perspectives as a way of including success criteria of relevance to them (Cooper et al., 2010, p. 240; Gilburt, Rose, & Slade, 2008; Perkins, 2001; Rose, 2001). Such a move towards more service-user led research could then impact the ways RCTs and research more generally are carried out, ensuring that they take account of success criteria and individual needs that are meaningful for service users (Perkins, 2001; Rose, 2001, 2014; Rose et al., 2011).

Discussion of the different priorities of different stakeholders in relation to what constitutes success in mental health services, has called attention to the differing levels of power and influence of those different stakeholders (Perkins, 2001; Perkins & Slade, 2012). In the case of some research (like RCTs), where taken-for-granted assumptions are often not made explicit, there is a risk that certain knowledge becomes privileged (McLeod, 2011, p. 248). Until recently it has been professionals who have designed studies, chosen the research methods, chosen the questions to ask and chosen the criteria by which success of therapy should be measured. Trujols et al., (2013, p. 556) argue that "clinical trials often fail to reflect patients' values or priorities" at the expense of "outcome variables defined by the scientific and clinical community".

For example, such research often starts from the perspective of testing effects of interventions on assumed illnesses, diseases or disorders, all of which (as discussed in Chapter 1) are contestable. These then form the basis of the criteria set for assessment and the whole study is then designed around those factors, whether or not they have any

meaning for the participants. (One might question then, perhaps, whether it is reasonable to consider such RCTs as the gold standard and whether the current set of NICE guidelines might, therefore, be flawed.) Furthermore, and potentially damagingly, research that results from a "nomothetic, rather than an idiographic approach" to therapy perpetuates the psychiatric hegemony (Pilgrim & Carey, 2010) because patients are "fitted into a priori categories which are then treated" (Pilgrim, 2008a, p. 265).

Jones et al., (C. Jones et al., 2012), for instance, reported that few trials in their meta-analysis of studies into CBT for schizophrenia reported on social functioning or quality of life. With an experience such as HV, with its often far-reaching practical, emotional, and physical effects, it might be just as relevant to assess the effectiveness of a therapy against how people cope with everyday living and how they feel able to relate to others, as it is to ask about effects on symptoms or hospitalisation (Gilburt et al., 2008; Perkins, 2001; Rose, 2001).

One of the ways to change this emphasis is by involving service users and other experts-by-experience in research into preferred outcomes of services and into what the experiences themselves may signify or be like. Professional researchers contribute to the silencing of the perspectives of experts-by-experience when they fail to involve them in research (Greenwood et al., 2009; Sweeney et al., 2013; Waddingham, 2015).

There have been concerns about involving service users in research and care does need to be taken to protect people if they are feeling vulnerable. But that is not an excuse for excluding the very people whose experiences are of interest. Indeed, Taylor et al., (2010) found that negative experiences of taking part in research studies were far outweighed by those people who felt they had benefited from the experience.

The recent welcome moves away from applying a technological paradigm (Bracken et al., 2012; P. Thomas, 2014) to mental distress are starting to be reflected in research into therapies as well as to its practice. Only by taking account of what is important to VHs or other people who have unusual experiences can we hope to understand what it is that is problematic and what can help alleviate any associated distress. Rachel Perkins sounds a note of caution, however, when she stresses that this involves more than paying lip-service to working with service users.

> If 'user involvement' is to be more than rhetoric, surely it is time both systematically to ascertain users' goals and to accord them the status currently enjoyed by the priorities of clinicians? (Perkins, 2001, p. 10).

Service users increasingly conduct research where their views on criteria that mark the success of therapy are considered (Beresford, 2005; Corstens et al., 2014; Drake, Haddock, Tarrier, Bentall, & Lewis, 2007; Greenwood et al., 2009; Perkins, 2001; Rose, 2001, 2014; Rose et al., 2011; Wood, Price, Morrison, & Haddock, 2010). Rose et al., (2011) have proposed a psychometrically robust model for developing outcome measures for use in mental health research, a model that itself was developed by service users using participatory research methods. They argue that service user perspectives on what constitutes recovery differ from clinicians. Whereas clinicians have traditionally focused on symptom reduction and global functioning, service users (see 1.9; 4.2.3) seem more interested in issues to do with social exclusion, stigma, emotional problems and difficulties with relationships (Rufus May, 2000); empowerment, choice, control and personal fulfilment (Perkins, 2001); and on finding a new direction for their lives, rather than a return to what they had before the onset of psychosis (Bellack, 2006). Greenwood et al., (2009) used Rose et al's., (2011) model to develop an outcome measure to assess the effectiveness of CBTp, one that not only took account of what service users considered important but also took account of the individual and

collaborative CBTp process. Unfortunately, such measures are not yet widely used

(Trujols et al., 2013, p. 557).

 As the service user movement, and survivor groups gain in power, however, the

possibility of help tailored to idiosyncratic needs becomes more likely (Newnes, 2004;

Newnes et al., 1999, 2001; Sanders & Tudor, 2001). The rise in peer group support

networks for VHs suffering distress is testament to that. More professionals appreciate

the need to be guided by experts-by-experience rather than trying to dictate what they

think people in distress need, should need or should do. That is a development to be

welcomed and will go some way towards changing the stigmatising attitudes in the rest

of society so that unusual experience is no longer seen as always frightening, damaging

or harmful. It also allows for appropriate help to be delivered as needed. Apart from

helping those in need in a more useful way, it might also have an impact on healthcare

costs if people aren't automatically treated as patients when they HV.

Chapter 5

5   RATIONALE FOR THE STUDY

5.1   Justification for more research into lived experiences of voice hearing and of psychotherapy

When a discourse holds such power over public perception, it needs to be justifiable. The challenges to psychiatric understandings of unusual experiences outlined above are significant, based, in part, on the lack of reliable success in treating these symptoms. As Pilgrim and Rogers suggest,

> In the field of mental health, with the dubious conceptual validity of professional notions like schizophrenia and the poor track record of clinicians at either helping patients or making predictions about the contact, lay people have every right to claim a mandate about a topic which is thrown expert into confusion and provoked incredulity, distrust and hostility in their patients. (1997, p. 39)

There is, therefore, a case for adding to the body of research that explores the experience of HV to gain a clearer understanding of what it might mean and what makes it happen – or stop. This study will not, however, explicitly be looking for potential causes of HV but the personal accounts may include some pointers (for example, psychological mechanisms and adverse life events) that relate to other research on that topic.

It appears that HV does not always cause problems for people and that, even if it does, those difficulties can cease when the experience is understood in a new way (Longden et al., 2012; Morrison et al., 2004; Romme et al., 2009). The impact of being diagnosed as mentally ill can cause problems although it can come as a relief (Barham, 1997; Barham & Hayward, 1991; Barham et al., 1995; P. K. Chadwick, 1997b). This study might help to elucidate the effects of such a diagnosis on VHs, on notions of identity

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and agency, and how or whether that changes after therapy. This will add to the evidence already established about what the experiences mean to the voice hearer.

If people are suffering distress, it may also be useful to explore why that might be and whether HV is connected in any way, what might help and the impact of therapy offered. As discussed above, client accounts of experience and of experiences in therapy can help researchers design relevant studies to test how or whether therapy works and what types of help are required alongside therapy (Elliott et al., 2013; Timulák, 2007, 2009; Timulák & Creaner, 2010). Hopes, fears and expectations are also important and may best be uncovered in wide ranging discussions, rather than through more structured instruments. This has implications for ensuring relevant, effective and ethical practice. The extent to which this might offer additional insights will be evaluated in Chapter 14.

This study will, uniquely, offer information about what it is like to HV before and after engagement in a type of therapy not researched before with VHs.

5.2 The value of finding out how person-centred therapy is experienced by people who hear voices

Person-centred therapy has, as mentioned above (2.5.4), been rarely researched and rarely offered to people in psychiatric settings in the UK in recent years. Theoretically, however, it offers a framework for how HV may develop, and an existing method of therapy, that concurs with research from other areas that the therapeutic alliance and client engagement are important predictors of therapeutic success (Bentall, 2009; Bohart & Tallman, 2010a, 2010b; Cooke, 2014; Duncan et al., 2010; Kilbride et al., 2013; Lambert, 1992; Lambert & Barley, 2001; Norcross, 2011; Wood et al., 2015). Whilst the principles and approach are much in evidence as implicit elements of several

therapy approaches (see 2.4), Rogers is rarely acknowledged explicitly (exceptions include Bentall, 2009; P. Chadwick, 2006).

There seems to be value in asking people what their experience of person-centred therapy is like and then analysing their responses systematically. This could offer a broad and deep perspective on the experience in a way that has not happened before. It also seems important to do this in a way that does not involve a bastardised and manualised form of the model (as used in a control group of a RCT) but by a trained practitioner who tries to embody the way of being proposed by Rogers (Cooper et al., 2013b; C. R. Rogers, 1961; Schmid, 2006). It is possible that this will give a more naturalistic picture of the operation of the therapy, even though it will never be the same as when it does not have the confounding element of a research study attached. As a study of person-centred therapy specifically, it might also offer different insights into HV from those that have been found in other approaches.

There seems to be an impetus behind developing new methods which might help VHs who are in distress. Several of these incorporate elements of existing methods to create something new. In fact, person-centred therapy is an established model that could reasonably be explored, as there have been no studies that focus explicitly on how VHs experience it. Findings may offer evidence that suggests further research is warranted.

5.3 The research questions

5.3.1 What is it like to hear voices?

The literature discussed above demonstrates the value of finding out what VHs think about their experiences to inform our understanding of the possible causes, mechanisms and associations (Geekie, 2007; Geekie & Read, 2009) and what might help those who suffer associated distress (Perkins, 2001). The analysis of subjective accounts can offer

valuable insights into the meaning of experience (Beavan, 2011; de Jager et al., 2016; Milligan et al., 2013). Yet, patients are not routinely offered the chance to explore their experiences from the position of expert in clinical settings (Wagner & King, 2005), even though patients find it helpful (Larsen, 2004) and some approaches within therapy recommend it (Johnstone, 2012).

Research into HV is also often designed by people who have no first-hand knowledge of the experience, despite variations in meaning across culture (Larøi et al., 2014; Luhrmann et al., 2015), social circumstances (Read, 2004; Read & Dillon, 2013; Singh et al., 2007; P. Thomas, 2014), support networks (Brett et al., 2007) and life events (Bentall et al., 2014; Moskowitz et al., 2009; Read et al., 2008; Read, Rudegeair, et al., 2006; Read, van Os, Morrison, & Ross, 2005; Varese et al., 2012).

If the criteria of investigation are not generated by those who live with the experience there is a risk that aspects of that experience will be overlooked or attention given to those that are of tangential relevance (Greenwood et al., 2009; Rose et al., 2011; Sweeney et al., 2013; Waddingham, 2015).

5.3.2 What was it like to have person-centred therapy?

It seems clear that person-centred values – for instance, acknowledging the importance of VHs' own understandings, offering the chance to explore personal meaning and of the need for therapists to take a non-expert stance whilst offering acceptance and understanding in therapy - have recently been incorporated into models of understanding HV (Bentall, 2009; P. Chadwick, Lees, et al., 2000; Romme & Escher, 1993, 2000) as well as the therapies that have been developed to help (P. Chadwick, 2006; P. Chadwick, Lees, et al., 2000; Duncan et al., 2010; Romme & Escher, 2000).

This study offers an unusual opportunity for VHs to undergo person-centred therapy itself, and to discuss the experience of it, especially in relation to any changes connected with HV.

These issues seem important because of the potential implications for the ways in which people in distress are helped, how unusual experience such as HV is interpreted, and how VHs are regarded by society. The research questions will therefore focus on exploring participants' concrete lived experiences. Participants will be asked i) what it is like to HV and ii) what it has been like to have person-centred therapy.

SUMMARY OF PART A

Part A has laid out some evidence relating to the phenomenology of HV and the different ways in which the experience is understood, including, especially, the views of VHs themselves. To date, there does not appear to be conclusive evidence for a single biomedical cause of HV, nor for the illnesses of which it is purportedly a symptom. Chemical and genetic studies are inconclusive, yet ideas persist that mental illnesses and disorders such as schizophrenia or psychotic depression are real, and such an understanding makes sense to many people. Some people are helped by medical treatments but these can cause side effects and do not always have the predicted results.

Challenges to a medical understanding claim that, even if definitive physiological causes or sites were found, it does not automatically follow that this constitutes illness or disease. The arguments for HV being an experience that lies along a continuum and that it can occur in the presence or absence of trauma, illness, or dysfunction is persuasive. Strong associations have also been found linking childhood trauma and other difficult or traumatising experiences such as poverty, oppression and loss to the development of HV. There is increasing evidence that such associations may even be causal and significant progress has been made towards identifying traumagenic pathways. It also appears that the ways people react to HV are what determine whether they suffer distress, or appear mentally ill.

This section then turned to the ways VHs who suffer distress are offered help. Various therapeutic models have been found to help people suffering distress associated with HV. Theoretically, person-centred therapy could be one of those, but more research is required. Evidence from some self-help and therapeutic models shows that people can come to feel differently about their voices if they are given the chance to explore the

personal meaning their voices may have. This may lead to a change in the quality of the voices they hear, to a new relationship with them, or to the voices disappearing.

Alongside this, reflection on public meanings - particularly related to the hegemonic medical model – might lead clients to reassess the relevance of those meanings for their own situations. This may then lead to their feeling less alienated and more accepting of the voices they hear, and of themselves as people of value, itself offering the potential for healing.

There are various issues to do with the notion of recovery and with methods used to help distress, many connected with the degree to which experts-by-experience are involved in research and service delivery. There are ethical and practical justifications for giving full attention to idiosyncratic perspectives on the phenomenology of HV and to what the distress might be connected.

The section ends with summarising the evidence that provides a rationale for this study and its exploration into subjective accounts of person-centred therapy with VHs.

Part B: Methodology and method

Part B: Methodology and method

OVERVIEW OF PART B

This section will explain how I designed and ran the study and the reasoning behind this. Chapter 6 covers my epistemological assumptions and the ways I decided to approach the data analysis. Chapter 7 details the actual operation of the study. Chapter 8 covers arguments about how I selected relevant evaluation criteria, what they are and how the study should be evaluated against them. It also discusses various potential limitations to the study.

Chapter 6

6   METHODOLOGY

This chapter will outline my epistemological position and how I decided on an appropriate method to explore my research questions. I will first explain why I feel the questions are suited to a specific type of phenomenological questioning, and how that approach to knowledge might affect the approach to data analysis. I will also describe the method used in this study. Brief examples will be included showing why other methods were not selected to answer the questions under investigation here.

6.1   Epistemological position and choice of method

6.1.1   Starting point

I wanted to explore the experiences of therapy and of HV by describing subjective accounts of the understandings and meanings attached to these experiences. I was not trying to test the efficacy of person-centred therapy or to measure any effects of the therapy on HV. The themes drawn out will be an account of the experiences of people who underwent a specific type of therapy.

It is perhaps important that I state my position as a therapist before going on to talk about how I approached this research.

I would place myself within the 'experiential' tribe of the person-centred approach (Sanders, 2004), specifically taking a relational or dialogical stance (Cox, 2015). That means I am persuaded by the idea that therapists need to acknowledge their place in the therapy encounter, sometimes also expressing their experiencing if it is in the service of the client. It does not mean I try to direct either the client's process as in process-experiential therapy (Greenberg, Rice, & Elliott, 1993) or the content of their sessions

as in other, more structured therapies. But neither do I operate in the classically non-directive sense of offering empathic reflections only.

I agree that our sense of self arises through the constant interactions between our inner experiencing and the world around us (Mearns & Thorne, 2000) and that we have different parts of ourselves, some of which come to the fore at different times and in different situations (Mearns & Cooper, 2005; Mearns & Thorne, 2000). I accept the idea that significant change can occur if client and therapist can engage at relational depth (Cooper, 2013; Knox, Murphy, Wiggins, & Cooper, 2013), a concept akin to Buber's (1922/1958) 'I-Thou' relating and which involves meeting each other without any defence or pretence (Mearns, 1997, p. 16). I believe that therapy is a dialogical encounter (Schmid, 2004) and that therapeutic change occurs within the co-created space. The change is likely to be greatest when therapist and client are relating with a degree of mutuality and are both operating from within, and in the service of, the client's frame of reference. But the impetus behind such encounters must come from the client and depth of relating is not necessary for therapeutic change to occur, in the spirit of the clients as active self-healers (Bohart, 2013; Bohart & Tallman, 2010a, 2010b).

As a therapist who is aware of debates around marginalisation of people who suffer mental distress, I want to privilege participant understanding and meaning. This means I must present a report that stays as closely as possible to participants' own descriptions, whilst making no claim that this offers a direct representation of 'reality', were such a thing even possible. Both participant and I will be affected by each other and by the unique contexts of our own lives, which will, in turn, affect the research encounter, the data given by the participant and how it will be received by me. The participant's account will be further refracted through the lenses of the research interview as a retrospective account, carried out by the person with whom they will have had the

therapy that they are discussing. My analysis of that account will then be refracted through my own context, my position as therapist, my position as researcher and my necessarily selective retelling of the story.

Bearing in mind these aims and potential obstacles, I sought an approach that might offer a way of answering my research questions. Phenomenological methods are often used in studies that explore concrete lived experience, claiming to focus on descriptions of phenomena in ways that elucidate meaning (Wertz, 2005). There are, however, debates about the ways, and extent to which, phenomena can be explained or understood (Langdridge, 2007). Relevant to the questions I needed to consider were whether Husserlian or existential phenomenological positions were appropriate and whether descriptive or interpretive methods could offer the analysis I sought. I will outline these issues below to explain how I chose an approach for this study.

6.1.2   Position within phenomenology

Phenomenological research methods in psychology and elsewhere are based on Edmund Husserl's philosophical phenomenology (1913/1931; 1900/1970). He asserted that the 'essence' of a phenomenon can be uncovered if the researcher achieves the epoché (bracketing) successfully. Later phenomenological thinkers argued that such a "God's-eye-view" could never be explicated because one can never separate a phenomenon from the context in which it is situated (Heidegger, 1927/1962; Merleau-Ponty, 1945/2002).

Heidegger (1927/1962) proposed that lived experiences have meaning only through our relationships with the world around us, so there can be no objectively discoverable "essence". He called this concept *"Dasein"* or "being-in-the-world" and it connects with Husserl's notion of "intentionality" which proposed that the experiencer necessarily experiences something or someone. For Heidegger, the experiencer and the

experienced will always be situated in relation to someone or something. This means that we can never isolate a singular essence and only, therefore, exist in relation to our own worlds (cf. C. R. Rogers, 1951, theory of personality development (2.5.1.1))

Merleau-Ponty (1945/2002) goes further, rejecting Cartesian dualism completely by positing the idea of embodiment: the notion that our body is inextricably linked to our sense of self, our world and our relations with others (Eatough, 2009, p. 187). This means that understandings of phenomena develop out of our culturally and historically embodied inter-subjectivity. Of relevance in this study, for example, are the ways that understandings of madness, people who are mad and HV vary across time and culture (Leudar & Thomas, 2000). The meanings attached to these experiences holistically affect the ways people are treated, and how they view themselves and the opportunities available to them.

Foucault (1975/1977; 1980; 1961/2001) might argue that these understandings are constrained by the structures relevant to the current episteme and that the prevailing structures in any society are those defined by power. Changes can occur, however, through the gaps, silences and contradictions in the hegemonic discourse (Blackman, 2001). This is of relevance here when considering the ways in which people describe their experiences in terms of commonly accepted discourse relating to unusual experiences (cf. Pilgrim, 2008a; Pilgrim & Carey, 2010).

Existential phenomenologists argue that we are in the world so can only know ourselves through the meanings we attach to being there. This disputes the notion of there being definite 'truths' as proposed in some more essentialist discourse, for instance the psychiatric concept of schizophrenia as an illness that exists.

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According to Merleau-Ponty, rather than our worlds being comprised of truths, we are all, thus, "condemned to meaning" (1945/2002, p. xix) and create our own set of understandings or "lifeworlds". Merleau-Ponty (1945/2002) and Heidegger (1927/1962) developed this existential-phenomenological philosophical perspective by outlining key structures of human existence (Finlay, 2011, p. 19) that make up the lifeworld: selfhood, sociality, embodiment, temporality, spatiality, project, discourse, mood-as-atmosphere (P. Ashworth, 2003, 2006b).

Such a perspective involves taking account of both ontological (the universal nature of what it is to be human) and ontic (the specific way of being of the individual) views of the phenomena as they present themselves (according to Heidegger, 1927/1962). Phenomena therefore emerge at the interface between self and world (Willig, 2007, p. 221) and become meaningful only through individual perception of them in the individual's world (Langdridge, 2007, p. 37). Just as perception is ambiguous, so is our being in the world; the meanings we derive in one situation may not necessarily be so in another, nor will they necessarily be the same as anyone else's.

Whilst everyone may experience a lifeworld, making the concept in this sense universal, this perspective suggests that "a particular lifeworld, as an actualisation of it – contextualised and temporalised – is certainly not" (P. Ashworth, 2003, p. 146). As Ashworth explains,

> the notion of intentionality culminates in Heidegger's insight that the self is not "internal" but is to be seen in the nature of one's concerns within one's world. In experiencing my world, I implicitly see in its priorities and foci, my own projects, cares and concerns. My world is laid out in terms of the objects and events that matter to me. Therefore, I see myself in the experienced lifeworld. (P. Ashworth, 2006b, p. 217)

Not only does this epistemological position appear to offer a focus that matches my research questions, it also seems to allow for ambiguity and individual difference.

Husserl's potentially realist position that there is an essence to be discovered, felt problematic for a discussion of what the experiences of therapy and HV were like. Both are intensely personal experiences, likely to be different for each person, given their own unique context and way of being in the world. The existential perspective seemed to offer the opportunity of ensuring I took more account of my participants' individual lifeworlds. In arguing for embodied inter-subjectivity, there can be no acceptance of the possibility of a Cartesian rational and disembodied subject allowing us to transcend context and achieve a God's-eye-view. It means that, in seeking to explore the experience of therapy and of HV, I am not trying to uncover the experience *per se*. I am seeking only to present *an* account of what emerges from within the co-created inter-subjective space of the research interview.

Although I am not taking a lifeworld approach to this study, specifically, Ashworth's (2003, 2006b) fractions of the lifeworld do provide a useful heuristic for use in interrogating data in phenomenological research in order to identify possible themes.

6.1.3   Description versus interpretation of phenomena

Both descriptive and interpretive approaches to phenomenological research accept that persons are all self-interpreting beings (C. Taylor, 1985) and that the phenomenon under investigation undergoes change as soon as it is studied because it is inevitably mediated by our existing understandings (A. Giorgi, 1992).

For the descriptive researcher this is not a problem because the aim of the project is not to deliver some immutable truth but rather to describe a phenomenon only as it appears to the researcher in consciousness as a meaningfully lived experience (Finlay & Evans, 2009, p. 187). The project can only work with the data available; if different data were added, or a different researcher were to approach it, there is an acknowledgment that the analysis would be different. This is not considered to invalidate the findings as long as

the research is conducted in accordance with clearly explicated evaluative criteria and claims can be justified (A. Giorgi, 1994).

In this sense then, all phenomenological investigation involves some interpretation. For descriptivists, however, it is achieved via the hermeneutic of empathy or meaning-recollection where researchers try to give voice to the participants' experience as closely as possible without adding in their own perspective (Langdridge, 2007, p. 158). Describing the phenomenon as it is presented does not mean, however, that I am not also aware of there being multiple interpretations. Individual context means there is unlikely often to be a univocal or unique meaning to any experience.

Interpretivists, conversely, may employ the hermeneutic of suspicion (Ricoeur, 1970). This involves the *intention* of adding in an interpretation of meaning by challenging surface accounts (Finlay, 2011, p. 123; Ricoeur, 1970), which, necessarily, means choosing only one meaning, or selection, of meanings, from the vast array of possibilities available. As a result the analysis may fail to capture elements of the individual sense of the phenomenon (A. Giorgi, 1992, 1994).

The hermeneutic of suspicion also seems to take us a step further away from the data and how research participants describe their lived experiences (A. Giorgi, 1992; Langdridge, 2007, p. 158). The researcher may become immersed in trying to allocate the data to a theoretical perspective, again moving away from what the participant has described as her experiences.

In practice, it seems as if description and interpretation lie along a continuum (Finlay, 2011, p. 19) and that avoiding hard and fast boundaries ensures that results remain true to "the spirit of the phenomenological tradition that prizes individuality and creativity" (Langdridge, 2008, p. 1131).

My aim was to develop an empathic understanding of the participants' accounts and for my description to stay as close as possible to those meanings whilst accepting the inevitability that I would be using some interpretation. I sought to work from the hermeneutic of meaning-recollection rather than of suspicion, placing myself part way along that continuum between description and interpretation.

6.1.4   Approach to data analysis

Finlay and Evans (Finlay, 2011; Finlay & Evans, 2009) have developed a reflexive-relational approach rooted in the existential-phenomenological thinking above and with specific reference to the therapy context. This resonated with me and has influenced this study so will be described in more detail.

The reflexive-relational approach (Finlay & Evans, 2009) tries to describe and give voice to the phenomenology of lived experiences, using a hermeneutic of empathy or meaning-recollection (Ricoeur, 1970, cited in Langdridge, 2007, p. 44). Such an approach allows – requires – researchers to embrace, rather than try to bracket, their roles in the research and/or any pre-existing therapy relationship of which they are necessarily an integral part. Given that I am researching participants' experiences of therapy with me, however, there are additional issues that have to be considered, including the power differential that is part of the research encounter anyway and also forms part of the therapeutic relationship (see 7.5).

The attitudes involved in the relational approach seem akin to empathy in therapy which:

> involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person…It means temporarily living in the other's life, moving about in it delicately without making judgements…as you look with fresh and un-frightened eyes. (C. R. Rogers, 1980, p. 42)

Such methods may be of particular resonance to the study of therapy by therapists "whose work brings them close to the naturally occurring struggles and triumphs of persons" (Wertz, 2005, p. 176). Broadly speaking,

> Phenomenological understanding is distinctly existential, emotive, enactive, embodied, situational, and non-theoretic; a powerful phenomenological text thrives on a certain irrevocable tension between what is unique and what is shared, between particular and transcendent meaning, and between the reflective and the pre-reflective spheres of the lifeworld. (van Manen, 1997, p. 345).

Of course, empathic understanding of another can never be an exact match, nor should it be. What is stressed in the person-centred approach is the necessity for a therapist still to retain her own identity as a separate person. It is neither helpful nor useful for the therapist or researcher to 'get lost' in the client's or participant's world. In research the aim is to describe another's experience as it is presented to the researcher's consciousness. Over-identification would be inappropriate as the researcher would be affected by their own responses to another's subjective lifeworld. Finlay (2005, 2014) advocates three interpenetrating layers of "reflexive, embodied empathy" as useful techniques in relational research. If this is not examined reflexively by the researcher, there is a danger that not only will the researcher over-identify with the participant and risk developing their own sense of an experience, but they may also end up describing their own experience, rather than the participant's, in the final report.

Finlay describes these layers as being similar to the 'technique' used by Carl Rogers in his person-centred approach (Finlay, 2005, p. 273). It may be that Finlay's notion of empathy as embodied and reflexive allows for the quality to be reflected on and genuinely lived (or dwelt-with) in such a way as to facilitate the depth of understanding in relational research that she advocates.

A positive aspect of embracing my part in the pre-existing relationship is that it may open the way to other avenues which the client/participant might not initially think of.

Whilst this might, in other methods, be seen as 'leading the participant', it seems justifiable here in that the interview is trying to co-create an account of our experience together of the therapy the participant has undertaken, If the participant does not want to pursue that avenue or feels it is not particularly relevant, then it is not pursued. It is also an issue to be considered reflexively by the researcher to ensure there was no attempt to uncover instances of "personal growth" (Timulák & Creaner, 2010, p. 82), or to "spot" instances that confirm the effectiveness of person-centred therapy (Timulák & Creaner, 2010, pp. 80, 85).

Furthermore, operating from within the participant's frame of reference seems to facilitate the exploration and expression of experiences in a more detailed way for those people who are not especially articulate or who struggle to find ways of expressing themselves. Obviously, this needs to be reflected on as part of the ongoing reflexive analysis to ensure that it has come from the participant's experience but often it can be experienced as a merging of reporting in these studies. Finlay describes an example where the client wondered "Did I say it or did she?" (Finlay, 2009, p. 1).

Whilst it can be argued that depth might be added to what is discussed in an interview such as this, it is also the case that something might be lost when a therapist researches her own clients (see especially power issue in 7.5 below). But it is always going to be the case that any researcher has a stance wherein some elements will be lost and some gained. A reflexive exploration goes some way to identifying and exploring the impact of each position.

While this approach seemed appropriate for my questions and the context of the research, the word constraints involved in seeking to answer two research questions made it impossible for me to employ the method at the depth required, given my other aim of giving voice to all participants' stories. I decided instead to employ the values

and approach of Finlay's and Evan's method, but to produce a thematic analysis adapted from Braun and Clarke (2006). This analytical method offers a systematic structure, yet is neither prescriptive nor aligned to a particular epistemological position and seemed the best option for giving voice to the idiosyncratic and the general.

In the thematic analysis findings chapters I have tried to attend as much as possible to variations between individual participants. I focused first on individual transcripts before developing cross-sectional themes and then returned again to look for individual variation. I also used Ashworth's fractions of the lifeworld (2003, 2006b) as a heuristic for "dwelling-with" and investigating the data corpus in a phenomenological way. Appendix B contains information based on Ashworth's (2003, 2006b) work on those fractions, with specific reference to relevant questions for this study.

During the research I became a bricoleur (Denzin & Lincoln, 1994, pp. 2-3; McLeod, 2011, pp. 82-83), taking the pragmatic view that I could still remain within the phenomenological attitude and embody the values of relational research, even if I could not offer the depth of analysis I would have liked. I have tried to retain a phenomenological attitude involving a dance between a phenomenological reduction and hermeneutic reflexivity (Finlay, 2008); I have sought to balance a bracketing of my presuppositions and assumptions with the acknowledgement and use of my involvemen to gain insight (P. Ashworth, 1996; Finlay, 2008; A. Giorgi, 1994, p. 205).

6.1.5 Decision to use clients as participants

When considering how to approach this study of person-centred therapy with people who hear voices, I was aware of the potential limitations of generating and analysing data from work with my own clients, especially when the data were accounts of their experiences of therapy they had had with me. Issues to do with therapist-researcher dual relationships are discussed in 8.5.1.

It would have been preferable at least to include data from clients who had undertaken person-centred therapy with other therapists to offer a comparison with the accounts from my participants. As mentioned in chapter 2, however, there are very few opportunities for person-centred therapists to work with clients in psychiatric populations in the UK, whatever their diagnosis. Since person-centred therapy is not 'evidence-based' in the way mental health services require, it remains difficult to access research participants in these groups within NHS settings in the UK, and ethical problems attach to offering NHS patients 'unsupported' interventions anyway.

There may be some therapists who are offering therapy to VH (with or without a psychiatric diagnosis) in private practice or in other agencies in the UK, but I was not aware of any who did similar work to me, as opposed to variants of person-centred therapy or those who offer person-centred and experiential or expressive therapy (see 2.5) as Wendy Traynor has demonstrated (Traynor, Elliott, & Cooper, 2011). These variations, whilst operating with person-centred values, often take a more active role in directing the process of therapy sessions, if not the content. It was just not feasible, therefore, to source data from participants who had had experience of my specific form of person-centred therapy with other person-centred therapists.

Some person-centred therapy has been offered within psychiatric settings in the USA (e.g. Prouty et al., 2002) Denmark (e.g. Sommerbeck, 2003), Netherlands (e.g. van Werde, 1998; van Werde et al., 2015), Austria (e.g. Berghofer, 1996), Belgium (e.g. Teusch, 1990) and Italy (e.g. Dinacci, 1997). Often these practitioners and researchers use Prouty's pre-therapy approach discussed above.

A similar attempt has been made to explore clients' experiences of therapy with one therapist by Hansen et al., (B. P. Hansen, Lambert, & Vass, 2015). Here, Eri Vass, a clinical psychologist, was interested in exploring "sudden gains and sudden losses" in

her clients, working with the other two authors to assess qualitative and quantitative data. Whilst Vass was involved in the recruitment of participants, dissemination of materials and collection of data, the analysis was carried out primarily by Hansen and Lambert, using reports Vass had written for the other researchers about her method of practice in relation to each. The same issues relating to Vass's direct input, potential participant deference, effects of gathering retrospective accounts, the small sample and lack of comparability with other therapists apply as here. But the rigorous and systematic approach taken to data collection and analysis, as well as the authors' claim that participant accounts appeared candid (p. 190) may mitigate those limitations.

I hope that the relational phenomenological method I have chosen here which involves an iterative approach towards data analysis and rigorous reflexivity will, similarly, ensure that I am aware of, and report on, those areas and instances that might have affected the findings and discussion in this study.

6.1.6 Other methods considered

These data could have been analysed in other ways to give useful insights into HV and therapy. But I felt that, following Rogers (C. R. Rogers, 1980), participants' experiences are their realities and I was interested in the everyday meanings that seemed important to them when they considered what it was like to have these experiences. I therefore decided against other methods as discussed briefly below.

6.1.6.1 *Discourse analysis (DA)/Foucauldian Discourse Analysis (FDA)*

I am exploring participants' lived experiences as phenomena rather than what they say about those experiences, the rhetorical devices they use and the structures they invoke when talking about them. I am not, therefore, assuming either that there is nothing

outside the text (DA) or that language is key but is historically and culturally situated (FDA).

6.1.6.2 Interpretative Phenomenological Analysis

This was initially interesting as it is a method increasingly used in the field of health research. It also tries to explicate the meaning of concrete lived experiences. I decided against it, however, because it initially operated within a social cognition model and because of its emphasis on theorising an interpretation. This seemed to take me further away from the data and from how people described their lived experiences.

6.1.6.3 Grounded theory

Original versions of this method were rooted within a positivist epistemology. I cannot accept that I am seeking, or will find, an objective truth in this study. A recent variation has been developed which is positioned within social constructionism (Charmaz, 2014) but which, for this study, does not seem to match with the position I am taking: that of trying to evoke an account of what people describe as their reality, believing it to be just that and not a construction. I am also more interested in individual accounts rather than accounts of social meaning.

6.1.6.4 Narrative and life-story methods

Although I am, indeed, recounting people's stories and can see that this is the way people construct their lives, my research questions are not looking at the storying process in itself.

Polkinghorne (1995) distinguishes between analysis of narrative and narrative analysis. That helped me make my decision about which method to use in this study. Rather than trying to focus on the meaning and structure of the storying process in a narrative

analysis, I was more interested in exploring participants' overall accounts of what HV and therapy is like. In other words, I had specific questions against which I wanted to 'code' the data. Use of the fractions that make up a person's lifeworld seemed to offer the opportunity to study these phenomena in this way.

I was attracted to the idea of life-story research, which places greater emphasis on the trajectories of life than on the process of constructing the story. Given that my participants often answered the interview questions in a 'storied' way, using beginnings, middles and ends, this method would have offered a good alternative to the phenomenological approach I have taken. Etherington's work is of particular interest (1996, 2001, 2004). But although I was interested in individual differences, I still wanted to draw together overall themes. For this reason, I chose existentially-phenomenologically informed thematic analysis instead.

Chapter 7

7 OPERATION OF THE STUDY

This chapter deals with the procedures of the study. It follows the path from setting the study up and gaining ethical approval through to recruitment of participants; who they were, issues connected with their participation and how I ensured they were protected in various ways. I also discuss the inclusion of independent assessment of therapy sessions as a way of ensuring the therapy offered was person-centred, along with issues associated with that process. I then report on the collection of post-therapy interviews which were the research data, and the method of data analysis. The processes of data collection and data analysis are shown below in Figures 7.1 and 7.3 respectively.

7.1 Participants

7.1.1 Ethical approval

This study was approved by the ethics committee of the University of East London (see Appendix Ci). It was also approved, and has been regularly reviewed, by the relevant NHS Research Ethics Committee (Reference number: 09/H0310/63. See Appendix Cii). The research was registered with UEL and with the relevant NHS R&D committee (See Appendix Ciii) for the NHS site at which the research took place.

7.1.2 Sample

Participants were a convenience sample of adults aged between 18-65 years old who heard voices, could give informed consent, and could speak English without an interpreter. They were clients from my voluntary clinical practice at a NHS mental health trust and a person-centred counselling agency, and from my paid sessional work at an independent low-secure psychiatric unit, all in the East of the UK.

Staff in the agencies I worked with were aware of the study and had been given an information leaflet on it (See Appendix Di: Information leaflet for Clinical Staff). I asked them to bear it in mind when considering if any patients/clients might benefit from therapy with me. Mostly, clinical staff would contact me with referrals. I also attended management meetings and made suggestions about which people might wish to have therapy with me.

7.1.3 Demographic data (summarised in Table 7.1 below)

There were seven women and three men. All identified as heterosexual. The age range was 18-57 years (mean 33.2 years). All identified as White British except for Aisha who identified as African.

Pseudonyms have been used to protect confidentiality. Names rather than letters or numbers were used to affirm participants as 'people as subjects', not 'objects of study'.

Elaine was an in-patient at an independent low-secure psychiatric unit; Fabien was a client of a person-centred counselling agency. The other eight participants were patients of a NHS mental health trust, seen as in-patients or out-patients, sometimes as both.

Fabien, Tina, Rhiannon, Gary and Robert had been unemployed for some time. Katie and Elaine had never worked. Olivia was a student. Aisha had given up her training course. Paula was a homemaker, caring for her husband and children.

Fabien, Paula and Gary lived independently; Olivia was living temporarily with her parents; Katie, Tina, Rhiannon and Aisha lived in supported housing; Elaine was an in-patient at a low-secure psychiatric unit. Robert started therapy whilst an in-patient on an acute psychiatric ward. After a few days at home he was re-admitted to an intensive care psychiatric ward and our therapy continued there.

Further information relating to the voices participants heard and what they signified is contained in Table 7.2 below; and data relating to therapy sessions is included in Table 7.3 below.

The process of data collection is then summarised in Figure 7.1.

Table 7.1:   *Participant data – demographic*

Name (Gender)	Age at start of therapy	Occupation	Healthcare situation	Home situation
Aisha[17] (F)	18-30	Student	In-patient then out-patient at NHS mental health trust	Lived in supported housing
Elaine (F)	30-45	Never worked	In-patient at Independent low-secure psychiatric unit	Long-term in-patient low-secure psychiatric care
Fabien (M)	45-60	Long-term unemployed	Client at counselling agency	Lived independently with CMHT support
Gary (M)	30-45	Long-term unemployed	In-patient then out-patient at NHS mental health trust	Lived independently
Katie (F)	18-30	Never worked	Out-patient at NHS mental health trust with occasional short-term hospital admissions	Lived in supported housing
Olivia (F)	18-30	Student	In-patient then out-patient at NHS mental health trust	Lived with parents
Paula (F)	30-45	Homemaker	In-patient then out-patient at NHS mental health trust	Lived independently
Rhiannon (F)	18-30	Unemployed, then started voluntary work	In-patient then out-patient at NHS mental health trust	Lived in supported housing
Robert (M)	45-60	Long-term unemployed	In-patient at NHS mental health trust	Long-term care on acute and low-secure wards
Tina (F)	30-45	Long-term unemployed	Out-patient at NHS mental health trust	Lived in supported housing

[17]Ethnicity - All participants identified as White British apart from Aisha who identified as African

Table 7.2:   *Participant data - experience of voices*[18]

Participant	Number and identity of voices	Length of time voices heard	Content of voices	Understanding before therapy	Understanding after therapy
Aisha	Many. Unknown	Since age 10	Critical, chastising	Symptom of mental illness. Confusing and frightening	Symptom of mental illness. Less frightening
Elaine	1 – Uncle who died 1 – Male stranger	Since age 17	Critical, commanding	Symptom of mental illness. Upsetting and frightening	Symptom of mental illness. No change
Fabien	1 – Spiritual entity. His higher self	All life	Guiding, chastising, controlling	Spiritual entity – higher self. Voice in control	Spiritual entity -higher self. 'In partnership'
Gary	Many. Unknown	3 years	Critical, commanding, threatening, urging him to harm others	Symptom of mental illness caused by head injury following assault. Frightening	Symptom of mental illness caused by head injury following assault. Controlled by medication
Katie	1 – Female family member 2 – Male sexual abusers 1 – Male stranger	Since age 9	Female family member: loving, comforting. Abusers: threatening, aggressive	Symptom of mental illness. Frightening	Symptom of mental illness. More manageable
Olivia	Many. Unknown	8 months	Threatening, critical, urging self-harm	Symptom of mental illness. Distressing and frightening	Symptom of mental illness but no longer present
Paula	Mother Many others. Unknown	Since age 18	Critical and, latterly, urging harm to husband	Symptom of mental illness. Upsetting and frightening	Internalised criticism from mother and others. No longer exerting power over her
Rhiannon	Many. Unknown	Few months	Critical but "not nasty"	Induced by illicit drug use. "it's not normal"	Induced by illicit drug use. No longer present
Robert	Many "chirrupers". "Authority voice". All unknown	Since early teens	Critical and urging to harm self and wife	In control of his life and feared harm to self and wife	"Part of him" he "doesn't want to lose". Supportive in past
Tina	Many. Unknown but with specific characters	Since age 14	Distressed and asking for her comfort and help	Distressed spirits punishing her for lack of faith. Upsetting and exhausting	Distressed spirits. Treated as "real people" offering respect and compassion

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[18] Participants did not, in the main, discuss their beliefs about what had caused them to hear voices apart from an assumption that it was 'mental illness.' This was rarely discussed in the research interviews, so the data in this table come from information given in therapy sessions.

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Table 7.3:   *Participant data - therapy information*

Participant	No. of sessions	Period of therapy	Reason for leaving	Outcome
Aisha	8	2 ½ mths	Felt therapy process complete	Positive. Making plans for future
Elaine	13	4 ½ mths	Moved to new hospital	Disappointed. No change or improvement
Fabien	51	13 mths	Felt therapy process complete	Positive. More in control of voice and life. Less isolated
Gary	17	8 mths	Moved away for personal reasons	Disappointed. No change or improvement
Katie	44	19 mths	Needed a break from therapy	Somewhat positive. More in control of voices and life
Olivia	9	2 ½ mths	Moved back to university	Somewhat positive. Voices gone. Resolution of relationship issues. Increasing self-acceptance
Paula	8	2 ½ mths	Felt therapy process complete	Positive. Voices gone. Resolution of relationship and self-acceptance issues
Rhiannon	14	3 ½ mths	Felt therapy process complete	Resolution of practical issues. Decided not to address historical distress
Robert	21	6 mths	Felt therapy process complete	Positive. Developed new relationship with voices. In control of voices and life.
Tina	23	10 mths	Felt therapy process complete	Positive. Developed new relationship with voices. Increased self-acceptance

Figure 7.1:   *Data collection process*
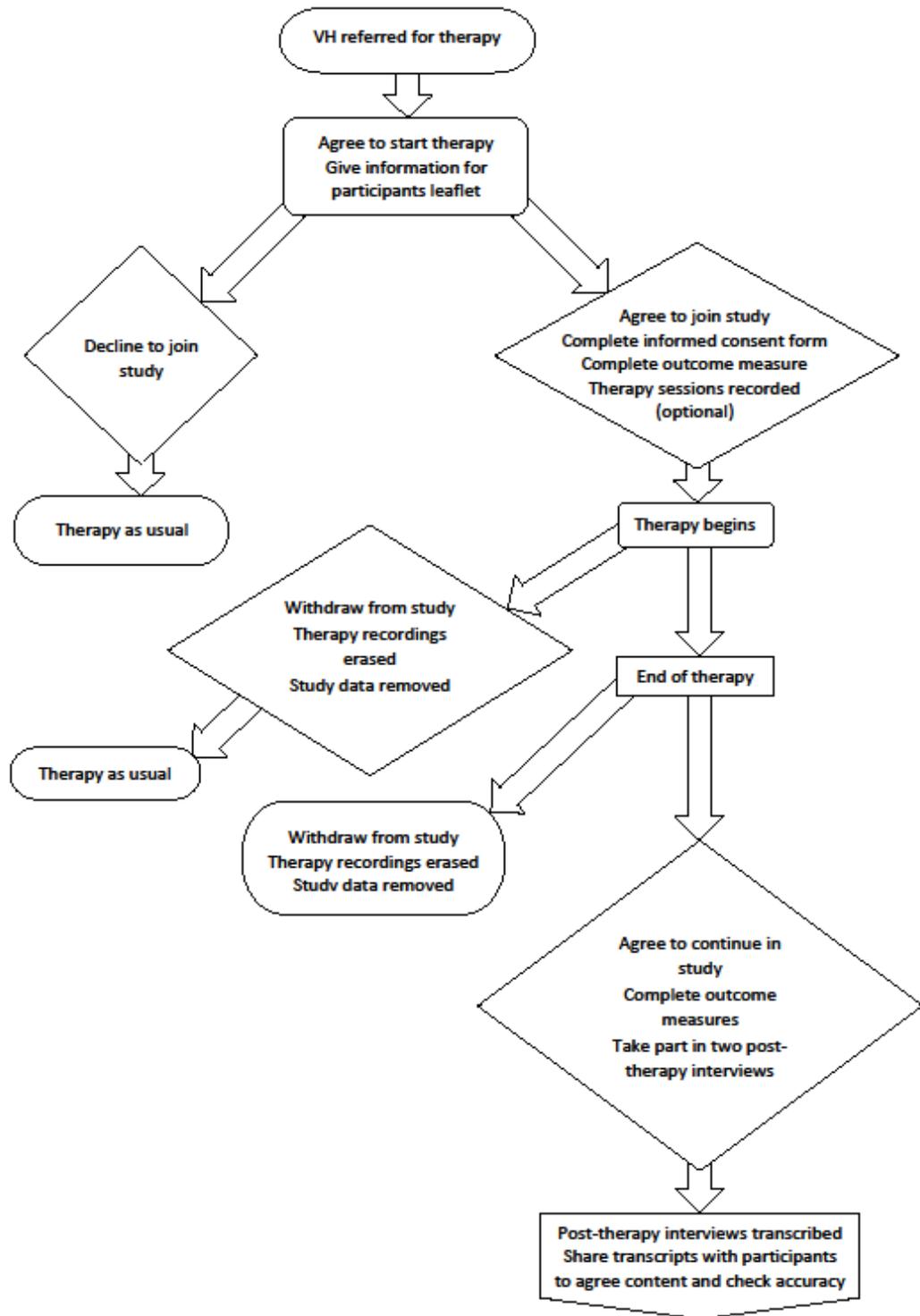
7.1.4   Recruitment

After clients who HV had decided to start therapy with me, I discussed the study with

them. I did not want the idea of the study to affect their decisions about whether to start

therapy and stressed that their therapy would be unaffected if they chose not to take part

in the study. 25 clients were approached as shown in Figure 7.2 (below).

Figure 7.2:   *Information of the 25 clients invited to join the study*
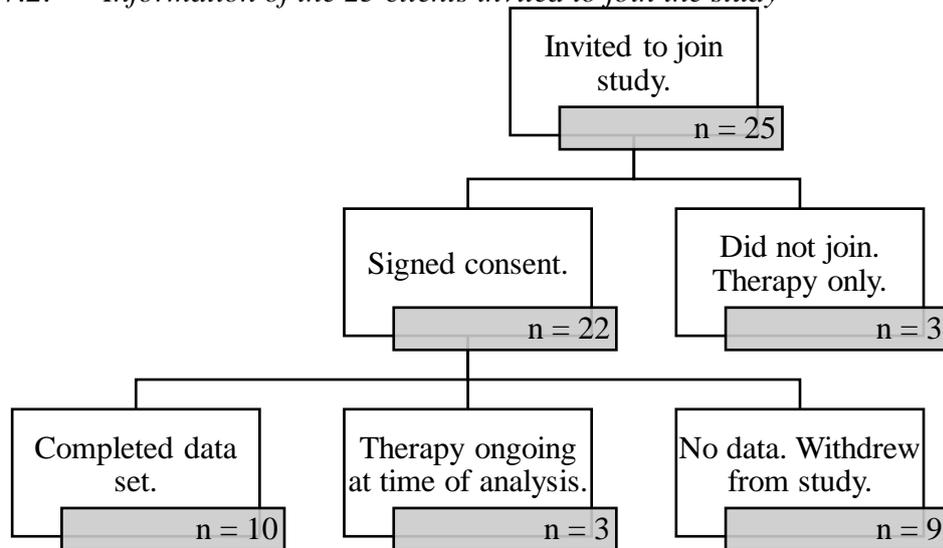
Three people approached decided not to take part and they undertook therapy as usual.

If clients expressed interest in the study, I gave them an information leaflet (Appendix

Dii) and a copy of the interview question areas (Appendix Diii) so they knew what we

would discuss if they took part in the post-therapy interviews. I also wrote to their Lead

clinicians (Appendix Div) to check that taking part in the study would be appropriate.

Lead clinicians consented in each case.

7.1.5   Informed consent

Twenty-two people entered the study and signed informed consent forms (Appendix

Dv). I later developed a Supplementary Consent form (Appendix Dvi) when I decided

to use information from therapy sessions in conference presentations and when

teaching. I confirmed with the UEL ethics committee and the NHS REC that this was

within the limits of my ethical approval. In practice, it was only necessary in two cases (Fabien and Paula).

At the start of each therapy session I asked each participant if they were comfortable with my recording the session and stressed that they could ask for the recorder to be turned off at any time. I also checked at the end of therapy that they were willing still to be involved in the research study and to complete the interviews. One decided she did not want to take part in the interviews once she decided she had finished therapy so withdrew from the study. As she had not wanted her therapy sessions recorded anyway, I had no recordings to delete but destroyed all written information.

7.1.6 Medication

I was aware that most clients were taking medication as they occasionally, but briefly, mentioned it in psychotherapy sessions and in the research interviews. I did not, however, systematically gather information on what medication they were prescribed and only Gary told me the specific drug he was taking. It seems reasonable to suppose that participants had been prescribed different antipsychotics, anti-depressants and mood stabilisers. A brief discussion of the potential effects of medication has been included in 2.1. Extrapolating from this, I will discuss the potential effects on the therapy and research process within the Discussion and Evaluation chapters, and it also forms part of my reflections on work with this client group in Chapter 9. I acknowledge, however, that the lack of information and speculative arguments may be a limitation of the study.

7.1.7 Attrition rate and data for study

Nine of the 22 participants withdrew from the study. Two decided they did not feel strong or well enough to undertake therapy at that time; two had their care taken over by the Early Intervention Team (EIS) so therapy with me had to stop; three decided not to

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continue with therapy and withdrew from the study; one withdrew from therapy and the study before the first full therapy session; and one completed her therapy but then decided not to do the post-therapy interviews.

I began my data analysis without waiting for the remaining three participants to complete their therapy. End dates for open-ended therapy can be unpredictable and my sample of ten participants compared favourably with that of other phenomenological research, which is often conducted on individual cases or with only 3-5 participants (B. Giorgi, 2011).

The analysis was carried out on ten data sets. For nine participants this included transcripts of two post-therapy interviews. Elaine, the other participant, only completed one interview. She became very distressed during that discussion so I ended it early, and we agreed that it would not be appropriate to attempt a further meeting. A week later I checked with her to confirm whether she wanted to withdraw from the study. She said she would still like to be included and that I could use the data from her first interview.

7.1.8   Therapist contractual position

I was given an Honorary Contract with the NHS Trust and arranged additional clinical supervision with one of its consultant psychiatrists for participants who were patients of that Trust.

I worked as a Volunteer Counsellor at the counselling agency and attended supervision sessions with one of their Senior counsellors for their clients.

I was a paid Sessional therapist at the independent low-secure psychiatric unit and arranged private supervision for clients I worked with there.

No clients paid for their sessions apart from the participant from the counselling agency who paid a nominal paid a fee to the agency (none of which I received).

My overall case load also included other clients who were not part of the study, and who were not VHs.

I usually offered weekly, 50-minute sessions. Occasionally, I would offer extra sessions if a client and I jointly agreed there was a need for a limited time to meet more frequently. Elaine and I agreed to meet twice a week for four weeks at one point. After a while, Gary and Tina decided they did not need to meet every week, and so moved to fortnightly sessions.

Ending therapy was initiated by the participant. During discussions, it was usually planned to happen over one or more sessions. The exceptions were Gary, who unexpectedly moved to a different city for personal reasons and Elaine, who was told she was to be moved to a different hospital.

7.2 Maintaining confidentiality

Once participants had agreed to join the study, I allocated them a unique reference number. Only I knew which participant the number belonged to.

All consent forms, letters from clinicians confirming that participants would be able to take part in the study, and any identifying information were stored in secure filing cabinets in my home office, separately from other study data.

All therapy recordings were uploaded immediately onto my home computer and password protected. They were then deleted from the digital recorder.

Any electronic files were stored on my home computer and were password protected. Only I had knowledge of the password. They were backed up to my Microsoft OneDrive Cloud storage facility, again accessed via a password known only to me.

My home computer was kept in my secure, locked home office.

All identifying information was removed from any written files, including transcripts.

All personal or therapy data (written, electronic or recorded) on participants was destroyed if they withdrew from the study at any stage.

7.3 Recording of therapy sessions

Part of the informed consent procedure was my request that participants allow me to record therapy sessions. I wanted to collect as many recordings as possible to give me a large number from which to make a random selection to send to my Independent Assessors (see 7.4.2 below). This was an attempt to confirm that I was, indeed, offering person-centred therapy.

Participants were assured that they could ask for the recorder to be turned off at any time and that they did not have to have sessions recorded if they didn't want to. All participants agreed to this apart from one, who chose not, in the end, to take part in post-therapy interviews at the end of her therapy anyway.

Consequently, of the 201 total sessions with participants in the study, I had recordings of 194. Two participants each asked me not to record on two occasions when they were feeling particularly vulnerable; another asked me not to record once as he was feeling vulnerable; one asked me to delete the previous recording when we began our next session because she regretted sharing the issues we had discussed; and on one occasion the recorder was not available.

7.4 Ensuring fidelity to therapy model

7.4.1 My qualification and practice

I completed a Post-Graduate Diploma in Person-centred Counselling (2006) and a MA in Counselling (2007) at the University of East Anglia. I have practised person-centred

therapy since in several settings. I am also an Accredited Member of the British Association of Counselling and Psychotherapy (2009).

7.4.2   Independent assessors

This was a control to ensure fidelity to the person-centred therapy model.

Three experienced person-centred therapists and theoreticians, Elke Lambers (EL), Paul Wilkins (PW) and a third person referred to as X, originally agreed to act as independent assessors in this study. They were all based away from the geographical areas in which I saw clients to ensure they did not know the participants. They also signed confidentiality agreements (Appendix Ei) which included an assurance that they would stop listening to a recording and alert me should they become aware of the identity of the participant.

I planned to send recordings of three randomly selected sessions to each of those assessors so they could comment on whether my practice could reasonably be described as being person-centred therapy. They were asked to assess what they heard against Rogers' six necessary and sufficient therapeutic conditions (C. R. Rogers, 1957, 1959) and more recent theoretical concepts such as evidence of a developing relationship. Notes giving brief information on the client, reason for referral, number of sessions attended and other relevant comments were also sent. Samples are contained at Appendix Eii and iii.

I assigned a number to each session based on date order across all participants then used a computerised random number generator to generate three (or two) sessions from within the batch. I used data collected up to each point and excluded data from the previous period(s) to capture sessions from the beginning, middle and end of therapy. I wondered if this would work, given that people were starting and finishing therapy at

different times throughout the whole period. Fortunately, however, the sessions that were selected did encompass different participants and different stages of therapy.

I carried out random selections at two points throughout the data collection period - April 2010 and May 2011. I carried out a further random selection when all therapy sessions were completed (April 2015).

I did not receive responses from X after sending the first recording in April 2010 so wrote asking if she was still able to help the study. She replied that she was and asked me to send the session again, which I did. I still received no response so, before the second session was due, I checked again. She said yes and asked me to send both sessions, which I did. I also saw her at a conference and she confirmed her willingness to be involved. I still received no responses so, after sending two further emails, I wrote asking her to destroy the discs.

Randomly selected recordings of the third selection were sent, therefore, only to EL and PW. I received reports on all three sessions I sent to each of them, and none from X. These six sessions represent only a very small sample of the 201 sessions in total ($\approx$ 3%). All were classified as person-centred therapy and I received detailed written reports on each. A sample is contained in Appendix Eiv.

I felt anxious about exposing my work to people I respect, and who had more experience than me. Once the sessions were selected, I listened to them again and was aware of how much I had 'done wrong'. It was a relief to read positive remarks and useful, but difficult, to read about 'errors'

7.5 Interview question areas

The questions for the post-therapy interviews (Appendix Div) were designed to be broad and to allow for further probing according to participants' different experiences. I

tried to ensure I could elicit data for both research questions and that the interview areas were sufficiently open to encourage participants to give me a full picture of their experiences – good and bad.

The draft interview schedule was shared with a group of service users before ethical approval was sought and minor changes were made in response to their comments. This was particularly useful in developing breadth of perspective.

7.6   Post-therapy interviews

7.6.1   Form and structure

The research data comprised two post-therapy interviews, not the therapy sessions themselves. In line with studies by Galvin and Todres (Galvin, Todres, & Richardson, 2005; Todres & Galvin, 2005, 2006) a second interview later (to give time for the initial transcript to be completed and offered to the participant for review) focused in depth on specific concrete experiences which were identified from the first interview as well as clarifying or expanding on issues previously raised.

Once a client chose to end therapy, or we became aware they would be ending for some other reason, we arranged the first post-therapy interview and completed the post-therapy questionnaires (see 7.8).

Participants had all been given a copy of the interview question areas (Appendix Div) when they were considering joining the study (before therapy began) and again when therapy ended and we arranged the interviews.

The interviews themselves were relatively unstructured and participants were briefed that we would not adhere strictly to the format. I hoped this would enable them to discuss those things that were most important to them in relation to their experiences of therapy and of HV.

Participants knew interviews were to be recorded but I assured them that we could stop the discussion or turn off the recorder at any time if they wished. All participants stated that they were happy for interviews to be recorded.

All participants took part in two recorded face-to-face interviews, except Elaine (see 7.1.6) and Gary. In Gary's case, we conducted his interviews over the telephone. No participants except Elaine reported, or appeared to suffer, distress resulting from anything that we talked about; in fact, most seemed to enjoy reflecting on their experiences.

7.6.2   Recording and transcription

Therapy sessions and post-therapy interviews were recorded using a digital recorder and were then immediately transferred onto my personal laptop and saved in password protected files, backed up in a Microsoft cloud account. Only I knew the passwords.

I transcribed the interviews and then offered participants the chance to review the transcripts, so they could confirm I had accurately represented their words.

I carried out verbatim transcription of their words using the following conventions:

> Short pauses were noted as follows *[Pause]*
> Pauses longer than three seconds were noted as follows *[Long pause]*
> Places where transcription was impossible were marked as *[Recording unclear]*
> Hesitations were included (e.g. Umm…; Err…)
> Other activity was logged in square brackets e.g. *[Smiles]*, *[Laughter]*, *[Reads transcript]*
> All personal and identifying information was removed, including names of places, relatives and other professionals.

Each recording took about 4 hours to transcribe.

7.6.3   Option of reviewing draft transcriptions, analyses and finished analysis

I offered all participants the chance to review interview transcriptions and the thematic analysis so that they could ensure I had captured their words and experiences accurately.

This option was included out of respect for participants on the information leaflet (Appendix Dii) and on the informed consent form (Appendix Div).

All participants saw interview transcripts and no errors or omissions were reported. Only one person had asked to see the analysis. He was sent an early draft which he said was an accurate representation of his experiences and that he did not feel he needed to see any further documentation. This issue is discussed further when the study is evaluated in 14.1.2.4

7.7   Method of data analysis and presentation of findings

Although I used Braun and Clarke (2006) as a framework, I adapted it to incorporate other elements that facilitated my attempts to maintain a phenomenological attitude.

As I went through the long process, regular discussions and feedback from my academic supervisors helped me develop my themes and tried to ensure I continued to take a researcher's, rather than a therapist's perspective. I also benefited from mentoring sessions with Linda Finlay, whose approach I was keen to use. Her phenomenological expertise was invaluable in helping me elucidate themes and remain within the phenomenological attitude whilst analysing data.

The progress of the data analysis is summarised in Figure 7.3 (below) and will then be discussed.

Figure 7.3: *Data analysis process*
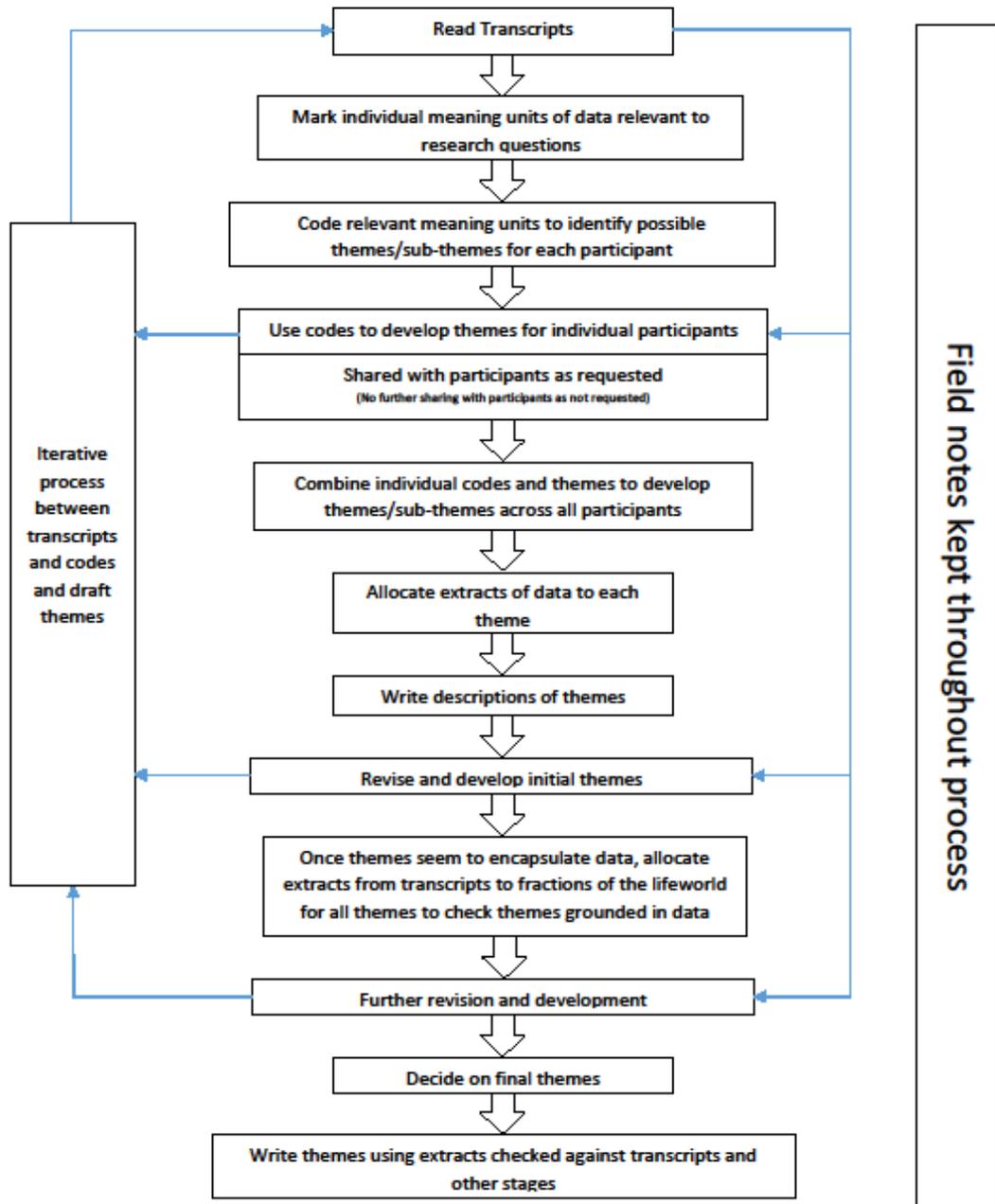
7.7.1 Reading transcripts

Transcripts were read completely twice and then several times in part, to gain a sense of what each participant was saying. An extract of a transcript is included at Appendix Fi. This enabled me to get a feel for the overall themes that might be emerging across all participants – both similarities and differences in experience. At all times, I tried to remain open to the meanings that participants appeared to be trying to convey, whilst remaining aware of how my own ideas might be affecting what I read. This involved checking whether I had empathically grasped the participants' meaning rather than imposing meaning based on my own values, experiences, assumptions. Although this is an attitude I have been trained in and have developed through my work as a therapist, there were times initially when I found it difficult to separate my understanding as therapist from that as researcher. This improved with practice.

The reading process was not a mechanism for providing a direct representation of what a participant meant, were such a thing even possible. Apart from the selection employed by anyone when answering questions, I was an integral part of the process of asking questions, the way the participant chose to answer (based, in part, on our pre-existing relationship) and our consequent exploring of those answers.

7.7.2 Coding data for meaning

I made notes about possible themes or sub-themes that each piece of relevant data might represent. Rather than just describe what was said, I embarked on the process of dwelling-with the transcripts to try and capture the implicit meaning. Not all data appeared relevant to the research questions. Again, I accept that another person might have made different choices about what data was selected. A sample of this coding procedure is included at Appendix Fii and a summary of the codes for one participant at Appendix Fiii.

7.7.3   Identifying themes

Once data had been coded in this way, I was able to make a map of all the themes that data related to for individual participants (see examples at Appendix Fiv) and then tried to collate these into initial themes across all participants (see Appendix Fv). There were many different ideas at this stage and the prospect of trying to impose some order or structure on it all was daunting. I made several charts which linked all the themes in different ways to try and delineate which might be main themes or sub-themes and which fitted together. This process changed and developed over time and an example of interim themes over that period is included at Appendix Fvi. I also wrote descriptions of themes, trying to ensure I captured the range of participants' experiences within each (see example at Appendix Fvii).

At every stage of this, especially during 2012 and 2013, I discussed what I had found in monthly meetings with supervisors. We reviewed whether these themes fitted together or should be included elsewhere, and we also reviewed the transcripts to ensure I had represented participants accurately. The most important part of this for me was supervisors' help in ensuring I remained within a researcher's perspective and did not bring in pre-existing knowledge from therapy sessions without justification from the research data. In several discussions with Linda Finlay, we talked more about what extracts signified and how to draw out the implicit meanings behind them.

By Spring of 2014 I thought I had developed a comprehensive analysis (see Appendix Fviii). I summarised each theme across each of the fractions of the lifeworld to try and ensure I was capturing different aspects of the experience. (Appendix Fix). This was not the final version (see 14.1.2.3), however, as I realised that the question of HV was not answered adequately. Linda Finlay helped me recognise this and helped in my re-working of the analysis to deal with each research question separately.

7.7.4   Coding data for each theme using fractions of lifeworld

Once I had identified the themes in 2014 I went through the transcripts again, allocating each data extract to one or more themes according to Ashworth's (2003, 2006b) fractions of the lifeworld (see Appendix Fx for a sample, using the Project fraction in connection with 'Difference' which now appears as 11.1.1, Not like other care in Chapter 11). This approach argues for the universality of a lifeworld but that each person's lifeworld is unique (P. Ashworth, 2003). I hoped that this would give me a comprehensive summary that evidenced the themes being grounded in the data and that I had constructed a coherent overall account that answered the research questions

It also grouped the data into sections that allowed me easily to select evocative quotations to illustrate different points and to ensure I represented the full range of experiences and gave voice to all participants, especially those who were less articulate or where data was less rich.

7.7.5   Iterative process between raw data and emerging themes

The process involved going back and forth between transcripts, coded data and theme to see which pieces of data fitted best where and how best to structure the overall narrative to give a comprehensive account that covered all I wanted to convey in a coherent way. It was a combination of a technical process of checking that what I had identified was supported by raw data from transcripts and a more sensory process of 'does this convey the feel of what I construe participants to mean?'

This continued throughout the data analysis process, from beginning to grasp the meaning of participant words (and silences), through the work with initial themes and sub-themes, to the construction of a narrative around the final themes selected. I kept reflective notes throughout and a sample is included at Appendix Fxi.

Sometimes it became clear that initial themes I had identified were better included as sub-themes elsewhere, or were covered under other topics. Supervision meetings were often the pre-cursors for such changes after we had discussed what a theme, sub-theme or extract signified or could be justified.

7.7.6   Writing up the themes

Once I had finally decided on the themes it felt relatively straightforward to write about the them. I had the data organised in a way that made it easy to access whenever I wanted to check to ensure the flow of the narrative was, indeed, reflected in the data.

I aimed for a balance between rigour and artistry (Finlay, 2006) to write an account that explicated the phenomena in a way that kept touch with the human nature of the story.

Extracts were sometimes edited for sense-making and reasons of space. Where text has been removed, it is marked with three dots (…).

7.7.7   Independent auditing of themes and illustrative extracts

As advocated by McLeod, (2015, p. 201), I sought feedback throughout the process of data analysis. There is a risk of producing a biased or incomplete analysis when only one person is involved in the development of a thematic analysis using such a vast array of data, especially when there are many ways of presenting an account. I was also aware that I was closely involved with the generation of the data and in the therapy process that had preceded it. I feared that I might make assumptions that were not justified by the data, or that I might miss aspects of participant accounts.

7.7.7.1   Professional perspectives

I submitted drafts to my three supervisors at all stages of the process that is shown in Appendix F. At subsequent face to face meetings with Dave Harper and Gordon Jinks, and in emails or phone calls with Rowan Bayne, we engaged in detailed discussions

about the meanings I had allocated to client accounts, whether a draft theme or sub-theme made sense or was representative of the overall data set, and whether extracts I selected were illustrative in the way I had thought. There were many times, especially in the early stages, when I discovered I had attached a meaning to an extract based on a therapist's, rather than a researcher's, perspective, or based on knowledge of things that had happened in therapy. The challenges from supervisors helped me reflect on whether such an interpretation was justified from a relational-phenomenological perspective. These discussions also helped me work out whether a theme could stand alone and whether there was sufficient evidence to justify its inclusion. For instance, I was certain initially that Surprise should be a theme on its own but later came to believe that it could be encompassed within others. Later discussions focused more on whether an extract was appropriately included under a theme and whether the range of experience across participants was represented.

I also had regular Skype and email contact with Linda Finlay. Her input had a different emphasis from that of my supervisors because of the depth of her knowledge and experience of using phenomenological methods. Those discussions helped me both to dwell with the data and to stand back, to sense the overall phenomenological meaning of participant accounts. From there I could consider what themes might be relevant and which extracts might illustrate them. She also offered helpful challenges on the selection of illustrative extracts and on whether I had captured the range of experiences described. She had an especially significant impact on helping me recognise that the question on HV needed to be analysed separately from that of the experience of therapy and how to go about achieving that. We also discussed how I could incorporate relational values into my approach to analysis even though I was not intending to do a full relational analysis in the same way as other studies (e.g. Eatough, 2009; Finlay & Evans, 2009).

The final 'auditor' of the analysis presented here was a doctoral level psychologist and counsellor who had experience of phenomenological methods, and who had not been involved in the study at all. I asked him to assess whether, for a new reader, the account conveyed the experiences of person-centred therapy and of HV. I asked him to point out where extracts did not make sense, where I might have included information that did not seem grounded in the data, or where I might have interpreted something based on person-centred allegiance. He offered several useful insights, which we discussed together. Changes I then made included adapting some language that might suggest bias towards humanistic therapy (e.g. 11.1.2, Being in a respectful, professional relationship had originally read Humanising, affirming); and reviewing Gary's experience of HV after therapy to acknowledge that his experience of HV had changed (due, he believed, to medication). This meant that I included his account in 10.4.2, Just getting better, rather than in 10.4.1, As bad as ever, as I had originally done.

7.7.7.2   *Participants' perspectives*

In their narrative approach to research and therapy, Epston and White (1990) recommend seeking feedback from clients and participants. As I was exploring subjective accounts, I valued such perspectives and had offered participants the chance to review interview transcriptions and the analysis so that they could ensure I had captured their words and experiences accurately (see 7.6.3). This option was included on the information leaflet (Appendix Dii) and on the informed consent form (Appendix Dv).

There are different views about the importance or desirability of sharing results with participants. Some regard it as an important part of rigorous research and suggest it acts as a form of triangulation and validation of data (McLeod, 2015; Stiles, 1993), something which is particularly relevant when exploring personal experiences. It could

be considered important from a moral or ethical perspective, demonstrating respect for participants in a study such as this where a lack of consideration or respect is often shown to participants in other parts of their lives (Waddingham, 2015, p. 209). Ashworth (1993) supports this view but also warns that it may not offer validation of results because of people's need to protect their socially presented selves, and also because they are unlikely in a research encounter to feel free enough to act or speak freely (see also 14.6.1 and 14.6.2).

This is a similar issue to that of client deference (Rennie, 1994), which will be discussed further under 8.5 and 14.5 below. I hoped that most participants would have established an open relationship with me and that they would offer negative and positive feedback on their experiences. If so, I suspected they would be equally honest about giving feedback on data.

Finlay raises another risk with inviting feedback on analysis from participants (personal communication, 28th August 2013). She argues that it could have a harmful effect on some who might feel shame or embarrassment when confronted with a written copy of intimate discussions.

I was aware of the need to handle the issue carefully with participants and was unsure about what the outcome would be. In the end, participants seemed to want to move on with their lives without reminders of what had often been a difficult (if sometimes successful) process so, understandably, showed little interest in continuing involvement with the study through reading analyses.

7.8   Inclusion of outcome measures

I originally intended to ask participants to complete three outcome measures (see Appendices Gi and Gii) that are sometimes used in other studies that test the

effectiveness of therapy (see Appendix Giii and Giv). I planned to administer them before and at the end of their therapy. The aim was not to test the effectiveness of person-centred therapy, but so I could find out from participants whether those measures had any meaning or relevance to their experiences.

I started to administer the measures but, as the research questions developed, I realised that I had a lot of material in answer to the other research questions and there would not be space to include a full analysis of their views. I have, therefore, included a brief analysis of scores on a case by case basis that will be presented in Chapter 12 (see also Appendix Gv). Those findings will be discussed in 13.3.2 and implications considered in 14.2.1.2. Tests of reliable and clinically significant change will be performed and qualitative outcomes will be summarised (although qualitative findings will be mainly explored in the thematic analysis).

I only gave the Brief Psychiatric Rating Scale – Extended version (BPRS-E) (Lukoff, Nuechterlein, & Ventura, 1986) to the first three participants, and only pre-therapy, as they did not seem to enjoy completing it and they were, understandably, keen to start their therapy.

They seemed, however, to feel differently about the Psychotic Symptom Rating Scales (PSYRATS) (Haddock, McCarron, Tarrier, & Faragher, 1999) and the revised Beliefs About Voices Questionnaire (BAVQ-R) (P. Chadwick, Lees, et al., 2000) which were quick and easy to complete so I carried on with them. Features of these two scales are discussed below.

7.8.1 BAVQ-R (Appendix Gi)

The Revised Beliefs about Voices Questionniare (Chadwick, Lees, & Birchwood, 2000) is a 35 item self-report questionnaire that measures VHs' perceptions of the voices they

hear rated on four point scales as follows: 0) disagree; 1) unsure; 2) agree slightly; 3) agree strongly.

The scales are Malevolence, Benevolence and Omnipotence which comprise six questions each (maximum score on each, 18); and Resistance and Engagement, each of which has two sub-scales relating to Emotional and Behavioural components. There are five questions in the Resistance – Behavioural sub-scale (maximum score, 15) and four questions in each of Resistance – Emotional, Engagement – Emotional and Engagement - Behavioural (maximum score on each, 12).

High levels of reliability were established with Cronbach's α ranging from 0.74-0.88 across the various scales (Chadwick et al., 2000, p. 230). No clinically important norms or cut-offs are reported but positive correlations were found between the Benevolence and Engagement scales and the Malevolence and Resistance scales (Chadwick et al., 2000, p. 231).

They found that the dominant voice is usually perceived to be malevolent, causing negative affect and behavioural resistance, notwithstanding any other positive aspects of the experience of HV. They also acknowledge Romme's and Escher's (Romme & Escher, 1989) finding that 15% people find the experience of HV to be positive.

It is also important to note that high scores represent negative impact and beliefs on Malevolence, Omnipotence and Resistance scales, whereas they represent a more positive experience on Benevolence and Engagement. Testing total scores may not, therefore, be appropriate.

7.8.2   PSYRATS (Appendix Gii)

The Psychotic Symptom Rating Scales (Haddock, McCarron, Tarrier, & Faragher, 1999) are semi-structured interview formats usually administered by a clinician to

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measure 11 dimensions of the experience of Auditory Hallucinations and six of Delusions on a scale from 0-4. The Delusions scale was not used in this study so is not included in Appendix Gii.

The dimensions on the Auditory Hallucinations scale are Frequency, Duration, Location, Loudness, Beliefs re origins of voices, Amount of negative content of voices, Degree of negative content of voices, Amount of distress, Intensity of distress, Disruption and Control. A higher score indicates a more negative or intrusive experience on all dimensions except the following: Loudness, where a score of 0 represents 'Voices not present' and 4 represents 'Voices are entirely outside head', with interim scores representing variations of partially inside and partially outside the head; and Beliefs re origins of voices where 0 represents 'Voices not present' and 4 represents 'Believes voices solely due to external causes' with interim scores representing degrees of belief about internal or external generation.

No clinically important norms or cut-offs were reported but median item and sub-scale total scores for 71 patients with schizophrenia ($n = 52$) or schizoaffective disorder ($n = 19$) were given as follows: Frequency, Duration, Location and Beliefs re-origin (items 1, 2, 3, and 5), median, 3, range (1-4); Loudness (item 4), median, 2, range, (1-4); Amount and Degree of Negative content (items 6 and 7), median, 3, range, (0-4); Amount of Distress (item 8), median, 3, range, (0-4); Intensity of Distress (item 9), median, 2, range, (0-4); Disruption (item 10), median, 2, range, (0-3); Control (item 11), median, 3, range, (0-4); Total Auditory Hallucination scale, median, 28, range, (14-39). For the AH sub-scale, inter-rater reliability co-efficient estimates ranged from 0.79 (item 10) -1.00 (items 4 and 8) (Haddock et al., 1999). Cronbach's α was not available in the original study but Hatton et al., (2005) used PSYRATS in a study with participants who had intellectual disabilities and demonstrated good internal reliability

with a Cronbach's α of 0.88. Perry et al., (2015) found an even higher α of *0.97* in their study of setting up an early intervention CBT service.

The dimensions were also found to be associated with one of three independent factors: physical characteristics (Frequency, Duration, Location and Loudness); emotional characteristics (Amount and Degree of negative content of voices, Amount and Intensity of distress); Cognitive interpretation (Beliefs re origins of voices, Disruption and Control). Further study has not replicated this factor structure (eg. Steel et al., 2007) but the original factors have been used in some research (eg. Valmaggia, Van Der Gaag, Tarrier, Pijnenborg, & Slooff, 2005). It may also be that change occurs in different ways across dimensions which means a total score is not necessarily representative of participants' experiences or of the items of relevance to a particular study (Freeman et al., 2004; Steel et al., 2007).

Chapter 8

8   DECISIONS ABOUT HOW TO EVALUATE THE STUDY

Once the data were analysed the study needed to be evaluated. Holt and Tickle
conducted a meta-ethnographical study of accounts of first-hand experiences of HV
(2014) where they noted that, according to Walsh's and Downe's (2005) quality
appraisal checklist, the evidence reviewed varied in quality. I have tried to account for
those criticisms and evaluate this study comprehensively. This chapter describes the
process by which I decided on appropriate criteria for evaluation and explains how the
chosen criteria, which form the basis of the evaluation of the findings presented in
Chapter 14, are applicable to the current study. Potential limitations will also be
highlighted here, prior to their more in-depth exploration in the discussion chapters.

8.1   Overview

I am aware I cannot present an accurate truth about lived experiences of HV or person-
centred therapy – if such a thing were even possible. There are several reasons why I
make no claims for the generalisability of these results, although I hope that some of
what I present will resonate with readers at a human level.

The generalisability of this study is limited by the fact that it involved a small sample of
ten people, all connected to one mental health trust in one rural English location whose
demographic mix is not representative of the UK.

The fact that participants all worked with the same therapist, who was also the
researcher, may have affected the things they felt able to discuss: whether freeing them
up to talk of issues previously discussed with someone they already knew and trusted,
or inhibiting them from discussing negative aspects of their therapy.

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Furthermore, people are necessarily selective when answering any questions and inter-subjectivity suggests this will be affected by the person doing the asking. As Ashworth (1993, p. 15) points out, this may at times lead those responding to protect their "socially presented selves." Even if they feel free to talk openly and with candour, they will still select facts, impressions, feelings or ways of talking when answering questions.

When studying human experience, it is impossible for a researcher ever to capture or present every aspect completely. This is especially the case when using methods concerned with explicating meaning rather than measurement[19]. Themes are identified which appear to form a coherent part of an overall narrative and which attempt to capture something of the commonality and diversity of the participants' experiences.

As researcher (and previously as therapist) I had my own assumptions, views, and research aims, all of which will have affected the way in which data was collected, analysed and then presented. A different researcher is likely to have developed a different set of themes which would tell an equally comprehensive story but in a different way.

8.2 Selection of evaluation criteria

I considered various factors when making decisions about how to evaluate the quality of this study. Firstly, I was interested in subjective accounts and wondered how I could elicit general and idiographic themes about the lived experiences of HV and of participating in therapy, with the possibility of exploring how, if at all, these two might be connected. I wanted to discuss the findings in the context of other research into therapy in general and person-centred therapy, specifically.

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[19] One might question whether 'naively realist' quantitative research can *ever* really capture an absolute truth either, and perhaps those researchers should also make clear their own positions or assumptions.

I was aware of the impact I would have on the process and how data were collected and analysed. The issues likely to have an effect included my dual role as therapist and researcher and the power differential implicit in therapist/client and researcher/participant relationships; the extent to which participants would remain committed to the study once their therapy had finished; and the psychological and physiological states of participants who might be medicated or vulnerable in some ways.

There are ongoing debates about how qualitative research can best be evaluated. Traditional criteria of reliability, validity, generalisability, objectivity, and representativeness do not always have relevance to the questions being investigated in studies which tend to focus on meaning. Nor can qualitative research methods, which often come from non-realist epistemologies, be meaningfully assessed against such criteria, (A. Giorgi, 1992; Willig, 2007).

Some reject the whole notion of evaluating qualitative research, arguing that the aim is not to produce any version of a truth but merely to interest the reader and stimulate debate (Forshaw, 2007). Here, the only judgement of value about the research is in terms of its originality and creativity. But this perspective seems as prescriptive and restrictive as trying to apply realist evaluation criteria to all qualitative research.

Some have proposed sets of criteria that try to mirror or adapt traditional criteria in some way (Lincoln & Guba, 1985). But if the appropriateness of 'traditional' criteria is disputed for the questions being investigated here and in other qualitative research, it does not seem to make sense to use criteria that equate to them.

Attempts to define criteria which can be applied in a generic way to qualitative studies (Elliott, Fischer, & Rennie, 1999; Henwood & Pidgeon, 1992; Stiles, 1993) have

sometimes emanated from the topics under investigation and methods favoured by the authors. Although there is undoubtedly some overlap, such approaches fail to take account of the array of epistemological and methodological positions within qualitative research (Finlay, 2006; Madill, Jordan, & Shirley, 2000; Willig, 2007). The range of questions explored, knowledge claims made and philosophical underpinnings of the different methods used are wide and various. Willig (2008, p. 152) notes that "it is clear that authors approach the question of evaluation from the particular standpoint afforded by their own preferred methodological approach." Criteria developed from within a particular epistemological position risk an evaluation of findings that will be persuasive only to those operating from within the same epistemology (Langdridge, 2007, p. 156).

Some criteria, however, are sufficiently broad to direct a researcher's focus towards matters of interest to qualitative researchers in general, whilst allowing the epistemological and methodological position of a study to be considered (Ballinger, 2006; Finlay, 2006; Yardley, 2000). Yardley's four criteria (2000) have been widely used over the last decade and seem closely linked to those proposed by Finlay and Evans (2009, pp. 59-68) as of interest to relational research. The method I am using is informed by relational thinking (although it is not a full explication of it), so it makes sense to assess this study against Finlay's and Evans' criteria, to ensure both methodological and epistemological consistency. It is hoped that the link between these and Yardley's criteria may mean the evaluation will also resonate with researchers from other positions. The two sets of criteria are compared briefly in Table 8.1 below:

Table 8.1:   *Comparison of criteria for evaluation*

Yardley (2000)	**Finlay and Evans (2009)**
Commitment and rigour	**Rigour**
Transparency and coherence	**Reflexivity**
Sensitivity to context	**Resonance**
Impact and importance	**Relevance**

By making my position, aims, assumptions and methods explicit according to each criterion, I hope to attune the reader to significant areas of the study which can then be judged according to those criteria (Finlay, 2006).

8.3 Evaluation criteria

8.3.1 Rigour

Demonstrating *Rigour* in research enables readers to regard results as trustworthy and meaningful. In qualitative research the methods need to be outlined explicitly so that readers are aware of the ontological, epistemological and methodological assumptions made and procedures followed. This includes an explanation of the ways in which the study has been designed and conducted, what is under investigation, what is at stake, and how it should be judged. This is important for the purposes of future research (for instance, for ensuring that similar studies can be conducted), for taking stock of limitations and strengths, and for evaluating the study on its own terms (Finlay, 2006, p. 325). Readers can then follow the process by which the findings and conclusions were reached.

Appendix H offers an 'audit trail'. Appendix Hi contains a list of documents used in the study, when they were administered and the responses to them. Procedures are listed chronologically and an evaluation given in Appendix Hii. This adds to information discussed previously, in other Appendices and in later chapters.

I adapted Braun's and Clarke's approach to thematic analysis (2006) and used fractions of the lifeworld (P. Ashworth, 2003, 2006a) as a heuristic to ensure I was operating with a phenomenological attitude. This involved going systematically through each transcript to check each fraction of the lifeworld against data segments for coding, and to ensure they fitted into themes that gave a coherent, comprehensive account of experience.

8.3.2   Reflexivity

Finlay claims that "reflection" can be understood as "thinking about". As a subject I can

reflect upon an object and some distance is created here as it takes place after the event.

(1998, p. 102). "Disciplined reflection" (Wilkinson, 1988 p. 493) can be the process by

which we engage in "reflexivity" which, as Etherington explains, is

> more than self-awareness in that it creates a dynamic process of interaction
> within and between ourselves and our participants, and the data that informs
> decisions, actions and interpretations at all stages of research. (2004, p. 32).

My interest in exploring subjective accounts of lived experiences allows for a level of

trust that people are describing their 'realities' as they appear to them. However, it is

also important that I acknowledge my own positioning. Willig proposes two levels of

reflexivity – epistemological and personal - that might help to capture those

complexities and features:

> Personal reflexivity involves reflecting upon the ways in which our own values,
> experiences, interests, beliefs, political commitments, wider aims in life and
> social identities have shaped the research. It also involves thinking about how
> the research may have affected and possibly changed us, as people and as
> researchers. Epistemological reflexivity requires us to engage with questions
> such as: How has the research question defined and limited what can be 'found'?
> How have the design of the study and the method of analysis 'constructed' the
> data and the findings? How could the research question have been investigated
> differently? To what extent would this have given rise to a different
> understanding of the phenomenon under investigation? Thus, epistemological
> reflexivity encourages us to reflect upon the assumptions (about the world, about
> knowledge) that we have made in the course of the research, and it helps us to
> think about the implications of such assumptions for the research and its
> findings (2001, p. 10).

My evaluation of the study will incorporate these criteria, as discussed briefly below.

8.3.2.1   *Epistemological reflexivity*

Here, I will explore my epistemological assumptions associated with the choice of

method and design of the study. I will reflect on how my affinity with person-centred

theory and the values of a reflexive-relational approach informed by existential-

phenomenological thinking influenced the ways I developed the interview format, ways I conducted the interview discussions and the ways I constructed my narrative of the results.

8.3.2.2   *Personal reflexivity*

Here, I will reflect on the impact my situation as therapist and researcher may have had on the study, results and analysis. I will explore my underlying assumptions and the effects they may have had on participants and on the results. I will consider the interplay between my philosophy as a person-centred therapist and the different perspective I needed as a researcher. The aim is not to indulge in 'navel gazing' or introspection, but to elucidate further the stories and experiences of the participants.

8.3.3   Resonance

Participants in this study had sometimes found it difficult to make their views known; they were used to being told what was wrong with them and what they should do about it. It felt important that my narrative ensured their voices were heard. I also wanted to convey the range of experiences, and to avoid producing a thematic analysis that "smoothed out" idiosyncratic accounts (Spence, 1994).

I also wanted to try and elicit – and give an account of - participants' own views and understandings about their lived experiences. My experience of working as a therapist, along with evidence from other research, discussed in 1.7; 4.2.3, suggests that, when asked about their lives, people involved with psychiatric services sometimes rely on rehearsed narratives, based on attitudes that they have taken on as their own from society more generally.

I have written this thesis for an academic audience. Whilst conveying my participants'
voices is a paramount concern, the study also needs to resonate at a professional and a
human level with people in academia, should they read it.

Finally, there are ethical issues related to the people who were participants in this study
and these must be accounted for.

8.3.4   <u>Relevance</u>

My hope is that this thesis will be of relevance in several areas. As mentioned above, it
can be difficult for people who have unusual experiences to make their voices heard. If
they also suffer distress it is important that we try to find out how best to help them. I
hope, therefore, that this thesis can offer something of relevance to that.

I will reflect on the relevance of the findings to the types of help offered to people
suffering distress, especially those in touch with psychiatric services, specifically if
those people HV.

I will also evaluate the study's relevance to ideas and research about models of therapy,
to the development of theories of therapy generally, and specifically to the development
of person-centred theory and therapy.

In addition, I will assess its relevance to other research about HV and to discussions
about the research methods appropriate for researching therapy.

8.4   Potential limitations

Linked to the evaluation of the study is a discussion of its limitations. The nature and
size of the sample has been discussed above (7.1). This sample will be evaluated for
effects it might have had on what information was offered, the claims that can be made
and what other knowledge might have been developed with a different sample.

As with qualitative research generally, it is hoped that there may be some universal elements included in what these ten people say about their experiences, alongside an illustration of the importance of individual difference. Findings might also suggest areas fruitful for further research.

Key issues to consider in any research, especially when participants might be particularly vulnerable, relate to the effects the study might have on those participants. There will also always be a power differential, and researchers have a duty of care to those willing to help them in their research. Those potential problems can be exacerbated when the researcher has a dual relationship and, in this case, is assessing the therapy that participants had with the researcher-therapist. The next sections will explore issues to do with that dual relationship, with the power differential, power and mutuality, and power which might exploit the participants. It will also balance that with a consideration of whether there are circumstances when research studies might benefit participants.

8.5   Power and dual relationships

8.5.1   Dual relationship

A common sense view would suggest that clients would find it extremely difficult to talk openly and honestly about things they found difficult or unhelpful in therapy, especially when talking to the person who has been their therapist (Rennie, 1994).The related ethical and power-related problems will be discussed in the following sections. It seems reasonable to conjecture, however, that if a vulnerable person is feeling even more vulnerable because of being asked difficult questions in a situation regarded as pressurised, they are likely to prevaricate, be evasive or not to tell the truth out of deference or politeness (Rennie, 1994).

Attempts have been made to specify guidelines and models for the undertaking of qualitative research, especially when the researcher has a dual role and therapy clients are involved (Bourdeau, 2000; Finlay, 2011; Finlay & Evans, 2009; Gabriel, 2005; Gottlieb, 1993; Meara, Schmidt, & Day, 1996). Such guidelines aim at ensuring participants are protected from exploitation and that researchers practise ethically. The ideas are similar to those in ethical codes for organisations, such as that for the British Association for Counselling and Psychotherapy (2016) to which I adhere.

8.5.2   Power differential

All relationships involve power dynamics. For the purposes of epistemological consistency, if I believe that everything is relational, then I must relinquish the idea that power is always coercive. Following Foucault (1980), power must also be relational and all are complicit in the dynamics of it. It may be that in a therapy situation there is an imbalance in that one person - the client - may be assumed to be feeling vulnerable and the other - the therapist - will presumably have been consulted because of some perceived expertise. This may lead to the client ascribing a position of 'power-over' to the therapist. As Masson notes, the 'expert' therapist decides times, fees, duration, and frequency of sessions and the client is seen as the "only one in trouble" (Masson, 1989, p. 290). Proctor notes that these definitions always position power as "domination or control" (2002, p. 12). If this is so, then there is always a very real and present danger of therapeutic relationships becoming abusive and damaging to the client.

Natiello (2001) and Proctor (2006) argue for person-centred therapists to acknowledge the power and expertise they do indeed have, but to use it collaboratively. They also suggest that therapy itself is about creating the environment that enables a client to rediscover her own personal power. It may be the case that vulnerable people coming to therapy are not best placed initially to do that, and so (as Foucault argued (1980)) are

implicated in establishing and then maintaining that power imbalance. Participants in this study, for instance, had often been involved with the psychiatric system for some time and were initially disconcerted when confronted with a different type of relationship that did not require their silence or submission to treatment by experts. But Rogers' theory (1951, 1961) rests on the premise that all individuals have the resources within to find a way to heal themselves, and that offering them an unconditionally accepting, understanding and genuine relationship can facilitate that healing – in this case, the ability to take back their own power.

Even if the power imbalance in therapy is changed as participants reclaim their personal power, there is still an argument that a new differential is introduced during the research interview. How much more guarded or 'polite' might my clients be when they are talking to me – their therapist – about the therapy they had with me? If therapy has not enabled them to reclaim their sense of personal power, the problem may be even worse. However, McLeod (2001, 2011, pp. 261-262) argues that clients feel better able to comment in the context of an unstructured interview, than when using a more structured measure, even about things they fear might be difficult for the researcher to hear. In such a context, they feel able to give a more nuanced view with the scope to justify a 'somewhat negative' and 'somewhat positive' position.

If this can be encouraged through an accepting, understanding interview situation, the problem of hesitant, evasive, incomplete or unduly restrained discussion may be ameliorated. If a client feels that therapy has 'not worked' or has been unhelpful, however, they may not feel able to say much about that, no matter how positive the interview situation. (On the other hand, one might argue that they might not even try to remain 'polite' or hide their negative feelings; they may not exhibit any deference at all!)

8.5.3   Power and mutuality

Despite any possible benefits that may accrue from a respectful relationship, it must be

acknowledged that there is a power differential in both therapy and research, and that

my power is increased here because of my dual relationship (Proctor, 2002, 2010).

There is an additional hierarchical 'expert-based idea' because of the extra researcher-

participant relationship, however much I might like to claim that person-centred therapy

minimises the imbalance and fosters mutuality. Proctor warns that,

> Although individual therapists challenge a hierarchical expert-based idea of
> therapy, therapy itself as an institution remains unnoticed, which is likely to be a
> major factor in clients not perceiving the therapy relationship as equal however
> the therapist behaves. There is a clear inequality in the roles of therapist and
> client which is not removed by any kind of therapist behaviour as a person
> (2010, p. 47).

My setting of boundaries in therapy was one exercise of power, despite my claim that

clients led sessions. But, in accordance with Proctor's suggestion (2010, p. 51), I always

explained that I needed to set limits so as to ensure I optimised my chances of working

effectively with each client. If I had not imposed boundaries I might not have been able

always to be reliable and consistent. This would be a source of unreliability in lives

where there was, often, already too much unreliability and inconsistency. Another

example of my power was in the setting of the times and the agenda for the post-therapy

interviews.

8.5.4   Power exploiting the participant

There is a great deal of evidence suggesting that the therapeutic alliance is an important

predictor of therapeutic success (Bentall, 2009; Cooke, 2014; Duncan et al., 2010;

Lambert & Barley, 2001; Norcross, 2011) – or failure (Goldsmith et al., 2015; Jarrett,

2008) (see also 4.1.3). Goldsmith et al.,(2015) showed that a poor therapeutic alliance

can have a harmful effect on therapy clients; Dale et al., (1998, p. 153) suggest clients

sometimes feel forced to act better so they can leave counselling; while Proctor has

shown that clients can feel blamed - shamed - for not getting better, especially when they are taking part in time-limited therapy (Proctor, 2010).

The power of such a therapy or research encounter must be acknowledged. A related view is that informal interviewing styles in research interviews may mean that people are likely to open up more than they would perhaps wish to (Hart & Crawford-Wright, 1999). Finch (1993, p. 173) even concedes having "emerged from interviews with the feeling that my interviewees need to know how to protect themselves from people like me."

Skinner (1998), however, asserts that creation of a 'safe' environment enables people to reflect on distressing or difficult things and to feel in control of what is revealed. Etherington (1996) acknowledges that her training as a counsellor enabled her to elicit more in-depth information than would have been the case for a researcher not trained in counselling. She was also more skilled at facilitating a trusting therapeutic relationship, which, as she notes, can spill over into research interviews. If a positive (rather than a negative (Goldsmith et al., 2015)) therapeutic relationship has already been established prior to research interviews, as in the current study, there is the potential for people to share more information than they, on later reflection, are comfortable with.

Furthermore, Batchelor and Briggs (1994) warn of situations where, unlike Etherington, researchers are not trained to cope with difficult disclosures that may arise during research interviews. This is a valid point but, as far as the current study is concerned, I would argue that I am trained to deal with such sensitive disclosures and would probably have already done so in therapy sessions. Because of this, I suspected that further information of this type would be unlikely to emerge in the research interview. In any case, the interview questions focused more on the process of therapy than on

sensitive details of a participant's life. But I ensured that participants were aware that other support would be immediately available if required.

Although I was not seeking further personal disclosure, the aim was to generate an open discussion of the participants' therapy experiences. Whilst clients had completed an informed consent form at the beginning of the study, I agree with Munhall (1988) that ongoing "process consenting" is important with each participant before and after each research procedure. It was important to make explicit that the post-therapy interviews were for the purposes of the research study and would have an agenda. Also, that if issues came up during those interviews which required further therapeutic exploration, further sessions would be organised at which they could be discussed (Cowles, 1988; McLeod, 1994).

Josselson raises several ethical questions about conducting research with ex-clients:

> Do you really feel like interfering in his or her life? Will you be able to live with the consequences of this encounter or intervention? Is it justified from the interviewees' perspective? (1996, p. 9)

I would argue that, in the current study, my clients had embarked upon the whole therapeutic process knowing they were participants in the study. They were also assured that they could at any stage withdraw from the study without it affecting their ongoing therapy. To that extent, then, the situation differed from one in which clients are re-approached for the purposes of a research study once their therapy has finished. In any case, other research has suggested that there is an ethical duty for therapists to seek feedback from clients in order to use this information to improve practice for the service of future clients (Duncan et al., 2010).

Supervision can play a part in monitoring the specific ethical problems which may arise with a dual role (Coyle, 1998, p. 71). In my case, I received separate clinical and

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research supervision. In addition, I met fortnightly with a psychiatrist working in the trust who had an interest in both my clinical and research work. Such ethical discussions formed a significant part of all such discussions.

With reference to feminist research which attempts to explain how the researcher impacts the research process, Doherty (1994, December) notes that feminist reflexivity may address, and try to reduce, the power differential in a research relationship. Such research reflexivity to minimise the power imbalance and avoid exploitation of participants can also help researchers ensure they do not overcompensate, becoming reluctant to take their share of authority in the collaborative research relationship (Etherington, 2001).

This process of reflexivity may help to give a greater voice to respondents. As researchers develop greater self-awareness of their own assumptions and prejudices (Skinner, 1998), this can affect the practice of ongoing helpful therapist-researcher attitudes (Etherington, 2001). This is like the process of counselling training, where the development of self-awareness enables a counsellor to keep her own process separate from that of her client/participant, whilst remaining aware of it - and yet be fully present in the relationship. It is also like the phenomenological research method to be employed in this project which attempts "bracketing", whilst accepting that this will be incomplete and that there will always be some interpretation. In person-centred terms, it is reminiscent of the need for a therapist to retain congruent self-awareness and implies that the research alliance could be further enhanced through these person-centred therapeutic qualities of unconditional positive regard, empathy and congruence.

8.5.5   Benefits of therapeutic research and therapist as researcher

Other research has suggested that participants might actually benefit from taking part in research which reflects on their therapeutic processes (Etherington, 1996). Commenting

on the benefits to be gained from research going on alongside a counselling process,

Wosket observes that,

> …research conducted sensitively and ethically by counsellors in their own
> practice settings, far from being damaging or exploitative, can actually enhance
> the therapeutic experience of clients. (1999, p. 106)

Etherington (2001), too, argues that qualitative data gathering methods create

opportunities for clients to gain new understandings and experiences, with fresh

emotions being recreated through storytelling. She argues that the nature of the research

relationship can also be discussed and made explicit, providing an opportunity to talk

about how and where to deal with any issues which could be regarded as more to do

with the therapy than with the research. Describing how the therapeutic process enabled

her clients to rediscover their own power such that they were subsequently able to be

honest with her in the research interviews, Etherington notes that

> …they were now much more aware of their own power, their ability to say "no"
> (even to me!) And were now at a new place from which they could look back
> over their story.(2001, p. 11)

Etherington's experience is of value to me, given that I wanted my participants to feel

'powerful' enough to say negative things about their therapy experience - and about me.

My experience of the person-centred approach to therapy suggests that by the time a

client reaches the end of her therapeutic process, a relationship of mutuality, trust and

openness will often have been established. By the end of therapy, clients will have come

to believe they are the experts in their own processes; both client and therapist will be

comfortable with expressing honest views to each other; and clients will have no need

to protect the therapist from difficult or challenging views they may hold. In short, the

therapy will have developed as an open, collaborative process, directed by the client

according to their wishes and needs. To that extent then, the post-therapy interviews

will merely be an extension of things we have already discussed and views we have

already shared. I would suggest that, with my participants, the pre-existing therapeutic

alliance and trusting relationship acted to enhance a positive research alliance.

As Grafanaki (1996) suggests, this therapeutic and research alliance may also make it

easier to discuss and work out possible solutions to difficult issues raised along the way.

In any case, McCracken says the qualitative interview gives the participant the chance

to "make the self the centre of another's attention, to state a case that is otherwise

unheard, to engage in an intellectually challenging process of self-scrutiny and even to

experience a kind of catharsis." (1988, p. 28)

Rennie (1994) notes that some clients, while feeling negative about therapists, do not

express this because they defer to the therapist's authority. In such a situation, he argues

the open-ended, qualitative, collaborative method of interviewing can be regarded as

therapeutic, because of its capacity to empower the client/participant and offer further

insights.

The qualities of a good research relationship are the same even if the researcher has a

dual relationship. They are based on respect and eliciting data through encouraging the

participant to engage as a co-researcher. They also offer the opportunity to reflect on the

participants' phenomenological experiences, even if the agenda belongs to the

researcher (Gale, 1992; Grafanaki, 1996).

I was aware that research interviews differed from therapy sessions because I was

setting the agenda in the interview in a way I hadn't in therapy. So, I tried to emphasise

a collaborative telling of their story of our shared experience of therapy which allowed

new feelings and perspectives to emerge. Following Gale (1992), I used the same types

of reflection and paraphrasing as I had done in therapy to check I had grasped

participants' meaning. I also tried to create the same non-threatening environment as we had had in therapy.

The parallel between the research interview and the therapy session is far from exact. For one thing, my interview agenda imposed constraints which were not present during therapy. But, as Skinner (1998) highlights, the research process is often centred on how people construct their reality; both researcher and participant co-construct a different reality which is similar to 'telling a story' for therapeutic purposes. To that extent, counselling skills of paraphrasing, seeking clarification and summarising are also in evidence in research (McLeod, 2011; Parry, 1991; Shepherd, 1990).

SUMMARY OF PART B

I have used chapters 6, 7 and 8 to explain how I made decisions about which method might be most useful in answering my research questions and how I would evaluate the study. My choice was based on the assumptions I made about what I wanted to know and felt I could know. I have explained how I approached the method and the operation of the study. I have also discussed how I decided on evaluation criteria and have made my assumptions explicit, so that readers are clear on how the study should be evaluated. Finally, I have outlined factors that might impact on the ways the study operated and on its evaluation.

I now move on to my findings. These constitute reflections on my therapeutic practice with this client group, a thematic analysis of what is it like to HV, and what it was like for VHs to have person-centred therapy, and consideration of quantitative and qualitative outcomes.

Part C: Findings

Part C: Findings

OVERVIEW OF PART C

Part C, which comprises four chapters, begins in Chapter 9 with a reflective account of my work as a therapist with this client group, to place the study in context. The themes and sub-themes that emerged for both main research questions are then discussed. Chapter 10 deals with what it was like to HV, while Chapter 11 explores what it was like for voice hearers to take part in person-centred therapy. Tables at the beginning of each chapter summarise the themes and sub-themes described for each research question. The experiential themes tap the commonalities and differences across participants and brief definitions are included at the beginning of each theme and sub-theme to explain the range of experiences covered. Extracts from the interviews of several participants are selectively offered to illustrate the points made. Sub-themes refer to groups of participants rather than encompassing the experiences of all of them. The numbers of participants included in each sub-theme are noted in the tables at the beginning of Chapters 10 and 11. Not all participants are always represented in all sub-themes with direct quotations but they are referred to in the text if no extract is included.

I was also interested in what participants felt about outcome and about standardised measures administered in studies researching the effectiveness of treatment for VH. A brief analysis of participants' scores and their qualitative outcomes will be included in Chapter 12.

Chapter 9

9   REFLECTIVE ACCOUNT OF MY EXPERIENCE OF WORKING WITH THIS CLIENT GROUP

9.1   Introduction

This chapter offers reflections on my therapeutic practice with these participants because, although therapy sessions were not the research data, they clearly informed the research interviews. In holding my practice up to scrutiny (Gordon, 2000, p. 342), it is a further attempt at research transparency given my dual therapist-researcher roles.

It may also contribute to "professional knowledge" (McLeod, 2016, pp. 71-86) where insights into the therapist's process and learning can benefit clients and other practitioners. I hope especially that readers can be alerted to potential assumptions about working with this client group, the issues VH may discuss or the goals for success VH may hold (Gordon, 2000, p. 341; Rundle, 2007, pp. 55-60).

The chapter is structured into four sections: a) topics discussed in therapy; b) the therapist's experience of the process of therapy; c) therapist learning; d) the practice of person-centred therapy. Protecting client confidentiality has been of paramount importance so broad issues rather than specific matters will be discussed.

9.2   Topics discussed in therapy

In my practice outside this study, I would have asked about HV only if clients raised it. With participants, however, it was the reason for referral, so it felt natural to include it in initial discussions about why they wanted to start therapy.

Participants had previously been told, and assumed (except Fabien), that voices were meaningless symptoms of mental illness. The invitation to explore their personal understandings appeared welcome, although not all chose to discuss HV directly in future sessions.

Robert, Katie and Elaine did discuss what their voices were saying during sessions and I offered to communicate with their voices via the participant. Robert's voices distrusted me and were critical of his talking to me and I would try to assuage their concerns. Apparently, this helped his voices trust me which, in turn, enabled him to trust me and to enter more fully into our relationship.

Katie's voices were abusive or threatening to us both. I stressed to them that I was not frightened and they evidently could not harm us. This seemed to help Katie feel safe within the session and to emphasise the voices' lack of power. Her sense of personal power and belief that she could defy her voices without suffering adverse consequences also increased.

Although Elaine told me what her voices were saying, she did not want me to communicate with them. She often became very distressed at their abuse and threats, which became worse if she tried to talk openly or disclose difficult issues.

More frequently, participants did not talk about voices or disclose that they were present. They discussed issues related to their lives and relationships, only occasionally relating those experiences to their voices.

Usually, participants described feeling confused, uncertain or muddled at the start of therapy, expressing a need to make sense of that confusion. Most had low self-esteem. The work of therapy was trying to work out what pre-existing understandings about self, relationships and past events might mean for them now. This sometimes resulted in

their making changes, coming to different understandings or to feeling differently about things that they could not change.

Some participants, for instance Fabien, had a plan of what they wanted to discuss. Others did not, but something would usually be triggered and they would explore issues for the whole session, thinking to themselves, or talking to me. Only Elaine struggled each week to find things to talk about.

Overall, the topics discussed by participants showed similarities with other client groups, and were often about self-worth and being in relationship. Levels of self-esteem were, perhaps, initially lower with this group as might be expected given the negative attitudes they perceived from their voices and from others in society.

9.3 The therapist's experience of the process of therapy

At the time, I expected, and found, that my practice with these participants was the same as with other work in a variety of settings with clients who had explored a range of experiences and problems, often very different from my own. That I might not share the same reality as some participants was not a matter of concern or fear, nor did I consider changing my practice because of it. It felt like another aspect of the usual challenge to find a way of engaging with the person in front of me at the level they found most appropriate.

I do not minimise participants' many struggles, not least the difficulties they found in experiencing an unusual reality. Gordon (2000, pp. 350-351) discusses being touched by different facets of his client group and I was often struck by how unlucky, sad or traumatic the lives of my participants had often been. When working at an adult male prison, I scheduled regular breaks to protect myself from burn out and the clients from receiving less than satisfactory therapy (Gordon, 2000, p. 347). I decided to do the same

during my work with these clients as I suspected the level of distress might take its toll on me. Supervision was a crucial support during this time.

Participants described therapy as a new way of relating, even though they had all been involved with other healthcare professionals. Some (Aisha, Fabien, Olivia, Paula, Robert, Tina) seemed to relish the opportunity to explore whatever was most pressing, at a pace and in a way of their choosing. Rhiannon and Katie were more reticent at first, but then decided they enjoyed this way of working. For Katie, particularly, this happened as she came to trust me. I found it exciting to bear witness to their efforts and to hear about the new understandings they reached.

Elaine and Gary, however, seemed really to struggle with what they perceived as the 'demands' of leading the therapeutic process. They found it difficult to find topics for discussion and were uncomfortable sitting in silence to think about things. I felt they required me to fulfil the role of 'expert helper' in the way that they were familiar with or wanted practical help with eliminating or controlling their voices. I sometimes wished I had been trained in other methods or feared that I was not best placed to help them. Even they, however, seemed to find some respite from their everyday struggles during sessions.

On reflection, I did 'do' different things even if my attitude towards 'being' with clients was the same – for instance, engaging with the voices participants heard. I might, therefore, have had different conversations with these participants but, overall, it felt like being with any other client.

9.4 Therapist learning

I believe participants received my attempts to lay down assumptions connected with their special situations (Gordon, 2000; Rundle, 2009b) as 'normalising', respectful and

helpful. But tracking their individual realities sometimes meant I was not able to rely on their words for understanding. Instead, I needed to grasp the meaning behind their experiencing (Gendlin, 1973, pp. 124-125). This meant I could not become caught up in my own interpretation of what something 'may mean' or 'may have been like' so empathic understanding, in a way, became more straightforward.

I wondered how participants' ways of being might have been affected by medication they were taking, but did not explore this as they mentioned it only fleetingly and I believed I should follow their leads. With hindsight, I wonder if I missed cues to explore their expectations of both interventions, the impact on selfhood of being 'someone who takes medication' and the potential effects of the medication itself. Perhaps I could have used Hammersley's list of questions (Hammersley, 2016a) to explore this. It might have changed their aims and experiences of therapy and their perspectives on HV. Their post-therapy interviews might have offered additional insights which may have altered my interpretation of the findings. This is an example of the need to be vigilant for cues from clients who have experiences very different from my own.

If participants felt respite during sessions, I had counted it as therapeutic and trusted that people could access their inner resources when necessary (C. R. Rogers, 1961). I ensured participants had someone available if they were distressed after sessions, and I regularly checked that they wanted to continue with therapy and taking part in the study, When I analysed my data, however, I started to question these beliefs and the effects on vulnerable people of talking about difficult issues, especially if they later regretted doing so. This felt significant and troubling, but I was left with the dilemma of predicting when person-centred therapy might be an appropriate option. Some participants had responded positively after initial misgivings.

My overall experience was that person-centred therapy can be a useful option for some people in this client group. It seemed important to offer the chance to explore the meaning of voices and life events that could be connected to HV. The unusual chance to develop a relationship with a therapist who valued, trusted and believed in them also seemed to have a positive impact on participants' lives.

But the impact on those whose expectations did not match the assumptions of the person-centred approach has implications for the practice of person-centred therapy, especially with particularly vulnerable clients.

9.5 The practice of person-centred therapy

The offer to communicate with participants' voices was well-received by some so may be an important aspect of work with this client group. It relates to other work on voice dialoguing (Corstens, Longden, et al., 2012; Stone & Stone, 2011). In person-centred terms, it could be approached in the same way as therapy with configurations of self which Mearns (Mearns & Thorne, 2000) describes as similar to work with groups or families, where it is important to ensure every voice is heard.

That participants were prepared to explore difficult issues in therapy was a surprise to some of them and some felt they had lowered their defences (in Rogers' terms) only to be left feeling unsupported after sessions. Sometimes the retaliatory or punishing effects of the voices after therapy sessions could also be serious, even life-threatening. It may be difficult to know in advance which people might fall into these groups but potential effects must be monitored and it is important that clients have access to support from other staff.

It may be helpful to explore the effects of medication in more detail with this client group. Although this may appear to be an adaptation of person-centred therapy, if it was

offered only when clients themselves mention medication and explored only if the client chose, it need not mean a shift towards directing content or process. Practitioners might also consider other ways of modifying the approach for this client group in ways that remain consistent with the theory such as has been claimed by work on pre-therapy (Prouty et al., 2002), by the pluralistic approach (Cooper & McLeod, 2011b) and by other "tribes" within "the person-centred nation" (Sanders, 2004).

I followed my usual practice of checking whether therapy was working for participants after a few sessions as they may have wanted to stop but felt unable to tell me. I checked every week that they were happy to continue their involvement in the study. I also tried to explore the reasons behind Elaine's regret at disclosing issues and we discussed how she could protect herself from this happening in future. It does not seem to have helped her to feel safer in sessions, however, as she continued to suffer from hearing critical and chastising voices.

Perhaps I should have explained the practice of person-centred therapy and other types of therapy in more detail. This might have offered clarity to those participants worried about whether another method might have been more appropriate.

A difficult ethical decision may remain regarding which potential clients should be invited to take part in person-centred therapy, and how best to monitor their continued involvement so that they are protected from harm.

OVERVIEW OF EXISTENTIAL-PHENOMENOLOGICALLY INFORMED THEMATIC ANALYSIS

I set out in this study to elucidate two phenomena by investigating subjective accounts of concrete lived experiences. First, I wanted to uncover something of what it might be like to HV: what it felt like, the meanings participants attached to their experiences and the impact of such experiences on their lives, relationships and how they felt about themselves. I also wanted to explore what it might be like for VH to have person-centred therapy, which is rarely offered to such a client group in the UK. I was interested to find out how participants might engage with a non-directive, non-medical approach, what they expected or hoped for, how they found being in such a therapeutic relationship, the outcomes achieved and what such outcomes meant for them.

I have tried to access the implicit pre-reflective meanings contained in their accounts and, hence, their lived experiences (including what they said or did not say). To avoid giving the impression that my account is a direct representation of their experiences, I have used words such as "said", "described", "reported" or "explained" to introduce extracts from interviews selected to illustrate the points I am trying to make. Throughout, I have tried to honour individual participant's stories whilst giving voice to the range of experiences I encountered. I have also tried to foreground their experiences rather than my own, while recognising that my interpretations have played a part in the co-construction of these findings.

As discussed in Chapters 6 and 7, my main method was a thematic analysis informed by relational, existential-phenomenological ideas.

Chapter 10

10 WHAT IS IT LIKE TO HEAR VOICES?

The themes that emerged from my analysis of this research question are presented in Table 10.1, below. The first three themes relate to participants' experiences of HV at the start of therapy, while the fourth covers their experiences afterwards. Some of the processes of change are discussed in Chapter 11, where the experience of therapy is explored.

Table 10.1: *What is it like to hear voices? Themes and sub-themes*

Theme	Sub-theme	Sub-theme	Sub-theme	Sub-theme	Sub-theme
Before therapy					
An unwelcome intrusion All participants	Frightening, confusing, a strain All participants	Distress and disruption 9 participants	Threatening, critical, commanding – and kind All participants	Struggling to stay in control 8 participants	Finding ways to manage? 3 participants
"Feeling like a freak" All participants	Feeling inferior, blameworthy, ashamed 6 participants	Feeling alone, ostracised 7 participants	Feeling deeply wounded 4 participants	Accepting a medical explanation? 10 participants	
Poignant yearning for things to be different All participants	Getting better = Not hearing voices 7 participants	Hope versus resignation All participants	Reaching a tipping point 6 participants		
After therapy					
Changing experiences, different views - sometimes All participants	As bad as ever 1 participant	Just getting better 3 participants	Accepting and learning to live with voices 3 participants	(Re-) integrating voices 3 participants	

10.1 An unwelcome intrusion

It seems HV created strong, embodied sensations that affected all participants' psychological and physical well-being. The intrusion meant they were often hindered

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from living in the ways they wanted or making positive changes and there was

sometimes an associated sense of disorder.

The experience of HV was often described as frightening and people were confused by

it. It was even worse if the content of the voices was aggressive, threatening or critical.

This theme discusses what it was like to HV, the effects of HV on participants' lives,

what the voices said to them, the effects on their senses of self, and how, or whether,

they tried to find ways of coping with voices.

10.1.1   Frightening, confusing, a strain

The strain that participants felt about hearing voices was related to several aspects of the experience such as having an unusual experience, the 'realness' of the voices, not understanding what the voices meant or why they were there and the physical drain of their constant presence. All participants reported on this range of effects.

It was often the idea of having an experience that was 'not natural' which discomfited and frightened participants.

Even though Rhiannon felt she could explain that she heard voices because of heavy

drug-taking, it did not prevent her from feeling afraid of this unusual experience:

> **Rhiannon:** It did frighten me because it's not natural to hear voices…

Furthermore, whatever the content of the voices, the strain of experiencing something

so unusual was compounded by a strong belief that the voices were 'real', even if

participants 'knew' this could not be so. For instance, Olivia believed her voices to be

symptoms of mental illness but, even so, she explained,

> **Olivia:** Umm... it was something that was very real and it was very scary *[Pause]* umm... I've been hearing voices since Christmas time. Umm... and it was just very negative, very unpleasant.

The idea that the voices were 'real' was unpleasant and frightening.

Another element of the strain for those who did not understand why they had started

hearing voices or what the voices might signify, was the struggle to make sense of it all

somehow. Aisha, for example, had attributed the voices to people in her class, but her classmates denied it was them:

> **Aisha:** When I used to turn round they would be still *[Pause]* I used to see them and they didn't say anything and I couldn't understand how they would say this but, you know, it was like they hadn't done anything and I thought, what is going on?

She was left feeling hurt and confused that people might say such things and then deny it. This often meant Aisha was confused about how to involve herself in the outside world or in relationships.

HV also seemed to have a physical effect on these participants. Repeatedly hearing things that they could neither explain nor control, was a heavy burden. Paula described how tiring it was to be struggling even to know her own thoughts:

> **Paula:** You could shout and shout and shout but you couldn't hear your own instinct; and it was exhausting and it was draining and *[Pause]* it was really heavy.

She conveyed the idea of the hard work involved in trying to hold on to what she felt or thought about things, in the face of the powerful presence of her voices.

All participants regarded the voices as an unwelcome intrusion, even those who did not find the experience wholly negative (Fabien and Katie). Katie summed up what it was like to labour under this burden:

> **Katie:** It's lovely when a day goes past and I've only heard them for an hour, it's just lovely.
> **Kirshen:** What is lovely? Tell me how that is lovely.
> **Katie:** It's just a break, instead of all the muffling going on.

The difficulty of trying to decipher what the "muffled" voices were saying was mentioned by others and caused yet more strain. Robert only realised what a weight he had been carrying after it had gone:

> **Robert:** Yes, I think that's what's been happening over the weeks and months *[Long pause]* putting a different light on things has made it lighter from me.
> **Kirshen:** Can you say a bit more about lighter?

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Robert: It's not having to carry the weight of the voices and what they want me to do.

For him the heaviness was twofold. He felt weighed down not only by the constant presence of the voices but also by his endless striving to resist their commands. Those different layers were alluded to by several participants, even if not acknowledged explicitly.

10.1.2 Distress and disruption

All except Rhiannon described the ways their voices interfered with their ability to get on with their everyday lives and spoke of lives that were disorganised because of the effects of HV.

Fabien described the effects of hearing voices on his life before therapy:

Fabien: No direction, no sort of umm... well *[Pause]* Chaos dot com.

It was as if he just didn't know which way to turn to impose some order on his chaotic life. Paula described a similar sense of disarray:

Paula: So, I'd got all those little bits floating around my head with no connectors, they were just all kind of bumbling, bumping into each other, you know, banging off each other…

Her voices had been so all-consuming that her own thought processes had become muddled. Unable to give her thoughts the attention they needed, or keep on top of practical issues, Paula eventually found herself stepping over the edge:

Paula: My head cracked and I couldn't listen anymore and I just started screaming one day…screaming and screaming and screaming and banging my head against a door saying, "shut up, shut up shut up shut up"…it scared the children, it scared *[Name of husband]* and then *[Name of support worker]* became my care worker because that is why she used to come round because my house was cluttered.

Other participants also struggled to cope with the stress, fearing there was nothing they could do about the situation (Aisha, Elaine, Gary, Katie, Olivia, Tina). As Robert put it,

Robert: Some of it was like standing on a fence *[Pause]* because you don't know which way to go.

It was as if he had become paralysed in his indecision because of the power and constant presence of his voices. He just couldn't choose what to do for the best.

In Aisha's case, HV had affected her ability to focus on her studies:

> **Aisha:** I used to think some people were saying things about me and *[Pause]* I wasn't sure if it was coming from my head or not, so I used to struggle in class, going to class…

Uncertainty, awareness of having an unusual experience, and anxiety about what was being said meant that Aisha was unable to work effectively in class or even feel comfortable there, adding another layer to the substantial distress she was already suffering. In different circumstances, other participants expressed similar effects (Elaine, Gary, Katie, Olivia, Paula, Tina, Robert)

Most participants (except Fabien) heard negative voice content much of the time and the distress and disruption caused went well beyond what the voices said to them. Most of the voices Katie heard were threatening and aggressive, so she was wary of them anyway. Her distress increased when the voices seemed to be taking physical shape. On one occasion, she had a frightening experience at the swimming pool:

> **Katie:** I went swimming yesterday *[Pause]* and they started *[Pause]* you know, and I had to look round the pool and *[Pause]* just get out and I had to look in the changing rooms ...you know, I really thought it wasn't a voice, it was him, he was there.

Paula also commented on the effects that her voices had on her ability to function in her everyday life:

> **Paula:** Sometimes I couldn't hear my baby crying because my head was so shouty…

The presence of the voices, and the control they imposed, often affected participants' ability to concentrate, with potentially dangerous consequences. Katie also highlighted the impact the voices had on her life.:

> **Katie:** When they're loud and you're in the city, going to cross the road with those fucking buses coming along everywhere…and you can't work out if someone is behind you talking to you because sometimes, like, the voice *[Pause]* I don't know who it is *[Pause]* the sound changes and the voice changes *[Pause]* and sometimes I have to look around to see who it is, to see if it's someone behind me... And when they're quite loud when you're out, it can be quite dangerous, especially if you cross the main road and...it is scary.

This was an example of where participants sometimes felt unable to concentrate on pressing matters, even, in this case, to the extent of keeping themselves safe.

Other participants, too, reported that the constant presence of voices and the consequent inability to hear, or think of, anything else left them struggling to cope (Aisha, Elaine, Gary, Katie, Olivia, Robert, Tina). Everyday living seemed impossible to manage.

10.1.3   Threatening, critical, commanding – and kind

Although the experience of voice hearing was unsettling, and the content was usually negative in a variety of ways, this was not always so. Sometimes voices could be comforting, kind or, at least, neutral.

Rhiannon, for instance, was more upset about the fact that she heard voices than about the content. She pointed out that:

> **Rhiannon:** …they weren't menacing voices…

Similarly, Tina's voices were not being negative towards her but she still felt they were making constant demands:

> **Tina:** …you know, more or less all of my voices were crying for help and stuff, you know…

If the voices were saying unkind, threatening or aggressive things, the experience of HV was particularly distressing (for Aisha, Elaine, Gary, Katie, Olivia, Paula, Robert). Katie, for example, heard the voices of two male family members who had sexually abused her from a young age. The terror she felt was a reminder and a re-living of the trauma she had been subjected to by the very people who were supposed to love her and protect her from harm. As she recalled,

> **Katie:** Sometimes I could hear *[Name of abuser]* and stuff that he used to say to me like *[Name of abuser]* with the soap *[Pause]* you know, when I had a bath *[Pause]* you know, years after that whenever I had a bath I was petrified of getting in the bath and umm... sometimes I got in the bath at night and I'm tired and *[Pause]* I've had a long day *[Pause]* and haven't slept properly the night before *[Pause]* and I get in the bath and I can hear *[Name of abuser]* saying 'Come on, soap!' and I have to get out of the bath.

The voices Katie heard said the very things that her family members had said at the time of the abuse, making her fear she might, even now, be at risk of further pain and terror.

Other participants heard critical and commanding voices which they could neither understand nor control. Some (Elaine, Gary, Katie, Olivia, Paula, Robert) feared they might act on the commands of those voices, causing harm to themselves or other people. Paula had heard critical, derogatory voices for many years, which was unsettling and distressing. She had initially equated her voices with a demonstration of her lack of worth and believed they were justified in the criticism they levelled at her. She described the ways her voices affected her ability to manage her life:

> **Paula:** It was in your main thought process; these voices were at the forefront of your mind all of the time, every decision I was making, things I was cooking, things I was wearing, places I was going *[Pause]* Critical, judgemental, with preconceived ideas of what was going to happen…

The difficulty of withstanding the constant, ongoing criticism and judgements (Aisha, Elaine, Fabien, Gary, Katie, Olivia, Rhiannon, Robert) was a common theme.

When her voices began telling Paula to harm loved ones, she became very frightened and sought a psychiatric admission to protect herself and her family:

> **Paula:** The voices had told me to kill myself before, but they'd never told me to hurt anyone else and they told me to hurt *[Name of husband]* …that was completely new and that scared me because *[Name of husband]* has only ever been the one consistent loving thing in my life and has only ever done good for me and my voices were telling me to kill him and to hurt him…not to leave him because I wasn't worthy of him, I've had that many a time umm... but to actually hurt him. And I told him and I cried and I was scared, really scared and then I got back in with the mental health team, I knew I needed it then.

The escalation from criticism to commands to hurt herself and then other people - who could not, in her view, be as worthless as she was - acted, paradoxically, as the catalyst Paula needed to seek help (see 10.3.3). She had become inured to the fear and distress caused by comments directed at herself. But she still believed that the voices had power to make her act, and that frightened her. This fear was expressed by others who heard such voices (e.g. Elaine, Gary, Katie, Olivia, Robert).

Not all voice content was negative, however. Despite the distress and fear Katie felt when she heard the voices of her abusers, she also, very occasionally, heard the voice of another family member who had died when Katie was a child:

> **Katie:** Then there's sometimes a really, really calming bit with *[Name of family member] [Pause]* just a soft sound of her voice *[Pause]* soft…

She loved the comfort she felt when she heard this voice. It was an enduring connection with the one person who had loved and tried to protect her. When I asked what it was like at the times when she had a break from the voices, she was ambivalent:

> **Katie:** Well, it depends. If I'm hearing *[Name of family member]*, I miss it. If I am not hearing her *[Pause]* it is a relief.

She yearned to hear that family member's voice, yet it was also a reminder that the person was no longer there to help or comfort her in real life.

Fabien could also see positive elements to the experience. He had heard one voice since childhood, and understood it as that of a spiritual or supernatural entity that was his higher self. Although valuing the guidance and knowledge offered by his voice, he was ambivalent sometimes as he believed that it also caused problems:

> **Fabien:** …it is a gift from the divine. That I have fought all my life to understand. I mean, I'm eternally blessed that I have been given the opportunity …but I, is it a blessing or a curse?

Katie and Fabien, however, were the exceptions in finding positive aspects to their experiences before therapy. All other participants seemed to describe HV as more of a "curse" than a "blessing" at that stage.

10.1.4   Struggling to stay in control

Voices were perceived as being in control for all except Rhiannon and Tina. That the content of the voices was often critical, commanding or threatening added to the participants' perceptions that they lacked power or value. The voices interrupted participants' trains of thought, making it difficult for them to listen to or trust their own instincts and undermining their sense of agency.

The following examples reflect the range of experiences reported by participants who felt that being controlled by their voices threatened their identities as agentic beings. Only Fabien, Rhiannon and Tina seemed immune to this. Rhiannon believed there was a concrete reason for her voice-hearing and that the voices would stop if she no longer took drugs. Although he felt overall that his identity was developing rather than diminishing through his voice's influence, Fabien believed that his voice had immense power over him and could cause him problems:

> **Fabien:** I've always thought I was taken over by this thing…

At the start of therapy, other participants also believed they had limited control over their lives, usually because they felt their voices had power over them or because they felt they were no longer able to act as agentic beings. As Katie put it,

> **Katie:** It's like *[Pause]* they control my life. It feels like sometimes they just control everything I do…

Paula, was almost primed to fail because of the control her voices exerted over her sense of self. She elaborated on the incessant negativity of their comments:

> **Paula:** I was obsessed with it, the voices in my head kept telling me I was going to die and *[Pause]* oh, I was a useless mother, I was going to lose my children and *[Pause]* you know *[Pause]* those voices just controlled everything, they were there all the time, it didn't matter what I did, or where I went to, what I was doing. Everything I'd done, there was always an answer *[Pause]* just *[Pause]* something bad to say about it.

It was as if every aspect of her life was available for criticism. The voices chipped away

at her self-esteem, challenging her right to live an adult life. Not only did she appear to

have no control over her voices, she could not even stay in touch with herself as a way

of trying to re-establish that control. She highlighted the pervasive nature of the

experience thus:

> **Paula:** My voices were here all the time and they were loud and they were
> suffocating and they were controlling my thoughts and my actions…

The intrusion was so problematic and negative that she used the metaphor of

"suffocating", with the implication perhaps that it felt almost life-threatening.

When their lives were disrupted by the unwelcome intrusion of a constant barrage of

criticism, threats and/or commands, participants seemed to find their very senses of self

under challenge. Robert felt himself to be under the control of his voices so much that

his sense of self was getting "smaller and smaller". He told me:

> **Robert**: *[Long pause]* and the voices were near enough taking over my life
> *[Pause]* there was just that little bit of me left *[Long pause]*
> **Kirshen:** What were you frightened of?
> **Robert:** That I would do what the voices said. And that I would hurt my wife
> and me.

The power of the voices was such that Robert was left feeling diminished, and

frightened that he would not be strong enough to resist their commands.

Similarly, Olivia, who had always enjoyed being able to rely on herself, found this

ability threatened when she started to HV. When I asked if she ever felt she had lost her

selfhood (as others had described) her response was:

> **Olivia:** It was always there it but it wobbled a bit.
> **Kirshen:** How did it get to be a bit a stronger?
> **Olivia:** I finally started believing in myself again…But the symptoms came
> back at a point when I wasn't feeling particularly great.
> **Kirshen:** Uh-huh…
> **Olivia:** That frightened me quite a bit when they came back *[Pause]* It
> frightened me because it made me wonder whether I was getting better or not.

The profound effect those symptoms had on her was frightening because she valued the control she usually had over herself and her life and she feared that she might revert to the situation she had previously been in where she had lost that control.

Nevertheless, some participants also reported a continued awareness that their voices were separate from them, however much the voices might try to exert control over them. As Paula explained,

> **Paula:** It was that voice in my head, not my inner instinct, it was different from that…

That she knew the voices she heard did not represent her own thoughts, feelings or instincts, implied a continuing effort to hold onto her sense of self.

10.1.5   Finding ways to manage?

Although they all followed psychiatric care plans, some participants seemed resigned to putting up with what their voices said and the distress they felt. Three others (Elaine, Katie, Tina) tried to develop additional strategies for managing the content of the voices they heard, in attempts to alleviate associated distress.

Several participants seemed resigned to living with some aspects of being a VH (Gary, Fabien, Olivia, Paula, Rhiannon, Robert). Paula, for instance, became so used to hearing negative comments about herself that she grew accustomed to it and offered no resistance:

> **Paula:** And the voices are sitting in my head telling me I'm a failure and useless and stupid and I believed it. You know, when you've got all those times of people telling you those things it's much easier to believe them.

Along with other participants, Paula had become so browbeaten that she had come to believe what the voices were telling her and saw no point in challenging that.

Some took active steps to resist or try to deal with them. When I asked Katie what she found helpful in dealing with the voices she heard, she responded:

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> **Katie:** Self-harm. Usually that 10 or 15 minutes of silence *[Pause]* it feels as if you're deaf. You can't hear anything; you get an adrenaline rush; I get the rush but it's silent, it's calming *[Pause]* it makes my heart pound…

Although her choice of action here was hardly positive, it did at least demonstrate an attempt to maintain some semblance of order over her life and minimise the negative impact of the voices. Elaine, too, tried to maintain control through self-harm, cutting or burning herself when the voices told her she was "evil". On a few occasions, however, she followed her voices' commands to try and kill herself by tying a ligature around her neck. But she always alerted staff straightaway, suggesting she had not given up on her struggles to hold on.

Tina had been so worn down by the voices she heard that she also tried to find ways of reducing their impact on her life:

> **Tina:** …I was distressed and mentally exhausted and wanted this to stop by trying to ignore it.

Her technique of ignoring her voices was not successful and she later concluded that it might have been "the worst thing [she] could have done".

All participants were in contact with psychiatric services because they heard voices and had received medical help, usually medication. The help they received is discussed in 11.1. Sadly, even if the help they sought started to have a positive effect, some participants still felt anxious about what the future held in store. Having felt so out of control once in their lives meant they were left with a residual fear of it happening again, even if they followed their care plans, as mentioned by Aisha, who said:

> **Aisha:** Well, I was told to be, you know, reassured that…as long as I take medication I will be fine but I am still scared about it. It's still worrying, you know, because they haven't gone totally and maybe they will be coming back and all the things that happened will be starting again.

It appeared that distress was an inevitable feature of experiencing something regarded by many as unusual, whatever the content of the voices. That vulnerability also seemed to linger even after initial crises had passed.

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10.2 "Feeling like a freak"

The fact that they heard voices usually led participants to seek medical help. This resulted in their being diagnosed with a mental illness, being given medical treatment. For many of them, their consequent positioning as mad, necessarily included being regarded as abnormal and inferior.

Whether viewed as a refuge from the stresses and strains of their lives (Aisha, Elaine, Gary, Katie, Olivia, Paula, Robert, Tina) or as forced imprisonment where treatment was a form of torture (Fabien, Rhiannon), admission to a psychiatric hospital and receiving medication (sometimes without consent) were accepted as the norm by participants, positively, with reluctant resignation, or with vehement resistance. Some participants found that a medical explanation of their experiences made sense and this helped them cope with the associated distress they felt.

Several felt deeply wounded by the shaming and stigmatising attitudes levelled at them as mental patients, but sometimes agreed with those views, positioning themselves as inferior and abnormal because of their unusual experiences. Some even blamed themselves for starting to hear voices, assuming they had done something to warrant experiencing something that caused them so much distress and shame. Fabien disagreed and felt angry as well as hurt by this.

Participants experienced feelings of isolation and ostracism, sometimes isolating themselves for fear of rejection. For some, this added to feelings of low self-worth, and the belief they had no opinions of value, especially if they also believed they could not access the help they needed from mental health services. Some even felt they were HV as punishment for having done wrong (Elaine, Katie, Tina), although they could rarely explain what might have deserved such punishment.

10.2.1   Feeling inferior, blameworthy, ashamed

For six participants (Aisha, Elaine, Katie, Olivia, Paula, Tina) the consequences of identifying as mad included accepting the associated negative stereotypes of inferiority and shame.

Alongside her feelings of inferiority, Paula described feelings of shame and blame because of stigmatising public attitudes that she had taken on towards herself. She said,

> **Paula:** I was just another one, you know, one of those, you know, we've got some in institutions, a couple who are, you know, really ill, one goes out digging dead babies up and stuff. I was one of those freaks…

It seemed as if there was a sense of inevitability about her demonstrable inferiority, based on pre-existing low self-esteem. Similarly, Katie had spent years believing she was to blame for having been abused and feeling ashamed about it. It was a short step from there to blaming herself for the fact she was also a person who heard voices.

> **Katie:** When I hear voices and I talk about them I feel ashamed because I feel that maybe it's my fault that I hear them.

Tina, also believed that she heard voices as a form of retribution:

> **Tina:** I felt that I was being punished in some way. I felt that some of the voices were tormenting me because I had showed lack of faith at times in the past, or for letting others down.

She had taken on the role of someone who had done wrong and deserved to be punished. Elaine also believed that she must be "evil" or have done something wrong because she heard voices.

A subtle variant on this was Olivia's idea that she had become ill because of some inner weakness or fault:

> **Olivia:** I suppose, with a sore throat, it's, it's not down to you whether or not you… you have no control over whether you get it or not.
> **Kirshen:** Hmm, but, if you were hearing voices, what?
> **Olivia:** To a degree, it is down to you. To your own personal strength, whether you end up in a situation or not.

She was sure that, had she been stronger, she could have avoided the situation in which she now found herself. The pressure and judgement she imposed upon herself were common features of participants' experience before therapy started.

10.2.2   Feeling alone, ostracised

Seven participants reported feeling isolated and marginalised, and in some cases this even extended to feeling excluded by mental health services (Aisha, Fabien, Katie, Paula, Olivia, Robert, Tina). Some kept themselves away from others because of fears about how they would be received which added to feelings of isolation and loneliness.

For instance, Aisha had initially thought the voices she heard were those of real people saying negative things about her. Even when she realised that was not the case she was still anxious and unable to know whom to trust:

> **Aisha:** You feel scared, frightened, even if you don't need to feel frightened, you feel very threatened and *[Pause]* and *[Pause]* you know, it's horrible. you avoid people, you make enemies sometimes, you know, it feels like *[Pause]* I was making friends and then I started avoiding people because I believed they were evil, they were not friends.

Aisha could not risk trusting people because of the constant fear that arose from her experience of HV. This distress was reflected in the experiences of other participants.

Their awareness of having unusual experiences that others could neither understand nor share also confirmed that their destiny was to be alone. As Fabien put it:

> **Fabien:** In a world that doesn't have them every day, it's very, very lonesome.

He demonstrated his awareness of how people who don't 'fit in' are regarded and treated saying:

> **Fabien:** Well, you should be burnt at the stake and that's the end of it, right so you've got a problem there and, therefore, you're rejection, rejection, rejection…

Aisha demonstrated a similar common concern that her mental health problems would have a lasting effect on her ability to form and maintain relationships:

> **Aisha:** If you say to someone that you, you say 'schizophrenia', they run away so I'm thinking *[Pause]* one day if I have someone in my life, how can I tell that person I have schizophrenia or if I have to tell that person, or that person sees me taking medication, what would I say to that person?

Her fear was that she would remain alone and lonely because of others' views about her illness. If people have such a fear, it makes sense that they would also be reticent about reaching out to others in case they are rejected, which perpetuates their isolation. As she also said:

> **Aisha:** I just think my mental health made me isolated and ... you know, ... yes ... isolated is the word and so ... I used to be an outgoing person, and I feel inside I am an outgoing person. But it just prevents me from doing things and sometimes ... when I was unwell, I was doing thing, isolating myself from other people, I was upset, because I believe that some people were against me

Even if participants wanted to engage with the world, intrusive voices sometimes hindered or prevented it. Tina felt that:

> **Tina:** I used to feel so caught in my world of voices and thoughts in my head that I could not see the outside world around me at all and therefore could not enjoy it at all.

While aware that there was an outside world, Tina, and others, could not separate themselves from their voice-hearing to try and access it (Aisha, Katie, Olivia, Paula). Another example is Robert, who explained how difficult it could be to manage alone when hearing voices that feel overwhelming:

> **Robert:** I only had my own thoughts and voices and feelings *[Pause]* and they [voices] were running riot.

He felt he could not compete with the force of those voices, to engage with the world. This exacerbated his sense of isolation. Even in therapy he found it difficult to present his own views:

> **Robert:** A lot of the time it was the voices *[Pause]* they were blocking me…
> **Kirshen:** But you didn't feel able to tell me that?
> **Robert:** No. The voices were saying 'You can't trust her, you can't engage.' *[Long pause]* And there was all this in my head *[Pause]* I just couldn't find the words *[Pause]* no, I just couldn't find the words.

Not only did the voices get in the way of Robert's ability to frame his own thoughts and share them with me, they also tried to influence him against talking to me (also experienced by Aisha, Elaine, Gary, Katie).

Even when some participants reached out and sought help for their unusual experiences they could feel let down. At such times, they felt their distress was unimportant to those supposedly there to help them. Tina found she had to take drastic action to get any response:

> **Tina:** I mean, if I wanted to get any support or anything my only choice was to drastically start shouting down the phone to them, 'Oh, this bad thing's happening' or 'that bad thing's happening' and I didn't actually really want to go over the top and keeps saying these things, but I felt like, if I didn't, I wouldn't get anyone to help me.

When participants felt their suffering was ignored, it added to their sense of being of no value and ostracised from society. Reflecting on the number of times he had asked for help over the years, Fabien conveyed a sense of resignation:

> **Fabien:** Well, I'd ask every time, you see, I go to my GP and I'd say, 'Can I have counselling?' And they'd say, 'Ooh, well, you know' and they'd say 'Well, you know there's a 3 to 5 year waiting list' and I'd say 'Well, hang on a moment, I've been in the system 15, how long have I got to wait?' But no, no, I never got put to the front of the queue.

It is as if those participants never expected to get constructive help that might enable them to make changes. Small wonder, then, that many felt resigned to their lives carrying on in this deeply unsatisfactory manner.

10.2.3   Feeling deeply wounded

Notwithstanding some participants' views that they deserved the stigmatising attitudes of others, four described how they felt deeply wounded by how they were treated by other people, including mental health professionals (Aisha, Fabien, Katie, Paula).

Aisha vividly described her whole painful experience of voice-hearing and becoming a mental patient:

> **Aisha:** It's horrible. It's, I wish my life I'd never had this kind of thing. It's, it's painful *[Pause]* it's pain a lot without really feeling it, without any reason You don't feel cut or nothing but you feel pain, horrible pain…

Aisha seemed to experience these wounds as physical injuries, made all the harder to bear by her not understanding why this was happening to her.

Distressing voice content added to feelings of low self-esteem which were often compounded by perceptions of negative reactions from others (all participants described examples of this). Paula cited the following example of things her hurtful voices said to her:

> **Paula:** She is looking at you funny, like, you shouldn't really be here, you're too old, you're too fat, you're too frumpy, you don't fit in.

It was clear that living under such circumstances had affected Paula deeply. She conveyed a sense in that extract of the deep pain she still felt from hearing that long list of negative judgements levelled at her. She offered a vivid metaphor for the ways that the wounds created by her own views and those of her voices were built upon which reflected the experiences of most other participants:

> **Paula:** It is kind of starting off with a hay bale curving and you not knowing where the centre of it is. It starts with lots of little niggles, and thoughts, and things being said. And, as you roll along life, you pick up more negativity and you hear more people saying bad things, and cruel things, and you lead yourself off into wrong choices and, and suddenly there's more and more of a pile-up on top until it got to a point where I couldn't distinguish any of it. I absolutely couldn't, it was just a great big muffled ball of straw with walls and all of this negativity bouncing around.

Fabien also remembered examples from his early childhood when things he had thought important had been dismissed or denied by others:

> **Fabien:** When you relive joyous moments, you realise that nobody realised how beautiful they were to you because they just were normal events to everybody else. And then they were put down like a whoopee cushion by a gorilla of a father and they were destroyed, you see, and my resentment was there.

Fabien's case was slightly different from other participants. He was so convinced of the value of the supernatural knowledge he had been given that he wanted to share it and was not willing to alter his perspective to "fit in" with mainstream society:

> **Fabien:** You think they're a bunch of arseholes for not listening, and they think you're a complete loony, and should be locked up.

His odd behaviour led to regular hospital admissions, and he was angry and resentful at how he was treated when he was experiencing what he regarded as a spiritual breakthrough;

> **Fabien:** Suddenly I'm faced with being taken out of, umm... spiritual heaven, you know, seventh heaven, up the beanstalk, and being abducted, imprisoned, assaulted, tortured and abused. And not listened to.

He found this lack of respect for his experience (which held immense significance for him) unacceptable.

Whatever their own understanding of their experiences, it was hard for participants to know they were regarded as odd or mad, and to experience the isolation and marginalisation that accompanied that. The knowledge that they were being rejected because they were unacceptable to normal society was deeply hurtful and upsetting.

10.2.4   Accepting a medical explanation?

> Before therapy, all participants except Fabien accepted the medical understanding of their experiences. Some found it made it easier to understand and bear the associated distress, although they were often upset at the stigma that attached to being a mental patient. Fabien, however, was angered and resentful at being positioned in this way.

Aisha described her feelings on being told of her diagnosis:

> **Aisha:** I said 'Oh, my God, no!'…like, for me schizophrenia is a horrible thing... but I'd never thought I was going to have it…

She was distraught and shocked to think she might have this very worst of mental illnesses and could not understand why she might have developed it:

> **Aisha:** …and it upset me because I haven't done any *[Pause]* reason to have it, you know because I always look after myself and I don't smoke, you know. If I'm going to drink, I just have a little bit. I eat healthily, I exercise, I do all that…

Interestingly, however, Aisha did not question the diagnosis; she said the symptoms matched her experiences.

Elaine appeared to struggle throughout our interview to find words to explain her experiences apart from "mental illness, I suppose". Maybe that was because I asked her the wrong questions, but others showed similar confusion even if they managed to offer some thoughts. Olivia's understanding of the voices she heard was common to several participants. She said:

> **Olivia:** It was just another symptom of me being unwell the same as any other symptom.

She, and most other participants (Aisha, Elaine, Gary, Katie, Paula, Robert, Tina), found that a medical explanation made it easier to cope with these unusual occurrences and they had never considered there might be another cause. Rhiannon was another of these people:

> **Rhiannon:** I think it would have been a lot more difficult to deal with if I *[Pause]* I hadn't *[Pause]* you know, got a reason for it.

For some, a medical diagnosis helped them to make sense of what was going on for them as well. Gary accepted without question that he had developed a mental illness after the head injury he sustained in an attack. Despite her distress, Aisha also felt a medical explanation made sense. She said:

> **Aisha:** I, yes, I do accept that I have schizophrenia. After they told me I went on reading about it and er ... the symptoms ... a lot of percent of the list were similar to mine

In addition to giving her some understanding, Aisha used the information to find out how best to manage her ongoing condition:

> **Aisha:** …knowing as well the reason behind what was happening ... yes ... it helps as well because ... and then I know, you know, I can find out how to look after myself then, when the things happen again.

She was considering diet and lifestyle factors. Others, such as Tina and Gary stressed the role their medication played in helping them to manage their lives as VHs.

Fabien, however, did not accept the medical explanation for his experiences. He believed that the voice he heard was a supernatural source offering him the prospect of profound learning:

> **Fabien:** But I don't toe the line, because I refuse to accept that what I perceive is ... um ... It is not an illness, it is a gift from the divine.

He was vehement in his opposition to accepting other interpretations of his own experience, yet aware that his beliefs were at odds with mainstream views.

10.3 Poignant yearning for things to be different

Participants all reported wanting a different future. Their views varied, however, between hope that such a difference could be brought about and resignation that a different future would not be available to them. Before the start of therapy, most saw their required change as the elimination of the voices they heard.

Many demonstrated a willingness to do anything to make things better, whether this involved positive action, some form of self-harm, or even attempted suicide, to end the unbearable situations they found themselves in. Sometimes, however, knowledge that things could be different simply highlighted the hopelessness of participants' situations (Elaine, Gary).

Several described events that had acted as triggers for their seeking help through therapy and, for some, the action of seeking help offered a glimpse of the possibility of reclaiming agency.

10.3.1   Getting better = Not hearing voices

Getting better was often perceived to be connected to change in participants'
experiences of HV. This was not the case for Fabien and not, explicitly, so for Tina.
Rhiannon believed that she would not HV if she did not take illicit drugs and that they
were only part of her vulnerabilities. Aisha, Elaine, Gary, Katie, Olivia, Paula and
Robert, however, all believed that their problems could be alleviated if they stopped
hearing voices.

Paula summed up a common feeling when she said:

Paula: I was sick of it, sick of being controlled by all these voices in my head…

Most participants felt initially that a new, better future necessitated the elimination of

the voices they heard, on the assumption that they would feel happier and better able to

function effectively (Aisha, Elaine, Gary, Katie, Olivia, Paula, Robert). Olivia's

discussion about what "feeling better" meant encapsulated the views of most:

Olivia: Umm... not hearing the voices any more, feeling safe, not feeling
suicidal, not feeling so depressed.

In Olivia's case HV was bound up with other negative feelings, ones which had

impeded her ability to continue her career. She obviously hoped that she would

successfully address issues that were perhaps blocking her recovery, above all the

persistence of the voices.

Participants generally yearned for the voices to stop. As Katie put it,

Katie: Yes *[Pause]* there are still quite a few times when I want to take my own
life because I can't *[Pause]* I can't deal with it every bloody day. Sometimes it's
not every day *[Pause]* I can go a week without them *[Pause]* but the majority of
the time they are there and I don't want that.

She knew she didn't want her voices in her life, apart from the one that offered her

comfort. She was aware of the impact they had and how hard it was to cope.

Such exasperation was sometimes the impetus for participants to act: to make changes

they hoped might lead to such a future. When pressed, however, several participants

found it hard to express in any detail what that different future might look like. But the powerful sense that it was there remained.

10.3.2   <u>Hope versus resignation</u>

> Participants held differing views about their hopes for a better future might be achievable. Some seemed to believe they could bring about the changes they wanted. Some, however, seemed resigned to their being no chance of making a difference and that they were destined to continue living in the same way. Sometimes they discussed these issues in relation to their decisions to start therapy.

Some participants (Fabien, Olivia, Rhiannon, Tina), had a view of a problem that could be solved that might enable them to live in the way they wanted. Fabien believed he could develop more equanimity if he conducted a chronological "reflective analysis" of his life; Olivia wanted to focus on ways to rediscover her self-reliance.

Tina had been raped and desperately wanted to recapture what her life had been before that:

> **Tina:** I just really, really wanted to get over it, you know, because, you know, like I had seen that there is a life beyond, you know, umm... having things like anger and stuff, you know, and I have seen that there is a life without suffering so umm... I just definitely wanted to *[Pause]* you know, sort my mind out…

Similarly, Rhiannon believed that issues from her past resurfaced whenever she felt particularly vulnerable, and that this often coincided with when she started hearing voices after taking drugs. She believed it was possible to prevent this distress if she addressed those issues (and therapy was one of the places where she thought she might do that):

> **Rhiannon:** I felt like there were a few things that hadn't been cleared up that needed to be cleared up, um ... *[pause]* ...
> **Kirshen:** From your past?
> **Rhiannon:** From my past, yes… Because I found that when I was ill these issues kind of arose again
> **Kirshen:** Okay
> **Rhiannon:** Um ... And I thought that if I got them cleared up I ... um ... maybe they wouldn't arise again.

She felt able to live her life as she wanted at other times and had a sense that she had the power to protect herself against additional distress.

Seven participants (Aisha, Fabien, Olivia, Paula, Rhiannon, Robert and Tina) remained hopeful that they could make things better and that the strength to do it lay within them.

Sometimes that new future related to coming to terms with things. For Aisha, this involved developing a new – positive - sense of identity as a person with schizophrenia:

> **Aisha:** It is one of the unfortunate things that I have *[Pause]* I will want to come over it, you know *[Pause]* because there is nothing I can do, it always stays but I just want to help with what makes me a better person and just come back alive again. So, okay, I have it, but I'm not taking it as something to prevent me from living and the things which I want to do.

Her determination to assert control over the situation, accept her difficulties and still find a way to "come back alive again" was shared by some other participants (Fabien, Katie, Olivia, Rhiannon, Tina). It seems as if these people refused to be defined by their current problems and that they possessed an inner identity capable of winning through. As Paula explained,

> **Paula:** And I've waited years *[Pause]* years and years and years and years and years to do that but I wanted it, I really, really, really wanted it so badly *[Pause]* Because I love my husband and my children and I didn't want anything to happen and I didn't want to live like that anymore.
> **Kirshen:** What was it in you that made that change happen? 'I don't want to live like this anymore'?
> **Paula:** The bit of me that's always been there, that strong part. There's always been a strong part in me. But it's been hidden by all the crap…

Despite all her difficulties, and her sense that her self-esteem had been under attack for years, Paula had retained a conviction that she had a level of inner strength – even though it might have been hidden from her at times. This enabled her to hold on to a sense of hope.

By contrast, Katie could never imagine coming to terms with the voices she heard:

> **Katie:** I'll never get there *[Pause]* I'll never get used to them *[Pause]*

> **Kirshen:** Right, you'll never get used to them *[Pause]* I wonder if there is any way you can see yourself getting to the stage where that won't matter so much.
> **Katie:** I don't think they would *[Long pause]*
> **Kirshen:** That sounds pretty hopeless…
> **Katie:** I've had them for years *[Pause]* and they are just as scary as the first time I had them.

Gary and Elaine also seemed to evince little hope that there was much they could do to make things better. They seemed to struggle to answer questions about their hopes for the future, often responding with "I don't know". Gary seemed to accept the prognosis his doctors had given him:

> **Gary:** I don't know, they said I wouldn't get better for about 25 years.
> **Kirshen:** They have said you are stuck with the voices for 25 years?
> **Gary:** Basically, yes, basically.
> **Kirshen:** What do you think about that?
> **Gary:** Err..., well I don't know *[Pause]* just as long as I can control them…

As far as he was concerned, there was little to add. Nevertheless, he had agreed to the staff's suggestion that he embark on a course of counselling:

> **Gary:** Because I was hearing voices *[Pause]* I just thought I would give it a go *[Pause]* probably to try and help me manage *[Pause]* I was a bit sceptical and wondered where it was going to go and stuff like.

His acceptance of his prognosis and his sceptical agreement to try therapy seem to demonstrate a resignation that there was little likelihood of his achieving much change, as well as a cautious concern about what would be involved.

10.3.3 Reaching a tipping point

In six cases (Aisha, Katie, Olivia, Paula, Rhiannon, Robert), recent crises or specific events had led to participants' contact with services just before I met them. Therapy was one of the options then available. Fabien and Tina had been requesting additional help for some time; Gary and Elaine were long-term patients who were advised by medical staff to try therapy as an adjunct to existing care plans.

Robert had previously obeyed the commands of his voices to step in front of a lorry. The voices had told him he was so worthless he should kill himself by doing so. When the voices started telling him to kill his wife as well as himself, both Robert and his wife were terrified that he would not be able to resist their commands. Robert could not,

however, understand why his wife also had to die. No matter how hard it might be, he

had not given up his struggle to resist the negative commands of his voices and this was

the catalyst for his seeking help to make changes:

> **Robert:** Well, I needed help because the voices were getting *[Pause]* dangerously close to getting what they wanted and I knew that it was wrong. *[Long pause]* But *[Pause]* I had to try something.

Like Robert, other participants knew they did not want to act on the commands made by

the voices they heard and were frightened to think they might:

> **Paula:** I came in because of that; because I couldn't cope *[Pause]* you know *[Pause]* I just was scared. I was really scared. It came from nowhere *[Pause]* I'd never had it that intense. I've always had the anxiety and low self-esteem bits and stuff umm... but I'd never had the voices get so loud and so strong that it could cause harm.

She also demonstrated that a crisis could act as the tipping point for seeking help:

> **Kirshen:** And the turning point was when the voices told you to hurt *[Name of husband]*?
> **Paula:** Yes, and that was it. I just, I just thought I'd rather be dead *[Pause]* I would rather *[Pause]* I would rather be dead than live like this anymore *[Pause]* I was terrified *[Pause]* I was absolutely terrified.

Not only had Paula's and Robert's fears for those they loved facilitated their actions; it

also made them realise that they could reclaim a sense of agency and start wresting

power back from the voices under whose control they had laboured for so long.

Others also seemed to report that the crisis that prompted them to seek help was also the

start of their feeling more in control of their lives. Even the fact they had asked for help

seemed to feel like a demonstration of their agency (Aisha, Katie, Olivia, Rhiannon). As

has already been mentioned, Tina and Fabien had been fighting to access the help they

believed they needed for some time, in their efforts to retain their agentic power.

Not all participants started therapy as a result of one particular instance. Some were

advised by clinical staff to try therapy as an aspect of their care plans – for what reason

was not clear, although there some suggested it was because they did not seem to be getting better with the existing interventions.

10.4 Changing experiences, different views - sometimes

There were a range of different experiences of HV after therapy. Some participants still heard voices, some did not, and the levels of distress varied across participants. A variety of reasons were proposed for changes in experiences, not all connected with the work participants had done in therapy. There were also changes in the ways some participants understood their voices and the narratives they created around them.

10.4.1 <u>As bad as ever</u>

Voices were experienced as intrusive and distressing as ever. There may have been an accompanying sense of disappointment

Therapy had little effect on how Elaine experienced her voices. Although she spoke of valuing the chance to talk about her thoughts, her hope that therapy would relieve her of her voices had not been borne out. She found voices just as distressing and difficult to control as before and acknowledged that therapy had not been successful in helping alleviate her distress.

10.4.2 <u>Just getting better</u>

Other participants, while experiencing change, did not attribute this to therapy. They believed either that they would have got better anyway, or that their medical treatment had been responsible for any changes they experienced.

While Gary noticed a change in the voices he heard, he did not attribute this to his therapy:

> **Gary:** I don't hear the voices so much anymore *[Pause]* now I'm on that clozapine.

It seems important to note that change can be linked to all sorts of factors; for Gary, medication rather than therapy had made the difference. As far as he could see, he had not found therapy a success.

Both Rhiannon and Olivia reported that their voices had disappeared. But, in common with Gary, both remained clear that the voices were symptoms of psychosis and their therapeutic experience was separate from having any effects on that. Rhiannon continued to believe that her voices were caused by heavy illegal drug use. As she saw it, her voices had stopped once she stopped taking drugs and would not come back unless she took drugs again:

> **Rhiannon:** My understanding of my experience of hearing voices hasn't differed, umm... from the beginning to now.

Olivia also believed that her symptoms would have got better in time, anyway. She attributed her improvement to the effects of hospitalisation, medication and just "getting better" from a psychotic episode.

10.4.3   Accepting and learning to live with voices

Three participants (Aisha, Katie, Paula) experienced less distress when they did HV and felt more able to live satisfactory lives. In some instances, they accepted the presence of their voices and their identities as VH without feeling the need to resist. This ameliorated some distress. In others, they also believed that they had a renewed sense of personal power which reduced the power they perceived their voices might have over them.

Following therapy, Katie admitted to still feeling scared of her voices and distressed by the idea she might never be rid of them. But she also reported feeling stronger and "more able to manage them". In part, she believed this was because she had been able to attend to them in her therapy sessions, and had defied their commands there with no bad consequences.

During the two years of our therapy, Katie had not had a hospital admission, nor had she seriously self-harmed. This seems to support her contention that she was developing

the capacity to take more control over her frightening voices. But she had also made other changes in her life which, she explained, were keeping her safe now:

> **Katie:** I've got too much to lose *[Name of husband]* *[Pause]* my cats *[Pause]* my home *[Pause]* my independence *[Pause]* I'd be back at square one in a residential home, I'd lose all my animals *[Pause]* I'd lose my flat, my furniture *[Pause]*

All this helped her feel more integrated into normal life, further reinforcing her ability to cope. It is impossible to determine the extent to which therapy was implicated in this process. By managing to defy her voices and being able to cope with their presence in therapy, however, Katie seemed to engage more positively in everyday life. Perhaps there was a cumulative effect from all these factors.

Aisha's new understanding and acceptance of her voices as symptoms of schizophrenia reduced her feelings of anxiety about the strange things she experienced:

> **Aisha:** I could see that, you know, that *[Pause]* you know, it was just my mind that was troubling me, so yes, my voices became not so powerful over me.

Although still very distressed at the idea she was suffering from schizophrenia, Aisha felt relieved to be able to regard those distressing experiences as an illness rather than something 'real'.

Paula's new understanding of what her voices signified was related to changes in how she felt about herself. She appeared to contradict herself, at one time saying that the voices had "gone, all gone", later revealing that she still heard the voice of her mother occasionally but that it no longer had the powerful negative impact it had once had. She believed that she now had the capacity to understand things differently:

> **Paula:** The occasional time I do hear something, it is negative - but then, what? What do I do with the negative? I *[Pause]* I *[Pause]* I challenge it and I question it and I push myself forward from it. So of course, I am going to have the negative, I've had it for 22 years, you know, it's not going to stop overnight, umm... but what I have got now is *[Pause]* umm... an understanding.

That new understanding seemed connected to the strength and assertiveness she drew

from feeling more positive about herself.

> **Paula:** Yes, it's making that detachment of always being insecure and always seeking for your mother's approval *[Pause]* and it's only now *[Pause]* you know, it's kind of as if I've woken up, with new eyes, and so I'm actually a grown-up and I'm actually a mother and wife *[Pause]* I can choose my family, I can choose my decisions, I can make those choices properly, and *[Pause]* I know from being a mother myself that those things were not acceptable *[Pause]* umm... but I can't hurt from that anymore and I can't judge her because it was her mistake, not mine.

Paula appeared to have changed the ways she felt about herself which then affected both

the way she understood the voices she heard and their impact on her.

10.4.4   (Re-)integrating voices

> The new narratives and explanations developed by Fabien, Robert and Tina involved integrating voices into their lives as welcome entities. Sometimes this was a process of coming to view voices as parts of themselves.

Tina had always believed there to be a spiritual element to the voices she heard, but she

thought they were demanding too much of her. As she started to feel more forgiving and

loving towards herself, she also found that she could offer her voices empathy and

compassion. When I asked her why she thought her relationship with the voices had

changed, she replied:

> **Tina:** I mean that I'm seeing… that there is also a positive side to them *[Pause]* they are like people to me *[Pause]* Like I said to you before, I've had voices that have been like umm... an army sergeant wounded in the war *[Pause]* but it's a matter of learning how *[Pause]* I was thinking to myself well, how would I treat an actual physical person I met who had done that? Would I, would I show them respect? … I was thinking, well really, instead of just saying 'Well no I can't do this', really go in for it. And speak to that person and comfort them and say the sorts of things and show them respect and you know, do all the things like you would in the physical world but do them in the spiritual world, you know, and …that sort of helped me, helped me *[Pause]* to change them into something more positive by looking at them as actual people, rather than just looking at them as thoughts in my own head.

Not only did this make her feel more in control of her life (she now negotiated with the

voices about when she could give them time) but she also felt she was living in a way

that was true to herself and in accordance with her faith. She described her voices as a

"beneficial" spiritual presence for her and a way of practising the tenets of her religion.

Fabien, too, had always valued his voice as a supernatural or spiritual presence but at

times had railed against his unusual experience. This changed following therapy:

> **Fabien:** I'm not fighting it anymore
> **Kirshen:** Previously you were fighting the *[Name he gave to his voice]*?
> **Fabien:** Well, I, I was trying to be normal because people don't do this.

Previously, Fabien had felt controlled by the voice. He had struggled to remain in

contact with a consensual reality, which had added to his distress at being not normal:

> **Fabien:** It is more that it was more in control than I was *[Pause]* I was not as
> reflective in analysis and umm... able to live in both worlds at the same time as I
> am now, 18 months down the line, you know. So, there has been a huge
> shift…that I am more integrated into normality but I can integrate and assimilate
> the voice rather than be in chaotic mode all the time.

It seems that, following therapy, Fabien had begun to perceive the voice as an integrated

manifestation of his higher self. He described the different relationship thus:

> **Fabien:** It's trust, you know, I'm not frightened of him, you see, it's a
> relationship. I mean it always was, but it was a shock when it came in and I first
> understood that this was a supernatural thing…
> **Kirshen:** Now it sounds like you have reclaimed some of your own power in the
> relationship. It's more of a partnership?
> **Fabien:** Yes, exactly, it's a partnership, it's a partnership, yes, yes, much more,
> that's a good word… yes, yes, it's a partnership, that's lovely, that's a lovely
> word.

He took great joy in the use of the word 'partnership' as it seemed to sum up for him the

way the relationship had evolved, and that it offered evidence of a constructive

connection between him and a significant presence in his life.

Robert had been so troubled by his voices when he started therapy that he had wanted to

eliminate them completely. But this changed as he started to attend to them and develop

the capacity to reflect on his own experiencing:

> **Robert**: It makes me wonder what I was *[Pause]* what was happening to me?
> It's *[Long pause]* it's a weird feeling now *[Pause]* you have to ask yourself what
> is going on *[Pause]* is it my thoughts or is it the voices?

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Kirshen: And how does that affect the way you feel about the voices?
Robert: *[Long pause]* I suppose it's given me a bit more control over them…You know, the fact that I can question them *[Pause]* now *[Pause]* 'You're asking me to do this but why?' Get them to justify it *[Pause]* that kind of thing.
Kirshen: And…what difference does that make to you?
Robert: That *[Long pause]* it's a shorter time now that they can be there.
Kirshen: How do you mean?
Robert: Well *[Pause]* if I question them, they sort of dive for cover.
Kirshen: And where does that then leave you?
Robert: Hmm *[Long pause]* Makes me feel safer.

The change in the way Robert felt about his ability to be in relationship with the voices seemed linked to changes in how he felt about himself. He felt capable of questioning his own thinking and then negotiating with his voices. This helped him realise he could wield his own power over them. From regarding them as separate, unwelcome entities, he had also started to regard them as integrated parts of himself:

> **Robert:** They are part of me and *[Pause]* there's been good times and I don't want to lose it.

In exploring the meaning of his voices, he had remembered that they had previously been supportive of him and that they often mirrored his own thinking patterns. As he started to feel more in control, he generated a more equal relationship that was no longer threatening.

With Robert, Tina, Fabien and Paula, it appeared that their increasing trust in themselves as persons of value and power helped convince them that they could take control of their lives, and of the voices they heard. For these four participants, the voices then became a welcome influence in their lives. In any case, the voices lost the negative power they were once assumed to have. Even for Katie and Aisha, still distressed and frightened by their voices, the increase in positive self-regard enabled them to feel as if they were starting to manage their voices more effectively.

Chapter 11

11 WHAT WAS IT LIKE TO HAVE PERSON-CENTRED THERAPY?

Four themes emerged from the analysis of what it was like for participants to have person-centred therapy and are shown in Table 11.1 below. The findings will now be discussed under those themes and sub-themes.

Table 11.1: *What was it like to have person-centred therapy? Themes and sub-themes*

Theme	Sub-theme	Sub-theme	Sub-theme	Sub-theme	Sub-theme
Being treated like a person All participants	Not like other care 7 participants	Being in a respectful, professional relationship 7 participants	Feeling heard and understood All participants		
Being offered possibilities All participants	A hopeful future? All participants	Sanctuary 8 participants	Finding inner resources 9 participants	Being able to talk about anything 7 participants	Being honest about needs 7 participants
Forging a way through All participants	Active, taking the lead 8 participants	Exploring meaning 7 participants	Making sense 7 participants	Hard work, but a different sort of tiredness All participants	
It's not always just about the voices All participants	It didn't work 4 participants	Somehow feeling lighter, stronger 4 participants	Making good 6 participants	A new perspective and a new start 8 participants	

11.1 Being treated like a person

All participants commented that they felt affirmed by the way I treated them. They reported a sense of being valued, as if their opinions had interest and merit, and described this as helping them to feel more normal. They also perceived that I understood and accepted what they said. This had an impact on participants' views about themselves and what they could say or do. They compared their experiences of person-centred therapy with the ways they were treated by other mental health professionals. All participants commented that the person-centred approach was a new

experience for them. The professional relationship was perceived as different from other

relationships and there were a range of perspectives about it.

11.1.1   Not like other care

When trying to describe what person-centred therapy was like, seven participants (Fabien, Katie, Olivia, Paula, Rhiannon, Robert, Tina) spontaneously used examples from other care to explain what it was *not* like. In contrast to other care, person-centred therapy was perceived as offering time for consideration of other perspectives and for getting to know participants as people.

Participants depicted the ways in which psychiatrists and other mental health

professionals worked with them as concerned primarily with offering hospitalisation

and medication to treat symptoms. Other talking therapies were also described as

different in approach and attitude.

Therapy was perceived as separate from other forms of treatment. This offered the

possibility of a different dimension for discussion. Olivia drew a comparison noting the

different focus of therapy which was also remarked upon in various ways by other

participants:

> **Olivia:** I suppose I saw you as something separate, um *[Long pause]* I didn't see you as being part of the same team that the doctors, that the doctors are working on and stuff …there's a different focus … their focus is more about *[Pause]* medication and *[Pause]* things like that…whereas yours is more about the person.

As well as the different focus of therapy, Robert's following comment is representative

of other participants' views regarding the contrast in approach between therapy and

other care:

> **Robert:** I can talk to you and you give me time, whereas the nurses and the doctors *[Pause]* they are *[Pause]* write up me tablets, 'Take them and you'll get better'

Not all participants were unequivocally against medication. Discussing her experience

of receiving medication by force, which she had found traumatic, Rhiannon had the

following to say:

> **Rhiannon:** I mean *[Pause]* They did the job, you know, they shut down my Dopamine receptors and they *[Pause]* stopped all the paranoid thoughts and things like that so they actually worked. But it's not the method to the outcome that I would have chosen.

She questioned, however, whether medication was the only option:

> **Rhiannon:** But they [clinicians] just think drugs are the answer when actually there are several more answers than just drugs.

It was also evident that participants were unhappy that during brief appointments major decisions were made about what was wrong and what treatment was appropriate:

> **Rhiannon:** You kind of sit down for five minutes and you talk to someone and then the doctor goes away and he decides what you've got and he gives you medicine for it and it's so impersonal and it's so *[Pause]* they don't really understand that every case is so dynamically different.

This disquiet at treatment plans being decided after limited contact was held by other participants. Tina also recalled her frustration at being subjected to an automatic and mechanistic appointment process:

> **Tina:** It's just like they've got all their questions written down or written down in their head because they've asked them so many times, you know, and they ask the same questions over and over again, every time you go and see them, about five minutes, asking the same questions, you know *[Pause]* like, 'Are you taking alcohol and drugs? Are you still hearing voices?' *[Pause]* I mean it's the same ones and they tick them off every time and I think, well how can they possibly know anything about me at all?

Tina questioned how staff could know her as a person based on the brief time they gave her and the information they repeatedly sought via formulaic questions. Other participants, too, reported frustration at the lack of opportunity to offer a personal perspective on their lives or problems. The overall experience of being treated by psychiatrists was perceived as depersonalising, and participants felt that being positioned as a patient invalidated any views they might have (see also 10.2).

Fabien believed he had to tell clinical staff that he accepted the medical view of his experience – even though he disputed it. He summed up the paradox of feeling under pressure to accept that you are mad in order to 'show insight':

> **Fabien:** I had to tell them what they wanted to hear *[Pause]* I had to lie about my consciousness to tell them that I was unwell, to convince them that I was better to get out.

Most seemed resigned, if not happy, to accept the decisions of mental health professionals without challenge. Paula explained her views thus:

> **Paula:** Because doctors, therapists, counsellors, all of those people, you say one thing and they jump in and tell you what you're thinking, why you're thinking that, where that process has come from. Actually, no. We are all individuals and we all process things differently and *[Pause]* I have just been consumed with everybody else's ideas on why I'm this way.

Here, Paula demonstrated growing awareness that she might be able to understand her experiences differently, something she had not considered previously. This was a common feeling among participants.

Overall, these participants seemed to believe that, although their care was not ideal, it was 'what had to be done'. The ways they experienced person-centred therapy suggested to them that there could be a different approach.

11.1.2 Being in a respectful, professional relationship

This sub-theme covers what seven participants described about the way I related to them and how that made them feel (Aisha, Fabien, Gary, Katie, Paula, Rhiannon, Tina). Feeling respected was perceived positively and all were aware of the professional nature of the therapeutic relationship. There were differing views on the implications of such a relationship.

There is often apprehension about starting therapy and a lack of knowledge about what the relationship with the therapist will be like. Fabien expressed the range of emotions he was going through at the start:

> **Fabien:** I mean, it was difficult at first to understand the boundaries and where they were and I *[Pause]* I was in trepidation really as *[Pause]* because I've

never, well, to be quite frank, anybody who works within the system has been totally an alien as far as I was concerned.

As with other participants, Fabien was unsure about a relationship he anticipated would be different from other contacts he had experienced in mental health care. He wasn't sure how the boundaries would operate but was particularly vehement when expressing his preference for a different approach to care, such as he had experienced in our work together:

> **Fabien:** Well, the first thing is you weren't a psychiatrist.
> **Kirshen:** What does that mean to you?
> **Fabien:** It meant you didn't have a clinical model and that meant that I could have empathy with you because I find the clinical model disgusting. Abhorrent.

For Fabien, this meant he could relate to me in a more personal way. Paula, too, seemed to value our relationship:

> **Paula:** It's like talking to someone on the same level. You're not sat there in your prim and proper suit, and your back arched up and your body language is just natural and *[Pause]* you know you're talking to me like a person …that's completely different, that's completely separate. There's no big desk in front of us and there's no piles of books and there's no *[Pause]* stiff collars *[Pause]* you're not looking at me up your glasses and writing things down as we speak *[Pause]* umm... that *[Pause]* that I always found very, very difficult

Although it seemed important to participants that they could relate to me, their therapist, as a person, they noted it was a professional relationship. This implied that they were aware of, and respected, the difference between talking to me and talking to a personal contact.

Rhiannon, the professional boundary meant she doubted whether she could trust that I genuinely accepted her without judgement:

> **Rhiannon:** I'm just another case and another file, another piece of paper, and as soon as you've got me out of the door then you can get another case and then boom, boom.

It may be that Rhiannon also found it difficult to work out the 'rules' of an intimate, yet professionally boundaried, therapy relationship. It could also mean that she did not trust

my genuineness in the relationship I offered her. The separateness of a professional

relationship was positive for Paula, however, and seemed to help her create an

environment in which she could do the work she wanted to do. She said,

> **Paula:** I don't see you as somebody I will depend on, that I need to have in my life. I don't need to have you every week, that's completely separate, it's professional.

Despite Rhiannon's concerns, she contrasted the relationship she formed with me with

that she had formed with a previous therapist, saying,

> **Rhiannon:** I connected with you... far better.

Such a connection appeared helpful to her and to other participants. It was perceived as

influencing how they felt about themselves. As Gary put it:

> **Gary:** I don't know, it just made me feel a bit normal.

The experience of working with a professional person who was prepared to talk to them

'as a person' seemed to help participants feel more accepted - and acceptable. Fabien,

who had often felt the pain from having his experiences dismissed as being of little

value, was aware of the difference:

> **Fabien**: The fact that you had empathy or didn't chastise it as being mad, but it was my experience, and it was justified because it was my experience, and because it enhanced my belief systems it didn't do anything damaging, um …
> **Kirshen:** Something you said there was about accepting your reality as it was for you, that that's what mattered?
> **Fabien:** Yes, yes, hugely.

What had been a rare occurrence in the lives of participants previously was remarked on

here as a welcome change.

11.1.3   Feeling heard and understood

All participants spoke of the value they attached to feeling listened to, understood and having someone bear witness to the often traumatic and distressing things they had experienced. They often drew comparisons with how they had felt treated by others, both professionally and in their personal lives.

Paula described the importance of my understanding her experiences, saying;

> **Paula:** You got it, you genuinely got it. You didn't just sit there and agree with me and tick a few boxes and write stuff down, you got it, got what I was thinking.

Her tone suggested that being understood was a new experience for her. Her comment "tick a few boxes" may also suggest she valued my attempts at being open to hearing her perspective, rather than assessing her against my own.

As well as feeling isolated and misunderstood (10.2.2), people who have unusual experiences such as HV are used to having their experiences dismissed as meaningless evidence of madness. Paula described the affirmation she felt from my understanding how hard things had been for her:

> **Paula:** I felt that you understood what I was talking about; I felt that you *[Pause]* you didn't need to comment on it; and you didn't and that was good.
> **Kirshen:** No, you don't need words always, do you.
> **Paula:** No, your body language was enough that you didn't show that 'Oh woe is you' but it showed me that you saw things must have been hard and that must have been difficult and challenging and *[Pause]* I saw that from you, but I didn't see any pity, which was nice.

The experience of being understood clearly seems to have been positive for Paula as was the experience of someone bearing witness to her struggles in a respectful, non-pitying way.

Aisha identified the value of feeling understood and how that can help a VH make sense of things herself:

> **Aisha:** You, kind of, understand what I mean, you know, if I'm struggling with the words, you can pick it up and say something, the words, and I'm like 'Yes, yes, that's right' and it's like kind of you can understand it *[Pause]*

This illustrates that Aisha believed she gained clarity because my understanding helped make explicit her implicit meanings. It may be reasonable to suggest that this is especially hard for those who experience unusual realities.

With Robert, my empathic understanding of what he was suffering appeared to give him the chance to reflect on what was happening:

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> **Robert:** I mean… you're not a miracle worker but you were giving me a second look at various things.

Robert's example reflected what all other participants also described about my empathic understanding creating a space in which they could explore what might be causing their problems.

Even those participants who decided therapy had not had any lasting positive outcomes for them found that the chance to be heard and understood had positive effects. As Gary put it:

> **Gary:** It's just different to what I thought it would be. Err…, I don't know, I probably talked more. It was more comfortable.
> **Kirshen:** What was it that made you feel comfortable?
> **Gary:** I don't know, you sort of understood and knew where I was coming from and stuff.

Feeling understood reinforced the comfort he experienced which helped him talk more openly. This, in turn, helped him feel better temporarily but the improvement lasted for only a couple of hours. For participants other than Gary and Elaine, however, the effects of feeling understood were more enduring. Katie had this to say about her overall feelings of the therapy she had completed:

> **Katie:** A relief. Having someone that understands *[Pause]* well, not just understanding but *[Pause]* but somebody to listen.

Acceptance and understanding facilitated the ability of Katie and other participants to talk in ways they had not done before. Person-centred therapy also seemed to offer them a connection with another that they had seldom experienced elsewhere.

11.2 Being offered possibilities

Therapy offered the possibility of a different future, even if expectations of success were limited. The way sessions operated offered an unusual opportunity to talk openly and honestly. It also facilitated participants' attempts to find a way of addressing difficult issues, or of choosing not to engage. The therapy space was an important

aspect of this opportunity, offering sanctuary from participants' everyday worlds. For

some participants, however, speaking openly may risk additional distress.

11.2.1   A hopeful future?

All participants described their hopes that therapy might help solve their individual problems but some seemed to have limited expectations that it would do so. Others seemed determined that they must make it work because they so wanted things to change.

Seven participants - Aisha, Elaine, Gary, Katie, Paula, Rhiannon and Robert - had had

previous experience of other types of therapy. However, only two of them - Aisha and

Elaine - had had a positive experience. Nevertheless, all were willing to try again.

Some participants were sceptical about whether therapy might be helpful (Elaine, Gary,

Olivia, Paula, Rhiannon). For instance, Olivia said:

> **Olivia:** Um…, at the start I wasn't sure if it would make much difference or not. I was quite cynical at the start but it really has helped.
> **Kirshen:** And that's, sort of, a bit of a surprise?
> **Olivia:** Yeah. I suppose my fear was that it wouldn't make any difference at all.

This apprehension was echoed especially by other participants who had had previous

experience of talking therapy such as Paula, who said:

> **Paula:** I didn't think it would fix anything to be fair, because counselling doesn't work.

Whatever expectations they had of this therapy and whether they were informed by

previous experiences, all participants wanted to take the chance. The hoped-for change

was described by Aisha thus:

> **Aisha:** [wanted to use therapy to explore] umm... actually my life, you know, that I struggle with, you know, umm... and that was important to me because I want to find a solution for myself and find an easy way for me to live and have a nice life *[Pause]* yes *[Pause]* because umm... sorting out, my childhood, you know, my *[Pause]* problem with people and my family, umm... and also my health, you know, how can I cope being around people and, you know, without having to run away and how to face people and those things *[Pause]* and also to do with, to focus on my mental health.

While Aisha naturally mentioned the factors that were specific to her, the general notion of finding solutions and making life happier or easier was shared by all participants.

At the time of starting person-centred therapy, many participants had tried other services, with mixed results. Fabien explained his attitude of hope mixed with uncertainty at the start of therapy:

> **Fabien:** I knew I'd got to get something out of it because this was the last chance saloon in a way *[Pause]* and at the same time it was *[Pause]* because it wasn't *[Name of psychiatric hospital]*, I felt better *[Pause]*

His phrase "last chance saloon" seemed to sum up the desperation of other participants regarding their situation and the need to try anything to change it (Katie, Paula, Robert, Tina).

The hopes participants expressed were not always to do with their own lives. Fabien, for instance, was keen to influence the ways the public view unusual experiences. He saw taking part in this study as a way of furthering that aim:

> **Fabien:** Here was an opportunity, that London University *[sic]* was doing research to see whether counselling helped people who hear voices. Now the opportunity meant that I could influence a change, in the perception of schizophrenia vis-a-vis the medical model.

Fabien had spent years advocating a non-medical understanding of his unusual experiences. After therapy, other participants had similar ideas of reaching out to others (Aisha, Paula, Tina) but, beforehand, this broader aim was unusual. Most hopes related to alleviating their distressing day-to-day lives, with varying degrees of an expectation of success.

11.2.2 <u>Sanctuary</u>

Eight participants described the importance of the therapy space to their therapy Aisha, Elaine, Fabien, Katie, Olivia, Paula, Rhiannon, Tina). It was perceived as a safe, comfortable environment that felt separate from the pressures of their everyday lives. This seemed to act as an important facilitator of the therapeutic process, especially for

those that chose to explore difficult issues. It functioned as a place of respite and refuge for all of them, although its physical location was perceived in different ways.

Participants described the therapy space as separate from other forms of care (see 10.1.1) and from the world, secure and comfortable. Although the room we used for patients of the healthcare trust formed part of the hospital, participants saw it as different from cold, clinical rooms they went to for other treatments:

> **Paula:** It was completely safe and separate - it wasn't in my home, it wasn't familiar and it wasn't your office. This is just a safe room that is used by lots of people.

To an extent aspects of the therapeutic relationship and my presence in the room appear to have been linked to those feelings of sanctuary. Several participants remarked on my being there in the room as an important factor in making them feel safe (Aisha, Fabien, Katie, Rhiannon, Tina). For instance, Paula said:

> **Paula:** But the fact that you always were so relaxed, that you were always so calm, yet you had a very friendly persona and energy and body language…
> **Kirshen:** Right,
> **Paula:** …made me really able to open up and talk to you um…along with the simple surroundings…

Above all, it seemed important to participants to feel safe, especially when talking about painful or frightening issues and the therapy room felt like a place of safety in which to do this. Katie gave a specific example of how this helped, saying:

> **Katie:** Sitting with you, you know, sometimes it is a comfort. Because I know that when I am hearing them [voices], I feel safe.

Elaine also mentioned that my presence helped her feel safe when she was anxious about what her voices were saying.

Katie described the impact of the therapy space on the process of therapy:

> **Katie:** I feel comfortable when I come here, more secure, knowing that I am going to leave the session and be able to leave it here. And go home.

Her comment about being able to "leave it here" was mentioned by others (Aisha, Olivia, Rhiannon, Tina) and suggested the therapy room offered a space where difficult topics could be addressed but then removed from them and deposited there.

Another aspect of sanctuary was expressed by Fabien when he described a welcome relief from a world where he felt required to deny his consciousness:

> **Fabien**: Me outside in the community is not me in here. Because I have to be very careful and keep a lid on it. In here *[Pause]* [it's] relief, you know *[Pause]* well to let the steam [out] *[Pause]* it's a pressure cooker out there. We can't be who we want to be, you know, I don't even know who I am, whether I want to be who I am, but I can express what I would like to become all right.

The metaphor of "a pressure cooker" which can be released only in the safety of the therapy room conveyed his stress. As Fabien also put it:

> **Fabien:** Here, this is structured, this is outside of the normal environment, it is encased. I feel enclosed.

This seemed to imply a solidity and security absent from his everyday life. All participants agreed that therapy offered them a chance, in a contained environment, to find answers to questions they had been unable to explore elsewhere.

The familiarity of returning to the hospital helped some participants feel comfortable (Aisha, Paula, Rhiannon). Others, however, disliked that the hospital, if not the room, had been associated with previous crises (Tina, Olivia) and Katie found the journey stressful.

11.2.3   Finding inner resources

This sub-theme illustrates how nine participants found ways of addressing difficult or painful issues, even, sometimes, while hearing voices that were trying to influence them otherwise. It also covers how this may not always be a positive occurrence when people come later to regret what they shared.

Gary and Paula did not report a struggle with accessing the inner resources they needed to do the work they wanted to do. Gary felt pleased at the strength he had shown and the fact that he had "talked more than usual". Paula also reflected that:

> **Paula:** It's not been scary; I haven't had to face up to things ... it's just been a nice steady, natural journey of what I needed to do.

Aisha, Fabien and Olivia, however, acknowledged the tension they initially felt at the prospect of confronting painful or difficult issues. This was sometimes compounded for other participants who were struggling also with what their voices were saying to them.

An example is Robert, who had to face fears on two levels. Firstly, he faced pressure from his voices not to engage in therapy:

> **Robert:** Well, in the beginning I was very wary and *[Long pause]* and the voices didn't want me to do it…but as it went on and I began to trust you, the voices also had to go along with me *[Pause]* even though they didn't agree *[Pause]* they couldn't *[Pause]* they wanted to know what was going on, you know, so *[Long pause]* after the sessions *[Pause]* the voices would *[Pause]* try and picking at me *[Pause]* they'd disagree *[Pause]* 'She's not right.'

As he was already exhausted by the presence and content of the voices, this must have caused additional pressure. But he persevered and, as mentioned above, the relationship between him, his voices and myself became more trusting.

Robert's second fear related to the implications of considering what the content of his voices might mean, as the following dialogue illustrates:

> **Kirshen:** What were you frightened of?
> **Robert:** That I would do what the voices said. And that I would hurt my wife and me.
> **Kirshen:** Right, so there was a fear that if you gave space to the voices that they would get more powerful - that you would act on what they were saying.
> **Robert:** Yes.
> **Kirshen:** Okay, I get that…fear that if I bring it out into the open…
> **Robert:** It will be worse. You feel like you are suppressing it…
> **Kirshen:** Yeah. But actually, what happened was what?
> **Robert:** It's given me a greater understanding *[Pause]*
> **Kirshen:** And have your fears been realised?
> **Robert:** No.

He discovered that it was only by paying attention to what he'd been avoiding that he

was able to understand what the voices meant for him and that his fears were also then

reduced.

Tina described a similar pattern of resisting any engagement with the voices she heard:

> **Tina:** There came a time when I had to face the bad feelings that I was having
> and I had to accept those and have a cry about things and go inside my head and
> really deal with the negative voices that I was having in order to *[Pause]* in
> order to turn them around... to help them become more positive.

She, too, found that the very thing she feared most was the key to her feeling better -

whether about herself, her traumatic experience of being raped, or the voices she heard.

Other participants (Aisha, Fabien, Olivia, Paula) also described a process of discovering

that addressing issues was not as difficult as they expected and might even hold the key

to their feeling better.

By having the courage to face the voices of her abusers in her sessions with me, Katie

felt herself becoming better able to manage the voices, whose power seemed

diminished:

> **Katie:** When I first started talking to you about the voices I just felt at ease a
> little bit *[Pause]* just for someone to sit there and listen and *[Pause]* you know
> *[Pause]* when it got hard just hold my hand and *[Pause]* you know, work out
> why they got angry when I talk about them and *[Pause]* it was sometimes really
> hard because if you're talking to someone about them then they are criticising
> you for talking about them *[Pause]* you know, and then it's a vicious circle.
> **Kirshen:** What was it like after you said it out loud?
> **Katie:** A relief.
> **Kirshen:** Why was it a relief?
> **Katie:** Just to tell someone what's happened.

Katie found several things helpful here. Being able to talk about voices at all appeared

to ease her tension and distress. It was as if my physical presence, as someone separate

but connected through holding her hand, acted as an anchor to a common – and safe –

reality We were then able to try and make sense of the voices together. Katie and others

took comfort from being able to stay with their perspective on things whilst feeling safe in therapy.

Despite some positive aspects of feeling supported in talking about difficult issues, this wasn't always enough to compensate for any distress. Elaine had felt supported by me in a similar way to Katie but later found that accessing those inner resources had caused problems. Twice she regretted opening up about particularly traumatic events because of how it left her feeling afterwards, with her voices being even more negative than usual.

These participants, therefore, varied in how they accessed the resources needed to talk about difficult issues. Most were pleased at the results but finding inner resources did not always result in overcoming fears or alleviating distress.

11.2.4   Being able to talk about anything

Confidentiality, trust and acceptance were three elements of feeling able to talk about anything discussed by Aisha, Fabien, Katie, Olivia, Paula, Robert and Tina. These aspects of therapy were important in helping participants feel safe and address the issues they chose.

In the wider medical system, it was usual practice for information about patients to be shared with all clinical staff. For Paula, this sharing of intimate personal details had been particularly painful. As she explained,

> **Paula:** My thoughts are private and that's the only thing in my life that has been private, not on display to anybody else.

Given common public attitudes towards mental health issues, it could easily be surmised that participants experienced associated feelings of shame or embarrassment. As a result, they seemed to value the knowledge that they could say virtually anything

in therapy (within previously agreed limits[20]) and that confidentiality would be

maintained:

> **Olivia:** I felt able to talk about it here rather than more than I did with other people [because] it felt like a safe environment to do so.
> **Kirshen:** Safe in terms of what?
> **Olivia:** Umm... confidentiality.
> **Kirshen:** And the thought of what you were talking about going back to medics would have done what?
> **Olivia:** It would put me off talking…I guess I don't want everybody knowing everything about me.

Participants feared clinical staff knowing what was discussed in therapy sessions,

especially if their discharges were dependent on doctors' decisions.

Robert told me that when he began therapy with me his voices were anxious about

confidentiality. But that changed as the weeks went by:

> **Robert**: …after a few weeks they began to trust you *[Long pause]* and when the voices started trusting you I did me-self as well.

Once Robert felt his voices trusted me to keep our discussions confidential, he was

reassured and felt free to engage with topics he might otherwise have kept quiet about.

At the start of our post-therapy interviews, however, he confided that the voices were

worried about this additional process:

> **Kirshen:** Would the voices be able to explain to me what their concerns are? Would you be able to tell me what the voices are concerned about? So that I could perhaps try and reassure them in some way…Because I think their point of view is very important.
> **Robert:** Yeah…um *[Long pause]* they think you are trying to trick me.
> **Kirshen:** Okay, how could I make it easier for them? How could I help them feel more comfortable about this?
> **Robert:** *[Long pause]* I think…I can trust you…but it is the voices…the authority voice who is telling me not to…
> **Kirshen:** Okay. What is the authority voice worried about*?*
> **Robert:** *[Long pause]* He is worried about how the doctors will perceive it.
> **Kirshen:** [Re-iterates confidentiality of research data]. How does he feel now I have explained that?
> **Robert:** *[Long pause]* He feels a bit reassured.

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[20] We had agreed at the start of therapy that if I felt the participant was at risk of hurting her/himself, I would suggest we involve other staff. I had also outlined the statutory requirements of working under the BACP code of ethics.

Robert and his voices needed to re-establish the trust we had developed over the course

of our therapy so that he could play a full part in our interview.

Trust was mentioned by several participants (Aisha, Elaine, Fabien, Paula, Tina) and

was one of the most important aspects of Katie's therapy. Not only did our trusting

relationship feel healing and comforting, but she also stressed that it enabled her to talk

about her voices in a way she had not done before and that this helped her feel more

able to manage them. She described how she felt:

> **Katie:** I let you in, I trusted you and I managed to ... I don't know, I let someone
> else in, someone to understand…

This trust meant she had also started to work on files relating to the sexual abuse she

suffered because she felt safe enough with me to do so. After a while, though, she found

that she needed to take a break from her work on the files

> **Katie:** I'm too scared to work on them at the moment.

This new vulnerability Katie experienced might be another risk associated with features

of therapy which facilitate in-depth exploration of difficult issues (as mentioned in

11.2.3).

A third aspect of feeling able to talk freely, that these participants all remarked upon,

was that they felt a lack of judgement from me as therapist. As Tina put it:

> **Tina:** I find you to talk to and easy to umm... express what my beliefs are to you
> without feeling like you are judging me or something.

Feeling accepted facilitated a wide-ranging exploration of issues as Fabien's remarks

suggested above (11.1.2). For Tina, this meant that she could broach a range of issues:

> **Tina:** What was very helpful to me is being able to say all of the things that I
> wanted to say without feeling that there was anything that was 'out of bounds' to
> talk about.

Aside from the benefits of discussing whatever was most important to them, some

participants described their experiences of HV and other personal issues in detail.

Therapy was an unusual opportunity for them to do this and many found it helpful to do

so.

11.2.5   Being honest about needs

The option of choosing their own method of engaging – or disengaging - in therapy
seemed an important possibility for participants, all of whom seemed to find
idiosyncratic paths that worked for them, at least to some degree. Being honest was also
related to whether participants felt they could talk to me about when therapy – or I - was
not operating in the ways they needed. (Elaine, Fabien, Katie, Olivia, Rhiannon, Robert,
Tina).

Rhiannon had believed that historical issues were preventing her from moving on with

her life but, when it came to it, she found that her perspective had changed:

> **Rhiannon:** It's not particularly relevant now I've moved out [*of her parents'*
> *home*], umm... it's relevant but it's not a pressing issue and actually it's going to
> take a lot of energy input *[Pause]* to get a result from it *[Pause]* and if it's not
> that pressing an issue umm... I'm quite unwilling to put the energy into it.

She was pleased that she could exercise the choice to disengage. Her previous therapy

had focused exclusively on her experiences of being sexually abused:

> **Rhiannon:** I just didn't have anything new or fresh to say about the issues that
> had happened and um ... And yet week after week that's all they wanted to talk
> about

In person-centred therapy, she had been able to choose not to engage with those issues.

Instead, she talked about a variety of practical issues to do with the life she was

developing at that time. When that process was complete, she found it easy to end

therapy.

Katie chose to take a break from therapy. She had been able to get to the stage of

addressing some historical issues she had never broached before. But that proved more

difficult than she had anticipated and she felt she could not carry on. We had therefore

agreed to end therapy and that she could re-approach me in the future if, or when, she

felt strong enough to continue. She said she was certain that she would, at some point,

revisit those topics[21].

Before I began work on this study, Olivia had had a few sessions with me but had

decided person-centred therapy wasn't working for her. However, she asked to start

again later. When I asked her about this during her interview, she explained it in this

way:

> **Olivia:** Umm... I wanted to give it another go just to see what would happen
> really. I hoped that it would help me get over hearing voices and stuff.

Both Olivia and Tina had realised that the time had to be right to 'do therapy'. As Tina

put it:

> **Tina:** When that thing that first happened to me, the first year I just *[Pause]* I
> wouldn't accept it at all *[Pause]* I tried to pretend it hadn't happened...so maybe
> that wouldn't have been the right time, and I needed a bit of time to get over it.

When Tina started therapy, the time was right for her, as was the approach.

Person-centred therapy did not always, however, seem suited to some participants.

Elaine, for instance, said:

> **Elaine:** Um, I didn't really know what to talk about
> And, later:
> **Elaine:** At my last hospital we had psychology and, you know, CBT and,
> **Kirshen:** Ok, …and how did you find that?
> **Elaine:** Helpful.
> **Kirshen:** Right so that worked for you. It made you feel better.
> **Elaine:** Yeah.
> **Kirshen:** How does it, what are the differences between the CBT approach and
> this?
> **Elaine:** CBT, you learn different ways of coping, [*whereas in*] the counselling
> you can just talk about what you want to talk about really.
> **Kirshen:** And which worked best for you?
> **Elaine:** Umm...,
> **Kirshen:** I do need you to be honest. I'm more interested, to be honest, in things
> that haven't been helpful than in things that are; so, anything that has been
> difficult for you or that hasn't worked, I really do need to know about.
> **Elaine:** Yes, I suppose CBT helped me more

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[21] Katie did approach me a few months later and we started working together again for a few sessions but she then decided not to continue as the travel became too difficult for her and there were few convenient sessions available.

Elaine had preferred the practical, concrete structure of previous CBT which had been much more helpful than the sessions she had had with me.

Her responses to my interview questions were often hesitant and brief. But I have chosen to include her perspective to demonstrate that all participants appeared to feel able to report – in the post-therapy interview, at least – aspects of our therapy that had not been helpful, or which could have been improved. For Elaine, it was an honest admission of her view that therapy had not seemed to be of use to her.

One final aspect of being able to talk honestly, was whether participants felt able to tell me when I made mistakes. In post-therapy interviews I asked whether participants felt I could have offered them a better service in any way and whether there were things I had done that hindered their processes. I include the example below as it may raise questions over the extent to which participants did feel able to be honest during sessions. It relates to the issue of silence. This often occurred when people were reflecting on what was being discussed, were deciding where to go next, or wondering how to broach topics.

Robert said that I sometimes let the silences go on too long. I had thought he was trying to catch his thoughts because his voices were intruding, as he often said was the case. But he said that this was not always so:

> **Robert:** The long silences *[Long pause]*, sometimes they were difficult [Pause] and *[Pause]* I think *[Pause]* I felt you were letting me drown…
> **Kirshen:** Right, God, okay.
> **Robert:** Because, you know, I was stuck *[Pause]* you know, not very much to say…

I asked Robert later whether he had felt uncomfortable about telling me when I had allowed that to happen. He denied this was so:

> **Kirshen:** I wonder what stopped you saying 'Kirshen, I'm drowning here' or 'You left me in silence there and it was awful'. I wonder what stopped you being able to say that.
> **Robert:** *[Pause]* a lot of the time it was the voices. They were blocking me.

> **Kirshen:** Blocking you
> **Robert:** Yes
> **Kirshen:** So, you were drowning because the voices were blocking you? But you didn't feel able to tell me that?
> **Robert:** No. The voices were saying 'you can't trust her, you can't engage' *[Long pause]* and there is all this in my head *[Pause]* I just couldn't find the words. No I just couldn't find the words.

It is possible Robert felt uneasy about raising some implied criticism of me at the time.

His later answer to a general question about his therapeutic preferences suggests

otherwise but there may be other cases where this was different.

Fabien was better able than some other participants to express his views in a forthright

manner. When replying to my question about how he had felt about being able to

challenge me or tell me if he disagreed with me, he gave the following response:

> **Kirshen:** What if I had got it [my understanding] wrong? What would you have done?
> **Fabien:** Probably *[Pause]* umm... well I would have exploded. Well, I would have given you a damn good argument as to why you were wrong.
> **Kirshen:** Right, so you would have felt okay about saying 'No, Kirshen, you've got that wrong, you have misunderstood.'
> **Fabien:** Yes, I would have had no compunction about, well, I know how my mind is in a muddle, and I know how my mind is when it's straight.
> **Kirshen:** So, in terms of say, someone might say a client can't be honest in the therapeutic relationship, what would you say to that?
> **Fabien:** Daft. I mean, you know, umm... I mean, I have been as honest as I can with you, even to the point when we had a great discussion about some serious matters.

He was adamant that he had not felt under pressure to refrain from making his views

known in our sessions.

These contrasting examples illustrate not only the range of participants' experiences and

preferences but also their senses of being able to express their views.

11.3 Forging a way through

Whilst many found person-centred therapy disconcerting at first, most responded

positively to the freedom involved. Taking an active lead in sessions seemed to help

them feel included in the type of normal discussions that go on between people,

reducing their sense of isolation. The exceptions were Gary and Elaine, who found the

lack of outside direction frightening and uncomfortable.

Most participants reported that they had used this opportunity to pay attention to what

had been troubling them and that this had helped them understand what it meant, then

resolve it in a way that had personal meaning. As mentioned earlier, this sometimes

involved choosing to disengage from therapy, or to engage in it only to a limited degree.

11.3.1   Active, taking the lead

This discusses six participants' experiences of directing the therapy sessions, but within
the boundaries set by me (Aisha, Elaine, Fabien, Katie, Paula, Rhiannon). The positive
and negative effects of those boundaries and the approach are also mentioned.

These participants found that the setting of the therapy session helped them focus on the

work they wanted to do. Fabien described how the format helped him plan how he

approached the work:

> **Fabien:** To try and relive all of the experiences and speak with a set time…,
> [*so*] I don't waffle You don't *[Pause]* force me over, it's *[Pause]* it's a
> professional relationship.

He appeared to like the boundaried nature of our sessions, which contrasted with the

chaos of much of his life. Aisha, however, found that it interrupted her process and said:

> **Aisha:** Sometimes I do feel that I want to talk more and more *[Laughs]* and
> when I've really kind of opened up and talking about things, I just want to
> continue to talk and I was cut off I was like 'Ohhh' *[Tone of voice suggesting
> disappointment and sadness]*

Those rules imposed by me contrasted with the freedom she had within the sessions to

choose what to discuss. She explained why she valued that freedom when I was asking

her about how the sessions functioned:

> **Aisha:** I decided, you know, what was troubling me and then we would discuss
> it and and I kind of feel any clearer, in my mind and I stopped thinking about it
> and worrying about it.

I also asked Katie if this approach mattered and she replied:

> **Katie:** Yes, it does. If people push me to talk about the voices, I won't talk about them.

The possibility of choosing what to discuss was evidently important to her as she reiterated it twice more.

In common with all except Fabien, Rhiannon commented on her feeling disconcerted initially about the lack of structure in sessions:

> **Rhiannon:** At first I didn't think it was really important. In fact, I thought I would rather you directed the session because it seemed easier. Umm... But I think actually it probably wouldn't have worked half as well as it did if you had directed the sessions. Because *[Pause]* I just *[Pause]* had these things that were important to me at the time.

She discussed issues unconnected with those mentioned at the start of therapy and enjoyed being able to set her own agenda. Paula also felt that the person-centred approach worked well for her and enjoyed the opportunity to explore her own meanings:

> **Paula:** I know I've got an hour and I can just come here and just *[Pause]* spout, never had it before, [and] it worked…It's not for everyone, because a lot of people will struggle without that constant pushing. I didn't. I've had too much structure. I wanted to get well, I wanted to understand it, and to understand it I had to hurt and I had to push it**…**and I had to go away and it wasn't just an hour a week and forget about it till next week, it was an hour with you and then 50 hours with myself and 20 hours with *[Name of husband]* and 20 hours with the children and pushing and questioning and learning…

Her process in therapy extended into her week because the drive for change was all-encompassing. It is important to note that therapy is only a very small part of people's lives and many factors play a part in whether or how people start to feel better. Katie also cited things in her life that were helping her recovery in 10.4.3 and Tina mentioned her faith as an important way in which she could maintain her increasingly positive feelings about herself.

Paula also highlighted that person-centred therapy would not be right for everyone. This

is supported by the views of Elaine who reported that she found it difficult to decide

what to talk about and seemed to find the lack of structure stressful.

11.3.2   Exploring meaning

For seven participants (Aisha, Fabien, Katie, Olivia, Paula, Robert, Tina), therapy was valued as an opportunity to explore their distress, and what might help make them feel better. In attending to their distress, they found that they were often able to explore what things might mean and whether they were relevant. What they discovered was sometime surprising.

Most participants took the opportunity to explore what might be behind issues they

believed were causing problems in their lives. Even doing this felt positive, as Olivia

noted:

> **Olivia:** Having the opportunity to talk just made me feel better.
> **Kirshen:** And what was it about being able to talk that made that happen?
> **Olivia:** It got me thinking about things I hadn't thought about before *[Pause]* I realised that *[Pause]* things don't have to be perfect with my family.

It seemed as if the act of talking felt therapeutic and led to her starting to think

differently about issues she had not considered before. Sometimes, participants were

surprised at what they found themselves talking about and its impact on how they felt:

> **Paula:** It's only through talking about other things non-relative…that I thought weren't relative to the voices, that made me realise that actually what it was, was something completely different. And only by understanding what they were was I able to, to deal with it and to change it and then be free from it.

As with other participants, Paula discovered it was important to explore something

separate from her voices and it was doing this that brought about the changes she

wanted to make. In Paula's case, the way she came to make sense of how she felt about

herself and her relationships, allowed her to change the narrative of her life.

Some participants (Katie, Robert) also found that paying attention to the voices

specifically sometimes helped them gain the clarity and understanding they sought. In

being free to explore whatever was most pressing (in his case, the voices), Robert

developed a personal understanding of his suffering and worked out how to manage it

(10.4.4; 11.4.4). As he put it:

> **Robert:** Well you listened to me. And you could give me a different view on
> things *[Long pause]* I think *[Name of psychiatrist]* *[Pause]* he just says,
> 'They're bad thoughts', you know, 'Send them away' *[Pause]* you gave me the
> chance to talk it out and I think that is where it has come from.

This extract highlights the difference between a person-centred approach to therapy and

the sort of advice given to Robert elsewhere, which tended not to engage with the

meaning of his psychotic symptoms.

Paula also described what person-centred therapy was like for her:

> **Paula:** Because I unravelled things and you were able to pick up on what I was
> unravelling and not think that I was just waffling a load of nonsense. And by
> prompting, not suggesting, but by prompting me to push further, I was able to
> see it much more clearly. You didn't suggest anything; you never suggested
> things and you never, and you never put words to me. But you would make,
> make me push myself further when it needed to be done, then I would go away
> and completely unscramble everything.

For those who chose it, personal exploration was often the start of making sense of

things and, on that basis, beginning to feel better.

11.3.3 Making sense

The result of the exploration undertaken by seven participants (Aisha, Fabien, Katie,
Olivia, Paula, Robert, Tina) undertook often resulted in their being able to make sense
of things that had appeared confusing or distressing before. Sometimes, they came to
understand themselves, their voices and other people differently. Making sense of things
had a positive impact on levels of distress and self-esteem.

Fabien wanted to make sense of his "supernatural experiences". These were so powerful

- and so different from everyone else's everyday reality - that they were difficult to

conceptualise. He described how we dealt with it in his sessions:

> **Fabien:** I'd see everything so clearly but I needed to focus and so *[Pause]* by
> focusing me back, or pulling me back, which you did at some points *[Pause]* I
> was waiting for you to come in and you didn't, you didn't lead me umm... and
> that was clever, because I was thinking, 'Well is she listening to me, or is she
> not *[Pause]* what am I getting?' and then you would come in with a 'Is this what

you mean?' Because you had already analysed it and I would say 'Yes that's what I mean', and I'd think 'Gosh, you've done the analysis, that that's where I was trying to get, thank you very much for that, yes, yes, yes.'

He obviously valued my attempts to understand what he, too, was working on. He found that my reflections on what he said gave some clarity and helped move him forward. Several other participants also found it useful even just to hear their words replayed back to them, as Aisha said:

> **Aisha:** …yes that's why I found it easier to talk as well … it is because, as I say, you can pick out the words for me that I am struggling with, you know …you can know exactly what I mean sometimes…and that's what helps me stay enthusiastic to keep it going.

The therapeutic process of attending exclusively to ones needs also seemed to help participants find a focus. They were then able to credit themselves with doing the work to bring about change. Aisha expressed it thus:

> **Aisha:** Umm... like I mean going through it is like, helping you help yourself with the illness and, like, focusing on yourself and think about yourself…It makes it easier because you can see the positive things, you know can you know how to *[Pause]* you know *[Pause]* how to overcome it and things.

In common with other participants, Aisha used her therapy to express her distress, fear and confusion as well as to explore difficult issues from her past. As a result, her fear diminished and her understanding and acceptance increased. Participants' increasing capacities to cope created space to contextualise and understand. For instance, Aisha's voices lost their power once she understood them in terms of illness. Others came to different understandings but also felt less worried by their voices.

Tina also commented on the wider benefits she derived through the hard process of developing new understandings of previously difficult experiences:

> **Tina:** I realised that I had to confront, in a compassionate way, the voices I was having and work hard to turn them into positive thoughts. My whole experience of hearing voices has helped me to gain a huge insight into the problems of other fellow human beings and allowed me to develop a deeper love and understanding for them, and also has helped me to know myself better and to

have, for the first time, love and understanding of myself, also self-worth and self-esteem.

These participants found that, once they could make sense of what they were experiencing, their levels of distress decreased, irrespective of whether they continued to HV. These understandings varied from continuing to see their distress as symptomatic of illness to accepting the presence of their voices without fear or welcoming the presence of their voices.

11.3.4   Hard work and a different sort of tiredness

Therapy was perceived as hard work by all participants. Eight found it worthwhile and that they gained something positive from the process. The effort was tiring but felt different from the exhaustion caused by the strain of living with distressing voices in a way that felt out of control.

Aware that he was working things out for himself, Fabien took great joy in doing what he called his "reflective analysis", despite acknowledging that therapy had been tough at times:

> **Fabien:** You go in there and you sort it out yourself, all right. And you know I burst into tears a few times, and it has been an emotional strain,

When someone has had their view of reality challenged or dismissed over many years, the prospect of exploring past events in the way they choose is, exciting, even if they know it might be difficult and painful.

Although the work might be upsetting or gruelling at times, participants generally felt no regrets about trying it, as Olivia reported:

> **Olivia:** It has been hard but, umm... there have been times when I have made myself do it rather than do it because I wanted to do it…but I don't regret doing it.

Despite the effort, the struggles were often compared positively with the situations participants had been in before they started therapy:

Paula: I know it's been long, and it's been working through and it's been quite difficult, but *[Pause]* it hasn't been as hard as living with it has been.

Those efforts and the impact on participants' lives was described by Tina:

Tina: I'd always be tired when I got home because I would be thinking things over and that, but then the next day I would feel slightly better, then slightly better, you know, and I think like, you know, I kept improving until I finally got over it.

The hard work of therapy was noted by all participants but the tiredness experienced afterwards by some appeared different from the exhaustion many had described experiencing prior to starting person-centred therapy. This was not always the case, however, especially if they were not able to process what they had discussed in the ways that Tina described above (e.g. Elaine, who had to live with punishing voices and feelings of regret on occasion). For Elaine and Gary, the hard work had not been worth the effort or extra distress.

11.4 It's not always just about the voices

Participants achieved different things from their therapy which included coming to feel and understand themselves and their experiences of HV differently. Some, however, found that therapy had been valuable only during the sessions themselves, and had not had any lasting effect on their ongoing distress (Elaine, Gary).

Very often the outcome of therapy was markedly different from participants' initial aims. With the exceptions of Elaine and Gary, all participants described feeling stronger and more in control, both of their lives and of their voices.

11.4.1 It didn't work

Person-centred therapy did not appear to have any effect on the voices heard by Elaine and Gary. Nor did it affect their levels of distress in any lasting way. Olivia and Rhiannon also believed it had had little effect on their recovery from psychosis.

Spending time in a supportive relationship was not sufficient for Gary and Elaine to feel

therapy had brought about any lasting changes in their lives. This meant that their

overall experience of therapy was disappointing. Elaine said there had been "No

changes", that her voices were just as troublesome and distressing as they had always

been and therapy had made no difference to her experience of them (see 10.4.1) She did

feel that some aspects of therapy were helpful, however, saying:

> **Elaine:** …when I was really anxious, you sat with me and that and talked to
> me…

When I asked Gary what the impact of therapy had been on his life his response was:

> **Gary:** Umm, I felt a little bit more in control
> **Kirshen:** A little bit more in control ok, so something was different because of
> counselling
> **Gary:** Yes, in a way
> **Kirshen:** At the time of the [session] or did it last all week? Or was it just that
> hour?
> **Gary:** Umm, just for a couple of hours
> **Kirshen:** A couple of hours. So, it didn't make a big difference to your overall
> life, it just sort of helped relieve the pressure at the time?
> **Gary:** Yes

Gary's lack of positive expectation of success had been confirmed. He admitted he had

been "sceptical" about whether "just talking" would make any difference.

The positive aspects of the therapeutic relationship (11.1) and the possibilities offered in

therapy (11.2) could offer comfort, but could also cause even more distress, as it

sometimes seemed to have done for Elaine. Despite their obvious efforts, this therapy

was not successful for them. Elaine even pointed out that another approach had been

more helpful.

Olivia and Rhiannon, while agreeing that it could be helpful to have someone to talk

things through with, did not feel that therapy had played "a massive role" in their

recovery either. Rhiannon said:

> **Rhiannon:** Umm... it's nice to have somebody to bounce ideas off of and to talk things through with, but, you know, I had psychosis and counselling isn't going to fix that.

Both were firmly of the belief that they had a condition which could not be helped just by talking, although they both found the process helpful in different ways.

11.4.2 Somehow feeling lighter, stronger

Four participants (Fabien, Kate, Paula, Robert) described feeling lighter and stronger after therapy, with associated feelings of calm and a release of pressure. The way changes happened was sometimes difficult to explain.

Although participants were aware of the hard work they had done in therapy and the tiredness they felt afterwards, they did not always know what had happened to make them feel that way. It seemed as if the detail of what was discussed dissipated - or perhaps stayed in the therapy room, as Katie had suggested. Paula recalled feeling vague about the content of therapy once she left the room:

> **Paula:** I'd quite often go away not knowing what we'd done, what we'd said, what we'd worked through, but I knew that I felt so much lighter and much better.

The work was hard and tiring but the resulting lightness Paula felt was like feelings reported elsewhere such as a release of pressure (Fabien) and a sense of relief (Katie, Robert). Robert described associated feelings of strength after therapy in relation to how he felt about his voices:

> **Robert:** I think that's what's been happening over the weeks and months ... *[Long pause]* putting a different light on things has made it lighter from me
> **Kirshen:** Lighter can you say a bit more about lighter? What does "lighter" mean?
> **Robert:** It's not having to carry the weight of the voices and what they want me to do ... *[Long pause]*
> **Kirshen:** Right you don't actually have to carry it …. or it's not such a burden to carry because you're stronger underneath it…. what is it?
> **Robert:** I'm stronger, yes.

Although Robert was still carrying the voices, they felt lighter because he was strong enough to bear them. He no longer felt he had to follow their commands, which released another heavy burden (see his related comment also at 10.4.4)

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Katie also said she felt stronger but in a different way. This was partly in relation to

managing her voices, but there was an additional facet to her new-found strength:

> **Kirshen:** A very general question: what difference has it made to your life to
> have these sessions?
> **Katie:** It's made me stronger.
> **Kirshen:** Right, go on. Can you give me a whole picture? Stronger, you said…
> **Katie:** I've learned to trust someone.

Katie equated being stronger with having learned to trust someone, a conclusion that

was easy to comprehend in the context of her abuse at the hands of those she should

have been able to trust as a child. On another occasion, she mentioned feeling stronger

as she opened up and talked more – again, based on the trust she had been able to

develop.

11.4.3   <u>Making good</u>

> While participants seemed to find it difficult to explain what happened 'just through
> talking', they often spoke of a sense of order and solidity being imposed where
> previously there had been chaos and weakness. As they developed a stronger sense of
> identity, six participants were also able to establish control over their previously
> powerful voices.

Robert told me about how he had progressed from a place where he had felt weak and

lost:

> **Robert:** *[Long pause]* Well, going back there were big bricks missing… And
> the counselling has helped fill them in.

While it had been tough for him at times, he had found that persevering had enabled

him to fill in "the bricks". This had helped him develop a new relationship with his

voices along with a different understanding of many things. He described the result

thus:

> **Robert:** *[Long pause]* Through talking and being able to put things in place,
> umm... filling the blocks up *[Pause]* it's *[Pause]* it's like a repair job *[Laughs]*.

This "repair job" helped him feel stronger as a person, which had the added effect of

helping him have power over his voices:

> **Robert:** Yes, the blocks certainly made a difference *[Pause]* because not only did it keep them [the voices] out, but it kept me safe…filling in the blocks gives you more strength in saying no to them 'No, that's not right' or 'No, you're not right there.'

He then used another metaphor:

> **Robert:** You know it's like untangling a knot and *[Long pause]* if you get one straight, you can start on another and then can start building the bricks.

Fabien also gave the impression of needing to untangle a knotted mess to describe how

he had established a sense of order in his life:

> **Fabien:** You've got this ball of string but you've got to untangle the mess and then you got to roll it up in a ball again. So that is what we've actually done.

This relates back to the chaos participants described at the start of therapy and how their

aims were usually to try and impose some form of order or sense on the disparate parts

of their lives.

Another way of describing the process was taking something apart to reveal what was

underneath. Paula felt she was being hidden, even smothered, and that the way forward

was to peel off the wrapping;

> **Paula:** *[Pause]* peeling back that onion…you know, and the layers are coming off *[Pause]* you know, until you get back, until you've just got left that nice sweet bit in the middle, and you know you can't put an onion back together… so it's just kind of *[Pause]* that middle bit and that bit was me… and if you imagine you can't get that little bit out when you've got all of that, all that skin, all the wrapping and you can't get through. It's just putting that slice in, like you did, in this therapy, that allowed me to see into it and dig in to peel it back.

By retrieving the "nice sweet bit" that was her, Paula also realised she would never need

to revert to how she was before. That offered hope of a better future. Again, she

suggested that therapy had acted as a catalyst for her to do the work herself. Others, too,

believed that the changes they had made were positive and lasting (Aisha, Fabien,

Robert, Tina), even if, as Olivia said, it was a "work in progress" (Katie, Olivia).

At the start of her therapy, Paula had spoken of a disorganised set of thoughts she couldn't control. But following therapy the "clutter" had gone:

> **Paula:** Actually, when you piece them all together they kind of slot into each other, and it's not so cluttered, and it's not so messy, and they all just fit into each other, and then you can pop them all just into one little box and say teenage years, 20s, 30s, you know.

Fabien, too, spoke of his new sense of organisation after therapy:

> **Fabien:** We were able to put all the bits into a filing cabinet, and there they all sit. I'm chilled, it's there, it's solid.

Fabien's use of the word 'solid' suggested that he felt grounded, a sense reiterated by other participants.

11.4.4 A new perspective and a new start

> When I asked participants at the start of therapy what their aims were and what getting better meant, all except Fabien and Tina said their aim was to eliminate the voices they heard. When I posed the same question at the end of therapy, eight reported different ideas.

The focus of Rhiannon's therapy changed once she decided her original aims were not important at that time and she wanted to talk about current issues affecting how she felt about her life. She said,

> **Rhiannon:** You helped me through in *[Pause]* those ways [everyday issues], just not the way we initially set out to.

This different perspective on what was important for well-being was reported by other participants too, and was often connected with changes in how they felt about themselves and their voices.

Katie had been desperate to eliminate her voices when she came into therapy, and that did not happen. But when I suggested that might mean we had failed she was positive that we had not. She explained her thinking thus:

> **Katie:** There's quite a few times we focused on them and I talk about them more than what I usually do. I know we haven't got rid of them but they're *[Pause]* you know they are easier to manage.

Robert had also changed his view of what recovery meant, having initially wanted the voices to go completely:

> **Robert:** *[Long pause]* having the voices but with control *[Long pause]* It's about taking control… I don't want to get rid of them.

He cited his therapy as the source of his new ability to understand that his thoughts were very like the content of his voices:

> **Robert:** The voices have been dampened down. But they haven't gone *[Long pause] [Shakes head]* I can't catch the thoughts *[Long pause]* It's been very helpful, in *[Pause]* understanding that the thoughts run along the same lines as me own thoughts. And they are very much alike *[Long pause]* and some of the questions you have asked, the voices had wanted to block them out completely *[Long pause]* but we have gone round in a different way and I have been able to answer them.

As he regained his own power, Robert started to renew his positive relationship with his voices and re-integrate them into his sense of self. He also spoke of the relief he felt about this:

> **Robert:** *[Pause]* it's given part of me back…because at the beginning of the sessions, I was totally lost.

A sense of feeling lost or unable to find a way through had been common among participants (Elaine, Fabien, Gary, Katie, Olivia, Paula, Robert). Sometimes they linked it to their existing narratives about how they felt they should live (Aisha, Katie, Olivia, Rhiannon, Tina). When Olivia began therapy she had anticipated feeling better if she had fewer thoughts of suicide and her voices stopped. Following therapy, however, she had different goals:

> **Olivia:** Umm... I suppose now it's more to do with how to develop a good relationship with my family and, I mean, improve self-esteem.

She now appeared to believe she could be happier if she developed more positive

relationships with herself and others. Whether this would have been the same had she

not stopped HV is unknown, as she did not feel that the two events were unconnected.

Self-esteem changes were also implicated for Paula. She had experienced an unhappy

childhood that affected her sense of self-esteem as an adult. After therapy, however, she

felt able to escape this narrative:

> **Paula:** But I don't hurt from that story anymore because it's not my story now *[Pause]* it's not who I am, and what I am and what I have learned through therapy is to let that go.

Paula felt more at ease as she came to realise she no longer had to take notice of those

critical views. She seemed to develop a new view of who she was, what she could

achieve and what she needed to pay attention to.

An alternative way of moving forward was expressed by Tina, who had learned to

accept she was not at fault for being raped. As she forgave and learned to value herself,

she also found she could stop trying always to please others, which had often been to

her own detriment:

> **Tina:** But now, with everybody that I meet *[Pause]* I am quite clear to people. You know, like I felt deep down, umm… I never liked sex, *[Pause]* I've always wanted to be a non-sexual deep down and the only reason I've ever agreed to people in the past actually doing that is to please them, rather than myself, and what it has actually done is, in order to please them, I've actually hurt myself more and more because I, I *[Pause]* wasn't being true to who I am rather than, you know, so now I can be true to who I really want to be and really be firm with people and say 'Look, this is who I am', you know, and 'If you don't like it then you don't have to be part of my life' so I don't have to feel like I have to do something like that to please other people.

It appeared that Tina's relationships with others, and herself, would be quite different in

the future. As with several other participants (Aisha, Katie, Olivia, Paula, Robert), the

way she had come to feel about herself was also affecting how she related to others.

That feeling seemed to assist participants in thinking more flexibly about issues and being more in control of their thinking. Tina, again, said:

> **Tina:** But I think because I have got on top of things in my mind *[Pause]* I am more in control… I am more able to turn that thought round into a more positive way of thinking rather than I was so under it all before, you know, the thought was being more able to control me rather than me control the thought.

Aisha had a similar sense of being in control and able to move on once she had come to some acceptance of her having an illness and developing an understanding based around it. She described the counselling she had gone through and the understanding she had reached as a "solution":

> **Aisha:** …because it's offered me one step so it's just continuing to develop …. like taking chances and growing up

She seemed to regard the process as a normal and integral part of everyday living that would enable her to be part of the world again.

Similarly, Fabien was pleased that his increasing self-acceptance had affected the relationship he had with his "higher self". He believed they were now "in partnership":

> **Fabien:** My understanding *[Pause]* my experience is...that ...we've come to an agreement, me and the voice, we are happy with one another…I don't have to fight him; he doesn't have to tell me, you know, 'you will go there, you will do that because I'm in control of you' …um I, I, I, he trusts me and I trust him yes, sort of like, you understand?

Alongside their changing perspectives on themselves and their voices, other participants started to understand their experiences differently. All except Fabien, had believed themselves to be mentally ill at the start of therapy. While some retained that belief, others revised their earlier opinion that HV meant they were mentally ill. Paula had wanted clarification of her diagnosis initially as she thought it would help her to get the right medication to improve her well-being. Eventually, however, she decided that she had not been mentally ill at all and that her voices no longer held any power over her. As she put it:

> **Paula:** That diagnosis would have been my perfect excuse as to why things had happened…and not have to realise that it was *[Pause]* my life *[Pause]* that's why I came and that's what I thought I'd get out of it but umm... what I did get out of it was much more, much, much, much more. I got my life, found myself, I really have.

She attributed 'getting her life' and 'finding herself' to the therapy process and the exploration she had done within it. She was both pleased and relieved at what she achieved:

> **Paula:** I'm pleased I came because otherwise I don't know where I would be.

She, and several other participants described taking part in new activities and making plans (Aisha, Katie, Olivia, Paula, Rhiannon, Tina). Aisha was, hesitantly, researching training courses in other parts of the country for a completely new start. For her and others, planning for the future was a new experience after many years of feeling stuck in their distressing situations. Paula illustrated this, when she said:

> **Paula:** First time I saw you I didn't know what day it was or what I was going to do in an hour's time, and now I'm making plans for the next five years, you know, that's the difference.

Movement rather than stagnation or paralysis was the result of therapy for most participants.

Chapter 12

12 CONSIDERATION OF PSYCHOTHERAPY OUTCOMES

12.1 Introduction

This chapter will analyse pre- and post-therapy data from BAVQ-R and PSYRATS[22].

Qualitative outcomes will also be outlined here, although participants' views are

covered in more detail in chapters 10 and 11.

12.2 Analysis of scores on outcome measures

12.2.1 Data cleaning, reliability, validity and normality testing

Where data were missing (see Tables 12.1a; 12.1b; 12.1c), I nullified scores by inserting

the mean across other participants for that item. Aisha did not complete measures pre-

therapy so has been excluded from the analysis. The remaining nine participants

therefore form the sample for the tests.

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[22] Features of BAVQ-R and PSYRATS have been discussed in 7.8. Measures are contained in Appendix
Gi (BAVQ-R) and Appendix Gii (PSYRATS.

Table 12.1a: *Participant scores - BAVQ-R pre-and post-therapy, prior to data cleaning*

Scale	Malevolence		Benevolence		Omnipotence		Resistance - emotional		Resistance - behavioural		Engagement - emotional		Engagement - behavioural	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Aisha	-[1]	6[2]	-	8	-	12	-	4	-	14	-	1	-	2
Elaine	18	17	0	2	18	16	12	12	11	14	0	0	2	0
Fabien	4	3.5	16	16	7	9.5	11	2	2	0	12	9.5	10	11
Gary	15	15	0	0	?	15	12	12	15	15	0	0	0	0
Katie	17	?	0	?	15	14	12	10	9	6	0	8	4	7
Olivia	2	4	0	0	12	4	8	8	8	14	0	0	0	0
Paula	11	0	8	2	12	2	8	0	11	15	4	0	8	3
Rhiannon	0	0	0	0	2	3	4	0	5	5	0	0	1	0
Robert	14	4	6	9	14	6	8	9	12	14	3	5	1	3
Tina	11	0	14	18	13	9	12	0	13.5	0	12	12	6	12

Malevolence, Benevolence and Omnipotence score from 0-18
Resistance   score from 0-27 - of which emotional score from 0-12; behavioural score from 0-15
Engagement   score from 0-27 - of which emotional score from 0-12; behavioural score from 0-12

Scoring: 0 - Disagree, 1 - Unsure, 2 – Slightly agree, 3 – Strongly agree

Notes: When participants were unable to select a single score, their variable experiences are shown.
    [1] Aisha asked not to complete the outcome measures before therapy
    [2] Question 7 not answered therefore 6/15 not 6/18. Voices not heard now so answers based on when voices were heard

Table 12.1b: *Participant scores - PSYRATS pre-and post-therapy, prior to data cleaning*

	PSYRATS (Haddock et al., 1999)																						
Item	Frequency		Duration		Location		Loudness		Beliefs re origins of voices		Amount of negative content of voices		Degree of negative content of voices		Amount of distress		Intensity of distress		Disruption		Control	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Aisha	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	4
Elaine	1	1	3	3	1	3	4	4	?[1]	3	4	4	3.5	4	4	4	4	4	3	3	3	4
Fabien	2	2	2	2	1	1	2	1-3	4	3	1	1	2	1	1	0	0	0	1	2	1	1
Gary	2	4	2	4	4	4	?[1]	4	4	4	4	4	4	4	3	4	4	4	3	3	4	4
Katie	2	2	4	3	1	3	2	?[1]	4	4	3	?[1]	4	4	3	4	4	4	2	2	4	4
Olivia	3	0	2	0	4	0	2	0	1	0	4	3	4	3	4	3	4	2	3	0	4	2
Paula	4	0	4	1	3	0	All	0	All	1	3	3	4	3	3	3	4	3	4	0	3	0
Rhiannon	0	0	1	1	4	4	2	2	4	4	0	0	0	0	4	0	2	0	0	0	0	4
Robert	4	3	4	4	1	1	2	2	4	4	3	3	3.5	4	4	4	4	1	3	3	3	2
Tina	1	1	4	3.5	3	1	2	2	4	4	2	0	4	0	3	0	3	0	2	0	3	0

Scores for Location ranged from 0-voices not present through 1-voices inside head only, to 4- entirely outside head.
Scores for Beliefs re origins of voices ranged from 0-voices not present, through 1-solely internally generated and related to self, to 4-solely due to external causes.
Scores for all other dimensions ranged from 0-4 with 0 representing lowest impact or voices not present.

Notes: When participants were unable to select a single score, their variable experiences are shown.
 [1]Could not select answer

Table 12.1c: *Missing data from BAVQ-R and PSYRATS*

Participant	Measure	Pre/post therapy	Item
Elaine	PSYRATS	Pre	5. Beliefs about origins of voices
Fabien	PSYRATS	Post	4. Loudness
Gary	PSYRATS	Pre	4. Loudness
Katie	PSYRATS	Post	4. Loudness
Katie	PSYRATS	Post	6. Amount of negative content of voices
Paula	PSYRATS	Pre	4. Loudness
Paula	PSYRATS	Pre	5. Beliefs about origins of voices
Gary	BAVQ-R	Pre	15. My voice will harm or kill me if I disobey it
Katie	BAVQ-R	Post	2. My voice wants to help me
Katie	BAVQ-R	Post	5. My voice wants to protect me
Katie	BAVQ-R	Post	13. My voice wants me to do bad things

Participant and group means *(n=9)*, are contained in Tables 12.2a and 12.2b. These measures cover a range of features, with improvement represented by increased scores on some items and decreased scores on others. Tests of individual scales may therefore have more meaning than overall scores. For BAVQ-R, means have been calculated for the overall score, for the five main scales and for the four sub-scales. For PSYRATS, means have been calculated for the overall PSYRATS (AH)[23] score and for three factors within it, as identified by Haddock et al., (1999).

Internal reliability was estimated using Cronbach's α. On BAVQ-R, all scales, sub-scales and the overall measure showed high levels of reliability. It was high on PSYRATS overall and the Emotional characteristics factor, but on Physical characteristics and Cognitive interpretations it was very low[24].

Descriptive and reliability statistics are contained in Table 12.3a; 12.3b.

A factor analysis could not be completed to test for validity due to size of the sample. Data were normally distributed across all scales.

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[23] Only the AH (Auditory Hallucinations scale) was used as delusions were not the object of study
[24] Similarly, low reliability on factors within PSYRATS has been found elsewhere (Steel et al., 2007).

Table 12.2a: *Group and participant means - BAVQ-R total score, scales and sub-scales*

	BAVQ-R pre	BAVQ-R post	Malevolence pre	Malevolence post	Benevolence pre	Benevolence post	Omnipotence pre	Omnipotence post	Resistance pre	- emotional pre	- behavioural pre	Resistance post	- emotional post	- behavioural post	Engagement pre	- emotional pre	- behavioural pre	Engagement post	- emotional post	- behavioural post
Group	53.39	43.63	10.22	5.94	4.89	6.03	12.00	7.72	19.28	9.67	9.61	15.11	5.89	9.22	7.00	3.44	3.56	7.83	3.83	4.00
Elaine	61.00	61.00	18.00	17.00	0.00	2.00	18.00	16.00	23.00	12.00	12.00	26.00	11.00	14.00	2.00	0.00	0.00	0.00	2.00	0.00
Fabien	62.00	51.50	4.00	3.50	16.00	16.00	7.00	9.50	13.00	11.00	2.00	2.00	2.00	0.00	22.00	12.00	9.50	20.50	10.00	11.00
Gary	57.00	57.00	15.00	15.00	0.00	0.00	15.00	15.00	27.00	12.00	12.00	27.00	15.00	15.00	0.00	0.00	0.00	0.00	0.00	0.00
Katie	57.00	62.19	17.00	9.94	0.00	7.25	15.00	14.00	21.00	12.00	10.00	16.00	9.00	6.00	4.00	0.00	8.00	15.00	4.00	7.00
Olivia	30.00	30.00	2.00	4.00	0.00	0.00	12.00	4.00	16.00	8.00	8.00	22.00	8.00	14.00	0.00	0.00	0.00	0.00	0.00	0.00
Paula	62.00	22.00	11.00	0.00	8.00	2.00	12.00	2.00	19.00	8.00	0.00	15.00	11.00	15.00	12.00	4.00	0.00	3.00	8.00	3.00
Rhiannon	12.00	8.00	0.00	0.00	0.00	0.00	2.00	3.00	9.00	4.00	0.00	5.00	5.00	5.00	1.00	0.00	0.00	0.00	1.00	0.00
Robert	58.00	50.00	14.00	4.00	6.00	9.00	14.00	6.00	20.00	8.00	9.00	23.00	12.00	14.00	4.00	3.00	5.00	8.00	1.00	3.00
Tina	81.50	51.00	11.00	0.00	14.00	18.00	13.00	9.00	25.50	12.00	0.00	0.00	13.50	0.00	18.00	12.00	12.00	24.00	6.00	12.00

Table 12.2b: *Group and participant means - PSYRATS total score and factors*

	PSYRATS pre	PSYRATS post	Physical pre	Physical post	Emotional pre	Emotional post	Cognitive pre	Cognitive post
Group	*30.75*	*23.75*	*9.73*	*7.72*	*12.33*	*9.25*	*8.68*	*6.78*
Elaine	*34.07*	*37.00*	*9.00*	*11.00*	*15.50*	*16.00*	*9.57*	*10.00*
Fabien	*17.00*	*15.00*	*7.00*	*7.00*	*4.00*	*2.00*	*6.00*	*6.00*
Gary	*36.29*	*43.00*	*10.29*	*16.00*	*15.00*	*16.00*	*11.00*	*11.00*
Katie	*33.00*	*34.25*	*9.00*	*10.00*	*14.00*	*14.25*	*10.00*	*10.00*
Olivia	*35.00*	*13.00*	*11.00*	*0.00*	*16.00*	*11.00*	*8.00*	*2.00*
Paula	*37.86*	*14.00*	*13.29*	*1.00*	*14.00*	*12.00*	*10.57*	*1.00*
Rhiannon	*17.00*	*15.00*	*7.00*	*7.00*	*6.00*	*0.00*	*4.00*	*8.00*
Robert	*35.50*	*31.00*	*11.00*	*10.00*	*14.50*	*12.00*	*10.00*	*9.00*
Tina	*31.00*	*11.50*	*10.00*	*7.50*	*12.00*	*0.00*	*9.00*	*4.00*

Table 12.3a: *Descriptive and reliability statistics – BAVQ-R total measure, scales and sub-scales*

Stage	*Scale/sub-scale*	*Number of items*	*Mean*	*SD*	*Std. error of the mean*	*Skewness*		*Kurtosis*		*Cronbach's α*
						Statistic	*Std. error*	*Statistic*	*Std. error*	
Pre-therapy	BAVQ-R – total score	35	*53.39*	*20.32*	*6.77*	*-1.14*	*0.72*	*1.51*	*1.40*	*0.91*
	Malevolence	6	*10.22*	*6.67*	*2.22*	*0.50*	*0.72*	*-1.39*	*1.40*	*0.90*
	Benevolence	6	*4.89*	*6.49*	*2.16*	*0.93*	*0.72*	*0.78*	*1.40*	*0.97*
	Omnipotence	6	*12.00*	*4.80*	*1.60*	*-1.23*	*0.72*	*1.56*	*1.40*	*0.86*
	Resistance	9	*19.28*	*5.83*	*1.94*	*-0.50*	*0.72*	*-0.37*	*1.40*	*0.83*
	- emotional	4	*9.67*	*2.83*	*0.94*	*-1.01*	*0.72*	*0.35*	*1.40*	*0.88*
	-behavioural	5	*9.61*	*4.12*	*1.37*	*-0.71*	*0.72*	*0.002*	*1.40*	*0.79*
	Engagement	8	*7.00*	*8.28*	*2.76*	*1.06*	*0.72*	*-0.42*	*1.40*	*0.96*
	- emotional	4	*3.44*	*5.08*	*1.69*	*1.29*	*0.72*	*0.03*	*1.40*	*0.98*
	- behavioural	4	*3.56*	*3.68*	*1.23*	*0.79*	*0.72*	*-0.82*	*1.40*	*0.89*
Post-therapy	BAVQ-R – total score	35	*43.63*	*19.06*	*6.35*	*-0.99*	*0.72*	*-0.27*	*1.40*	*0.86*
	Malevolence	6	*5.94*	*6.52*	*2.17*	*-0.87*	*0.72*	*-0.74*	*1.40*	*0.93*
	Benevolence	6	*6.03*	*7.02*	*2.34*	*0.90*	*0.72*	*-0.72*	*1.40*	*0.94*
	Omnipotence	6	*7.72*	*5.35*	*1.78*	*0.17*	*0.72*	*-1.68*	*1.40*	*0.81*
	Resistance	9	*15.11*	*10.45*	*3.48*	*-0.42*	*0.72*	*-1.60*	*1.40*	*0.95*
	- emotional	4	*5.89*	*5.30*	*1.77*	*-0.11*	*0.72*	*-2.19*	*1.40*	*0.97*
	- behavioural	5	*9.22*	*6.46*	*2.15*	*-0.58*	*0.72*	*-1.69*	*1.40*	*0.96*
	Engagement	8	*7.83*	*9.63*	*3.21*	*0.83*	*0.72*	*-1.08*	*1.40*	*0.96*
	- emotional	4	*3.83*	*4.89*	*1.63*	*0.72*	*0.72*	*-1.35*	*1.40*	*0.92*
	- behavioural	4	*4.00*	*4.85*	*1.62*	*0.88*	*0.72*	*-0.88*	*1.40*	*0.91*

Table 12.3b: *Descriptive and reliability statistics – PSYRATS total measure and factors*

Stage	Scale /factor	Number of items	Mean	sd	Std.error of the mean	Skewness Statistic	Skewness Std. error	Kurtosis Statistic	Kurtosis Std. error	Cronbach's α
Pre-therapy	PSYRATS – total score	11	30.75	8.03	2.68	-1.38	0.72	0.31	1.40	0.81
	Physical characteristics	4	9.73	2.01	0.67	0.16	0.71	-0.01	1.40	-0.55
	Emotional characteristics	4	12.33	4.34	1.45	-1.41	0.71	0.58	1.40	0.85
	Cognitive interpretations	3	8.68	2.32	0.77	-1.27	0.71	0.84	1.40	0.27
Post-therapy	PSYRATS – total score	11	23.75	12.36	4.12	0.48	0.72	-1.82	1.40	0.90
	Physical characteristics	4	7.72	4.94	1.65	-0.19	0.71	0.12	1.40	0.86
	Emotional characteristics	4	9.25	6.69	2.23	-0.63	0.71	-1.59	1.40	0.97
	Cognitive interpretations	3	6.78	3.70	1.23	-0.54	0.71	-1.35	1.40	0.70

12.2.2   <u>Testing for change between pre- and post-therapy scores</u>

Tests of statistical significance on such a small sample lack power and are at risk of Type I and Type II errors, especially when several tests are performed. In any case, change can be statistically significant without reflecting meaningful change in participants' lives. I have tried, instead, to determine reliable and clinically significant change (Jacobson & Truax, 1991), using The Leeds Reliable Change Indicator (RCI) (Morley & Dowzer, 2014), which identifies individual and group change.

Reliable change (RC) indicates whether change in scores can be attributed to more than errors of measurement. Clinically significant change (CSC) is a measure of whether alterations in scores signify an improvement (or deterioration - D) that makes a difference to someone's life. If scores move beyond a clinical cut-off point, participants are deemed to have returned to "normal functioning" and demonstrated CSC (Jacobson, Roberts, Berns, & McGlinchey, 1999). Calculations compare study data with clinical and non-clinical samples[25] using a formula that includes one of three criteria (a, b or c) (Jacobson & Truax, 1991). The relevant criterion is selected based on whether clinical and non-clinical samples overlap (c) or do not overlap (b), or that comparison means were unavailable (a) (Jacobson & Truax, 1991, p. 13).

I chose to use reliability co-efficients from published work where available; otherwise, I used the mid-point between relevant pre-and post-therapy scores from this study.

12.2.2.1   RCI tests on BAVQ-R data

I used the Cronbach's α given for each scale in the original paper for BAVQ-R (P. Chadwick, Lees, et al., 2000). They are shown with those in this sample in Table 12.4.

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[25] Non-clinical samples here were voices hearers in the general population so 'return to normal functioning' does not imply elimination of voices.

Table 12.4:   *Comparison of Cronbach's α between this study and original BAVQ-R study (Chadwick, Lees et al., 2000)*

	Malevolence	Benevolence	Omnipotence	Resistance	Engagement
Chadwick et al., 2000	*0.84*	*0.88*	*0.74*	*0.85*	*0.87*
This study Pre-therapy	*0.90*	*0.97*	*0.86*	*0.83*	*0.96*
This study Post-therapy	*0.93*	*0.94*	*0.81*	*0.95*	*0.96*

Cronbach's α was not available for the total score or for the sub-scales so I used the mid-point of the pre- and post-therapy co-efficients in this study, shown in Table 12.3a.

BAVQ-R scales were compared against the clinical (*n=22*) and non-clinical (*n=21*) samples analysed by BAVQ-R scale in Andrew et al., (2008) (Appendix Giv). I could find no studies that analysed BAVQ-R total score or sub-scales with clinical and non-clinical samples.

12.2.2.2   *RCI tests on PSYRATS data*

A reliability co-efficient was not available in the original PSYRATS paper (Haddock et al., 1999) and other studies report high reliability without specifying Cronbach's α. Although Perry et al., (2015) study may, perhaps, have used a similar sample (EIS providing CBT), the α of *0.97* was very high. I chose instead to use the more conservative *α=0.88* provided by Hatton et al., (2005) even though those participants' diagnoses of intellectual disabilities was very different. This also fell between the two scores in this sample (see Table 12.3b). I have used the mid-point between the pre- and post-therapy co-efficients for emotional characteristics PSYRATS factor in this study (see Table 12.3b) as none were reported in other studies. The estimated Cronbach's α for Physical characteristics and Cognitive interpretations were so low that, unfortunately, those tests cannot be regarded as reliable. They will be reported but will not be discussed.

I used a clinical (*n=20*) and non-clinical (*n=20*) comparison of PSYRATS total score

from Hill et al., (2012) (Appendix Giv). No comparison data were available for the

PSYRATS factors.

12.2.2.3   *Summary of RCI tests*

Based on these comparisons and assumptions[26], Tables 12.6a, b and c summarise RC,

CSC and deterioration (D) demonstrated by these participants. These will be discussed

for each participant in 12.3 below. The figures contained in Appendix Gv present

graphs for each scale, showing cut-offs, lines of change and plots for each participant

showing whether they experienced RC, CSC or D.

No RC or CSC was found for most participants on each test. But each test demonstrated

RC or CSC in 2-4 participants, except for Benevolence on BAVQ-R where CSC was

observed only in Katie. D was demonstrated in one participant on 4 tests, and in two

participants on Resistance-behavioural in BAVQ-R.

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[26] I made no checks on the degree of homo/heterogeneity between different samples so cannot control for the relevance of the comparison groups to my participants.

Table 12.5a: *Reliable and clinically significant change or deterioration - BAVQ-R total score, scales and sub-scales*

	BAVQ-R (total)	Malevolence	Benevolence	Omnipotence	Resistance	- emotional	- behavioural	Engagement	- emotional	- behavioural
Range of possible scores (Direction of clinical gain)	0-104 (Decrease)	0-18 (Decrease)	0-18 (Increase)	0-18 (Decrease)	0-27 (Decrease)	0-12 (Decrease)	0-15 (Decrease)	0-24 (Increase)	0-12 (Increase)	0-12 (Increase)
Cronbach's a	0.86	0.84	0.88	0.74	0.85	0.93	0.87	0.87	0.95	0.90
Criterion	a	b	c	b	b	a	a	c	a	a
Clinical mean (sd)		10.77 (5.24)	3.09 (5.30)	13.00 (3.75)	17.86 (8.39)			7.09 (8.71)		
Non-clinical mean (sd)		0.10 (0.44)	12.38 (4.40)	3.33 (2.10)	0.62 (1.66)			15.62 (5.34)		
Pre-treatment mean (sd)	53.39 (20.32)	10.22 (6.67)	4.89 (6.49)	12.00 (4.80)	19.28 (5.83)	9.67 (2.83)	9.61 (4.12)	7.00 (8.28)	3.44 (5.08)	3.56 (3.68)
Post-treatment mean (sd)	43.63 (19.06)	5.94 (6.52)	6.03 (7.02)	8.72 (5.35)	15.11 (10.45)	5.89 (5.30)	9.22 (6.46)	7.83 (9.63)	3.83 (4.89)	4.00 (4.85)
Pre-post effect size	0.48	0.64	0.18	0.68	0.72	1.34	0.09	0.10	0.08	0.12
Standard error of measurement	7.60	2.67	2.25	2.45	2.26	0.75	1.43	2.98	1.14	1.16
RCI value	21.08	7.39	6.23	6.78	6.25	2.07	3.96	8.27	3.15	3.22
No change	7	6	8	6	7	5	6	7	7	7
D	0	0	0	0	0	0	2	1	1	1
RC	2	3	1	3	2	4	1	1	1	1
CSC	0	2	1	3	2	0	0	0	0	0

BAVQ-R notes

a)   Cronbach's' α from Chadwick et al., (2000) for BAVQ-R main scales; mid-point of pre-post scores from this study for overall score and sub-scales.

b)   Criteria for assessing RCI according to Jacobson and Truax (1991, p. 13) - 'a' = no comparative norms; 'b' = clinical and non-clinical norms do not overlap; 'c' = clinical and non-clinical norms do overlap.

c)   Clinical and non-clinical comparisons from Andrew et al., (2008) used for main scales on BAVQ-R. No comparison data available for overall score or sub-scales.

Table 12.5b: *Reliable and clinically significant change or deterioration - PSYRATS total score and factors*

	PSYRATS (total)	Physical	Emotional	Cognitive
Range of possible scores (Direction of clinical gain)	0-44 (Decrease)	0-16 (Decrease)	0-16 (Decrease)	0-12 (Decrease)
Cronbach's a	*0.88*	*0.18*	*0.91*	*0.49*
Criterion	b	a	c	c
Mean of clinical norms (sd)	*30.10 (7.40)*		*11.99 (2.64)*	*7.76 (2.26)*
Mean of non-clinical norms (sd)	*15.30 (4.50)*		*9.38 (1.95)*	*5.25 (1.86)*
Pre-treatment mean (sd)	*30.75 (8.03)*	*9.73 (2.01)*	*12.33 (4.34)*	*8.68 (2.32)*
Post-treatment mean (sd)	*23.75 (12.36)*	*7.72 (4.94)*	*9.25 (6.69)*	*6.78 (3.70)*
Pre-post effect size	*0.87*	*1.00*	*0.71*	*0.82*
Standard error of measurement	*2.78*	*1.82*	*1.30*	*1.65*
RCI value	*7.71*	*5.04*	*3.61*	*4.58*
No change	6	6	6	6
D	0	1	0	0
RC	3	2	3	3
CSC	3	2	2	3

PSYRATS notes

a)   Cronbach's' α from Hatton et al., (2005) for PSYRATS total score; mid-point of pre-post scores from this study for factors.

b)   Criteria for assessing RCI according to Jacobson and Truax (1991, p. 13) - 'a' = no comparative norms; 'b' = clinical and non-clinical norms do not overlap; 'c' = clinical and non-clinical norms do overlap.

c)   Clinical and non-clinical comparisons from Hill et al., (2012) No comparison data available for overall score or sub-scales.

Table 12.5c: *Reliable and clinically significant change or deterioration by participant*

	BAVQ-R	Malevolence	Benevolence	Omnipotence	Resistance	- emotional	- behavioural	Engagement	-emotional	- behavioural	PSYRATS	Physical	Emotional	Cognitive
Elaine														
Fabien					CSC	RC								
Gary												D		
Katie			CSC					RC	RC					
Olivia				CSC			D				CSC	CSC	RC	CSC
Paula	RC	CSC		CSC		RC	D	D	D	D	CSC	CSC		CSC
Rhiannon						RC							CSC	
Robert		RC		CSC										
Tina	RC	CSC			CSC	RC	RC			RC	CSC		CSC	CSC

Key:
CSC = clinically significant change (improvement significantly closer to range of normal functioning)
D = significant deterioration
RC – reliable change (not reaching clinically significant improvement)

12.2.3   Summary of participants' levels of change after therapy

These participants showed similar levels of symptoms to other clinical samples pre-therapy, although Rhiannon scored lower than the means in those studies, and Elaine and Gary showed more extreme symptomatology pre- and post-therapy.

Individual participants' findings will now be explored, and reference made to the experiences they recounted in their post-therapy interviews.

12.2.3.1   Aisha

Aisha chose not to complete the measures before therapy. After therapy, her views on PSYRATS reflect that she was no longer HV with scores of 0 on all dimensions except Control (4), signifying a feeling of having no control over their presence.

She completed BAVQ-R as if she still heard voices to convey what the experience had been like. Most scores were mid-scale, with Benevolence at 8 and Malevolence at 6, suggesting she held relatively positive beliefs about the voices. Her score for Omnipotence of 12 relates to her high score for Control on PSYRATS.

12.2.3.2   Elaine

Elaine scored the maximum on BAVQ-R for Malevolence and Omnipotence, and the minimum for Benevolence pre-therapy. She also showed the least possible Resistance or Engagement with her voices. She showed some minor improvements in her Engagement and her beliefs about the Omnipotence and Benevolence of the voices but none of the changes were reliable.

Her PSYRATS scores showed little change and are at the negative end of the scales.

These scores reflect the continuing distress she reported and the significant effect that HV had on her life and they place her above the means of other studies pre-and post-therapy.

12.2.3.3 Fabien

Fabien reported moderate levels of distress on PSYRATS and BAVQ-R pre- and post-therapy, although he showed CSC on Resistance, with RC on Resistance-emotional on BAVQ-R. This relates to what he told me about feeling he and his voice were now "in partnership' and he "no longer had to fight". If there was no conflict, there would be no need to resist its presence.

He scored highly on 'Benevolence' pre- and post-therapy which reflects his low scores for distress on PSYRATS and confirm his assertion that he valued his voice.

12.2.3.4 Gary

Gary scored highly pre- and post-therapy on scales that indicate high levels of distress and negative impact, on both scales. He also scored 0 on the positive scales of Benevolence and Engagement on BAVQ-R.

Although he described some improvement in the frequency of the voices due to his medication, this is not reflected in his scores.

12.2.3.5 Katie

On BAVQ-R, Katie showed CSC on Benevolence and RC on Engagement and Engagement-emotional. This may reflect her reports of increasing sense of power in relation to the negative voices, and ability to engage with the more positive one.

She was unable to select an answer for five items (see Table 12.1c) because, amongst the negative voices, she heard the "soft" positive voice of a family member.

12.2.3.6   Olivia

On BAVQ-R, Olivia showed CSC on Omnipotence and deterioration on Resistance-behavioural. Her overall score on PSYRATS showed CSC and emotional characteristics showed RC suggesting the voices had less impact, although her beliefs about them changed only in relation to their power[27].

This ties in with her discussion of feeling more able to rely on herself again. When considering her deterioration on Resistance-behavioural alongside those results, it may suggest less need to resist her voices.

12.2.3.7   Paula

Paula showed CSC on the Malevolence and Omnipotence scales and PSYRATS overall[28]. She showed RC on BAVQ-R overall and the Resistance-emotional sub-scale. She also, however, showed deterioration on Resistance-behavioural, Engagement and both Engagement sub-scales.

These results may reflect her contradictory statements about whether her voices had gone. She had told me that she no longer felt under the power of her voices and that they were no longer harmful to her when they did occur which ties in with her CSC on Malevolence and Omnipotence. The changes in her Resistance-emotional and Resistance-behavioural scores suggest she felt less distress, but took more action to

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[27] Olivia's scores on Physical characteristics and Cognitive interpretations also showed CSC but cannot be regarded as reliable.

[28] Paula also demonstrated CSC on Physical and Cognitive factors but these cannot be regarded as reliable

resist voices. The D shown on Engagement scales may be because she felt less need to engage with voices if they were rarely present or absent.

12.2.3.8   Rhiannon

Rhiannon's scores pre-and post-therapy were low on BAVQ-R suggesting that her beliefs about voices did not cause her a great deal of distress or have much impact on her life. She did, however, show RC on Resistance-emotional, indicating less emotional impact after therapy. Her PSYRATS scores also indicated low impact across most items, although she demonstrated CSC on Emotional characteristics.

Overall, her scores pre- and post-therapy appear more in line with the means from non-clinical populations.

12.2.3.9   Robert

On BAVQ-R, Robert showed RC on Malevolence, and CSC on Omnipotence. These improvements may reflect his desire to keep the voices as he now felt in control. Other scales showed movement in a positive direction but change was not reliable.

Scores on all items in PSYRATS except Frequency (4-3) Intensity of distress (4-1) and Control (3-2) remained the same pre- and post-therapy.

He stressed that his answers to Loudness did not reflect all his different voices.

12.2.3.10   Tina

On BAVQ-R, Tina showed CSC on Malevolence and Resistance, with RC on each of the Resistance sub-scales, on BAVQ-R overall and on the Engagement-behavioural sub-scale. She showed CSC on the PSYRATS overall and on emotional characteristics[29].

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[29] Tina also showed CSC on Cognitive interpretations but this cannot be regarded as reliable

This links with her reports of feeling less need to resist voices, that they did not appear harmful to her and that the presence of the voices was not as problematic overall any more. There was a slight increase in her – already high – score on Benevolence (14-18).

12.3 Qualitative outcomes

A detailed discussion of these participants' experiences is contained in the thematic analysis but a summary of outcomes can be described as follows: 'No change but some short-term benefits' (Elaine and Gary); 'Improved but not recovered' (Katie and Olivia); 'Some positive change, but not in the way anticipated' (Olivia and Rhiannon); and 'Positive change' (Aisha, Fabien, Paula, Robert, Tina).

12.3.1   No change but some short-term benefits
Elaine and Gary said they found therapy sessions helpful but that "it didn't last" (Gary) and they experienced no overall change. Although they did not say so explicitly, therefore, therapy may have been disappointing[30].

12.3.2   Improved but not recovered
Olivia described herself as "a work in progress" and Katie also said wanted to re-engage after taking a break. She felt, despite continuing struggles, therapy had enabled her to cope somewhat more successfully with life and her voices - "I can manage them better".

12.3.3   Some positive change, but not in the way anticipated
Olivia and Rhiannon experienced changes that differed from their original aims. Rhiannon decided to work on different issues. Olivia had assumed "getting better" would mean eliminating the symptoms of her psychosis. She found instead that working on her relationships and how she felt about herself had helped her feel better. Both

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[30] This may have been deference induced because of my dual relationship

derived some benefit from therapy but felt it was unrelated to their recovery from

mental illness.

12.3.4 Positive change

Five participants reported positive change after therapy that they attributed to "what I've

been able to do here…" (Fabien), partly because they had felt "able to say all of the

things that I wanted to say without feeling that there was anything that was 'out of

bounds'" (Tina).

Change usually involved feeling in control and having a stronger sense of self, as

Robert and Paula described:

> **Robert:** *[Pause]* it's given part of me back…because at the beginning of the
> sessions, I was totally lost.
>
> **Paula:** …what I did get out of it was much more, much, much, much more. I got
> my life, found myself, I really have.

Fabien's "reflective analysis" enabled him to integrate his "earthly and spiritual lives"

so that he felt less "Chaos.com". Tina also explained how she felt more in control and

compassionate towards herself and her voices. Aisha believed therapy had helped her

find a way of living positively with her new identity of being a person with

schizophrenia.

That these participants had successfully used therapy to meet their own needs was

another aspect of the experience of positive change.

12.4 Summary

Qualitative outcomes varied and were not usually connected with reduction in HV.

There were several instances of RC and CSC with occasional deteriorations but most

tests showed no change. These will be discussed in Chapter 13. Scores on both

measures were broadly in line with those from other studies, with three exceptions.

SUMMARY OF PART C

A reflective account of my experiences of working with this group of participants is presented in Chapter 9. It is hoped that this has given a flavour of the work and the learning offered by the unusual opportunity to offer person-centred therapy to people with a psychiatric diagnosis who hear voices. The two research questions relating to the experiences of HV and of person-centred therapy have been answered in Chapters 10 & 11 respectively. I have tried to give voice to the range of experiences expressed by different participants, but also to elucidate commonalities, where they arose. The data from outcome measures given pre- and post-therapy were analysed and discussed in Chapter 12.

HV is a powerful experience that can have a profound impact on people's lives. But it seems that this experience can change for some people, if they are able to think about the voices, and about themselves, differently. It is also evident that other people's attitudes can affect VHs, in a very practical way if those people are medical professionals.

Person-centred therapy appeared to be generally helpful in a variety of ways, many of which impacted on participants' views of themselves. There were, however, exceptions.

The findings will be discussed in the light of other evidence in the following chapters and implications will be explored.

Part D: Discussion and conclusions

Part D: Discussion and conclusions

OVERVIEW OF PART D

The final part of this thesis will try to work out what the themes from Chapters 9, 10, 11 and 12 can tell us about the lived experiences of HV and of person-centred therapy for VHs.

Chapter 13 will focus on links between literature discussed in earlier chapters and the two research questions. It will comment on where findings support previous studies and where there are questions still to be answered. The study will be evaluated in Chapter 14 against criteria previously outlined in Chapter 8 and limitations will be discussed.

Implications and further ideas on theory, research and clinical practice will be covered in Chapter 15, before final reflections are made and conclusions drawn in Chapter 16.

Chapter 13

13   WHAT DO THE FINDINGS MEAN?

In this chapter, the findings from my systematic analysis will be linked back to the literature reviewed in Part A, in relation to research questions posed in Chapter 5. The focus will be on contributions to knowledge on the meaning and experience of HV; contributions to research into person-centred therapy with clients from a psychiatric population; and, the value of researching subjective accounts of experience.

I begin by presenting a summary of what was contained within the thematic analysis.

13.1   Summary of findings

13.1.1   Summary of what it was like to hear voices

For these participants, HV was a fully embodied experience that affected their senses of agency and identity, their relationships, their physical well-being and how they lived their lives. It was perceived as an unsettling and, usually, unwelcome intrusion which they often wished would go away. There was a very real sense of discomfiture at being unable to control when the voices were present or what they said, as well as at being unable even, sometimes, to access their own thoughts. Frequently, the voices said critical, threatening, aggressive things and were commanding in nature and tone. Only occasionally did participants say, at the start of therapy, that the voices offered them comfort or positive guidance.

The fact of HV was frightening, even if the voice content was not negative or threatening and even if participants believed the voices to be a positive or spiritual occurrence. This often affected participants' already low or fragile self-esteem, partly

because participants were aware of public stigmatising attitudes towards people who have unusual experiences.

Participants' views about HV and the experience itself sometimes changed after therapy. For some, the voices had disappeared, or had reduced. Some developed different or positive relationships with their voices, feeling also more confident and in control of voices and their lives. Understanding of voices and feelings about their presence varied. Changes were not always attributed to therapy. One person reported that her experience was the same and she was still unable to live in the way she wished.

13.1.2   Summary of what it was like to have person-centred therapy

The experience of taking part in person-centred therapy was valued by participants to varying degrees. Some wanted to participate in the process and reported changes that they sometimes linked to the work they had done in therapy. Others did not, either because they felt the time was not right or because I was the wrong therapist for them, or because person-centred therapy did not feel appropriate for them. But, all described feeling a benefit from the time they spent away from their day to day lives.

It appeared to have been an unusual experience for their opinions to be sought, for them to take an active lead in the therapy process and for them to be encouraged to consider what their voices were saying to them and what that might mean. This was not always perceived positively. A prime goal for many participants was to make sense of confusing or chaotic situations and, when this happened, it often felt healing.

If participants experienced change they usually attributed it to their own efforts within therapy, which had a further effect on their increasing senses of self-worth. When this happened, they reported feeling able to move on with a renewed sense of optimism for the future and described being more in control of their lives. Outcomes were often different from what participants had initially hoped for and yet were often regarded as

positive and likely to result in their continued well-being. Two participants, however, were disappointed in the process overall.

13.2 What do the findings tell us about voice hearing?

As I had suspected, based on the ways participants talked about HV in therapy, phenomenological aspects of the experience such as loudness, number and location of voices – criteria not always selected for examination by VHs (Daalman et al., 2011; McCarthy-Jones et al., 2012; Nayani & David, 1996; Stephane et al., 2003) - were only fleetingly discussed in post-therapy interviews, if at all. The topics of interest and importance to these participants seemed to be far more to do with qualities such as the overall impact of HV on their lives, relationships and senses of agency and self-esteem.

Some aspects of their accounts relate more closely to themes identified in research into subjective accounts of HV discussed in Part A, especially 3.1 (Beavan, 2011; Fenekou & Georgaca, 2010; Geekie, 2007; Holt & Tickle, 2014; Milligan et al., 2013), although not all elements of the experience were the same. The ways those themes relate to the findings in this study will be explored further in 13.2.1 below.

13.2.1 How did findings relate to research on subjective accounts of hearing voices?

My participants were patients of a NHS mental health trust, and were interviewed immediately after therapy. This may have offered a specific, medical context within which to interpret their experiences, as Fenekou and Georgaca (2010) also found with participants who were long-term psychiatric patients. Holt and Tickle (2014, p. 291) suggest the wide-ranging attempts at understanding the VH experience evident in the studies by Beavan (2011) and Karlsson (2008), may relate to an acceptance of differing perspectives on HV in New Zealand (Beavan and Geekie) and Sweden (Karlsson). Similar acceptance may be found in sub-cultural groups elsewhere, such as within the

Spiritualist church in the UK (S. Jones et al., 2003) and the HVM (Corstens et al., 2014), and by clairaudient psychics in the USA (Powers, Kelley, & Corlett, 2017).

The personal relevance demonstrated elsewhere (e.g. Beavan, 2011), suggests it was useful to seek participants' personal understandings of their voices. Participants found it validating to tell their own stories, having previously felt that, 'as psychotics', their stories had been dismissed or invalidated by others, noted (10.2.2) by Fabien especially here (Beavan & Read, 2010; Geekie, 2007). Medical explanations were rarely challenged (before therapy), perhaps because they accepted that their own perspectives were not as valuable as those of professionals (Wise, 2004).

Feelings of rejection, being avoided and feeling odd or different were reported by my participants in line with other research (e.g. Fenekou & Georgaca, 2010; Geekie, 2007; Holt & Tickle, 2014; Karlsson, 2008; Mawson et al., 2011). Aisha (in 10.2.2), for instance, expressed concern about her opportunities to form and maintain relationships. Even though Chin et al., (2009) suggested that loneliness could be alleviated through the presence of voices, that only appeared to be the case for Fabien. Jackson et al., (2010) proposed that loneliness was alleviated through joining HVN groups where people can share experiences, but these were not operating locally for my participants.

All participants perceived their voices as 'real', attaching gender and identity to them (Beavan, 2011; Chin et al., 2009; Karlsson, 2008; Mawson et al., 2011). Sometimes, voices were identified as strangers (e.g. Elaine, Gary, Olivia, Robert); others were identified as belonging to people from participants' worlds. For instance, Katie, (10.1) recognised her voices as those of her abusers and a family member; Paula recognised one voice as her mother's.

Before therapy, HV was often similar to a "battle for control" (Holt & Tickle, 2014, p. 289) or as "Me vs. the voices" (Chin et al., 2009, p. 8), where the voices had more

control (10.1.4). Few participants seemed to use coping strategies although Tina had tried, unsuccessfully, to ignore her voices and Katie and Elaine gained temporary relief through self-harm (10.1.5). It was not until after therapy that some (Fabien, Katie, Tina and Robert) described engaging with their voices, to challenge and negotiate with them (10.4.3; 10.4.4). This is more like what has been reported elsewhere (Chin et al., 2009; Fenekou & Georgaca, 2010; L. J. Jackson et al., 2010; Mawson et al., 2011), suggesting recruitment of samples with different levels of distress and need.

It may be that participants on other studies were not seeking therapy for distress, so were, therefore, talking about their experiences from positions of greater equilibrium. The exception here is Geekie (2007). He used transcripts of therapy sessions for his research data and found similar evidence of the fragmenting effects of HV, which might have mitigated against my participants developing positive ways of managing them.

Negative voice content (Chin et al., 2009; Fenekou & Georgaca, 2010; Karlsson, 2008; Mawson et al., 2011), was sometimes related to participants' own views of their failings (e.g. Olivia, Paula, Robert 10.2.1), which seemed to reinforce those views and the power attributed to voices (Holt & Tickle, 2014). Voice content was not, however, the biggest predictor of distress as reported by Beavan (2011). Significant distress was also related to participants' perceptions that they had little control over voices, and their fears of the stigma and discrimination associated with being a 'mental patient' (10.2).

Paula stated that her voices were different from her "own instinct" (10.1.1) and were in her "main thought process" (10.1.3), implying a separateness; Robert also suggested he was aware of the difference when he said that, as therapy progressed, he came to believe that the voices ran in line with his own thoughts (11.4.4). This idea was also experienced elsewhere (Holt & Tickle, 2014).

Experiences of change might be similar to "new understandings" (Milligan et al., 2013) or to phases of "organisation" or "stabilisation" (Romme & Escher, 2000). They may signify an "experiential journey" (Milligan et al., 2013), or movement within Geekie's constructs of "invalidation-validation" and "fragmentation-integration" (2007).

Fabien felt his life was more ordered and Aisha felt she had accepted her voices as aspects of illness (less "fragmented"). Fabien and Robert believed they had integrated their voices into their senses of self (more "integrated"). Paula and Tina were developing increasing feelings of self-acceptance in relation to HV (more "validation" given to self, implying "invalidating" responses from others would not be accorded as much importance). Katie still experienced most of her voices as problematic and "invalidating", but claimed to feel more able to manage them, suggesting less "fragmentation". Elaine, who experienced no change, might be assumed to have remained at the same place. Olivia and Rhiannon, who no longer heard voices, and Gary, who felt medication was controlling his voices, continued to hold "invalidating" views about the experience of HV, but increased order in their lives may have positioned them as less "fragmented".

The differences between this and other qualitative studies of HV, included the extent to which voice content was the main predictor of distress and the lack of coping strategies employed at first by these participants. Overall, this study concurred with other research that HV is a meaningful experience which, if explored, can lead to personal understanding that may be positive and useful for VH.

13.2.2   A problematic experience

The very fact of HV was often problematic because participants knew it was an unusual experience that is perceived negatively in society. They had often experienced negative reactions from others, or feared such reactions, and sometimes found their psychiatric

treatment difficult (10.2; 11.1.1). This is in line with evidence on negative appraisals and the further trauma of negative reactions (Birchwood & Trower, 2006; Morrison & Baker, 2000; Morrison et al., 2004; Morrison et al., 2005, p. 328; Morrison & Renton, 2001; E. Walsh et al., 2003). Negative appraisals can also be affected by the way people view themselves in relation to others (Pickett & Wilkinson, 2009). Several studies reported on themes relating to emotional impact (Beavan, 2011, p. 70; Chin et al., 2009; Fenekou & Georgaca, 2010; Holt & Tickle, 2014; L. J. Jackson et al., 2010; S. Jones et al., 2003; Karlsson, 2008; Mawson et al., 2011). This impact was demonstrated by several participants in a number of ways, both in terms of how they felt treated and how they regarded themselves.

The practical consequences of no job, living in supported housing, attending doctor's appointments or being admitted to hospital, and the side-effects of medication, sometimes added to that (10.1.2; 10.2) and perpetuated the negative appraisals of the experience (Morrison & Baker, 2000; Morrison et al., 2004; Morrison et al., 2005).

Even if participants welcomed their voices (Fabien and Katie (occasionally)), the fact of HV was still problematic. Feeling more in control if voices are perceived positively, as mentioned by Jenner et al., (2008), seemed not to apply to these participants before therapy, but sometimes this changed later (10.4.3; 10.4.4; 13.2.8).

Another problem was that participants had usually been given a medical explanation for their experiences as symptoms of mental illness and had been offered medication which had not always been effective at helping them feel more in control or less distressed. Barham (Barham, 1997; Barham & Hayward, 1991; Barham et al., 1995) reported that psychiatric patients' accounts reflected practical problems involved in maintaining

everyday functioning because of exhaustion, but also because of the psychiatric help

they had been given[31].

13.2.3   Being a mental patient and the language of disorder

Even those participants who felt relieved at the thought that their unusual experiences

might be to do with an illness (Aisha, Olivia, Rhiannon) (10.2.4), were also aware of the

social stigma attached to being a mental patient (10.2). They were hurt at society's

negative judgements towards people who act differently from the norm or who hold

unusual beliefs (10.2.3). The sad thing is that they shared those views and feared they

would be unable to fit in with normal people (10.2).

Participants were all aware of their being different from others in society and that there

were negative implications of this (Beavan et al., 2011; Read, 2007; Read, Haslam,

Sayce, & Davies, 2006). Whereas some evidence argues that lay understandings of HV

typically attribute psychosocial causes to the experience (Dietrich et al., 2004; Read,

Haslam, et al., 2006), that was not what these participants reported. All except Fabien

believed that HV was a symptom of mental illness, in line with Fenekou and Georgaca

(2010, p. 139). If I tentatively suggested that there may be some connection with

previous adverse events – e.g. the assault Gary had suffered, the sexual abuse Katie had

suffered – they denied any connection and seemed surprised to even consider they

might be linked (10.2.1; 10.2.4). Some participants, however, did change their views

after therapy (13.2.8) and it was those who might be described as dealing with HV by

"turning toward/empowering" (de Jager et al., 2016, p. 1409) or "recover[ing] from" it

(Larry Davidson & Roe, 2007).

Before therapy, participants often felt written off, with no chance of a positive future,

even if recovered, (Barham et al., 1995, p. 136) (10.3). Fabien also described (11.1.1)

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[31] The potential impact of medication on the process of therapy is discussed in 13.3.4

the need for him constantly to engage in "the insight trap" (Harper, 1999, p. 192) when patients feel under pressure to accept they are mad in order to show insight, to prove they are well enough to be classified as recovered (see also Barham et al., 1995, p. 135). Fabien (11.1.1) reported that he had to "lie about my consciousness" but other participants (e.g. Gary, 10.2.4) accepted their positioning unequivocally (S. Jones et al., 2003). This has implications for hopes (10.3) that the chance of a different future might be available to participants which is crucial when starting any form of therapy or treatment, and, indeed, for there to be any chance of recovery (Barham & Hayward, 1991; Duncan, 2002; Repper & Perkins, 2009; Yalom, 2005).

The vocabulary participants used to talk about their experiences was often couched in medical terms. Some participants found it comforting to be able to think of the voices as part of their illness. Aisha had been so frightened at what the voices were saying and trying to get her to do, that she found it a relief to be told she had schizophrenia (10.2.4). This meant she had an explanation for these scary occurrences, even though it was distressing to think she had a mental illness. Gary and Elaine displayed this attitude, as did Rhiannon who differentiated between any help she could get from therapy with what she needed to manage her psychosis (11.4.1; 11.4.4). Olivia explained that her professional training meant it was "natural" for her to think in this way.

Geekie's (2007) construct of "validation-invalidation" is relevant here. These participants patently felt invalidated by stigmatising attitudes from others and themselves, but the construct also covers ways of invalidation of self. For instance, Olivia struggled not being able to rely on self; Paula had never acted like an adult, owning neither a handbag, nor her house keys; Aisha had to work out a new identity for herself as a person with schizophrenia. Fabien, on the other hand, felt invalidated when others referred to him as "a loony", but received "validation" through contact with his

"higher self". Katie also found comfort when she heard the voice of a caring family member which could be presumed to validate her distress at the abuse she had suffered.

Even if the medical explanation of their experiences made sense to them and did not threaten their sense of personhood as appeared to be the case with Aisha, Katie, Olivia (10.2.4), several also stressed their fears about how others would react to them if they admitted their psychiatric history (Beavan et al., 2011), as they were aware of the "toxic stereotype" attached to schizophrenia (Read, Haslam, et al., 2006, p. 304) (10.2.1; 10.2.2; 10.2.3). This may have been even worse for those who felt they were defined primarily by their illnesses (Barham, 1997; Barham & Hayward, 1991; Barham et al., 1995; Johns & van Os, 2001). For instance, Gary wistfully admitted that there were not many times when he got the chance to feel "a bit normal" (11.1.2).

These findings demonstrate the range of perspectives about the HV experience. Whilst some participants here found it emancipatory and respectful for HV to be treated as a version of normality with attempts to understand them idiosyncratically (e.g. Fabien, 10.4.4), others (e.g. Aisha, Tina) (10.2.4; 10.4.3) claimed the right to understand their experiences as symptoms of illness (Corstens et al., 2014, p. 292; Woods, 2013) – despite the attendant difficulties.

13.2.4   Power and control

When participants joined this study there was, invariably, a disturbing lack of control over when the voices were present and, for some, a wariness about the perceived power the voices may have over them (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000). The theme 10.1, An unwelcome intrusion was related to the perceived power and control of voices. This was noted by Chin et al., (2009) as an "invasive quality" (p. 8) that had elements of conflict and tension construed as "Me vs the voice(s)" (pp. 7-8). It was described by Mawson et al., (2011, pp. 264-265) as "A 'Battle' for control". This

was related to feeling a loss of self and distress at the disruption voices caused (10.1.2; 10.1.4) which is contained within Geekie's (2007) construct of "fragmentation", and with wanting things to be different (10.3) which, before therapy, often felt out of reach. As Jones et al., (2003) found, participants felt powerless in relation to their voices if they attributed HV to illness (most of them at first) or spiritual presence (Fabien).

Most participants attributed such power to their voices that they felt unable to conceive of their having ability to manage them (10.1.4) when therapy started. This power was exerted over participants in various ways. When the voice content (10.1.3) was commanding, critical, demeaning or punishing (Chin et al., 2009; Fenekou & Georgaca, 2010; Karlsson, 2008; Mawson et al., 2011), it also often seemed related to participants' views of their own weaknesses or failings which increased the power attributed to voices and exacerbated participants' negative views of themselves (Holt & Tickle, 2014) as discussed by Olivia, Paula and others (10.2.1). After therapy, however, some participants felt they had regained a sense of power which was often related to their voices (e.g. Aisha and Katie reported that they felt less powerless in relation to them). Tina and Robert, described new strategies of engaging with their voices, to challenge and negotiate with them (10.4.3; 10.4.4). Jackson et al., (2010) also reported that engagement with voices was found to be empowering and it might be that my participants found their engagement to be similarly reinforcing of their renewed senses of power and agency. This relates to the notion of "turning-toward/empowerment" identified by de Jager (2016) and was experienced by some participants here (see 13.2.8). It has also been found with methods of helping such as voice dialoguing (discussed in 13.3.8).

13.2.5   Effects on self

Several other studies reported effects on participants' self-esteem through perceived stigma attached to HV and hearing negative voice content (Beavan, 2011; Chin et al.,

2009; Mawson et al., 2011), but the effect on identity that these participants described is captured most comprehensively by Geekie's constructs of "fragmentation-integration" and "invalidation-validation" and is in contrast to the findings of Fenekou and Georgaca (2010) whose participants reported well-managed strategies of integrating and managing their experiences.

Geekie (2007) argued that his construct of "fragmentation-integration" was part of his participants' psychosis. Whilst these participants did report such feelings in 10.1 and 10.2, the "fragmentation" also seemed to be a *result* of the psychosis, sometimes because of the persistent intrusion of the voices, sometimes because of other factors such as distressing or frightening voice content, all of which made it difficult to feel in control of their lives (10.1.4) (Chin et al., 2009; Karlsson, 2008; Mawson et al., 2011). The "Chaos.com" Fabien reported in 10.1.2 describes participants' experiences of this and is reflected in evidence from Mills (2002) who (also) used the term "fragmented", and Wagner and King (2005, p. 142) who used the term "disorganised".

In this phenomenological study of lived experience, participants viewed self as something real and important (C. R. Rogers, 1959, pp. 200-201; Wilkins, 2003, p. 32, 2016). Many talked of feeling they had lost (Robert, Tina), or were in danger of losing themselves (Aisha) and of not being in control of self (Olivia) at the start of therapy. Similarly, there was some discussion about finding self (Paula), being given part back (Robert), integrating voice with self (Fabien), by the end of therapy (10.4.3; 10.4.4; 11.4.4). Several (Katie, Olivia, Robert, Tina) talked of this meaning they were stronger and better able to cope (de Jager et al., 2016).

Some participants appeared to lack autonomy. This was sometimes because of the control they felt their voices had over them (Birchwood et al., 2000), or because they actually had little say over day-to-day decisions (e.g. Elaine), and had developed a

"learned helplessness" (Roberts & Wolfson, 2003, p. 40) from that. This meant their chances of achieving the different future they yearned for (10.3; 11.2.1) felt limited, as were their senses of agency and even personhood.

The important point is that the ways participants felt about themselves, their senses of agency and identity were intricately connected with their experiences of HV.

13.2.6   Having the chance to explore the meaning of voices

Participants had been positioned as mental patients, as out of touch with reality, and as people who do not hold views of any merit, such that they should not be encouraged to talk about the content of their psychotic symptoms (for instance, Robert in 11.3.2) which appears to happen commonly (Boyle, 2013; Fenekou & Georgaca, 2010; Geekie & Read, 2009; Larsen, 2004; Wagner & King, 2005; Wise & Rapley, 2009), even though health service policies state differently (Perkins & Slade, 2012). VHs' stories are, then, effectively silenced (Waddingham, 2015; Wise, 2004; Wise & Rapley, 2009). It appears that health service policy may have been contravened here (Perkins & Slade, 2012) because, at the start of therapy, most participants had never considered attending to the content of the voices they heard and were surprised I asked them about it (11.1.1).

Participants all, positively made use of the opportunity to talk about their experiences (Birchwood & Trower, 2006; Geekie, 2007; Larsen, 2004; Stephane et al., 2003; Wagner & King, 2005) and the validating effects (Beavan & Read, 2010; Geekie, 2007; Geekie & Read, 2009) of it will be discussed in 13.3 below.

These participants discussed their voices as real entities (10.1.1) and, usually, as people, many of whom were known to them (Beavan, 2011; Chin et al., 2009; Holt & Tickle, 2014; L. J. Jackson et al., 2010; S. Jones et al., 2003; Mawson et al., 2011). The content became personally meaningful for some once they paid attention to it (Beavan, 2011). They were usually in relationship with their voices – even if that relationship was

difficult, and the voices invariably had a big impact on their lives (10.1) (e.g. Holt & Tickle, 2014).

It is important to note that changing understandings and experiences of voices can happen throughout VHs' lives, not just after therapy. Several of these participants (e.g. Paula, Robert, Tina, Fabien) reported voices being positive or supportive earlier, or at different times in their lives. This fluidity affected, and was affected by, their beliefs about (P. Chadwick, 2006; P. Chadwick & Birchwood, 1995; P. Chadwick, Lees, et al., 2000), and appraisals of (Bak et al., 2005; Morrison & Baker, 2000; Morrison et al., 2004; Morrison et al., 2005), the tone and content of voices. It seems as if the change in tone happened for these people when distressing things were happening for them and it is then that they might be considered to enter the "startled" phase described in the HVM approach (Corstens et al., 2014; Romme & Escher, 2000; Romme et al., 2009). To that extent, then, it may not be the onset of HV, *per se*, that initiates becoming "startled", but the experience of it becoming problematic. This links to the "negative triggers" identified by Milligan et al., (2013) that, they claim, often precede the onset of voices. It might be that such a trigger caused the content of voices to change for participants who had previous experience of positive voices, such that they then enter a "startled" phase, where they tried also to reject the voices. This may suggest that people who have positive experiences of voices (at least initially) only ever "organise" and "stabilise" their voices, or that the "startled" phase is but fleeting or forgotten.

13.2.7 Culture effects and spiritual understandings

These findings broadly supported those from cross-cultural studies discussed in Part A (Larøi et al., 2014; Luhrmann et al., 2015) where people from western societies are more likely to talk about HV using the medical metaphor.

Participants in this study usually fell into this category at first, often using diagnostic categories to describe their experiences and considering the voices to be symptoms of illness (10.2.4). They had rarely developed relationships with their voices (at least, before their therapy) which affected their negative appraisals of HV (10.1; 10.1.4). This contrasts with studies cited in Holt and Tickle (2014), which often found VHs were in relationship with their voices, sometimes because of a paucity of other relationships being available (Chin et al., 2009, p. 9).

As discussed in 13.2.1, a medical understanding was also typically reported by long-term psychiatric patient participants in Fenekou and Georgaca (2010). Geekie's participants (2007, p. 214ff.), however, offered a range of different understandings of their experiences. His study took place in New Zealand, in a context where, Holt and Tickle (2014) suggest, there may be more accepting attitudes towards different perspectives.

Fabien, who thought of his voice as a spiritual entity, as is more common in other cultures (Larøi et al., 2014; Luhrmann et al., 2015), had always been told by other professionals he should accept it as a symptom of mental illness and should take medication to get rid of it. He had, therefore, struggled to fight his voice in his attempts to be normal and fit into Western culture (10.4.4). But this had led to a conflict between what he saw as his earthly and his heavenly existences (10.4.4), as well as seeming to be a futile fight, as reported by Jones et al., (2003). He claimed that exploring his experiences with someone who accepted him without judgement (11.1.2), changed the relationship he had with his voice and resulted in him describing an integration between it and himself (10.4.4; 11.4.4). This ties in with research that claimed HV was perceived more positively once voices could be integrated into a person's religious or spiritual beliefs (Cottam et al., 2011; M. F. Davies et al., 2001; Miller, 2000). It might be that participants in the Jones et al., study (2003) attributed their voices to powerful spiritual

forces that were not in line with their own beliefs, whereas Fabien was able to bring about an integration because he regarded his voice as his "higher self".

This resonates with Geekie's (2007) third construct - "spirituality". Apart from Tina and Fabien having a spiritual perspective on HV that, occasionally, included notions of punishment and control, the only other evidence of this construct in this study was that Elaine and Katie attributed HV to their being bad and Katie thought it was punishment for allowing the abuse to happen to her (10.2.1).

13.2.8   Changing understandings?

For several of the participants in this study, the experience of voices changed over the courses of their therapy (10.4; 11.4). Not only that, but there were changes in the ways some participants understood their voices and the relationships they had with them (10.4.3; 10.4.4; 11.4.3).

By the time Aisha and Olivia came to the ending of their therapies they had developed different feelings about themselves which enabled them to find their own power in relation to the medical model and technological paradigm (P. Thomas, 2014) (10.4.3). As Davidson and Roe (2007) expressed it, they seemed to "recover in" relation to the experience. They attributed the changes to their own hard work and their drive for establishing a more positive future. But they also acknowledged the impact of feeling valued as people with stories worth listening to, as opposed to being viewed as people who were mad and whose perspectives were therefore of little worth. This seemed to have helped them internalise positive views about themselves in relation to their perceived power (Levitt et al., 2016).

Although Katie engaged with her voices to some degree in therapy sessions, she might be considered still to be "turning away/protective hibernation" (de Jager et al., 2016, p. 1409) because of the extreme distress she felt at their presence.

A strategy of "turning away/protective hibernation" (de Jager et al., 2016, p. 1409), where people try to manage their symptoms, rather than try to work out the personal meaning and integrate them, is a form of recovery and should not be pathologised (de Jager et al., 2016, p. 1417). The changes Aisha, Katie and Olivia made to cope with life do suggest success rather than failure, even though some of them were still troubled by their voices (10.4.3). They reported feeling happier and more in control of their voices and their lives (10.4.3; 11.4.2; 11.4.3), which relates to the finding that people suffered less distress if they had a more "solid sense of self" (de Jager et al., 2016, p. 1417). This is like evidence already discussed relating to negative appraisals leading to more distress (Morrison et al., 2004; Morrison & Renton, 2001).

Another study of relevance, especially to Katie, argued that abused people are so used to being silenced that it can be difficult for them to be put in a situation where they might be expected to talk openly and are also likely to be more fearful of trusting people (Dale et al., 1998). Katie stressed several times that the most important aspect of her therapy had been that she had learned to trust me and that it was this trust that made her feel stronger. In the light of that paper, and de Jager's ideas about a more "solid sense of self" (p. 1417), her decreasing distress makes sense.

Gary and Elaine, however, seemed still to feel powerless in the face of their medical conditions (10.4.1; 11.4.1). They reported feeling no change. For them the voices they heard were just as intrusive, powerful and distressing as they had always been (10.4.1), except that Gary felt his voices were being somewhat controlled since he had started taking new medication (10.4.2).

Paula, Robert and Tina, by contrast, seemed to "recover from" (Larry Davidson & Roe, 2007) their experience, all reassessing their understandings of their voices (10.4.4; 11.4.4), which could also be described as "turning toward/empowering" (de Jager et al.,

2016, p. 1409). The approach they took was actively to engage with their voices and explore what relevance they might have for their lives (L. J. Jackson et al., 2010). Perhaps, as Corstens claimed (2014, p. s291), they viewed their voices as messengers of issues that could be addressed to help them feel better; or felt that the voices served an adaptive function (Faccio et al., 2013; Fenekou & Georgaca, 2010).

Fabien and Rhiannon retained their original views. Fabien already regarded his voice as a valuable 'messenger' but believed he had developed his power in relation to it after therapy; Rhiannon still believed her voices were drug-induced symptoms of illness that, though problematic, did not pose a threat to her sense of self.

For VHs to move beyond being "startled" and wanting to reject the voices it seems as if curiosity is required (de Jager et al., 2016, p. 1414; Levitt et al., 2016). Several participants were pleasantly surprised to discover the personal meaning of their voices even those who had not sought it explicitly (e.g. Paula, Robert, Tina).

Any changing understandings of their experiences, however, rarely seemed to extend to a reconsideration of the causes of their voice hearing.

Whether they "turned-towards", or "turned-away" (de Jager et al., 2016) or whether they "recovered from" or "recovered in" (Larry Davidson & Roe, 2007), there was a sense of resolution for some participants which might be akin to Geekie's (2007) construct of "integration", "new understandings" (Milligan et al., 2013), or "stabilisation" (Romme & Escher, 2000).

Unexpected findings

13.2.9   Crisis and agency

Several, but not all, participants had found that a crisis had been the impetus they needed to seek change (Milligan et al., 2013). An important aspect of that, for some

participants, was that Reaching a tipping point (10.3.3) led to their seeking help, which was then the start of their reclaiming a sense of agency – especially if it was in defiance of the commands of their voices. This has not been mentioned explicitly in other studies but feels significant with people who have often felt controlled by the voices they hear and by other forces in their lives. Regained agency seemed to feel healing in itself and might have contributed to the development of a more "solid sense of self" (de Jager et al., 2016, p. 1417).

13.2.10   Embodied responses

I was not expecting the physical effects of HV to be so vividly discussed. But the embodied physical experiences associated with HV before therapy (10.1.1; 10.1.4) appeared to change into almost the exact opposite after therapy (11.4.2) for those who felt satisfied with therapy.

Blackman (2001) describes HV as a fully embodied experience which is borne out by these findings (10.1.1) and has implications, perhaps, for the ways associated distress and the voice hearer herself, are interpreted, especially by clinicians.

At first participants described feeling "drained" and "exhausted" by the "heavy" burden of the voices. This contrasted with the type of tiredness some experienced after therapy sessions which had been hard work (11.4.2). Several described a "lightness" or energy afterwards which some explicitly linked to how they felt about the changes in the way they felt about their voices, in turn affected by the ways they felt about themselves (e.g. Robert (10.1.1) and Paula (11.4.2)).

13.2.11   Metaphor

I noticed that participants used vivid metaphors to describe their experiences of therapy and started to think more about that. After reading more about the use of metaphor I realised their use of it in relation to HV as well. It is briefly discussed below in 13.3.14.

13.2.12   <u>Summary</u>

These findings support the evidence for a "post-technological psychiatry" (Bracken et al., 2012; Corstens et al., 2014; P. Thomas, 2014) that takes account of, and gives primacy to, the importance of examining values, relationships, politics and the ethical basis of care and caring (Bracken et al., 2012, p. 432). The range of ways in which even just these 10 people told the stories of their lives (P. Thomas, 2014, p. 27) was wide and varied. The themes developed here related to other studies of subjective accounts from VHs that offered the opportunity for participants to share their stories, but with some differences. This might be expected bearing in mind the range of research methods and, probably, the specific focus of interviews in different studies. If we accept the view that HV lies along a continuum of human experience and that everyone lives within their own unique context, it may be the case, anyway, that any study will only ever be able to capture some aspects of the experience. This account offers my account of elements of HV that seemed to be of interest and importance to these ten people.

13.3 What do the findings tell us about what it was like for voice hearers to have person-centred therapy?

In reviewing these findings in the light of other literature on therapy with VHs, I was struck that the focus of other therapy – even the more emancipatory approaches - was on the voices, even if the aim was integration rather than elimination of the experience (P. Chadwick, 2006; Corstens et al., 2014; Longden et al., 2012; Morrison & Barratt, 2009; Wykes, 2004). The person-centred therapy I offered here did not have HV as its focus at all, even though participants were referred to me because they were VHs and knew they were taking part in research into therapy with VHs. Sometimes the voices themselves were discussed or we engaged with them directly, but only if the client raised voices as a topic themselves; at others, clients did not mention HV at all.

Some did choose to focus on voices, or their voices were so demanding of attention that they had no choice but to acknowledge their presence; but most did not. Despite this, all except Gary and Elaine came to feel differently about their voices and their lives. That is not to claim an outcome for person-centred therapy specifically, although some participants reported that therapy had had some impact on the ways they came to feel.

Much of the evidence alongside which these findings will be reviewed is, therefore, gathered from within very different perspectives. Longden et al., call for the development of well-defined therapeutic approaches that can address interpersonal adversity (2016, p. 355) and they suggest combining trauma focused models with established treatments such as ACT, CBT, CFT, Open Dialogue. Person-centred therapy values seem to align with those of the HVM and both hold that a variety of therapy outcomes can be successful (Corstens et al., 2014, p. s290). Also, the therapy has a sound theoretical base and could, potentially, accommodate the heterogeneity of any causal pathways, allowing for the development of individual formulations (Johnstone & Dallos, 2014), as advocated by Longden et al., (Longden et al., 2016).

I will start by reviewing the findings in the light of other literature that explored subjective accounts of doing therapy.

13.3.1   How did findings relate to research on subjective accounts of therapy?

All participants confirmed the significance of the therapeutic relationship to the therapeutic process (Göstas et al., 2013; Lilliengren & Werbart, 2005; B. Morris, 2005; Nilsson et al., 2007; Timulák & Creaner, 2010). 11.1, Being treated like a person, and 11.2, Sanctuary, seemed especially important and may have stimulated the "curiosity" identified as a pre-cursor for exploration by Levitt et al., (2016).

Paula differentiated between the independence she felt from me and the "caring" she felt from her support worker and from friends (11.1.2). She also, however, stressed that

our relationship was different from that she had experienced with other professionals. There is, perhaps, a way of relating in a professional relationship that allows for personal connection, which Rhiannon also acknowledged. This seems to have been reflected by most participants in 11.1, Being treated like a person. Rhiannon also said, however, that she felt she was "just another case" (11.1.2), which may reflect the lack of personal caring reported elsewhere in connection with the boundaried nature of the professional relationship (Levitt et al., 2016). Others might have felt the same without saying so explicitly.

Participants were disconcerted when they realised I had not taken on the role of 'expert' in the same way as other professionals with whom they had had contact (11.1.1) but most embraced the person-centred format (11.3.1), even though the process was sometimes hard (11.3.4) (Göstas et al., 2013; Kilbride et al., 2013; Wood et al., 2015). Elaine however, said (11.2.5) that she preferred the format of a CBTp approach (Kilbride et al., 2013; Wood et al., 2015) which seems to be more structured and practical, and included reality testing, evidence gathering and homework.

Some participants were hopeful about the possibility for change (10.3; 11.2) which might equate with "recognising needs" and "agentic curiosity" about how to deal with them (Levitt et al., 2016). They enjoyed the process of person-centred engagement and collaboration (11.3) (Kilbride et al., 2013; Levitt et al., 2016; Wood et al., 2015), which often involved talking about things in ways they did not do elsewhere (11.2.4) (Göstas et al., 2013). Perhaps this was because therapy was experienced as a sanctuary (11.2.2). Other participants appeared to feel they had little control or agency in relation to their problems. They may have found it difficult to access their inner resources because of overwhelming emotions and lack of self-worth (Göstas et al., 2012), perhaps because of their experiences of institutional care or of feeling stigmatised.

Despite their original ideas that getting better would involve the elimination of their voices, several participants came to view recovery in a more global sense, related to relationships with others, their voices and themselves. Symptomatology was rarely mentioned (Levitt, Butler, & Hill, 2006).

Gary and Elaine, however, did mention that continuing to hear voices was a reason for their dissatisfaction with therapy. This may be because I was not flexible in offering them the guidance and direction they needed (Levitt et al., 2016, p. 821; Lilliengren & Werbart, 2005, p. 333; Nilsson et al., 2007, p. 564). It is concerning that they might have been left with additional feelings of vulnerability because I did not meet their needs and they felt that talking, which was hard, was not enough, or was not what was necessary to solve their problems (Lilliengren & Werbart, 2005; Wood et al., 2015).

They might, however, be regarded overall as dissatisfied but with some sense of gain (B. Morris, 2005, p. 37) because they reported valuing the opportunity to "offload", feeling understood and feeling supported at difficult times in the safe therapy space.

Participants felt they could differentiate change that had occurred through therapy from that in other parts of their lives (McLeod, 2000). Gary believed he had improved because of his medication; Olivia and Rhiannon were sure they would have recovered over time anyway; Katie separated the effects of therapy from other things that made life worth living; others attributed changes to the work they had done in therapy (Aisha, Fabien, Paula, Robert, Tina) and outside of it (Paula, Tina).

Overall, these findings were reflected in other qualitative research into the experiences of therapy, for many different problems, across a variety of therapies.

Disappointment with therapy, and other areas of interest, will be covered in the remaining sections of this chapter.

13.3.2   Discussion of therapy outcomes

13.3.2.1   Context

Although the aims of this study were to investigate the experiences of HV and of undertaking person-centred therapy, the extent to which person-centred therapy was effective may also be of interest. Chapter 12 offered an analysis of quantitative and qualitative outcomes.

Qualitative outcomes will be explored in more detail in later sections of this chapter where the thematic analysis is also discussed. This section will focus on quantitative outcomes, with the caveat that this was not a controlled study, it was a small sample and effectiveness was not one of the research questions. Findings would be different had participants been primed to complete the measures for those purposes. Nevertheless, these data offer an additional perspective on these participants' experiences.

13.3.2.2   Discussion of qualitative outcomes

In brief, outcomes varied and improvement was not usually connected with reduction in HV, as shown in other studies (Kilbride et al., 2013; L. Pitt, Kilbride, Nothard, Welford, & Welford, 2007; Wood et al., 2015). In some cases, findings on outcome measures appeared to contradict the accounts offered in post-therapy interviews. For instance, Paula showed RC, CSC and D on several tests of RC even though her post-therapy interviews suggested she had made significant positive change in her life. Examination of qualitative accounts alongside scores helped clarify and understand such discrepancies, as discussed in 13.3.2.4 below.

Positive outcomes were often related to psychological improvements that resulted, as described by (Göstas et al., 2012), in an increasing ability to engage with life, such as Paula and Aisha making new social and work commitments. As Göstas et al., (2012)

also identified, awareness of reclaimed agency plays a large part in people feeling positive about the future. Aisha's belief that she had successfully used therapy to meet her own needs was an example of this. Such outcomes may be related to achieving more balanced emotions and improved cognitive functioning (Göstas et al., 2012), as demonstrated by Fabien's belief that his thoughts were now organised "in a filing cabinet"; and Tina, who had started to feel more compassionate to herself and her voices, and more in control of who she was. Another aspect of these psychological changes is an increased understanding of problems (Levitt et al., 2016), such as Katie feeling more able to manage her voices.

Changes were usually described in concrete ways. For example, participants used metaphors connected with untangling, rebuilding, organising, and described feeling more organised, more in control, stronger (11.4.2; 11.4.3). Maybe that is because it was difficult to isolate cognitive, behavioural or emotional components (Levitt et al., 2016, p. 283; Merleau-Ponty, 2002). It may be, however, that different research methods (e.g. visual methods, Reavey, 2011) would be more effective at eliciting such components.

Consideration of quantitative findings may also aid understanding or elucidation of what participants are trying to describe. The focus of specific items on a scale may help direct participants' thinking towards how best to describe their overall experiences. Such discussions seemed to happen to some small degree in some of these post-therapy interviews when outcome measures were being discussed.

13.3.2.3   *Comparison with other studies*

These findings will be evaluated in relation to those from other research into therapy with people experiencing psychosis that used BAVQ-R and PSYRATS, or elements of those measures (shown in Appendix Giii).

Apart from Elaine, Gary (more extreme levels of symptoms) and Rhiannon (more in line with non-clinical means), participants' scores pre- and post-therapy were broadly in line with those of participants in other studies.

Overall, change was not demonstrated for most participants on each RCI test. It may be worth considering these findings in the light of a concern that cut-off points for "normal functioning" may be too stringent for some clinical populations with schizophrenia (which several of my participants had been diagnosed with) given as an example of that (Jacobson et al., 1999). If this is so, it might be that more participants achieved RC or CSC than are reflected in these tests.

The only study that mentioned clinically significant change was Durham et al., (2003) and, although they identified changes in their experimental group, they did not use the same procedure, they used different criteria for clinical cut-off and did not use BAVQ-R or PSYRATS as the measure tested.

Other studies tested for statistically significant change after therapy. Comparison is, therefore, problematic because the small sample here meant I was unable to perform the same tests, despite the data demonstrating normality.

There were few examples of significant change on BAVQ-R and PSYRATS in the studies shown in Appendix Giii. Different measures, however, sometimes demonstrated positive change in experimental groups and other studies that used different measures have also shown consistent support for the effectiveness of CBT approaches with people experiencing psychosis (Wykes et al., 2008). It may be that BAVQ-R and PSYRATS deliver measurement of different factors from these other studies. As Thomas (2015) has argued, consideration should continually be given to factors of importance in the success of the therapy and which measures might most appropriately assess effectiveness. This is where qualitative subjective accounts may prove of value

(Greenwood et al., 2009; Sweeney et al., 2013; Wood et al., 2015) by adding in a different or more nuanced perspective on what is important.

It would be interesting to compare person-centred therapy using other measures. For now, however, the tests for RC and CSC here may offer tentative prospects of positive change in some individuals, in some ways. More research is needed before any conclusions can be drawn and larger samples should be studied so that statistical tests can be completed and comparisons made with other approaches.

13.3.2.4   *Implications of using these measures to represent experience*

Several participants found it difficult to complete the measures and commented that the requirement to choose one answer did not enable them to reflect their complete experiences of HV. The instructions ask participants to answer based on the most dominant voice but some felt this did not apply to them. For instance, Robert answered based on his "authority" voice as it was usually louder than the other "chirrupers" that he heard. But he did not believe that was 'dominant'.

Equally, some heard voices that had different qualities. For instance, Katie heard the comforting voice of a family member amongst the other more critical and abusive voices of her abusers. She answered based on the negative voices but was upset that the measures did not, then, capture the experience of her positive voice. A third difficulty was the variation some found in their experience of voices. For instance, Fabien said he needed to offer two scores on loudness because of varying experiences at different times.

Some also found it difficult to understand some of the dimensions on PSYRATS. For instance, it was difficult for some to separate amount and intensity of distress and

amount or degree of negative content, even using the descriptors given and even though we explored what that might mean for them.

The implications of these difficulties mean that some items were unscored, or the participants stressed that their answers did not reflect their experience. The findings therefore offer a flawed representation of the experience of this sample. One might question whether this might be the same in other studies.

Another factor that might have influenced the ways participants completed the measures might be the extent to which they were satisfied with therapy. If they were satisfied, they might have allocated scores that suggested lower levels of distress or negative impact than those who felt therapy had been disappointing, who might have scored correspondingly higher levels of distress and negative impact. Our pre-existing therapy relationship may also have had some influence here.

Furthermore, change that was different from what was anticipated or hoped for before therapy may have affected the ways participants perceived their voices and scored these measures. This will have an impact in studies that use the measures to test effectiveness of therapy. For instance, Olivia retained the same beliefs about her voices (suggesting therapy was ineffective) but did not experience the same impact on her life once they had stopped and showed CSC on some scales (suggesting therapy was effective). The thematic analysis showed that she did not believe therapy played a part in her recovery from HV. She did, however, believe that therapy had contributed to her feeling more positive about herself and her relationships with her family. This might be a positive outcome for therapy but may not be captured in a RCT that relied only on measures of symptoms. Similarly, Paula showed deterioration on some scales and improvement on others. Her post-therapy interview data were needed to illuminate these seeming contradictions with nuanced explanations.

13.3.2.5   Summary

These findings suggest that consideration of qualitative outcomes alongside quantitative findings may offer additional context and understanding about the effectiveness of therapy, especially where results seem to vary. Other measures that assess quality of life, social functioning or well-being might also capture those features. Standardised scales offer a way of measuring the degree of change and a comparison of samples in terms of severity of disturbance. Those scales should, however, have relevance and resonance for service users and researchers need to be clear about the criteria by which successful therapy can be evaluated.

13.3.3   Examination of findings in the light of a person-centred approach

This section relates the discussion of the person-centred approach and the learning from the Wisconsin study (Rogers et al., 1967) as explored in 2.5. As discussed elsewhere (2.1; Chapter 9; 13.3.4), it is important to bear in mind that medication may have influenced the findings in ways that cannot definitively be determined.

My experience of working with these participants was that they all seemed to value my attempts to understand them and the worlds they were living in (10.1; 10.2.4) and that this felt unusual for them. They had all chosen to enter therapy and exhibited some sense of agency in relation to it. It may be that these participants were not as withdrawn or institutionalised as those in the Wisconsin study so their senses of motivation and agency were different. Participants at Wisconsin were allocated to the experimental group without necessarily having shown any previous inclination to seek therapy which might be another reason why they often showed little motivation to attend or engage (Rogers et al., 1967).

Though sceptical and ultimately disappointed, both Elaine and Gary attended sessions regularly (Gary travelled some 15 miles each week) and both tried to engage even

though they struggled to decide what to talk about. Furthermore, they both reported that they had valued various aspects of our relationship. Both liked having the opportunity to "offload" (Gary) in sessions. Elaine said she valued my support in staying with her when her voices felt overwhelming; both liked feeling understood "You knew where I was coming from" (Gary); and Gary liked that it had made him "feel a bit normal". This does not appear to be evidence of reluctance or a lack of motivation to take part in therapy, in the same way as those in the Wisconsin study (Rogers, 1973, pp. 182-184). It may have been, instead, that they had an externalised model of change, had been socialised into a medicalised approach or been afraid of facing difficult emotions. Schmid (2005) reflects on this in relation to the notion of alienation and inauthenticity where people can be greatly influenced by the social mores of their situations. This would then affect the ways they processed information as Warner (2013) suggests.

Whilst Elaine's and Gary's experiences might not, as Rogers suggested (1973, p. 184), count as psychotherapy, it does seem to be evidence of a positive relationship at some level as Gendlin reported (1973). It may also be related to Rogers' finding that relationship development and being accepted was of more importance to "schizophrenic" participants, with self-exploration, empathy and genuineness being perceived and required by "neurotics".

Other participants who did report self-exploration and change (Fabien, Olivia, Paula, Robert, Tina), may be similar to those few schizophrenic patients who did embark on "an active, struggling fearful exploration of self" (Rogers, 1973, p. 185) and who demonstrated an increase in degree and depth of self-exploration across the course of their therapy. It is as if they were operating less like the usual "schizophrenic" participants in Wisconsin participants and more like the "neurotics". It may be, however, that these participants were not so withdrawn or had not been so affected by their experiences of HV and their lack of being in relationship. Even though most had

been inpatients for at least some of their lives, their stays would have been comparatively short. It is less frequent in the 21st century for people to be hospitalised for many years in the same way as would have been the case in the 1950s.

The differences in the ways these participants used their therapy perhaps offers support for the pluralistic perspective discussed by Cooper and McLeod (2007). It may be that working with people experiencing different realities is an ideal time to embrace such flexibility, as reported by Levitt et al., (2008) in their summary of a range of therapies.

It appeared that some of my participants had suffered significant adverse events in their lives. This links with findings discussed in 1.5.4 that links HV with such events. The person-centred approach to working with trauma (Joseph, 2015), which stresses the value of clients being able to deal with issues at their own pace, was reflected in comments by these participants. For instance, Katie needed to "take a break" and Tina said she would not have been able to start therapy earlier as the time was not right.

It was interesting that participants had not been asked about their experiences of trauma by other professionals involved in their care (Sampson & Read, 2017) and were surprised when I asked them whether they thought there might be some connection between their voices and their life histories. Some participants who embarked upon a process of self-exploration, however, did reassess how they interpreted things which might be akin to the start of post-traumatic growth (Joseph & Linley, 2006).

All participants here seemed able to establish psychological contact, so I did not use pre-therapy contact reflections (Prouty et al., 2002). Again, this may suggest that they were not as withdrawn as those in the Wisconsin study. Indeed, they described how unusual and welcome it was to be offered the chance to reflect on their own understandings of their experiences. It was also a new experience to be able to set the tone, content, pace and direction of their therapy. This will have been similarly unusual

for participants at Wisconsin. Not all participants found this easy. For those that chose

to embrace the approach, however, it was as though they were called into being in the

way Rogers expressed it when he encountered it with his participants in the Wisconsin

study - as the "germination and budding of the will to say 'I *am*, I deserve to *be*'"

(Rogers, 1973, p. 188).

13.3.4   Potential impact of medication on the process of therapy

As discussed in 2.1, medication can have a range of powerful effects on the people that

take them. During therapy sessions, some alluded occasionally to their medication but

we did not discuss it in any depth and I did not have details of their prescriptions. Only

Gary specified what tablets he was taking (Clozapine).

In post-therapy interviews, all mentioned that they had, at some point, been given

medication and some (Aisha, Elaine, Gary, Olivia, Rhiannon, Tina) reported that it had

been necessary or beneficial. Others felt it had not affected the voices they heard

(Fabien, Katie, Paula, Robert).

None mentioned whether they felt their medication had affected their ability to engage

in therapy and I did not explore this explicitly. It may be, however, that factors which

seemed to be psychological to the participant and/or to me (e.g. apathy, lack of

motivation) were, in fact, the side-effects from prescribed drugs (Hammersley, 2016b).

It seems worth speculating, therefore, on how participants might have been affected by

medication throughout therapy and the research interviews.

Some of the recognised side effects (listed by Read & Bentall, 2013, p. 276) might have

affected how participants felt, and were able to communicate with me during our

sessions. If, for instance, they were experiencing physiological effects such as tardive

dyskinesia, tremor or rigidity, they might have felt ill at ease or unable to communicate

clearly. They might have felt uncomfortable if they were constipated, or experiencing

urinary retention. There may have been feelings of embarrassment or shame for those who were overweight. The extent of ill health they suffered might have been greater, had they developed diabetes, hypertension or cardiovascular disease. One might conjecture that symptoms of these illnesses would be exacerbated if participants were trying to explore painful or frightening issues, or if they perceived that the voices they heard were putting them under pressure. I was unaware explicitly of any of these adverse effects (except for some of my participants who were clearly overweight. But I cannot know if that was an adverse effect from medication).

Participants were all able to establish contact and then a therapeutic relationship with me but it might be supposed that this was affected by the interpersonal side effects noted in other research (Gibson et al., 2014; Moncrieff, 2013a; Moncrieff et al., 2009; Moncrieff et al., 2013; Read & Bentall, 2013). Far from flattened or numbed emotions (Moncrieff et al., 2009), or emotional detachment (Gibson et al., 2014; Healy, 1989), my participants appeared able to experience depth of feeling, which may, itself, be a heightened response due to medication (Gibson et al., 2014; Moncrieff & Cohen, 2009; Moncrieff et al., 2013). Usually this was confusion fear and distress in the early stages of therapy (again, a potential side-effect?); but there was sometimes a corresponding level of joy or hope later (especially Aisha, Fabien, Olivia, Paula, Robert, Tina). Not all participants experienced changes in their initial feelings.

There was much that might be construed as dysphoria (Moncrieff, 2013a; Moncrieff et al., 2009; Moncrieff et al., 2013; Ramaekers et al., 1999), but that surely is to be expected when people are distressed and worn down with life. Although I perceived no lack of motivation to engage with therapy, it may be that what I interpreted as resignation in some participants was evidence of side-effects such as decreased motivation or apathy (Gibson et al., 2014; Moncrieff, 2013a, 2013b; Moncrieff et al., 2009; Moncrieff et al., 2013).

At times, some participants appeared unable to follow a train of thought (Elaine, Gary, Katie, Robert). With Robert, it was usually because his voices were interrupting his thought processes. The same happened occasionally with Katie. But it is possible that their medication had created a form of mental clouding or slowed mental processes (Gibson et al., 2014; Moncrieff et al., 2009, p. 107).

One could speculate that, if medication decreases the intensity of symptoms and reduces agitation (e.g. Mizrahi et al., 2005; Moncrieff, 2013a; Moncrieff et al., 2009), it might have made it easier for some participants to engage with therapy when it involved broaching painful or frightening problems. A decrease in agitation may have made it easier to focus on the issues being discussed. Conversely, the absence of symptoms or lack of distress may have removed the "alert" of the work to be done in therapy (Hammersley & Beeley, 1996). I cannot know for sure.

In summary, I did not have specific information available to explore the effects of medication on participants' therapy. Nor can I know how they would have engaged had they been taking different or no medication. Some previous discussion with participants might have enabled us to contextualise their processes differently and in more depth.

13.3.5   A unique experience

In describing what their person-centred therapy was like, most participants spontaneously compared it with other treatment they had been offered and remarked upon its difference (11.1.1) The main criterion was that, in person-centred therapy, they felt treated like a unique person with views worthy of consideration and this felt humanising (11.1.2). The de-humanising nature of some psychiatric care that neither seeks, nor seems to value, the views of experts-by- experience has been well-documented (Boyle, 2002b, 2011; Corstens, Longden, et al., 2012; Corstens et al., 2014; Geekie, 2007; Geekie & Read, 2009; Repper & Perkins, 2009; Roberts & Wolfson,

2003; Waddingham, 2015; Wagner & King, 2005; Wise, 2004; Wise & Rapley, 2009). The same research notes another important aspect of what some of these participants remarked upon which was the value of feeling understood (11.1.3), and of how it helped them move forward in their therapeutic process (11.2; 11.3).

These factors are indicative of a person-centred approach to therapy (C. R. Rogers, 1957, 1959) where therapists try to understand what it might be like for clients to live their lives. Other research has also argued that such an approach helps participants to internalise positive self-regard (Lilliengren & Werbart, 2005). This seems to have contributed to some participants' regaining a sense of agency and power (11.4.3).

13.3.6   The chance to explore and find personal meaning

Most participants responded well to the invitation to use therapy in the ways they chose and to address whichever issues were most important to them (11.3.1). It has been suggested that other relationships, personal and professional, typically, attempt to silence the voices of those who have unusual experiences (Gail A. Hornstein, 2011, September; Waddingham, 2015) even though the opportunity is well received when it occurs (e.g. Wagner & King, 2005).

So, this was an unusual opportunity and is discussed in 13.2.8 in relation specifically to the meaning of voices. It also seemed to facilitate the exploration of important issues for some participants and a few chose to explore the content and meaning of their voices (e.g. Robert, 11.3.2) as advocated in some, more recently developed, models of therapy (Corstens, Longden, et al., 2012; Longden et al., 2013; Longden et al., 2012; Morrison et al., 2005; Wykes, 2004).

The meta-categories Timulák and Creaner identified in their meta-analysis of qualitative outcomes from person-centred and experiential therapies (2010), namely, "Appreciating experiences of self", "Appreciating experience of self in relation to others" and

"Changed view of self and others" - are all involved in what happened for some of these participants when they went through the process of 11.3.3, Making sense, 11.4.3 Making good, as well as in 11.4.4, A new perspective and a new start.

Some therapies use "formulations" (Johnstone & Dallos, 2014) to develop individual perspectives on how to help specific problems of living (e.g. Turkington et al., 2006). One might suggest that participants in this study developed their own "formulations" through being able to talk about whatever was most pressing at any time, even if that was different from their original therapy aims (e.g. 11.2.4; 11.2.5; Rhiannon at 11.3.1).

The curiosity that leads to the exploration necessary for change (Levitt et al., 2016) appeared to have been limited to exploration of participants' experiences. It did not include consideration of why they might have started to hear voices in the first place. Aisha could not understand why she might have developed schizophrenia; Gary was certain his mental illness developed because of the attack he suffered; Fabien attributed his voice to a spiritual source but did not discuss why this had occurred in his life; other participants seemed to consider that they had developed mental illnesses because of some failing in themselves. That was the extent of their thinking on the matter.

13.3.7 Factors that facilitated personal exploration

Factors connected with taking the chance to explore personal meaning were invoked by for those participants who seemed to find the inner resources (11.2.3) necessary for them to do the exploration they chose. It is important to note that the level and type of exploration chosen was different across all participants and followed their lead (11.3.1). Sometimes this was a decision not to explore issues at depth (Elaine, Gary, Rhiannon).

The value of talking to someone in an environment where there is no fear of judgement is the approach taken within the HVM (Corstens et al., 2014; Dillon & Hornstein, 2013; Gail A. Hornstein, 2011, September; Romme & Escher, 1993, 2000; Romme et al.,

1992), as well as other therapeutic modalities (Bentall, 2009; Duncan et al., 2010; Norcross, 2011). It has been reported by participants to be of importance in many different therapeutic approaches (Levitt et al., 2016), including person-centred and experiential therapies (Timulák, 2007; Timulák & Lietaer, 2001) and was noted by some participants here (11.1.2; 11.1.3; 11.2.4; 11.2.5; 11.3.1). For instance, Tina's expression of feeling that "nothing was out of bounds" (11.2.4) seems particularly relevant in this study where participants had previously found they needed, even with professional helpers, to deny their experiences (Repper & Perkins, 2009; Waddingham, 2015; Wise, 2004; Wise & Rapley, 2009). Fabien was especially vociferous about this, e.g. 10.2.2; 10.2.3.

The feeling of being free to talk extended also to feeling able to be honest about various negative aspects (Gary, Elaine, Robert, Olivia) or about wanting to stop therapy (Katie, Rhiannon) (11.2.5). I would suggest this might reflect my use of collaborative power (Natiello, 1990, 2001; Proctor, 2002, 2010) within the session, that minimised the effects of client deference (Rennie, 1994). This will be discussed further in 14.5 and 14.6.

Participants were used to entire teams of staff discussing the very intimate details of their lives, not always with them present. So, to have the chance for a separate space where they could talk privately was attractive, yet worrying in case their conversations were not, after all, kept confidential (11.2.2) (see also 13.3.11; 13.3.12). My trustworthiness and reliability were important to all participants, who said it enabled them to talk about issues they would otherwise have avoided (11.2.2; 11.2.4). Robert was particularly anxious about ensuring confidentiality, and so were his voices. He perceived that it was only when his voices came to trust me that he could too (11.2.3).

This is also bound up with power, as participants know that the therapist could betray their privacy (Proctor, 2002; Smail, 2005). So, it is a huge risk for already vulnerable people to trust a professional, when their experience of others is that information is widely shared. Once trust was established, however, it provided another means for some to access their inner resources necessary to 'do' therapy (11.2.3).

This was especially important with clients who had suffered abuse or other adverse events (e.g. Katie) where building trust is hard and where being free to talk is an experience that had often been denied before (Dale et al., 1998).

13.3.8   Bringing the voices into therapy

Only Elaine, Katie and Robert talked directly with their voices in therapy sessions and it appears to have been helpful to all three participants for me also to engage with the voices that they heard during those times (e.g. Robert in 11.2.3; 11.2.4). This could be described as a form of "voice dialoguing" and relates to other evidence showing engagement with voices can help people to feel more in control of their lives and the voices they hear (Corstens, Longden, et al., 2012; Corstens, May, et al., 2012; Dillon, 2012; Rufus May, 2000, 2004; Romme et al., 2009).

Apart from it being evidence of my affirming their reality (11.1.2) (C. R. Rogers, 1951), they seem to have been able to use my engagement with their voices as a way of re-assessing their own views about what their voices signified, how they felt about themselves and how they related to their voices in the future (10.4.3; 10.4.4; 11.4.3; 11.4.4). It created movement from a feeling of being stuck (10.3.3) and, for Robert, was a way of testing my trustworthiness for the voices and, hence, for him (11.2.3). It helped Katie develop her resistance to their commands and to their critical, threatening tones (10.4.3). She could see that she came to no harm when she talked about the voices in

my presence and this somehow reinforced her belief in her ability to resist them at other times (11.2.3). They, therefore, lost some of their power and control over her (11.4.2).

13.3.9   Active clients

These findings support the notion of client as active self-healer (Bohart, 2013; Bohart & Tallman, 2010a, 2010b; Duncan et al., 2010; Lambert, 1992). The different outcomes for each client demonstrate that all engaged with therapy to the level at which they wanted and were able. As was noted in 13.2.9, the process of 'healing' had seemed to start for some participants once they had taken the decision to seek help anyway.

Paula relished the opportunity to impose her own structure on therapy, rather than having to follow the plan or interpretations of someone else (11.3.1). Others agreed, with Katie even saying that she would not have engaged with therapy if I had tried to tell her what to talk about (11.3.1). Elaine and Gary, however, did not find that this approach suited them and they did not enjoy feeling responsible for finding their own way through, even with my support (11.2.3; 11.3.1).

The various ways in which participants described their therapy processes might be explained by Rogers' seven stages of process theory (C. R. Rogers, 1961) (2.5.1.3). This theory allows for timing as an important issue as also noted by Timulák and Lietaer (2001, p. 70). Tina, for example did not think she would have been able to broach the issues she did with me, at the time of the trauma she suffered. She was working too hard to deny or ignore it (11.2.5) – in Rogers' (1961) terms, she would not have been sufficiently far along the stages of process. Rhiannon was aware of what was a priority and decided the issues she thought had been important just did not impact on her life in the way she had feared. She, therefore, made a constructive choice not to engage with them in therapy (11.2.5) which might indicate an openness to experiencing such that she could set those issues aside.

For clients to be active self-healers in therapy, they need to feel free to exert their wishes (which is not always the case as discussed in 8.5.4). Fortunately, here, some participants felt free to tell me when they no longer wanted to do therapy (e.g. Katie and Rhiannon) and most participants had also discussed in 11.3.1 that they valued feeling in control of the process (e.g. Aisha, Fabien, Katie, Olivia, Paula, Rhiannon, Robert, Tina). There is also evidence that clients take what they need from a therapist and can ignore 'mistakes' because they are primarily following their own agenda (Bohart & Tallman, 2010a). This might explain why Robert and Olivia had not mentioned in therapy that I broke into the silences too soon (Olivia) or didn't break in early enough (Robert) (11.2.5).

This may, of course, not be so for those participants who found that person-centred therapy did not suit them.

13.3.10   Disappointment after hope

As discussed in earlier chapters, the experience of therapy can sometimes be disappointing for people. It was so for Elaine and Gary in this study.

Although, during therapy, some clients who feel locked into a certain narrative about their lives may start to see that things are not fixed which automatically challenges their existing world views (13.2.1), others may experience a resignation that things must always be so (10.3.2), especially if it is a narrative put forward by experts or is taken for granted by society (Repper & Perkins, 2009; Rose, 2001). Gary, for example, had been told "I wouldn't get better for about 25 years" (10.3.2) and offered no hope that this might be a pessimistic prognosis, just so long as he felt he could control his voices.

Elaine said she had preferred the more practical approach of previous CBT which offered her "different ways of coping" (11.2.5). When people have lived for a considerable period with other people making decisions for them, they may feel let

down, as if a therapist has not offered them practical, concrete help or guidance to help them solve their problems (Lilliengren & Werbart, 2005, pp. 332-333; B. Morris, 2005; Nilsson et al., 2007, p. 562).

For her, the promised self-knowledge to be gained by "just talking about what you want really" (11.2.5) was not enough to lead to desired change. In any case, as Lilliengren and Werbart (2005) note, talking is hard, tiring, anxiety provoking and the addressing of painful issues may cause more distress (p. 330). That additional distress may feel just too difficult to persist with in the faint hope, and fainter expectation, that things might get better.

The potential for change is an indication of hope, both identified as important factors in therapeutic change (Asay & Lambert, 1999; Duncan, 2002; Duncan et al., 2010; Yalom, 2005). If hope and expectation account for 15 per cent of therapeutic change (Asay & Lambert, 1999), and this is based on expectations that the therapist has skills and will employ practices that will bring about change (Duncan, 2002), one might suppose that Elaine and Gary would have felt a crushing disappointment that I did not demonstrate the skills they needed, they felt no better and their hopes of a way out of their intense confusion, fear and distress had been dashed.

Gary stressed that his initial fears about whether 'just talking' would make a positive difference were, indeed, borne out and nothing had changed for him in a lasting way (11.4.1). He acknowledged that he had experienced temporary relief by having the chance to "offload" and that he had valued the chance to "feel a bit normal" because of the way I treated him. But, in the end, nothing in his difficult life had changed and, though he felt the voices were being controlled by his medication, he was still distressed by them and felt that therapy had not had any impact on his own ability to control them. His experience bore some resemblance to the category "dissatisfied, but with some

sense of gain" identified by Morris (2005, pp. 37-38). Here, her participants were dissatisfied with therapy overall but could identify some positive features of it.

Elaine also mentioned that she had valued the chance to talk and be supported during sessions, but the lack of practical skill she could take forward and the additional distress she sometimes suffered after sessions meant that any temporary relief had not made the experience worthwhile.

In this study some participants seemed to revel in the opportunity for open exploration (Nilsson et al., 2007, p. 564) (11.3.1). In person-centred theory, this is described as developing an internal locus of evaluation[32] (C. R. Rogers, 1951, 1961). Whilst some of these people acknowledged my help in the process they went through, it was themselves that they credited with having done the hard work, concurring with Hoener et al., (p. 330) that they had - as agentic beings - delivered the desired results. They felt affirmed by this and proud that they had had the courage to do it (11.4.3; 11.4.4).

Elaine and Gary, however, did not appear to give themselves credit – and, hence, affirmation – for working hard at talking about difficult things in therapy. Was there a consequent attachment of self-blame for what they perceived to be its 'failure'? This would be supported by other evidence related to the social experiences of those described as mentally ill (Barham, 1997; Barham & Hayward, 1991; Barham et al., 1995); and from writers who argue against the individualising of distress (e.g. Harper & Speed, 2012; Smail, 2001b).

It's all very well to explain participants' disappointment or lack of change as being because they were at an early stage of process in Rogers' terms, but it does not address

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[32] It should be noted that such a position does not neglect the social context of the individual (cf. David Smail's work). Rather, it means that a balance is achieved between the actualising tendency and the forces of social mediation that are in existence for any individual (see 2.5).

the embodied pain and deflation Elaine and Gary expressed in their interviews. Add to this the issue of regret that Elaine felt on a couple of occasions after talking of personal problems and it might appear that therapy could be regarded as a dangerous and risky activity by some people (Goldsmith et al., 2015; Jarrett, 2008)[33].

From a person-centred perspective, Mearns talks of the need for therapists to be responsible *to* their clients but not responsible *for* their clients (1997, pp. 30-31). This is a useful distinction and, supposedly, allows for a duty of care whilst respecting the client's right to self-determination and (re-)establishment of agency. The notion of client as active self-healer positions her as a thinking, deciding agent who makes decisions based on her best interests (Duncan, 2002, p. 50). But what about people like Elaine or Gary (10.4.1; 11.4.1), for whom many decisions and choices about their lives were determined by other people (Roberts & Wolfson, 2003)? Placing responsibility for engaging as required, or for something like choosing to stop therapy if it was not helping – or, indeed, for protecting themselves against disclosing something they could later regret - might have been asking too much and requires therapists to be sensitive to when they do, perhaps, have a duty to be responsible for, as well as to, their clients.

13.3.11 The quality of the encounter – Presence?

Participants often found it difficult to elucidate what it was about the therapy relationship that facilitated the process for them (11.1.1). They could sometimes describe concrete examples of things I had done – like finding a word for Aisha when she was struggling (11.3.3) or helping Fabien in his "reflective analysis" (11.3.3) – but could not describe the quality of the relationship that had helped. Maybe that is because it was experienced in a holistic way and it was difficult to isolate cognitive, behavioural

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[33] It is important that therapists address the issue of regret to explore how clients may protect themselves in the future and that they alert clients if they start, in future sessions, to disclose something they may also regret. This gives clients the chance to consider whether to proceed and to remain in control of the process, which is important especially if clients are about to disclose something about which they may feel shameful.

or emotional components (Levitt et al., 2016, p. 283; Merleau-Ponty, 2002). It may be, however, that different research methods (eg. visual methods, Reavey, 2011) would be more effective at eliciting such differences.

I wonder if it might have been a quality of presence that was at work here, that is pre-reflexive as in Gendlin's (1996) felt sense (Purton, 2004; Todres & Galvin, 2008), rather than something to which words can be attributed. Buber (1922/1958) suggested that, in being present, space is allowed for the numinous and spiritual dimension to emerge, through a process of "hallowing the everyday". This might be experienced as confusing when participants reflect on their experiences and so becomes difficult to grasp and express holistically. But, in their descriptions of the relationship in an everyday kind of way they, paradoxically, seemed to illuminate something more.

There appears to have been a 'something' that was to do with our relationship, that participants found healing or helpful (11.1; 11.2), and that was connected to Gary's sense that I "knew where [he] was coming from" (11.1.3). A tentative suggestion is that presence is what participants identified even if they could not articulate or (sometimes) respond to it.

Some relationships seemed to embody a quality that brought about change which those participants reported was significant. Paula, Robert, Tina seemed to bring a particular quality to the therapeutic encounter that was different from that which others brought, over and above that achieved by the usual 'active clients' (see 13.3.9) (Bohart, 2013; Bohart & Tallman, 2010a, 2010b). Not better, but different. It was difficult to describe – for participants and me – but they seemed to be immersed in what we were doing, and that enabled them to bring about substantial changes to the ways they felt, most importantly, about themselves, but also to the ways they felt they could live their lives, especially in relation to other people.

This was not dependent on our relating at depth. In the spirit of Bohart's notion of client as active self-healer (2013; 2010a, 2010b), they could have done it alone. Participants reflected on their total immersion in the process, of which an important part happened within therapy sessions and, specifically, included my being with them to bear witness and understand. To that extent, participant presence was important and that is different from the usual emphasis on presence as a quality offered by the therapist (Geller, 2013).

Unexpected findings

13.3.12   Therapy as sanctuary

The sanctuary of therapy (11.2.2) for these participants was often connected to being able to talk about anything (11.2.4) confidentially and without feeling judged (see also 13.3.5) (Corstens et al., 2008; Corstens et al., 2014; Romme & Escher, 1993; Timulák, 2007). Timulák and Lietaer (2001) argue that as well as "safety" being connected with the therapeutic relationship, it may also be "a sign of the client's preparedness for fruitful engagement in the therapeutic process" (p. 70). That was also evident here and discussed under Being offered possibilities (11.2).

What I had not expected was that the space itself would be mentioned so frequently and that it would have such an effect of how participants felt about their therapy and what they felt able to do in sessions (11.2.2). A confidential therapy space seemed to offer sanctuary from a world outside which often felt difficult to manage. But, bound up with the rooms themselves in the different organisations (which were familiar to many of them as they were used for other things), was my presence with them there that created the tone and environment they found so helpful. Therapy itself has been referred to as "sanctuary" by Craig (1986, p. 22) thus:

> …provision of this human sanctuary is temporally manifested in the form of clear and inviolable arrangements about time, spatially in the form of a room where the patient may feel a sense of existential at homeness, and in the

> therapist's attunement as an alert, abiding human presence that is both
> permissive and protecting.

This description is written in phenomenological language and is from an existential perspective. The point that resonated for me was the inclusion of the therapist as well as the space in a discussion of sanctuary. Craig also claims therapy as sanctuary is linked with therapist attunement, which was another factor that seemed to be of importance in different ways here (see 13.3.11). This was certainly the sense I had from these participants – that it was my attunement with them in a safe space that was important.

Gary and Elaine, for instance, both felt they were only able to manage their voices during therapy sessions and not afterwards. It may be that the sanctuary afforded gave them a break from pressure and they were supported there by my presence. Once the session was over, they had to continue the struggle of managing things again on their own, without someone who explicitly tried to understand what the whole experience was like. In the end, however, neither felt that therapy had helped (10.4.1; 11.4.1). Others, however, found that, to be separate from the world for a while helped them do the work they needed to do and that they could leave the difficult issues behind there (e.g. Katie). For participants who often feel uneasy about others' judgements of them, or who felt, like Fabien, that it was a "pressure cooker out there", the sanctuary of therapy was of immense value.

13.3.13 Specific ways of working with voice hearers in person-centred therapy?

Debates about specific ways of offering person-centred therapy to people who have unusual experiences have been discussed in 2.5.4, but the findings here, although generally favourable towards person-centred therapy, may challenge Shlien's (1989, p. 160) claim that "…there is only one treatment for all cases". As also discussed above, if we accept therapy has effects, we need to acknowledge that some of those might be harmful (Goldsmith et al., 2015; Jarrett, 2008) and to guard against them.

There might be several reasons why some participants did not achieve their aims from this person-centred therapy (10.4.1; 10.4.2; 11.4.1), including whether I was the right therapist for them. Elaine, however, found the approach so difficult to be with that there is an ethical question around whether to continue when someone is so vulnerable. She said she valued the chance to talk and always arrived on time to each session, but her feedback in the interview was clear about feeling she would have preferred more direction and help with practical coping strategies, and that she did not know what to talk about. It contrasts with Warner's view (2013, pp. 344-345) that the lack of structure and higher levels of control available in person-centred therapy can often mean this is the only type of therapy that such vulnerable clients can tolerate.

I wonder what would have happened if I had taken a pluralistic perspective (Cooper & McLeod, 2007, 2011a; McLeod, 2013). I could have helped participants such as Elaine and Gary to develop a formulation that might have given them a structured and manageable way of working on their goals of 'dealing with their voices'. The Maastricht Interview (Corstens et al., 2008) or the construct developed by Longden et al., (2012) may offer a way of doing this within a framework of person-centred values.

My difficulty with this perspective is that most participants expressed surprise and initial disquiet at the non-directive stance and my offer for them to take the lead in the process of sessions. Yet, most responded well to the opportunity after a short while. I fear that, if I had stepped in too early with offers of more structure or direction, that it would, ultimately, have been a mistake. The dilemma is whether or when to trust in the process of therapeutic change according to Rogers' theory (1957, 1959).

13.3.14   Metaphor

I was struck by the ways these participants used metaphor – of which, the medical model is, after all, an example - to describe their experiences of HV and therapy. My

first thought was that there seemed to be aspects of therapy and of HV for which participants did not seem to use metaphor and that was also of interest.

For example, when talking about the process of therapy, there were descriptions of unravelling in the sense of uncovering (Paula) and untangling (Fabien and Robert); of there being gaps (Robert), muddle (Paula) or chaos (Fabien); of the need to do rebuilding and do a repair job (Robert); and, of establishing solidity (Robert) or order (Fabien).

When I started to look for research on metaphor, I realised that, although my data were generated from discussions about therapy (and HV), they were not actually from within therapy sessions. The metaphors that had struck me so vividly were more to do with how people described their experiences of therapy than with any day to day issues that might have formed the basis of their therapeutic work. This distinction meant that evidence exploring the uses of metaphor in therapy did not seem directly relevant (Angus & Rennie, 1988, 1989; McMullen, 2008). When I then read other research I also realised that participants had used metaphor throughout every part of the interviews in any case and I had not noticed.

Lakoff and Johnson (Lakoff & Johnson, 1980a, 1980b, 2008) demonstrated the ways metaphor forms an important part of the way we conceptualise experience, but that it occurs in a taken-for-granted way. This offers the possibility of a far wider exploration into the way metaphor was used by these participants to describe what it was like to HV and have therapy. One example that illustrates the way metaphor infiltrated or structured the participant accounts (note the language I am using to introduce the example there is metaphorical, suggesting either movement into or construction of) is when Robert said, "You were giving me a second look at things". This is an example of ideas as containers and as entities that can be acted on (Lakoff & Johnson, 1980a,

1980b, 2008). Robert viewed his experience in concrete terms and paying attention to it was 'looking' at it again. Sight was the metaphorical sense which needed to be employed to find meaning. Lakoff and Johnson make the point that some metaphors are culturally influenced and are contextualised (Lakoff & Johnson, 1980a, 1980b, 2008). An exploration of the meanings of HV and of individual therapy might be usefully explored in the light of such potential cultural and contextual differences.

13.3.15   Summary

The findings support the importance of offering clients the opportunity to talk about what is important or pressing in their lives, without the necessity of following an agenda set by a professional (unless the client would prefer that). This is particularly important when people have had so few chances elsewhere to explore these issues and most participants welcomed the chance to pay attention to them here. But it is also important that the timing is appropriate and these participants were very clear that such painful details could only be discussed when they felt ready to do so. The sanctuary of the therapy space helped create the environment where people felt safe enough to do this. Some participants, however, struggled when sessions ended and they had to face the prospect of living the rest of the week without that support.

Far from being unable to engage with therapy, most of these VHs relished the chance to construct and communicate their own understandings as Geekie (2007) and others have discovered. There were participants, however, who found person-centred therapy difficult and, ultimately, unsatisfactory, despite valuing the opportunity of spending time with me in that safe space.

The potential impact of medication on the process of therapy has been noted.

These findings are in line with other evidence discussed in earlier chapters, and especially that emanating from service user accounts which note the idiosyncratic pathways to recovery and the meaning of it.

Quantitative outcomes demonstrated some evidence of reliable change after therapy although most tests did not demonstrate significant levels of change had occurred.

Overall, the study offers insights into the variable responses to person-centred therapy with this client group, albeit from a small sample who worked with just one therapist. Many elements of the model have also been used to good effect with other approaches to therapy so it was interesting to note that the same effects occurred here as well. The findings also illuminated those aspects of the process that some clients might struggle with. This does not mean it should be withheld, as many participants enjoyed the approach, but it does mean that adequate steps should be taken to monitor the effects of the process on clients who do not – a duty of care all therapists should consider in any case.

One of the most striking findings in relation to person-centred therapy specifically was the effects on HV for participants despite voices not being the focus of the therapy. This is different from other approaches to therapy with VHs and demonstrates, perhaps, that we do not have to take a specific approach to this client group after all.

Whilst making no claims for outcome, as such, these findings suggest that person-centred therapy, as a model, could form a useful addition to the bank of available therapeutic options for VHs.

Chapter 14

14 EVALUATION OF THE STUDY

Rigour, reflexivity, resonance and relevance (see Chapter 8) are the criteria by which this study will be evaluated in this chapter. These features were selected as they seemed to reflect criteria used in a range of epistemological positions, but also resonated with the specific position taken here. The dual researcher-therapist relationship and limitations of the study will also be covered.

14.1 Rigour

Rigour demonstrates that research has been carried out systematically so that findings can be considered trustworthy and procedures are available for other investigations. Appendices A-G show the documents and procedures used in this study, offering detail about the process of data analysis. Appendix H summarises these documents and procedures, offering additional reflections. Key points will be discussed further in this chapter.

14.1.1   Rigour in therapy practice

I submitted eight randomly selected recordings of therapy sessions to independent assessors and received reports back on six (as discussed in 7.4.2). I was aware this did not offer a significant check ($\approx$ 3%), although my original plan of 9 sessions ($\approx$ 5%) would have done. All reports confirmed that the sessions could be classified as person-centred therapy (see sample briefing notes at Appendices Eii & Eiii, and sample report at Appendix Eiv).

I am trained to MA level in person-centred therapy and am an accredited member of the British Association of Counselling and Psychotherapy. It seems reasonable to assume, therefore, that the experience of person-centred therapy that was explored in this study.

14.1.2 Rigour in data analysis

14.1.2.1 Reading transcripts and coding data and themes for meaning

The method required a combination of systematic reading with a more intuitive dwelling-with to see what emerged from the words, gaps, silences and contradictions (Finlay, 2006). I monitored my approach to ensure I was staying with the data and that I was aware of when I was drawing on previous knowledge of the participant.

While such knowledge can be useful and facilitative of different areas for discussion, it might also mean that some things are left unsaid because they are assumed. I tried to reflect on the meanings I allocated to statements to ensure that I grasped the intended meaning rather than what I might have assumed I knew, based on the previous therapy sessions. This was difficult to do, especially when I was first confronted with all the data.

Supervision challenges helped to highlight occasions where the narrative was not rooted in the data and I had added to, or left out, information that made sense to the overall analysis because of my previous knowledge. Linda Finlay was involved at this stage to ensure I was taking a phenomenological perspective and highlighted instances where I was demonstrating (or not) relational values. This was important in helping me find the depth to which I could take the analysis in terms of relational research, given the amount of data, number of participants and focus of the study.

Another researcher who had not also been the therapist would have gleaned a different understanding and the interview data themselves would have been different.

14.1.2.2   Iterative process between raw data and emerging themes

During this stage I felt overwhelmed at the amount of data and unsure of how to develop a coherent account (not an unusual experience when conducting qualitative research, I understand (Finlay, 2011; A. Giorgi, 2009)). Paradoxically, the methodical and systematic process of reading and coding data enabled me, concurrently, to dwell-with the data empathically and intuit an account of participants' meanings.

This discipline was useful when considering some of the more vivid language that participants used. I had to ensure I did not allocate a general sense to others on the basis of one particularly striking metaphor (Carpenter, 2008). For example, Paula described the process of therapy as being like "unravelling a hay bale". I was tempted to attach that powerful image generally, but the data show that this was not the same process as others went through. Fabien had talked of "untangling a big ball of string", Aisha described "finding solutions", Katie talked of "feeling stronger", Robert of "putting building blocks in place", Olivia of things "being the same but thinking about them differently". The actions and images conjure quite different ideas.

It was difficult to give up some of the sub-themes I identified initially – to "murder my darlings" (after Quiller-Couch, 1914) – but on reflection the possibility struck me that those initial themes were included anyway. Once again, challenges from supervisors and Linda Finlay, helped me become aware of where I had made assumptions based on therapist knowledge that had no basis in the research data.

For instance, the element of 'surprise' was expressed so strongly and frequently by participants, on a variety of subjects, that I had considered making it a separate theme to ensure I acknowledged it. But it seemed, in the end, to be contained within other themes so I did not. I wonder if other studies of subjective accounts that I have referred to

might have had similar findings but I could find no explicit discussion of 'surprise' in those reports either.

14.1.2.3   *Writing themes*

Feedback on draft analyses was provided by supervisors and by Linda Finlay. Such feedback proved invaluable in helping me to see where I needed to explore more, where there were gaps in the account and where I was not writing about the participants' experiences. All read draft themes and we engaged in detailed discussions about whether themes made sense, were representative or could be incorporated into others as sub-themes. We also discussed specific extracts to try and establish whether they were illustrative of the points I was making or whether another extract might work more effectively. Linda Finlay also offered feedback on whether the analysis could be classified as phenomenological and where relational values were evident or missing.

In discussion with Linda, early in 2015, I realised that my analysis did not attend sufficiently to HV, even though I had hoped it had been encompassed in the overall analysis. I therefore focused separately on the experiences of HV and of therapy, using the data I had already allocated to fractions of the lifeworld. This enabled me to deliver the analysis that is presented here and I noted a relief of tension once I had written these themes. I trusted that I had found a structure that captured the breadth and depth of participants' experiences (Todres & Galvin, 2005, 2008) and the personal meanings participants attached to HV and to their person-centred therapy.

I tried to ensure I accurately reflected the experiences of participants. One word misremembered could change the sense and affect the development of themes. For instance, Paula had said her the voices she heard "crowded out your ability to listen to yourself and to listen to your own gut instinct, although that instinct was always there." The use of the word "instinct" rather than "voice" (as I had initially misremembered)

give a different feel to the statement, which is important when exploring the voices people hear as well as the way they feel about themselves. "Instinct" makes the point that she had always had a sense of self in a way that "voice" does not, perhaps, convey.

14.1.2.4 *"Consulting my consultants"?*

All participants saw interview transcripts and no errors or omissions were reported. Each participant and I spent as much time reviewing the first interview transcript together as they wished. Those who asked for further documentation received it, but few did and it was not pushed towards them. Only one person asked to see the analysis. He was sent an early draft which he said was an accurate representation of his experiences. He then made it clear that he did not feel the need to see any further documentation.

This did not have a significant impact on triangulation over the whole study because of the lack of input from most participants. I hope the invitation did not have a detrimental effect on participants and I have no reason to suppose it did. But it does raise important ethical considerations about what support is available to research participants after a study has finished. This is especially pertinent given the risk of distress and threat that some participants might feel, discussed under 14.2.1.1; 14.3.4; 15.1.3; 15.2.1) below.

Another consideration is the involvement of participants in the overall research process. The question areas were submitted to service users (not participants) for comment and were changed to take account of factors they considered relevant and useful to this study. But, apart from what is mentioned above, I did not involve participants in the development of themes and so have run the risk of failing to honour their stories in a way that resonates for them. This is particularly important for participants such as these who may often have found their stories have been "stolen" or "warped" by professionals (Waddingham, 2015, pp. 209-210). I wonder what themes might have emerged had we undertaken the analysis process together.

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14.2 Reflexivity

This section will discuss reflexivity in epistemological and personal terms as proposed by Willig (2001, p. 10). Each will be explored from a therapist's and a researcher's perspective to take account of my dual roles in this study. The aim is to demonstrate my ongoing awareness of how I was operating, what I was trying to find out and what knowledge claims it would be reasonable to make. It was also about trying to make sure I acknowledge all my personal, academic and clinical assumptions.

14.2.1 <u>Epistemological reflexivity</u>

14.2.1.1 From a therapist's perspective

My position as a person-centred therapist would have affected my approach to participants in therapy, and this in turn would have had an impact on the way therapy and research operated. That impact, of course, was one of the questions under investigation here. But those findings need also to be contextualised in the light of the theory behind my practice. My reflections in Chapter 9 are an attempt at that and offered learning for me to take forward to future work, for instance in relation to the potential effects of medication on the process of therapy.

The assumption that everyone has, within themselves, the resources to bring about change (C. R. Rogers, 1961) will have affected my approach towards clients and how they felt about themselves. For instance, some of these participants were vulnerable and had little experience of such autonomy. This should be acknowledged as a feature of Western culture which may have little or no relevance elsewhere. Kirmayer (2007) demonstrates that the notions of therapy, self and recovery vary across different cultures so that how it is practised (by therapist and client), what the goals might be and the ideas underpinning who we are, might be irrelevant in some cultures. Such ideas could

potentially be harmful for others or for those who might not 'fit in' to their prevailing culture.

I am aware that my own practices and theoretical perspective will have affected how I approached clients, however much I tried to follow their lead. For instance, Aisha was the only person who identified as other than White British. She described the way her African mother wanted to deal with her unusual and disturbing experiences, which was different from that culturally accepted in white, Western society. There is research showing that the hearing of voices is experienced and treated differently in different cultures (Larøi et al., 2014; Luhrmann et al., 2015; McCarthy-Jones, 2012; H. B. M. Murphy et al., 1963). Aisha herself found that it made sense to think of her voices as symptoms of illness and she framed her plans for recovery to incorporate that, entering therapy as a way of helping to achieve it. It would be interesting to see how others who took a non-White-Euro-American perspective might receive person-centred therapy, traditionally seen as operating from within an individualised Western discourse that prizes autonomy (Lago, 2011; Lago & Hirai, 2013). This is despite claims that, as an organismic theory, it contains within it the facility to take account of individual context (Tudor & Worrall, 2006; Wilkins, 2016).

Elaine, who had experienced few chances to live autonomously, seemed to have little conception of how person-centred notions of accessing inner resources might help or be relevant. The further assumption that talking might help could have felt like yet another pressure on a life that was already a struggle. She admitted that she had not known what to discuss in therapy and became so distressed at discussing her experiences in our first post-therapy interview that I ended it early and we agreed not to attempt the follow-up.

I acknowledge that I embraced the pre-existing therapy relationship hoping it might ease the transition from therapy into an interview that might have provoked further anxiety in

participants (it did not help Elaine, clearly). My previous knowledge of what had happened in therapy would also have affected the ways I asked and followed up responses to questions, as well as the ways the participants answered. This will be explored in 14.5 and 14.6 below.

14.2.1.2   From a researcher's perspective

Cultural differences (Kirmayer, 2007) also have relevance for the ways I designed this study and my assumptions behind it. I follow a model of therapy immersed in a research culture based on "Euro-American values of individualism" (Kirmayer, 2007, p. 232). This incorporates various assumptions about what 'the good life' might mean and as such will have affected the questions I chose to ask in the research interviews as well as how I read the research data and drew out themes to present. Although an individualistic perspective might facilitate an openness to different perspectives, I acknowledge that, if the study was not designed explicitly to try and capture those differences, participants might not have been able to show them and I might have missed them.

I had anticipated that using a framework of fractions of the lifeworld (following P. Ashworth, 2003; 2006b) might act as a useful method of helping me remain within a phenomenological attitude when dwelling-with my data. What I found was that it also acted as a very helpful check on whether my writing was grounded in the data and whether extracts were relevant to themes. To take just one example, I used the extract below as part of illustrating 10.2.2, Feeling alone, ostracised:

> **Tina:** Well really, I mean if I wanted to get any support or anything my only choice was to drastically start shouting down the phone to them "Oh, this bad thing's happening or that bad thing's happening" and I didn't actually really want to go over the top and keeps saying these things but I felt like if I didn't I wouldn't get anyone to help me.

I placed it there because it seemed to convey Tina's apparent sense of isolation and that she was coping alone. It could equally well, however, have appeared elsewhere because

of seemingly contradictory experiences happening for her simultaneously. It also seemed to show that she was doing something to take control and wanted things to change, so it could have appeared under 10.3.3, Reaching a tipping point. Or, it could have been included in 10.1.4, Struggling to stay in control to signify the struggles she felt in trying to manage.

This illustration confirms that themes are fluid distinctions and that experience does not fall neatly into categories. It also shows the many ways of describing accounts of experience, underlining the point that this analysis in no way offers 'truth'. I acknowledge the influence of my focus on experience that will have determined the emphasis of my questions and what I was searching for. It will also have affected my choice of themes and the data I used to illustrate them. See, for example, 14.1.2.2 for mention of my struggles with whether to include 'Surprise' as a separate theme.

Similarly, I knew that the lifeworld fractions were inter-related rather than discrete categories. But what became clear from using them was how this method brought out the wide-ranging and conflicting ideas that can occur in everyday experience. This method allowed me to find evidence of phenomena co-existing, rather than emerging in a linear way. It was through a consideration of temporality specifically that I understood this as demonstrated with Tina's extract above.

As mentioned in 7.8, participants completed some outcome measures before and at the end of their therapy and their scores are analysed in Chapter 12, and discussed in 13.3.2. There was usually some discussion about the measures at the start of the post-therapy interviews and any changes between pre- and post-therapy scores were often remarked upon by participants. This sometimes led into discussions about their experiences of HV and of therapy. Usual comments were that they did not feel the questions and options for answers were flexible enough to cover the complexity of their experience. They then

went on to explain that experience in detail. So, the measures did affect the research process to some degree, often by offering a lead in to an exploration of the issues that were the focus of the study. I hope that we would have explored the issues to the same depth without the 'prime' of the questionnaires via a different route as it was my focus.

14.2.2   Personal reflexivity

14.2.2.1   *From a therapist's perspective*

I was shocked when a participant told me, during an early therapy session, that she felt offended when people said there was 'no such thing as mental illness', a view which, she felt, minimised her suffering. By challenging an automatic medical explanation for extreme mental distress and odd experiences, I had run the risk of privileging that view over hers, an alert reported by others (Corstens et al., 2014; Woods, 2013). That will have affected my previous work with clients and my ideas about approaches to research.

Differing experiences of HV were straightforward to explore openly. But I was pleased that I managed to isolate participants' experiences of being offered a valuing relationship – received positively by all – from the ways in which they felt they had been helped therapeutically, if any. For instance, Gary and Elaine would both have preferred a more systematic, directive approach that focussed on giving them practical coping strategies. Whilst I can interpret this as their being at an early stage of process in person-centred theory (C. R. Rogers, 1961), it doesn't matter. Person-centred therapy, with me, 'didn't work' as they had hoped, at that time. Another approach or therapist might have done.

That's fine, and I don't feel personally harmed by that view. I feel affirmed by the value they placed on having the chance to spend time with a professional who treated them as people of worth, with views that merited attention. It also seems important that they felt able to tell me honestly about the shortcomings of therapy for them and the

disappointment they felt about it – even though I was the one who had offered them the unsuccessful experience. I suggest this has implications for clinical relationships.

I felt vulnerable when conducting interviews that were exploring my 'work' as a therapist and when inviting reports on my therapy practice from independent assessors. I suspect that vulnerability affected aspects of the study and my therapeutic practice with these participants. It is further evidence that research into therapy can never offer a direct match with 'usual' therapy, especially where there is a dual relationship.

14.2.2.2   *From a researcher's perspective*

Although I tried to maintain the phenomenological attitude throughout every interview, there were variations in the way I engaged in each, so that the co-created data collected will be inconsistent to some degree. All these sessions might have proceeded differently had I dwelt-with different aspects of the participants' experiences, some of which might have delivered my agenda of generating data that could help answer my research questions.

Similarly, I was aware of my confidence increasing as I conducted more interviews. This freed me up to probe other areas and to facilitate further discussion, sometimes in the light of experiences discussed by other participants. One might suppose that data collected latterly would be richer in some ways, but that might not necessarily be the case. I found that the data from Olivia's interviews (the first I carried out) were not as rich as some others. However, what she did say was as indicative of her own story as the responses of others who spoke at greater length. Similarly, Gary was one of the last people I interviewed and he also said very little, which may reflect the discomfiture he appeared to show in therapy when asked to think about the meanings of his experience.

It was difficult sometimes to switch from the role of therapist to that of researcher and really stay with the data from the interviews. Here, using the framework of fractions of the lifeworld (P. Ashworth, 2003, 2006b) again proved beneficial. It helped ensure that I dwelt-with the data in the transcripts according to those fractions, which helped me keep separate my 'knowledge' of what happened in therapy and what that might also mean. This does not mean I was not affected by it, merely that it helped me monitor its effects – a form of parallel processing, perhaps.

14.3 Resonance

In evaluating the resonance of this study, I need to demonstrate that the findings express the range of experiences contained within the participants' subjective accounts. I want the analysis to touch people in a human way so that participants' voices can be heard, because psychiatric patients often feel their voices are silenced or dismissed (see 1.7; 4.2.3). The findings also need to resonate on an academic level for other researchers who might be considering questions to investigate or methods to use. Finally, there are ethical considerations to consider.

14.3.1   Human resonance

Although I hope that the extracts I selected to illustrate themes will evoke human stories successfully, it might be the case that they lose some impact when presented as part of a descriptive theme. One concern is that those people who found it difficult to express their thoughts might be represented less than those who provided 'richer' data – even though their stories are equally valuable. I was aware that I found it hard to balance my desire to use vivid extracts with the need to ensure all voices were included. That is germane to a study expressly focused on exploring the perspectives of people who are often dismissed or invisible elsewhere. Only another reader will be able to judge the

extent to which I have succeeded in presenting moving evidence from *all* the people behind this academic process.

A more effective way of conveying personal stories might be to construct individual narratives, using individuals' own words as far as possible, so that their voices are more completely heard. Wertz (2005) accomplished this when describing examples of being criminally victimised. Word constraints mean I would have lost the important chance to discuss themes across all participants, had I done so. A future project, however, could focus on individual stories and phenomenological research often uses between one and three participants (Galvin et al., 2005; Giorgi, 2011; Todres & Galvin, 2005, 2006).

Finlay's relational-centred research (Finlay & Evans, 2009) may be an appropriate approach to use here as it could build on the phenomenological basis I have initiated in this study. It would give me the opportunity really to explore individual stories, therapeutic and research encounters, using data I already have. It could offer valuable insights into the experiences of the participant, what it might be like to work as a therapist with people labouring under different types of distress and stigma, and the transformative process of therapy and research encounters.

14.3.2   Academic resonance

I have discussed above the ways in which I attempted to ensure 'rigour'. But it is also important that the study resonates with other academics. If it does not speak to them in ways that make sense, it will have little impact on future studies.

I have tried to present a well-written, rigorous thesis that convinces others that this method is a useful way of exploring questions about therapy, HV and, perhaps, other dimensions of how we live. The method is ontologically and epistemologically sound, and rooted in solid philosophical theory. In this way, I suggest that useful information can be established that can be of use in other research into these important issues. I

would argue that there is value in asking people about their lived experiences, and that there is a way of answering those questions rigorously using well validated methods.

As mentioned in 13.3.2, and in 14.4.1 below, the combination of qualitative and quantitative findings offered clarification of seemingly contradictory results in some cases. The qualitative reports also sometimes offered challenges to conclusions of change or no change that might otherwise have been drawn from findings on the standardised measures used in this study. Those measured changes in symptoms which might not, as others have argued (Levitt et al., 2016), be the factors that determine whether participants believe therapy has been effective.

I hope my findings support the moves discussed in 4.2.2 and 4.2.3 towards research that has meaning for, and is carried out by, experts-by-experience (Gilburt et al., 2008; Rose, 2001; Rose et al., 2011; Sweeney et al., 2013). Only if my findings resonate with what those researchers require, however, will this be achieved.

14.3.3   Professional resonance

I have attempted to convey something of my experience of working as a therapist with this client group in my reflections in Chapter 9. One reason for this was to give some context to the findings. I also wanted, however, to offer what might be termed "professional knowledge" (McLeod, 2016) for other therapists who seek the challenges and rewards of such work. The balance between retaining the integrity of my person-centred approach with the need to ensure I offered the best therapy I could to these participants, was a matter of serious consideration. I have reflected on instances where that balance might not have been achieved in other sections and it is something that other professionals must bear in mind when starting work with such clients.

The issue of the potential effects of medication was a feature that feels important now I have come to reflect on it in relation to this client group. Without suggesting that

therapists should jump to conclusions or make assumptions about a client's way of being, it might be useful to explore the interpersonal implications of being someone who takes medication, even if not the physical effects.

14.3.4   Ethics

The presentation of real life stories involves attending to ethical issues. If a practice can bring about positive change, it must also be able to bring about harm (Goldsmith et al., 2015; Jarrett, 2008). Those considerations need to be conveyed so that they resonate with researchers on both a human and a professional level.

One example here is Elaine, who became seriously distressed in our post-therapy interview. Another researcher would not have known that she had previously asked me to delete a therapy recordings because she regretted having shared the things we had talked about. I complied and checked regularly that she wanted to continue therapy and to be in the study. This demonstrates that a safe, accepting empathic environment has the power to elicit information from clients/participants who might later change their minds (Etherington, 1996; Finch, 1993; Hart & Crawford-Wright, 1999).

It is also an example of how a pre-existing relationship affects a research encounter. I was, I hope, especially attuned to Elaine's vulnerability in our interview, having been with her at times of extreme distress in the past. That information, however, can only properly be discussed as part of the evaluation as it does not form part of the data corpus. Nevertheless, it seems worth alerting other researchers to such potential risks.

The arguments for affirming the humanity of people who have unusual experiences are demonstrated in this study. Ways of helping people in distress, despite their odd behaviours or inability to conform to societal norms, would seem to be a priority. A research method such as that used here, appears useful in finding out what is wrong, and what might help, in a way that does not pathologise or position the participant as

inferior in any way. If practised sensitively (as it should be), it can also offer protection

for those who are especially vulnerable.

14.4 Relevance

The relevance of this study will be determined by the extent to which findings

contribute to other research into experiences of HV and of therapy, specifically person-

centred therapy. The choice of research approach also has some bearing here.

14.4.1 Success criteria in research

This study demonstrates that participants valued the chance to undertake therapy even if

they still found life a struggle and still heard voices (Katie, Fabien, Tina, Aisha,

Robert). Only Paula, Olivia and Rhiannon could be said to have returned to some

putative state of normality in the sense of no longer HV. Nevertheless, Tina, Robert and

Fabien all talked of feeling happy that they still heard voices and that there was some

benefit to them in doing so. It appears that the process can be 'therapeutic' in a variety

of ways. Account must be taken of all perspectives, however. Although they reported

valuing our relationship and that talking was sometimes helpful, Gary and Elaine found

the process difficult and disappointing overall. The 'therapeutic' aspects in-session need

to be balanced with consideration of what clients' lives might be like outside the

therapy room. There is a case for including such factors when measuring the

effectiveness of therapy.

It was also demonstrated that changes on standardised scales that measure symptom

change may not always represent changes in participants' feelings of well-being. Yet,

when considered alongside qualitative accounts, clarification could sometimes be found.

This has implications for what features are assessed when testing the effectiveness of

therapy and for the importance of taking account of subjective reports.

The findings above support calls for success criteria in research to be determined in consultation with experts-by- experience (Gilburt et al., 2008; Rose, 2001, 2014; Rose et al., 2011; Sweeney et al., 2013) (see 1.7; 4.2.3).

14.4.2   Exploring personal understandings

A method that delivers findings such as these offers the chance really to explore what meanings experiences have for people over the period in which an intervention happens. The breadth and depth of discussions offer valuable data that demonstrate change – or lack of change - and provide insights into personal understanding. Such data can shed light on the different ways people understand and live with their experiences. The breadth of topics covered might also offer more varied opportunities to discuss experience for those who sometimes struggle to express themselves.

If we can find new ways of exploring and understanding experience, preferably directly from those who have the experiences, this may enable us to discover effective ways of helping distress and influence the ways attitudes (for example, towards unusual experience and distress) and structures (for example, therapy and the psychiatric system) operate in society (S. Hansen et al., 2003) (see Chapter 4.1.4) .

14.4.3   Evidence of how person-centred therapy is received by voice hearers

I was fortunate to be given the opportunity to work clinically with psychiatric patients. That happens rarely for a person-centred therapist in the UK. To that extent, this study offers new findings which might be of relevance to the development of theory and practice. Two points bear emphasis here.

Firstly, there appears to be a pressing need for more research involving practice with people who have unusual experiences. Yet this seems to be a 'Catch-22' situation. If person-centred practitioners and researchers cannot access clients and participants, how can rigorous and systematic research be conducted? As discussed in 4.2, a manualised

or adapted form of the therapy used as a control in other studies can offer only limited evidence of how it operates with this client group. Apart from the changes to its format, the studies in which it is included will, justifiably, be more focused on the actual intervention under investigation.

The second point relates to the research method used in this study, especially its ability to deliver interesting, broad and deep insights (Galvin et al., 2005; Todres & Galvin, 2005, 2006) into lived experiences. As it seems to be an approach that uses skills familiar to therapists (Finlay, 2011; Finlay & Evans, 2009), it may offer an attractive option to therapist-researchers.

14.4.4   Applicability of engaging with therapy

Gary and Elaine both felt that therapy had not helped them, although they had valued the chance to talk openly to a therapist once a week. It would be interesting to consider how one might make use of that information and investigate it further. For instance, in both cases their therapy endings were unplanned. Maybe their views would have been different had they been interviewed after they ended therapy in a planned way and of their own choosing, as other participants had done. Or it may be that this therapy would never have suited them, or that it would with a different therapist or at a different time. Other participants also commented that the time needs to be right for engaging in therapy, which, again, places the focus on experts-by-experience making decisions about what to do, with whom and when.

Person-centred theory suggests that the sustained offering of therapeutic conditions will eventually result in people developing an internal locus of evaluation where they can remain to open to their experiencing and evaluate it in their own terms (see 2.5). That raises ethical issues when participants (clients) find that the process is too stressful and difficult. Researchers need to consider such issues when planning studies, while

therapists need to be aware of them when entering therapy with vulnerable people. Indeed, that this did not seem to happen in the Wisconsin study, was a criticism levelled by Masson (1989) and noted by Rogers (1967). Those concerns go beyond attempting to put extra support in place. An approach such as person-centred therapy may pose a threat to a worldview that is too difficult to bear alongside everything else.

14.5 Dual relationship

This section will explore the impact on my findings of my dual therapist-researcher role. It will take account especially of issues to do with power and mutuality that are bound up with therapy and with research encounters (Masson, 1989; Proctor, 2002, 2006, 2010).

As I explained in the Chapter 6, I decided to make use of the fact that I had a pre-existing therapy relationship with these participants. I believed I would not be able successfully to separate myself from it, were such a stance even possible (Finlay, 2011; Finlay & Evans, 2009).

Another researcher would not have had access to the same information as me and so, in addition to any other reason, the researcher-participant relationship would have been very different. Any resulting account would also have been different from mine in all sorts of ways.

All participants expressed their ease with the change in emphasis from working on their agendas in therapy to working on mine in the post-therapy interviews. Paula and Fabien even said they would be happy to share their experiences publicly. In line with Gale (1992) and McCracken (1988), the participants in this study seemed to enjoy the opportunity to reflect, as co-researchers (Grafanaki, 1996), on the process they had been through in therapy and on their experiences of HV. For some, Usually, as Rennie found

(1994) this reinforced their satisfaction about how far they had travelled along the path to feeling happier in their lives.

The exception was Elaine. Apart from perhaps fearing the same regret that she had experienced in therapy sessions, she may have felt duty-bound to give me the information I sought in her research interviews. This may have meant that she struggled on until I made the decision to end the interview (Rennie, 1994). How much more of an imposition and risk to well-being might it have been when the questions I asked were focussed on the distress of someone who had not benefited to any significant degree and might have suffered harm from uncovering difficult issues? The interview may then have resulted in the resurfacing of the pain that had been suffered in our therapy sessions.

It is an indication of the need constantly to review informed consent for research procedures and support given where needed (McCosker, Barnard, & Gerber, 2001; McLeod, 1994; Munhall, 1988). But maybe that is not enough when research is with participants who are vulnerable and in distress. Even informed consent might be regarded as questionable if we consider the power imbalance (Masson, 1989; Proctor, 2002, 2010) and deference in therapy and research (Rennie, 1994) – a double effect in this study.

It may be that participants who had unplanned endings were more likely to become distressed during their interviews and to need extra support at the end (Natiello, 2001). They did not have the benefit of having decided that they could live their lives successfully without therapy so that reflection on the process might have generated feelings of being abandoned, sadness, or unfinished business.

Katie, however, did finish therapy before she was secure in a new way of being because she had felt increasingly vulnerable after attempting a deeper exploration of long-

standing distress than ever before. She had been able to start this, she said, because of the trust we had developed that enabled her to go at her own pace. Although it became too difficult in the end, she did not regret having started and was definite about wanting to continue after a break. The difference here is that she felt she had been able to use our relationship to reclaim her personal power (Natiello, 1990), in a way that Elaine had not. Katie felt more secure in her ability to control her voices and her life.

For most participants, the post-therapy interviews were usually the two weeks following their final therapy sessions. Participants were therefore used to committing an hour a week at those times, and it happened seamlessly. The exception was Rhiannon, who found it inconvenient to come back to the hospital for the meetings, making it necessary for us to rearrange a couple of times. I realised I was exerting my power as researcher to ensure the interviews happened and wondered how she might approach them. Once in the meetings, however, she seemed able to give an honest, balanced description of her experience of therapy, including things that helped or hindered, and her impressions of me as a therapist. Rhiannon's interview, and those of others, supported McLeod's (2011) contention that unstructured research interviews give participants the chance to elaborate on a 'somewhat good', 'somewhat bad' experience in a way that questionnaires do not.

This included comments around the boundaries of therapy session. Fabien and Aisha both said they would have preferred more choice on the length and frequency of sessions. Aisha noted that, although she felt in control of what she discussed and how, she felt that I was in control of when the sessions had to stop (which I was) and that this was a problem for her sometimes. She also would have preferred a choice of location.

These were not the views of all participants. Others, such as Paula and Fabien, liked the imposed structure of coming to the same place, for one hour every week as it gave them

a focus for the work they wanted to do. Those structures appeared to allow them then to be free within the sessions to follow their own path, as Aisha had also found.

Nevertheless, there seemed to be tacit acceptance by participants that I set the limits and boundaries of the sessions, even if they then felt able to exert their own power over how the sessions progressed. This demonstrated to me that, however much person-centred therapists might claim to offer mutuality and aim to minimise the power differential, the reality was that, during therapy and in the subsequent research interviews, I set the "rules of engagement" (Proctor, 2002, 2010). I agree that the arbitrary choice of a 50 minute 'therapeutic hour' and weekly sessions can be problematic for people who want to address, perhaps for the first time, issues that cause immense distress. To be cast adrift at the end of that time, still feeling the emotions that have arisen, can be difficult, or even risky. I did try to pre-empt that by alerting participants to the time remaining but Aisha and Robert would have preferred that I emphasised that even more.

One limit the clients/participants had the power themselves to impose related to the number of sessions they had. Open-ended therapy was regarded positively by all in this study because they did not feel restricted on what they talked about and they knew they had the choice of when we ended. For instance, Tina asked to have fortnightly sessions as she felt better but was not ready to stop completely. Participants contrasted this openness and choice with other help offered and they seemed to regard it positively, especially those who felt they had few choices in other areas of their lives.

I used my previous knowledge to flag up areas for discussion in interviews and my attitudes towards participants will have been affected by my knowledge of them as clients. For instance, I had experienced Fabien often talking around issues at length as a prelude to the exploration of something with deep, personal meaning. In one of our interviews he seemed to be talking at length about something that I could not see was

relevant. Later, when I was in the stage of dwelling-with the data, I suddenly realised

that what he had been talking about was new, exciting and of crucial significance to him

and to this study.

This raises two points. First, another researcher would not have known that the way

Fabien became able to talk about personal issues was to get there obliquely, so they

might have missed the importance of that section. Second, I was aware of feeling

irritated at the time and wanting him to answer my questions directly. Did this mean I

was not always as accepting and empathic in my interviews as I had been in therapy

sessions? In trying to become a researcher, rather than a therapist, what might I be

losing along the way and how might that have affected participant responses? All I can

say is that I am aware of this, and that I found no other instances.

I stress that I am exploring inter-subjectivity, in both the therapy sessions and research

interviews, when I talk about the findings of the study, and that I sometimes found it

difficult to hold onto the differences between the two. I feel I have been sliding between

the inter-subjectivity of therapist and client and the inter-subjectivity of researcher and

participant. It has been difficult to sustain a consciousness of both roles because I was

present in the first and I am present as well as researching in the second. This has made

it difficult to maintain the separation between different types of knowledge that I have

about the same subject, which Finlay and Evans describe thus:

> One way of understanding these complicated entanglements where we find
> ourselves responding to another at multiple levels, is to recognise the multiple,
> interacting subjectivities present. The 'here and now' contains something of the
> 'there and then' where subjectivities of one person elicit those of another. As the
> selves set each other off, they trigger responses that are habitual to the persons
> involved. (2009, p. 118)

For instance, Elaine did not say in her research interview that there had been occasions

where she regretted telling me things in therapy and had asked me to delete the recorded

sessions. I did, however, use that information when writing about her experience of

therapy and research in this discussion. Another researcher would not have known or been able to include it. It might be argued that this is not, therefore, research data. It seems disingenuous, however, to pretend that I have no knowledge of what happened in the therapy as I was there and involved. In trying to describe the meaning of the experiences of my participants in a phenomenological way, it surely makes sense to use data relevant to the phenomena under investigation – so long as I acknowledge it and acknowledge I am being selective. In the case of research with vulnerable participants, as here, it seems to have especial relevance and poignancy when considering ethical issues to do with power and dual relationships in research.

In summary, I accept my position of power as therapist and researcher (Natiello, 2001; Proctor, 2002, 2010), especially in these areas. But I would also argue that I used my power in a collaborative way that facilitated the exploration of issues by clients in therapy and the eliciting of rich research data from them as participants. The expertise I have as a therapist was used to similar effect in conducting the research but the dual role remains a limitation of this study as will be discussed in the next section.

14.6 Limitations

14.6.1   Limitations of using my own clients as research participants

Issues to do with differences between a researcher-therapist dual relationship and other researcher-participant relationships have been discussed in 14.5. As mentioned in the method section (6.1.5), the only feasible way for me to carry out this research was to use my own clients as participants, because there are so few opportunities in the UK for person-centred therapists to work with clients in a psychiatric population. Nevertheless, it is a clear limitation and will have coloured the process of therapy, data collection and data analysis. Participants reported that I had understood their meaning in therapy sessions, so I would hope that the same might be so in research interviews. But, again,

other researchers might also have been successful at capturing meaning, without the additional influence of therapist involvement on the accounts participants gave in their interviews.

Participants knew before therapy started that they were taking part in a research study, had been offered the opportunity to continue with therapy without taking part in the study and were assured they could withdraw from the study at any stage without it affecting their ongoing therapy.

I also asked them to allow me to record their therapy sessions which might have affected what participants felt able to discuss in therapy and in interviews. At the beginning of the study I stressed that they could always refuse to have their sessions recorded, that they could ask me to turn off the recorder at any point or ask for sessions to be erased. I tried to mitigate the potential effects of this during the process of therapy by asking their permission to turn on the recorder at the beginning of each sessions and checking that they were happy to continue with the recording if they started to disclose something particularly personal or painful. I also stressed each week that they could ask for the recorder to be turned off at any point.

Despite this, I was aware that participants may have been concerned at there being a record of what they had said. Indeed, Elaine asked on two occasions for her previous sessions to be deleted and Fabien asked one week that I did not record his session. The same concern would be so for what they offered at research interviews.

When I asked participants for their views on whether they felt their therapy had been affected by being involved in the research, all said they had not noticed any effect, although, naturally, they cannot know what therapy would have been like without being also part of a study. Nevertheless, it seems reasonable to assume that their involvement would have had some effect on the therapeutic process and I tried to remain aware of

potential effects, asking participants when I noticed anything related to the study that might be affecting their therapeutic process. This was usually connected with recording of sessions when a client was feeling particularly vulnerable. Then I would ask if they would prefer a session not to be recorded, or if they would like me to turn off the recorder or erase a recording. Other steps taken to help clients when they were particularly vulnerable – such as ensuring they had access to people to support them after sessions – were not specifically related to the study and were actions I would have taken with any vulnerable client.

The other difference from my usual practice was the completion of outcome measures before therapy which I would not normally do. This might have affected the things they chose, or were primed, to discuss, at least in that initial session. To some extent, this may have 'primed' them to focus on their experiences of HV at an earlier stage than they might otherwise have done, if at all.

14.6.2 Methodological issues arising from the use of retrospective interviews to gather accounts of therapy

Data were gathered after participants had finished therapy. Rodgers and Elliott (2015) identified various problems when research data are retrospective accounts of experiences. If participants had found therapy traumatic, or that it was closely associated with difficult issues, their recall may have been further affected (Colman et al., 2016).

Although the accuracy of recall can be affected if there has been a long gap between the therapy and the data collection interviews (Rodgers & Elliott, 2015, p. 572), this was the not the case in this study. We conducted the interviews over the two weeks after the final therapy session in the same time slots (except for Rhiannon where there was a gap of a few weeks because she was unavailable and then forgot one appointment).

Nevertheless, there could still have been an effect because the interviews were asking about what they remembered.

More relevant perhaps is that it may have been difficult to recall what life had been like before therapy or to identify changes which had taken place and which may appear indistinct (Rodgers & Elliott, 2015, p. 572). This is more likely to be the case if therapy had taken place over a long period which was the case with some participants here (such as Fabien and Katie. See Table 7.3).

If participants had felt that changes had been significant, it may even have felt like talking about another person. That may well have affected the interpretation or meaning they attached to their experience of events, of other people and of themselves (Rodgers & Elliott, 2015, p. 572). Specifically, it may have been difficult to remember what their previous experiences of HV were like if they had stopped hearing them, had changed their relationships with the voices or if they now understood them differently.

Rodgers and Elliott suggest that mid-therapy interviews may mitigate these difficulties to some degree as people are being asked to recall events over a shorter period of time (Rodgers & Elliott, 2015, p. 573). Some participants, however, only had a few sessions and changes took place very rapidly (see Table 7.3). For instance, Paula only had seven sessions yet said she had noticed meaningful positive changes in her life; Fabien worked with me for a year before deciding his process was complete; Olivia ended therapy but still considered herself to be a work in progress and planned to recommence therapy again in the future; Katie worked with me for two years before "taking a break" with a view to continuing the process later. It is difficult to predict an appropriate point for all participants that would yield comparable 'stage of therapy' results across all participants. A pragmatic approach might be to interview participants after a few

sessions as part of the usual review that I conducted when asking participants their views on how therapy was progressing.

Medication might have affected participants' abilities to give accurate retrospective accounts because one of the side-effects of anti-psychotic or anti-depressant medication is a deleterious effect on memory (see 2.1). The interpersonal side effects of being 'a person on medication' may have meant that participants felt inhibited about discussing a difficult experience in their lives, or, at least, discussing a process that had involved addressing difficult experiences.

If people get to the stage of starting therapy, it is possible that they are already starting to reclaim a sense of agency after a difficult time in their lives. This implies that their attitudes might be changing towards other aspects of their lives. It might, therefore, be difficult to identify what changes can be attributed to therapy and which to other events. Given that the focus of the post-therapy interviews was the experiences of HV and of therapy, it might be that participants were primed to interpret their experiences in terms of those two phenomena. They had, after all, been given information relating to the interview question areas at the start of their therapy and again before at the last session so they knew in advance what we would be discussing. McLeod (2000), however, found that clients possess their own idiosyncratic ways of evaluating therapy, and that they feel they are able to differentiate which changes are attributable to therapy and which to life events. Katie, for instance was clear about the factors in her life that were also affecting how she felt (see 10.4.3). I cannot ascertain the extent to which other participants were able accurately to discriminate between the effects of different elements of their lives.

Finally, I was also the participants' therapist so, other issues notwithstanding, I may have affected the accounts they offered. This may have been out of deference (Rennie,

1994). For instance, they may have felt inhibited from offering a truthful account for

fear of offending me if they had been dissatisfied with therapy. Conversely, if

participants felt satisfied with therapy, their perspective may have been more positive or

they may have wished to be helpful to me out of gratitude, both of which could have

affected their responses.

14.6.3   Potential effects of medication

I did not ask for specific information on the medications prescribed to participants in

this study and it was only mentioned occasionally by them in therapy sessions and in

post-therapy interviews. I did not follow up on those occasional comments although I

wondered whether their ways of being had been affected (see Chapter 9) and how much

their exploration or engagement had been limited because of side effects (Hammersley,

2016b). Even with detailed information, however, any discussion would remain

tentative, especially without a comparison of therapy with participants in a medicated

and a non-medicated state.

At the time, I was not aware of any significant lack of engagement or inability to remain

in psychological contact, such as has been found in research into the effects of

antipsychotics (Healy, 1989, 2002; Healy & Farquhar, 1998; Mizrahi et al., 2005;

Moncrieff, 2009, 2013a, 2013b; Moncrieff et al., 2009; Moncrieff et al., 2013; Read &

Bentall, 2013). It may also be the case that the symptoms are a necessary way of

alerting the client to the work that needs to be done (Hammersley & Beeley, 1996) so

that medication that is effective at removing or reducing symptoms will also remove the

cues (such as distress or HV) that could lead to an exploration of underlying issues.

Hammersley points out that the side effects of drugs may limit the extent to which

clients can engage at depth in therapy (2016b). Maybe Gary, for example, had not felt

the need to explore underlying issues because his Clozapine had controlled his

distressing voices to some degree so he did not have the 'alert' of the symptoms (Hammersley & Beeley, 1996).

Hammersley notes that psychotherapists should not assume everything to do with medication is within the domain of doctors because of the potential effects on the therapeutic process and also because the connotations of taking such drugs may affect how clients feel about themselves (1995, p. vii, 2016b, p. 259). She notes also that an open and honest exploration around the medication they are taking may help clients think about what aspects of their experience will be affected by the drugs, what expectations they might have about both interventions and how they might interact (Hammersley, 2016b, p. 260).

One implication of being prescribed medication, for instance, is that the problems are medicalised and assumptions made that the problem has been identified and is being treated (Hammersley & Beeley, 1996, p. 211), as is often the case with HV. This effectively removes space for exploration of other causes, effects or underlying issues. As we have already seen (1.5.4; 1.7), this may mean that people do not even consider whether adverse life events may have been connected to their starting to HV. With evidence showing that medical professionals can be reluctant to ask about these events or are unaware of their potential relevance (Read et al., 2016; Rossiter et al., 2015a; Sampson & Read, 2017), a psychotherapist can offer an important forum for such discussion. This can provide the chance to explore the effects that medication have had on the patients experience of HV, what their own understanding of the experience might be and where medication and therapy might each play a part in alleviating any associated distress. Therapy can also help deal with the effects on identity of being a person who needs to take antipsychotic, antidepressant or mood stabilising medication and the extent to which it is found helpful (Hammersley, 2016b).

Medication prescribed for experiences such as HV has a range of effects and implications that go beyond whether it acts effectively to eliminate or reduce symptoms. Some of those effects will also have an impact on psychotherapeutic interventions that may also be offered to alleviate distress. Future researchers should ensure they ask participants about any prescribed medication and Hammersley provides a list of questions to discuss with clients that could be equally useful in research and therapy contexts (Hammersley, 2016a).

14.6.4   Nature and size of sample

This study is based on only 10 participants, from one rural English location with limited demographic variation. They all identified as white British apart from one who identified as African, and all identified as heterosexual men and women from within a relatively narrow socioeconomic and geographical band. What might findings derived from a more diverse sample of participants look like? I can make no claims for the ways in which people who identify differently might have experienced either the hearing of voices or person-centred therapy with a white, middle-class female therapist.

14.6.5   Other factors that might deliver different findings

All therapy was carried out by me. Evidence suggests that different therapists are differently able to establish therapeutic working alliances (Goldsmith et al., 2015). It would be useful to conduct a similar study with other therapists to see what themes might arise and then explore the implications of any differences.

The findings would be substantially different had I adopted a different research method or been doing outcome research. I acknowledge that my account is only one representation of the participants' experiences. All I can do is hope that the rigorous method I employed has helped me present a coherent narrative about these phenomena, one that is informed by some general as well as some idiosyncratic experiences.

Overall, it remains the case that the analysis is a collection of themes constructed by me from my experience with ten people. Any one participant is not going to find her or his account recorded completely in it, were such a representation possible. It will also be coloured by the circumstances of my researcher-therapist position and the specific nature of the sample.

Chapter 15

15   IMPLICATIONS AND FUTURE DIRECTIONS

This chapter will explore the implications of this study for understanding more about HV, for appropriate help for VHs in distress and for further research. It will also offer ideas for future study, reflecting especially on theoretical and practice issues for the person-centred approach.

15.1   Unusual experiences and help for distress

15.1.1   The importance of personal understanding

For these participants, HV had a range of effects, with myriad complex and nuanced meanings, suggesting a need for help that is tailored to idiosyncratic understanding (Sanders & Tudor, 2001). For instance, many people felt frightened by HV, but Katie felt frightened or comforted, according to which voice she heard (10.1.3); Tina disliked hearing her voices before therapy because of the exhaustion she felt (10.1.1), but she wasn't frightened or threatened by them; Fabien often felt controlled and chastised by his voice (10.1.2) but also regarded it as a valued aspect of his life (10.1.3).

Many of these participants were medicated and some were ashamed of the experience, in accordance with current mainstream Western cultural mores. Their positions were often accepted without question, sometimes until they started, often for the first time, to think about what their voices might signify. For some, the power of the prevailing discourse then shifted. Others chose to retain a medical understanding; others, still, seemed unaware of there being other explanations (10.2.4; 10.4.2; 11.4.1; 11.4.1). These findings suggest a need for respecting choice and, in therapy, making sure that the client's worldview is paramount (Perkins, 2001; Perkins & Slade, 2012; Repper & Perkins, 2009; Rose, 2001; Woods, 2013).

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Theme 11.1, Being treated like a person suggested that many participants appreciated feeling that their views and experiences were of importance and interest. This often seemed to be facilitative of what they discussed and was remarked upon as being a new experience. The approach, which included offering participants the chance to attend to what was troubling them and, in some cases, to take "a second look at things" (Robert 11.1.3) was described as affirming, seemingly helping them bring about change. It allowed the participants to reflect on their own understanding, with someone bearing witness; it also privileged the participants' rather than the professionals' account. Given that change is what most clinicians aim to help their clients achieve, it might be an approach that should be employed more widely.

Seeking help was, for some, the start of recovery. It was a glimmer of hope that they, themselves, could act to make things better. Acknowledgement of this increasing agency helped affirm clients in their struggles to take control of their lives once more. It also demonstrated to them that they had the power to do so.

15.1.2 <u>Person-centred therapy with this client group</u>

All participants valued the person-centred therapeutic relationship but were helped in different ways. Overall, the participants made good use of the encounter and many felt empowered by being able to impose their own structure on it. There were significant exceptions, however, and these have implications for a therapist's duty of care as discussed in 9.5; 11.2; and 15.1.3. Where vulnerable people have been unused to operating autonomously, the prospect of an unstructured engagement can prove disconcerting, even threatening to some. That is not to say they cannot benefit from person-centred therapy at all, but it might be at a concrete level which gives them the chance, as here, to take a break from the usual stress of their lives. One benefit of the approach was that clients were free to talk to whatever depth they chose. But therapists

should ensure clients can manage the levels of distress they feel and provide adequate support after sessions, if needed.

The arbitrary constraints of 50 minute sessions at weekly intervals may not always be appropriate and some people may benefit from meeting more, or less, frequently. Such an option may be difficult to achieve in a psychiatric setting in 21st century Britain, however, where even the concept of open-ended therapy is a rare occurrence

15.1.3 The risks of therapy

Whilst it may be ethical to offer everyone the chance to do therapy, this study suggested that person-centred therapy may not, necessarily, be suitable for everyone in all circumstances. Gary was disappointed that it had not helped (10.4.2; 11.4.1); Elaine was not only disappointed, but also distressed (11.4.1). This raises ethical questions about when to offer, or stop, therapy. Therapists have a duty of care to vulnerable clients, which is not the same as withholding therapy in the first place. The therapist, in consultation with the client, needs to ensure it is always appropriate to continue.

Elaine was disconcerted by the non-directive approach, in a way that others were not. She also found the research process difficult, asking for therapy recordings to be deleted and becoming distressed when re-living experiences of therapy that involved discussion of the voices she heard and what they said to her. When someone has limited autonomy day to day, they may not find it easy to make decisions for themselves – and then, perhaps, lose the ability always to make sure they protect themselves from harm. That is when the therapist needs to step in. This is not something therapists often practice as there is an assumption, as a matter of respect, that we do not make decisions for clients (Mearns, 1997). Nevertheless, there may be situations when it is advisable. In any event, therapists – and researchers – should ensure they continue to check that a client/participant is really feeling safe enough to continue with the session/interview.

15.2 Research

15.2.1   The risks of research

Although some participants enjoy taking part in research, researchers have a duty of

care as mentioned in 15.1.3. This involves reviewing informed consent regularly and

remaining vigilant about any possible negative effects.

15.2.2   How can we generate broad and deep data?

These participants were verbally articulate to differing degrees, which can be

problematic when exploring verbal subjective accounts. It is not to say that rich data is

more valuable, but there is a risk that some voices are under-represented. If these are

also people whose voices are frequently least heard, that is a problem.

There are other ways of eliciting accounts in research (Reavey, 2011). For instance,

Upthegrove et al., (2016) used photographs and diary entries to elicit data from

participants who found the more usual procedures intimidating or difficult. This study,

however, demonstrated that identifying themes across 10 participants can represent all

stories to some degree, as well as allowing individual differences to be conveyed.

15.2.3   Research informing services required

Research can offer a valuable way of finding out about experiences that few people

have, or admit to having. It can also offer information about what help is needed, for

what, and how it should be offered (Perkins, 2001; Rose, 2001).

The ways clinicians relate to clients can have an impact on how they feel (see 10.2,

"Feeling like a freak" and 11.1, Being treated like a person). The investigation of

subjective accounts seems a valid and useful way of generating data that can be used for

training staff in the skill sets they need in order best to help people. The detailed

descriptions of the form and content of voices, the physical and emotional effects on

participants, and the ways those changed in this study, are testament to the value of such research.

15.2.4   Research method

Taking an approach informed by relational existential-phenomenological thinking seems to be a useful way of moving from a therapy to a research encounter and of eliciting useful data to answer these questions. This study has added to the body of therapy research, and the findings and limitations can inform further studies.

Involving participants more fully was not a practical option here as they expressed so little interest in continued involvement. I have discussed the issue above (14.1.2.4). Other studies might like to consider ways of achieving further checks on trustworthiness. But, for data to be generated and analysed by a participant herself could give a fascinating comparative perspective and would, arguably, have more resonance for other service users. This is of such importance when trying to ensure a voice is given to people who are so often excluded from debates about their own futures (Waddingham, 2015).

15.2.5   Therapy research

These findings demonstrate that the therapeutic encounter is crucial to success at whatever level the client chooses to engage, and that there are many different successful therapy outcomes, which clients do not necessarily know about before they start. They also show what people can feel like at the start of therapy and the potential obstacles to their starting to engage, some of which are to do with hope of change (Duncan, 2002). The process of therapy illustrated here might have implications for other studies which explore the process of 'making sense' and ways in which people 'make good' their lives.

When testing the effectiveness of therapy, the experiences of these participants support other research that argues for service user involvement in the development of meaningful success criteria. If standardised measures are to be used, they must explore factors of relevance to those who are undertaking the therapy under investigation. Successful outcome is not always related to symptom reduction as we have seen, and it makes sense to use qualitative subjective accounts to inform development of outcome measures.

15.2.6   Research into person-centred approach

That I managed to access research participants - albeit on an unpaid basis initially - and that the approach was generally positively received, offers hope that other person-centred researchers may also seek out similar work and research studies with such clients.

15.3 Further research using these data

15.3.1   Further phenomenological analysis

With two research questions to investigate and ten accounts, I was not able to explore individual stories to the depth I would have liked. When studying their accounts for a thematic analysis, I was also attending to each participant in relation to what they could tell me about the questions in relation to the other participants as well. A more thorough relational existential-phenomenological analysis (Finlay & Evans, 2009) could attend more to the ambiguity of these lived experiences within each individual.

15.3.2   Analysis of discourse

Given that so many participants described their experiences of HV in terms of the medical model, it might be interesting to analyse the discourse to try and uncover the ways in which they structure and view experiences and themselves in the light of it. The way that some people changed their views after therapy and how they constructed their

accounts then, and that some others experienced no such change, is also of interest. A Foucauldian discourse analysis, with its focus on power and other structures, might offer a way of focusing especially on the political implications of a medical understanding.

15.3.3   Research using outcome measures to test effectiveness of therapy

There were 11 items across all participants, pre- and post-therapy, that were not scored on BAVQ-R and PSYRATS in this study. Most participants reported, however, that they struggled to select one answer and that the options did not always capture the entirety of their experiences. Furthermore, these measures reflected changes in symptoms, which may not, necessarily, be related to improvement in well-being after therapy. A consideration of the qualitative outcomes in 12.3 also shows that 'successful outcome' was not always linked to symptom reduction, as reported also in other studies mentioned in earlier chapters. BAVQ-R and PSYRATS may not, therefore, be the most appropriate for testing the effectiveness of an intervention. Indeed, the significant change after therapy that was found in other studies (see Appendix Giii) was more frequently found on measures other than BAVQ-R and PSYRATS.

In a future project where evaluating the outcome of therapy was an aim, I would seek measures that may offer a more flexible and participant-centred way of representing experience.

For instance, PSYCHLOPS is a client-generated measure developed by a group of primary care professionals in conjunction with Depression Alliance (M. Ashworth et al., 2004), although a recent study has explored it in relation to its use with participants who undertook CBTp (Kelly, Holttum, Evans, & Shepherd, 2012). It asks participants to record two issues that cause them problems, how long they have experienced the problems and something that has been hard to do because of them. It also asks them to

score how they have been feeling in general over the past week. They are asked to allocate a score of between 0-5 with 5 being the most severe effect. They are also asked to write about the problems and their effects.

After therapy, participants are asked to record how those problems still affect them, using the same scale. They are also asked if other problems have arisen during therapy and, if so, how much they have been affected by them over the past week. The final question is to compare how they feel after therapy compared with when they started with a score of 0 indicating 'Much better' and a score of 5 indicating 'Much worse'.

This measure is useful to compare individual changes over time and offers the chance for participants to describe problems of relevance to them. It has less applicability to assessing changes in the same problems across a group.

CHOICE (CHoice of Outcome In CBT for psychosEs) (Greenwood et al., 2009) was developed through input from service users with experience of CBTp. It comprises 20 items identified by focus groups of service users as of importance in the experience of CBT and in recovery. Participants are asked to score each item from 0-10 (with 0 being 'Worst' and 10 being 'Best') and how satisfied they are with this rating (with 0 being 'Not at all satisfied' and 10 being 'Very satisfied'). They are then asked to write about one or two other goals that are important to achieve over therapy, scoring themselves in the same way.

This measure has the advantage of allowing comparison of different factors across a group as well as including measures of individual importance. That the items were developed after discussion with those who have experience of psychoses and of the therapy under investigation, suggests the scale might resonate with a higher proportion of potential participants.

Both these scales seem to offer ways of collecting data that is measurable and of meaning to the people who complete them. The comments from my participants about the lack of flexibility on BAVQ-R and PSYRATS, and the failure of those scales to reflect their experiences, suggest alternatives such as PSYCHLOPS and CHOICE may be more appropriate and meaningful.

15.3.4   The need for research into client presence

15.3.4.1   What might client presence involve?

Some, but not all, participants reported that they had used therapy to reassess how they felt about things in their lives. Others used the time as a break from the pressures of their everyday lives or talked about practical issues that were affecting them. All mentioned the quality of the therapy encounter as being of importance (see Chapter 9 & 11.3; 13.3.5; 13.3.7).

I want to know more about the client's role in the creation of what might be called presence (Geller, 2013). It might be that, if client and therapist are fully present in the encounter, and if both can also experience the presence of the other, that relational depth may then occur (Cooper, 2013; Knox, Murphy, Wiggins, & Cooper, 2013). I suspect, however, that it is not necessary for such relating to occur and that a client can be fully present anyway. This position seems in line with evidence suggesting that the client is the major predictor of therapeutic change (Bohart & Tallman, 2010a; Duncan et al., 2010). An effective therapist and therapeutic environment will help, but the agency remains with the client.

One can assume that the quality of presence overall is dependent not just on the therapist's way of being, but also on that of the client, so that the way the encounter develops is because of both. Tannen and Daniels (2010) discuss inter-subjectivity as an active process, for both therapist and client, so that what occurs in the inter-subjective

space will develop according to input from all sides. The quality of my presence as

therapist could be affected (restricted?) by the presence offered by the client; the

relationship that results would, then, be similarly lop-sided and the quality of presence

of all three elements – therapist, client and relationship – would develop according to

the level of interaction available. So, although researchers (Geller, 2013) discuss the

importance of therapist presence, the extent to which this may be useful could be

limited by the way in which the client feels able to be present and the way the

relationship thus develops.

15.3.4.2   Finding out about client presence

The notion of presence has been explored in relation to therapists' embodied attitudes

with clients (Geller, 2012; Geller & Greenberg, 2012) and in assessing clients'

impressions of therapist presence (Geller, Greenberg, & Watson, 2010). But there does

not seem to be the same attention paid to the notion of client presence. What is the

nature of the presence the client contributes to the relationship? Is it different from what

the therapist brings? What are the different outcomes if one or other, or both are

present? The arguments for co-creation of encounter (Finlay, 2009; Finlay & Evans,

2009; Schmid & Mearns, 2006), the energy implicit in the inter-subjective space

(Tannen & Daniels, 2010), and the suggestion that the client is the most significant

predictor of therapeutic change (Bohart & Tallman, 2010a, 2010b; Duncan et al., 2010),

together with the findings from this study, all surely suggest that the concept of client

presence is worthy of study in its own right.

15.3.5   <u>Exploration of the use of metaphor</u>

As discussed in 10.3.10, I was surprised at the ways participants used metaphor to

describe their experiences. I was not, therefore, looking for it explicitly in my analysis.

Having started to read about the use of metaphor (Angus & Rennie, 1988, 1989; Lakoff

& Johnson, 1980a, 1980b, 2008), I am keen to revisit these data to explore the issue in more detail.

15.4 A tentative proposition: Unusual experience as a positive manifestation of the actualising tendency

In person-centred therapy, unusual experiences are sometimes regarded as evidence of a thwarting of the actualising tendency (Warner, 2013, p. 347) the idea of which carries with it connotations of pathology. This did not seem to fit with the notion of a potentiality theory, nor with the position that the actualising tendency is always in operation to optimise the potential of the organism. So, I wondered what would happen if I thought differently, and assumed that HV *must*, in the spirit of person-centred theory, be evidence of potential.

15.4.1 Hearing voices as evidence of a powerful actualising tendency

I am tentatively proposing, therefore, that HV might be evidence of authentic experiencing breaking through the self-concept. Although the experience itself might appear dysfunctional – if someone is hearing distressing voices of a previous abuser, for example – the ultimate purpose may be to alert the person to what needs to be worked on so that healing and growth can occur. It can, therefore, be considered as a positive manifestation of the actualising tendency. (The same thinking might be applied to other experiences such as unusual beliefs or unusual thought patterns.)

By paying attention to such experiences and trying to work out what they might mean, a person may discover what is troubling her, or be able to resolve inner conflicts or difficult feelings arising from previous traumas. That such experience is powerful enough to break through whichever social or cultural mores contextualise and constrain any individual might, I suggest, offer further evidence of the strength of the organism's actualising tendency.

15.4.2   Engaging with the experience

By implication then, people might be encouraged to explore their unusual experiences, as suggested by the HVM and others discussed in earlier chapters. In cultures where HV is more acceptable, it may be that the voices as "messengers" (Corstens et al., 2014) can be more freely accessed without connotations of madness. In Western cultures, we accept that people have embodied responses like anxiety, or discomfort, or 'just a feeling' relating to issues that affect them. If we could also regard more unusual experiences as similar signals of underlying issues, or of genuine experiencing, people might be able more easily to access, recognise and attend to what can be healed or can offer opportunities for growth.

One might further theorise that the reaching of a new understanding might lead to relief, like that posited in a focusing approach (Gendlin, 1996; Purton, 2004), where attending to an embodied felt sense can help someone discover what the felt sense signifies. Such feelings of relief were also described by participants in this study.

15.4.3   A corollary

Although person-centred therapy facilitated the restoration of agency and consequent exploration for some participants in my study, it did not happen with two people. It might be that the information was too far into the "edge of awareness" (Mearns & Thorne, 2000, pp. 175-176) for them to recognise the alert from their actualising tendency. Or they were not able or willing to attend to any alerts because I was not the right therapist to help them, or it was not an appropriate therapy, or because they were not ready.

A corollary to this proposition, therefore, is that it is not enough to say the actualising tendency is making manifest the areas for potential growth and healing. Those matters

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can only be attended to if they are a) recognised and b) the person is ready to attend to them.

15.4.4 <u>Summary</u>

In accepting the notion of an actualising tendency that operates constantly to optimise the potential of an organism, I have proposed that psychotic experience be considered as a manifestation of authentic experiencing that has been strong enough to break through a conflicted self-concept and force of social mediation. That it does not have to be construed as a problem, but should be recognised and attended to, as it could hold within it the clues to the work necessary for moves towards more positive functioning and growth. The impacts of relevant social and cultural norms are acknowledged.

Such a proposition is in line with the person-centred approach as well as with evidence from other sources that try to understand why people have strange experiences and what may be the best way to alleviate associated distress. It offers us the opportunity as therapists to practice in accordance with Rogers' maxim that 'it is the client who knows what hurts, what directions to go' (1961, p. 11).

Chapter 16

16   SUMMARY, REFLECTIONS AND CONCLUSIONS

16.1   Summary and reflections

I would like to end by summarising the conclusions I have drawn from this study. These fall into the areas of therapy, theory, research and personal considerations.

Person-centred therapy was broadly valued by participants for several reasons. They responded well to the, unusual, experience of being treated like a person rather than a patient. Some reported meaningful therapeutic change, although this was not always attributed to their therapy. Others did not report change. That was fine in some ways because the relationship offered a time of respite that had healing properties, temporary though they might have been. I was concerned at the level of distress experienced by one participant and stress the need for therapists to be wary of the impact of therapy outside of sessions. What seemed important, however, was that all participants were all offered the chance to 'do' therapy in the way that felt right for them, at that time.

Surprising findings were salutary lessons for me. I had trusted that person-centred therapy would facilitate healing in all clients if they were given long enough to experience the therapeutic alliance. That was not, strictly, so. In any case, practical conditions in mental health services in the UK are not, currently, conducive to the frequent contact discussed by Dave Mearns in his story about 'Rick' (Mearns & Cooper, 2005, pp. 98-112) and which may suit some people. These are important considerations. People in distress should be able to access appropriate therapy, and person-centred therapy might be an option for some. But effective delivery according to idiosyncratic needs may, realistically, be restricted.

My findings suggested that client presence had a part to play in the process for these participants and it seems important to try and elucidate that further. I also started to consider HV from a potentiality perspective. What could it be evidence of potential for? I have proposed that unusual experiences like HV might be a positive manifestation of the actualising tendency, breaking through the self-concept and the force of social mediation. It would, therefore, be the most authentic form of processing and worthy of attention. Obviously, this proposition needs more work which I can move onto later.

The research process was difficult at times, partly because of my dual relationship. But I found that using a rigorous and systematic framework, within which I could roam freely, allowed me, hopefully, to elicit some interesting findings.

The investigation of subjective accounts using this method confirmed that this data source can provide a wonderful amount of broad and deep first-hand knowledge. That must be of value in deciding how to offer mental health services and in advocating for a change in attitudes towards unusual experiences and the people that have them. If those findings could be considered alongside findings from standardised measures they may also offer additional insights into what may constitute distress and well-being.

Finally, this study has taken far longer than I imagined. Obviously, the preliminary organisation takes time (e.g. getting ethical approval from NRES); then the process of recruiting participants and offering open-ended person-centred therapy took even longer. I became so immersed in it that I lost sight sometimes of the significance of what I was doing. It was just my everyday life. That participants were having such unusual experiences that I was privileged to share and, sometimes even engage in, I understood and appreciated. The scale and complexity of the findings, however, did not strike me until I had finished the research. It was then that I really understood the significance of what they had been through, the work they had done and the help they

had offered me. I am honoured to have played a part in presenting their stories and hope I have done justice to the struggles they suffered and the joys they celebrated.

16.2 Conclusions

I believe my findings can impact on clinical practice in psychotherapy and in other areas of mental health services. This is in terms of how professionals relate to patients/clients and the services should be available for those who feel distressed.

My study has offered an insight into useful ways of researching therapy and lived experiences, and concurs with other evidence that demonstrates the value of listening to subjective accounts of experience. It also confirms the need to take account of personal understanding of experience and that therapists need to respect and work with their clients' perspectives, whether they be medical, spiritual or idiosyncratic.

I have been surprised as well as reassured by what I found here about the approach to therapy and about person-centred ways of understanding experience. It has confirmed the power that therapy can have – for good and ill – and has reinforced my belief that practitioners need to be very aware of their duties of care when working with vulnerable people. Despite what the theory tells us, person-centred therapy might not always be the right approach for all vulnerable people, all the time.

The time seems right for more person-centred practitioners and researchers to work with people in this client group and to conduct systematic research into the approach, ideally involving experts-by-experience in study design and analysis of data. Only then can we refine our thinking about how best to work with people who have unusual experiences.

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Appendices

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Rogers' approach to therapy and personality development

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ii   Summary of Rogers' Process Conception of Psychotherapy: the seven stages of process (adapted from C. R. Rogers, 1961, pp. 132-159).

i   Propositions of personality development (C. R. Rogers, 1951, pp. 483-524)

No.	Proposition
1	All individuals (organisms) exist in a continually changing world of experience (phenomenal field) of which they are the center.
2	The organism reacts to the field as it is experienced and perceived. This perceptual field is "reality" for the individual.
3	The organism reacts as an organised whole to this phenomenal field.
4	A portion of the total perceptual field gradually becomes differentiated as the self.
5	As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of the self is formed – an organised, fluid but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me", together with values attached to these concepts.
6	The organism has one basic tendency and striving – to actualise, maintain and enhance the experiencing organism.
7	The best vantage point for understanding behavior is from the internal frame of reference of the individual.
8	Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.
9	Emotion accompanies, and in general facilitates, such goal directed behavior, the kind of emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.
10	The values attached to experiences, and the values that are a part of the self-structure, in some instances, are values experienced directly by the organism, and in some instances, are values introjected or taken over from others, but perceived in distorted fashion, as if they had been experienced directly.
11	As experiences occur in the life of the individual, they are either, a) symbolised, perceived and organised into some relation to the self, b) ignored because there is no perceived relationship to the self-structure, c) denied symbolization or given distorted symbolization because the experience is inconsistent with the structure of the self.
12	Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of self.
13	In some instances, behavior may be brought about by organic experiences and needs which have not been symbolised. Such behavior may be inconsistent with the structure of the self but in such instances the behavior is not "owned" by the individual.
14	Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self.
15	Psychological maladjustment exists when the organism denies awareness of significant sensory and visceral experiences, which consequently are not symbolised and organised into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension.
16	Any experience which is inconsistent with the organization of the structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organised to maintain itself.
17	Under certain conditions, involving primarily complete absence of threat to the self-structure, experiences which are inconsistent with it may be perceived and examined, and the structure of self-revised to assimilate and include such experiences.
18	When the individual perceives and accepts into one consistent and integrated system all his sensory and visceral experiences, then he is necessarily more understanding of others and is more accepting of others as separate individuals.
19	As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system – based extensively on introjections which have been distortedly symbolised – with a continuing organismic valuing process.

ii   Summary of Rogers' Process Conception of Psychotherapy: the seven stages of process (adapted from C. R. Rogers, 1961, pp. 132-159).

STAGE 1
Clients rarely come voluntarily to counselling and exhibit a fixity and remoteness of experiencing, as well as some, or all of, the following:
- an unwillingness to communicate self
- feelings are neither recognised nor owned
- personal constructs are rigid
- close communicative relationships are seen as dangerous
- problems are not recognised as such
- there is no desire to change
- internal communication is blocked

STAGE 2
Clients have some experience of being 'received' by the counsellor which encourages a loosening of expression. They are likely to exhibit:
- expression flowing in regard to non-self topics
- problems seen as external to self
- no sense of personal responsibility in problems
- feelings as remote and not owned
- experience as being at arms' length or in the past
- rigid and unrecognised personal constructs that are presented as facts
- the presentation of personal meanings and feelings as limited and global
- expression of contradictions which are not recognised

STAGE 3
Many clients come into therapy at this stage and stay here for some while, describing non-present feelings and exploring the self as an object. They often:
- are more freely expressive about self and self-related experience as object
- are more freely expressive about self as a reflective object existing in others
- are expressive of feelings and personal meaning not currently experienced
- exhibit feelings and sometimes recognise them as feelings but can't accept them seeing them as shameful, bad or abnormal
- describe experience as in the past and remote from self
- have rigid personal constructs but recognise them as constructs rather than as facts
- differentiate feelings and meanings more sharply and less globally
- recognise contradictions in experience
- see personal choices as ineffective

STAGE 4
Clients can allow a freer flow of feelings and a relaxing of constructs. Here they:
- describe more intense feelings, though those feelings are not currently present
- describe feelings as objects in the present
- may express some feelings as in the present, almost against their wishes
- may fear or distrust the possibility of experiencing feelings in the immediate present
- can accept some feelings

Appendix Aii: cont'd.

- express experiencing as less bound to the past, less remote
- recognise and question personal constructs
- increasingly differentiate feelings, constructs and personal meanings
- are concerned about contradictions and incongruities in self
- experience some sense of personal responsibility in problems
- may still fear close relationships but begin to risk relating on a feeling basis

STAGE 5
Clients are much closer to their organic being and to the flow of their feelings. Here:
- feelings are expressed freely as in the present and are close to being fully experienced, despite the fear and mistrust (rarely pleasure) which might accompany this process
- self-feelings are increasingly owned, with the desire to feel these, to be the 'real me'
- experiencing is more immediate
- there is a critical examination and questioning of personal constructs as constructs
- feelings and meanings are more exactly differentiated
- contradictions and incongruences are recognised
- there is increasing recognition of personal responsibility and a freer dialogue with self

STAGE 6
This is a crucial phase indicative of lasting change:
- present feeling is experienced with immediacy and is fully flowing.
- both the immediacy of feeling and the feeling itself are accepted fully by the client
- there is a sense that clients are *living* the experience not feeling *about* it
- self as object disappears; the self *is* what is felt
- experience takes on a process quality
- there is a physiological loosening – tears, muscular relaxation, sighs…
- internal communication is free and relatively unblocked
- incongruence disappears and personal constructs are dissolved; clients feel cut loose from previous structures
- differentiation of experiencing is sharp and basic
- clients subjectively live their problems
- the problem is not an object 'out there'

STAGE 7
The therapist is no longer essential. This stage may take place outside the therapeutic hour:
- feelings are experienced with immediacy within and outside the counselling session
- there is trust by clients of their processes and ownership of changing feelings
- experiencing is no longer bound by previous structures but the situation is experienced in its newness not as the past
- self becomes the subjective and reflexive awareness of experiencing rather than a perceived object
- personal constructs are loosely held, tentatively formulated, validated against experience
- internal communication is clear
- there is the experience of the effective choice of new ways of being

APPENDIX B

Framework of data analysis

Fractions of the lifeworld with source material (adapted from Ashworth, 2003, 2006)

and examples of phenomena to be interrogated in this study

Fractions of the lifeworld with source material (adapted from Ashworth, 2003, 2006) and examples of phenomena to be interrogated in this study

Fraction	Explanation including source material from Merleau-Ponty (1945/2002); Heidegger (1927/1962)	Examples of phenomena to be interrogated in this study
Selfhood	What does the situation mean for social identity; the person's sense of agency, and their feelings of their own presence and voice in the situation? The central phenomenon, at the root of both my subjectivity and my transcendence towards others, consists in my being given to myself. I am given, that is, I find myself already situated and involved in a physical and social world . . . The fundamental power which I enjoy of being the subject of all my experiences, is not distinct from my insertion into the world. (Merleau-Ponty, 1945/2002, p. 419)	What does the experience of hearing voices mean for participants' identities/senses of self-hood? How does the person feel within the therapy setting as compared with other settings to do with experience of hearing voices? Has sense of agency/identity changed over the course of therapy in any contexts?
Sociality	How does the situation affect relations with others? There is no doubt of the intrinsic relatedness of one and the other. …it is precisely my body which perceives the body of another person, and discovers in that other body a miraculous prolongation of my own intentions, a familiar way of dealing with the world. . . . All of which makes another living being but not yet another man. But this alien life, like mine with which it is in communication, is an open life. It is not entirely accounted for by a certain number of biological or sensory functions. . . . There is one cultural object which is destined to play a crucial role in the perception of other people: language. In the experience of dialogue, there is constituted between the other person and myself a common ground; my thought and his are interwoven into a single fabric. (Merleau-Ponty, 1945/2002, p. 412)	Therapy itself is about relationship so how do people view that particular relationship? How has that relationship changed and developed? How does it compare with other relationships involved in their care? How has therapy affected interaction with others? How does the hearing of voices affect relationships with others? How do others view the experience?
Embodiment	How does the situation relate to feelings about their own body, including gender, emotions, "disabilities"? To have a body is to possess a universal setting, a schema of all types of perceptual unfolding and of all those inter-sensory correspondences which lie beyond the segment of the world which we are actually perceiving. A thing is, therefore, not actually given in perception, it is to be internally taken up by us, reconstituted and experienced by us in so far as it is bound up with a world, the basic structures of which we carry with us, and of which it is merely one of many possible concrete forms. (Merleau-Ponty, 1945/2002, p. 381)	How does the experience of voices affect feelings about participants' own bodies including the notion of 'disability'? Do others views of where they are positioned accord with their own? What are their vulnerabilities and strengths in terms of being a voice hearer and has that changed in any way through therapy? (NB may have become more vulnerable through opening up) How do feelings about the 'body' affect 'project'?
Temporality	How is the sense of time, duration, biography affected? [E]ach present reasserts the presence of the whole past which it supplants, and anticipates that of all that is to come, and by definition the present is not shut up within itself, but transcends itself towards a future and a past. (Merleau-Ponty, 1945/2002, pp. 488-489)	How is the meaning of time, duration, biography intrinsic to the situation in which one finds oneself? How has biography changed since hearing voices and since having therapy? Ideas about 'returning to normal'/life on hold/endless suffering/life before and after voices. Limited length of session. Boundaries. Good and bad
Spatiality	How is their picture of the geography of the places they need to go to and act within affected by the situation? Traditional psychology has no concept to cover these varieties of concept of place because consciousness of place is always, for such psychology, a positional consciousness … Now here, on the other hand, we have to create the concepts necessary to convey the fact that bodily space may [for example] be given to me in an intention to take hold without being given as an intention to know. (Merleau-Ponty, 1945/2002, p. 119)	Physical environment. Social norms. Are any comments made about the room, furniture, location? Are there any associations with the particular space that therapy happens in? What effect does the therapist's presence have on ideas about the space? (cf. mood-as-atmosphere)

Appendix B, cont'd.[34]

Project	How does the situation relate to their ability to carry out the activities they are committed to and which they regard as central to their life? The thing is inseparable from the person perceiving it, and can never be actually in itself because its articulations are those of our very existence, and because it stands at the other end of our gaze or at the terminus of a sensory exploration which invests it with humanity. (Merleau-Ponty, 1945/2002, p. 373)	Everything that people 'care' about. How does the hearing of voices affect their ability to fulfil their 'project'? (eg Get a job/run a home/live in a marriage/try to impart the spiritual knowledge they feel the voices have imparted) How is therapy and/or 'mental illness' regarded in terms of important 'projects'? How does therapy enable them to carry out their 'project'?
Discourse	What sort of terms—educational, social, commercial, ethical etc— are employed to describe—and thence to live—the situation? Speech is, therefore, that paradoxical operation through which, by using words of a given sense and already available meanings, we try to follow up an intention which necessarily outstrips, modifies and itself, in the last analysis, stabilises the meanings of the words which translate it. (Merleau-Ponty, 1945/2002, p. 452)	The terms used to describe the experiences under investigation – eg., for HV - 'symptom of mental illness'/spiritual occurrence/aspect of self/result of trauma; for therapy - personal development/'cure'. Language can illuminate participants' worldviews about HV or therapy.
Mood-as-atmosphere (Ashworth, 2006, p. 216)	This is not the same as "having a mood" or anything else which presupposes a cause. The phrase ''mood as atmosphere'' reminds us that a feeling-tone is an essential element of any situation for us, and that we must represent this in describing the lifeworld. From Heidegger (1927/1962 section 29) where he describes ''Being-there as a state of mind'' (p.172), explaining that In a state-of-mind *Dasein* is always brought before itself, and has always found itself, not in the sense of coming across itself by perceiving itself, but in the sense of finding itself in the mood that it has (p. 174)	The effects created by the operation of the therapeutic relationship over course of therapy. How the mood facilitates change and exploration of difficult topics. The effect of being listened to and being heard. The impact (pressure) of setting the tone and pace. The pressure felt to talk in a weekly session, or to address difficult issues. The way participants experience a mood change in other people who realise they are in the presence of a voice hearer- eg on a bus/in the street/when it becomes known that someone is 'a mental patient'.

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[34] All fractions from Ashworth (2003) except Mood-as-atmosphere which is from Ashworth (2006)

APPENDIX C

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Ethical approval

i   Confirmation of UEL Ethics Committee approval 10th March 2009

ii   Confirmation of NHS Research Ethics Committee approval 7th July 2009

iii   Confirmation of NHS R&D approval and registration 29th July 2009

i   Confirmation of UEL Ethics Committee approval 10th March 2009

REC REFERENCE NUMBER 09/H0310/63 - Statement of indemnity arrangements – UEL ETHICS APPROVAL 10.03.09

UEL
University of
East London

Professor R Bayne
School of Psychology
Stratford

ETH/09/97

10 March 2009

Dear Professor Bayne,

Application to the Research Ethics Committee: People who hear voices (K Rundle)

I advise that the University Research Ethics Committee has now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Administrative Officer for Research
d.dada@uel.ac.uk
02082232976

Research Ethics Committee: ETH/09/97/0

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.......................... Date:................10 / 3 / 09..........

Please Print Name: Rowan
                    Bayne

i   Confirmation of UEL Ethics Committee approval 10th March 2009

ii   Confirmation of NHS Research Ethics Committee approval 7th July 2009

NHS

National Research Ethics Service

Norfolk Research Ethics Committee
c/o The Norfolk & Norwich University Hospitals NHS Foundation Trust
East of England REC Office [2]
Room 2.08 First Floor
Aldwych House
57 Bethel Street
NORWICH
NR2 1NR

Telephone: 01603 289813
Facsimile: 01603 286573

07 July 2009

Ms Kirshen Rundle
PhD Student
School of Psychology
University of East London
Romford Road
Stratford
London
E15 4LZ

Dear Ms Rundle

Study Title:	**People who hear voices: their lived experiences of person-centred counselling.**
REC reference number:	09/H0310/63
Protocol number:	**NHS REC 1**

Thank you for your letter of 18 June 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair in correspondence with Lead Members.

Confirmation of ethical opinion

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

Ethical review of research sites

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

Conditions of the favourable opinion

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

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

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England*

iii   Confirmation of NHS R&D approval and registration 29th July 2009

East Norfolk and Waveney Research Governance Committee **NHS**

Please reply to: Research Governance Committee Office
Research and Development Department
Level 3, East Block, Room 032
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Colney Lane
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Ms Kirshen Rundle
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Direct Dial: 01603 287408
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29 July 2009

e-mail: rdoffice@nnuh.nhs.uk
Website: www.norfolkhealthresearch.nhs.uk

Dear Ms Rundle

Re: 2009MH05S (114-07-09) People who hear voices: their lived experiences of person-centred counselling.

Following confirmation of a favourable Ethical opinion I am pleased to confirm that your project has been given full approval from the East Norfolk and Waveney Research Governance Committee and Research Management Team and you may start your research.

Please note that this approval applies to the following sites:

[Name of site removed to protect confidentiality of participants]

I have enclosed two copies of the Standard Terms and Conditions of Approval. Please sign and return one copy to the Research Governance Committee office. Failure to return the standard terms and conditions may affect the conditions of approval.

Please note, under the agreed standard terms and conditions of approval you must inform this Committee of any proposed changes to this study and to keep the Committee updated on progress.

If you have any queries regarding this or any other study please contact Julie Dawson, Research Governance Administrator, at the above address. Please note, your reference number is **2009MH05S (114-07-09)** and this should be quoted on all correspondence.

The Committee would like to take this opportunity to wish you every success with this project.

Yours sincerely

Dr Richard Reading
Chair
Consultant Paediatrician – NHS Norfolk

Encs – Standard terms and conditions
Guidance for screening of patient notes

East Norfolk & Waveney Research Governance Committee – a partnership between:
Norfolk & Norwich University Hospitals NHS Foundation Trust.   NHS Norfolk
Norfolk & Waveney Mental Health NHS Foundation Trust.   James Paget University Hospitals NHS Foundation Trust.

APPENDIX D

Study documentation

i   Information for clinical staff

INFORMATION FOR CLINICAL STAFF AT NHS MENTAL HEALTH TRUST. ANONYMISED FOR THESIS

[1]INFORMATION FOR [NAME OF NHS MENTAL HEALTH TRUST] CLINICAL STAFF
People who hear voices: their lived experiences of person-centred therapy
Kirshen Rundle, Counsellor, [NAME OF] Therapy Team

Patients who hear voices required as participants for PhD study
When deciding on care plans for those of your patients who hear voices, please would you consider their suitability for person-centred therapy and, thus, for my ongoing PhD research. Brief details are below but please do contact me on [phone and email details] if you would like more information, or to discuss it further.
Many thanks,
Kirshen Rundle

Outline of the study
This will be a qualitative analysis of subjective accounts of the experience of hearing voices. I will explore whether participants perceive person-centred therapy contributes to the alleviation of associated distress, what elements are considered to be helpful/unhelpful, and what they consider to be evidence of 'successful outcome'. Discussion will include the extent to which changes on standardised measures match participants' own experiences of change.

Inclusion criteria
Men and women aged between 18-65 years. Experience the hearing of voices. Able to give informed consent.

Procedures involved
- On referral for therapy, I will approach the lead clinician to ensure an invitation to join the study is considered appropriate and (as far as possible) risk-free.
- I will discuss the study and give potential participants an information leaflet at their initial exploratory sessions – but only after they have decided to enter into therapy with me.
- They will not be put under pressure to join the study and their continuing therapy will be unaffected if they decide against taking part. They will be able to consider their response between their exploratory session and the start of their full therapy sessions (at least a week).
- If they agree to take part in the study they will complete a consent form and three outcome measures at their first therapy session.
- Therapy sessions will be recorded if participants agree.
- The outcome measures will be completed again at the end of therapy.
- At this time, participants will take part in two post-therapy interviews, each of which will last up to an hour.
- Participants will be offered the chance to review draft analyses to assess whether they concur with general and specific themes and 'essences' identified. Doing this is optional.

Care of participants
- All participants will be given a reference number known only to me so they cannot be identified; all identifying information will be removed from research data; data will be stored securely and password protected.
- It will be made clear to participants that I and/or their clinical team will be available to them if they feel distress at any stage of the research procedures.
- It will be explained on the information sheet, and at the time, that they can stop or take a break if they no longer feel comfortable completing questionnaires, taking part in the interviews or if they wish to have the digital recorder turned off.
- It will also be made clear that they can withdraw from the research at any stage without needing to give a reason, and without it affecting their ongoing therapy.
- The study has been approved by the Norfolk NHS Research Ethics Committee, by the R&D committee of [name of NHS mental health trust] and by University of East London Ethics Committee.

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[1] NHS mental health trust letter heading included

ii   Appendix II – Information for participants

APPENDIX II – INFORMATION FOR PARTICIPANTS ANONYMISED FOR THESIS

[1]APPENDIX II - INFORMATION FOR PARTICIPANTS
PEOPLE WHO HEAR VOICES: THEIR LIVED EXPERIENCES OF PERSON-CENTRED THERAPY

Invitation to Participate in a Research Study
I am a counsellor and a research student at University of East London. This letter is to give you information that will help you decide whether to participate in my study. Please note you **DO NOT** have to take part but, if you do decide to, you will be asked to sign a form giving your consent to the activities listed below. You will also be asked to consent to information you give being included in a thesis (which goes towards my qualification as a Doctor of Philosophy) and, possibly, published articles or further research. If you change your mind later you are free to withdraw at any time without needing to give a reason. Your therapy will not be affected whether or not you take part in the research or leave that study at any stage. Furthermore, if you decide to withdraw from therapy but still wish to be included in the research your input will be greatly valued.

What is the aim of the study?
Some people who hear voices (sometimes called 'auditory hallucinations') find it distressing and want help in coping with the struggles caused in their lives because of it. By talking to people who undertake therapy we hope to learn what is seen as useful or helps them to feel better about their lives. It is equally important to try and discover what is not helpful or causes more problems. Greater awareness of 'what works' and 'what hinders' will enable service providers, and service users themselves, to access appropriate care tailored to individual needs. Whilst participants in this study may not benefit immediately, it may help them, and others in the future, to decide what form of help may suit them. You may, however, find it useful to have the opportunity to explore your own situation and thoughts in greater detail through the research. You will, of course, be offered the chance to receive feedback, summary findings or a copy of the full thesis if required.

What will you have to do if you take part?
• You will be asked to complete some questionnaires at your first and last sessions. These should take about 30-45 minutes altogether each time and will give us an idea of your thoughts and feelings, as well as what you believe are the main problems affecting your well-being.
• You will be asked if you will allow your therapy sessions to be recorded. These recordings, or the transcripts, may be assessed by independent raters to make sure your counsellor is providing you with appropriate therapy.
• All independent raters will be experienced person-centred counsellors. They will all live some distance from [local area] so it is unlikely participants will be known to them. They will sign confidentiality agreements which will state that they will stop the assessment immediately if they do recognise any participant.
• You will be asked to take part in two interviews when you finish therapy to get your views on how you are feeling, whether you feel better or worse than before, what has helped or hindered any changes and what you think may have been responsible for those changes.
• You will be asked to allow these interviews to be recorded. Tape recordings are useful ways of making sure the experience of therapy can be studied in detail and that your views are represented accurately.
• Written transcriptions of the recordings may be made and quotes from them used in the final thesis to illustrate the points you make.
• All information that identifies you (eg names, places) will be removed from all recordings, transcripts and reports before anyone other than the researcher has access to them.
• You will be invited to review written transcripts of recordings to make sure you are happy that they are accurate records of what happened.
• You will also be invited to review draft analyses to check that your experience has been accurately captured.
• It will be possible to complete these questionnaires and do the interviews at the same time as your sessions.
• If you withdraw from the study for any reason, the researcher will destroy all data relating to your participation.

Are there any risks involved in taking part in this study?
During therapy or psychotherapy people can become distressed at times because of some of the painful or difficult things they talk about.
It is unlikely that the activities from this research will cause extra discomfort or distress but, if you feel

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[1] NHS mental health trust or UEL letter heading included as appropriate

Appendix Dii: cont'd.

APPENDIX II – INFORMATION FOR PARTICIPANTS ANONYMISED FOR THESIS page 2

uncomfortable at any time, or are particularly affected after completing the questionnaires or interviews, please talk to your counsellor or doctor who will try to help. They will arrange for you to speak to someone else if you wish.

If, for instance, you feel uneasy or distressed while completing the questionnaires it is perfectly all right to tell the researcher you want to stop or take a break. Or, if you decide after the start of a taping session that you do not want the digital recorder on, it is fine to ask for it to be turned off. The session can still continue if you wish.

Who will be able to access the information you provide?
You will be given a reference number which will be kept separately from any information which links you with it. Only Kirshen Rundle will know it is your number. All questionnaires you complete, as well as any recordings and transcripts, will be logged by that number.

Transcripts of sessions or interviews will remove any information which may mean people could find out your identity. For instance, names of individuals or locations will be changed or left out.

Information used in the final thesis or other publications will be treated in the same way.

All written reports, questionnaires and recordings will be kept in secure filing cabinets in Kirshen Rundle's offices.

Information kept on computers will be protected by passwords known only to Kirshen Rundle.

Personal data will be stored securely on [name of mental health trust] premises for 12 months after submission of the thesis. Anonymised research data will be securely stored for 5 years after submission of the thesis at UEL premises. Written data will then be shredded and information kept on computers deleted.

Sometimes people from regulatory authorities or the NHS Trust may need to review study data for auditing purposes, where it is relevant to your taking part in the research. This is standard procedure but you will be asked on the consent form if you will allow access to your study records for this.

Who has reviewed this study?
The University of East London Ethics Committee and the Norfolk Research Ethics Committee (REC) have reviewed and approved this project. The Norfolk REC is an advisory committee to the East of England Strategic Health Authority and part of the National Research Ethics Service (NRES) which represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

Thank you for taking the time to consider joining this project. Please remember:
You are not obliged to take part in this study, and are free to withdraw at any time during the tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Contact details
If anything is unclear, or you have concerns or want more information, now or later, please contact:
Kirshen Rundle (Chief Investigator) Tel: 0208 223 4604 or 01603 421672   Email: k.g.rundle@uel.ac.uk or
Professor Rowan Bayne (Academic Supervisor) Tel: 0208 223 4463   Email: r.s.bayne@uel.ac.uk
School of Psychology, UEL Stratford Campus, Romford Road, London, E15 4LZ

Local resources for information about the study or for help with issues that arise
Members of your clinical team or your GP
[Name and contact details of Research Officer at NHS mental health trust]
Guidance for Research Participants website, http://www.norfolkhealthresearch.nhs.uk/phr/33.html

University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate please contact the Secretary of the University Research Ethics Committee: Ms D Dada, Administrative Officer for Research, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel: 0208 223 2976 e-mail d.dada@uel.ac.uk)

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iii   Appendix IV – Question areas to be covered in post-therapy interviews
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APPENDIX IV – QUESTION AREAS FOR POST-THERAPY INTERVIEW ANONYMISED FOR THESIS

¹APPENDIX IV - QUESTION AREAS FOR FIRST POST-THERAPY INTERVIEW

The interview will cover the following areas. Possible questions are listed under each area heading but we may not necessarily cover them all and may talk about things in a different order. You do not have to answer any questions you feel uncomfortable about and can take a break, or stop completely, at any time. You can also ask for the tape recorder to be turned off if you like. The main reason for asking you these questions is to get an idea of how *you, specifically,* feel about the distress that lead to your coming to see me, how you are feeling now and what you believe the reasons are for any changes. In order for the service to be improved, I am as interested in aspects of your therapy that you found negative or irrelevant as I am in those you believe to have been useful or helpful.

1.   Your experience of hearing voices
   - How did you experience the hearing of voices before we started therapy?
   - How did you understand this experience before we started therapy?
   - Why do you think you thought and felt this way?
   - How do you feel now about your experience of hearing voices?

2.   Your reasons for coming into therapy.
   - What was the initial reason you sought help which lead to our working together?
   - What was the initial help offered to you?
   - What was your experience of it?
   - Was this the first time you had experienced distress related to this issue?
   - What help had previously been offered to you?
   - How successful was it in helping you feel better?

3.   Your experience of the therapy sessions we have had
   - What is your overall experience of the therapy you have received?
   - What did you find helpful?
   - What did you find unhelpful?
   - How could the sessions have been improved to help you more?
   - How does your experience of this therapy compare with your experience of other help you may have received for the same problems?

4.   Your feelings about the questionnaires we asked you to complete
   - How do you feel about the questionnaires we asked you to complete?
   - How accurate was the picture they gave of you when you filled them in before your therapy sessions started?
   - How accurate was the picture they gave of you when you filled them in on completion of your therapy sessions?
   - Are there any other questions or statements that you feel should have been included in the questionnaires?

5.   Your feelings now about the issue that first lead you to seek help
   - How do you feel now about the issue that first brought you to therapy?
   - What do you think has caused you to feel this way?
   - Before we started therapy, what did you think 'feeling better' would mean?
   - What do you think now?
   - To what extent are you still experiencing problems associated with the issues that brought you to therapy in the first place?

Any other issues you want to discuss that might be relevant

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¹ NHS mental health trust or UEL letter heading included as appropriate

iv   Appendix I – Letter to Head of Clinical team

APPENDIX I – LETTER TO CLINICIAN RE APPROACH TO POTENTIAL PARTICIPANT
ANONYMISED FOR THESIS

[1]Kirshen Rundle
Counsellor and PhD student
[Date]

[Name and address of clinician]

Dear [Name of clinician],

Re: **[Name of potential participant]**

As you know, the above patient meets the inclusion criteria for the PhD research I am
undertaking into therapy with people who hear voices. Further to our recent discussions,
I am now writing formally to ask whether you feel it is appropriate to invite her to become
a participant in the study.

Enclosed with this letter are brief details of the study which are given to all participants
(Appendix II). People who join the study will be asked to complete a number of
questionnaires at the start and end of their therapy with me. They will also be asked to
take part in two taped interviews at the end of the therapy process, which will cover areas
shown in the enclosed list (Appendix IV). Thirdly, participants will be asked to allow me
to tape their therapy sessions so that independent assessors can confirm that I am, in fact,
offering person-centred therapy. These assessors will sign agreements before listening to
tapes to protect and maintain confidentiality for participants.

At all stages participants will be assured that they are under no obligation to take part in
the project and can withdraw at any time without it affecting their therapy, and without
their having to give a reason. All data collected will be treated confidentially and
identifying information removed.

Please could you complete the slip below to let me know whether you feel it is appropriate
for me to invite this person to take part in the study. I would, of course, be happy to discuss
matters further and can be contacted via email [email addresses] or by telephone on
[telephone numbers].

I look forward to hearing from you.
Best wishes,

Kirshen Rundle
MA, MBACP (Accred.)

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[1] NHS mental health trust or UEL letter heading included as appropriate

Appendix Div: cont'd.

APPENDIX I – LETTER TO CLINICIAN RE APPROACH TO POTENTIAL PARTICIPANT
ANONYMISED FOR THESIS page 2

KIRSHEN RUNDLE
UNIVERSITY OF EAST LONDON
PhD STUDY

PEOPLE WHO HEAR VOICES:
THEIR LIVED EXPERIENCES OF PERSON-CENTRED THERAPY

PATIENT NAME:...

I confirm/cannot confirm (**PLEASE DELETE AS APPLICABLE**) that, to the best of my knowledge, the patient named above is able to consent and participate in research being conducted by Kirshen Rundle on therapy with people who hear voices.

Signed:...**Date:**.........................

Name:...

Position:..

v Appendix III – Consent form

APPENDIX III – CONSENT FORM ANONYMISED FOR THESIS

[1]APPENDIX III - CONSENT FORM

Title of Project: *People who hear voices: their lived experiences of person-centred therapy.*
Name of Researcher: *Kirshen Rundle*

	INITIALS
I confirm that I have read and understand the information sheet for the above study dated ...., and have been given a copy to keep. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. **YES/NO** *(delete as applicable)*	
I understand that my involvement in this study, and the data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen to the data once the experimental programme has been completed and that all personal data will be stored on [Name of mental health trust] premises. **YES/NO** *(delete as applicable)*	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without it affecting my ongoing therapy and that all identifiable data will then be withdrawn from the study. **YES/NO** *(delete as applicable)*	
I understand that relevant sections of my data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. **YES/NO** *(delete as applicable)*	
I consent to the recording of my therapy sessions and my post-therapy interviews. **YES/NO** *(delete as applicable)*	
I consent to anonymised recordings of my therapy sessions being made available to independent counsellors who will assess the therapy being offered. **YES/NO** *(delete as applicable)*	
I consent to anonymised data collected for this study being used in further research or in publications. **YES/NO** *(delete as applicable)*	
I consent to anonymised quotes being included in this study, and in any further research or publications. **YES/NO** *(delete as applicable)*	

I hereby fully and freely consent to participate in the study which has been fully explained to me.

....
Signature of Participant   **Date**   **Name of Participant**

....
Signature of person taking consent   **Date**   **Name of person taking consent**

Thank you for agreeing to take part in this study

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[1] NHS mental health trust or UEL letter heading included as appropriate

vi   Appendix VI – Supplementary consent form

APPENDIX VI – SUPPLEMENTARY CONSENT FORM ANONYMISED FOR THESIS

[1]**Kirshen Rundle**

PhD study

PEOPLE WHO HEAR VOICES:
THEIR LIVED EXPERIENCES OF PERSON-CENTRED THERAPY

APPENDIX VI - SUPPLEMENTARY CONSENT FORM FOR RESEARCH PARTICIPANTS

I ....have agreed to take part in this project as part of Kirshen Rundle's
PhD research at University of East London in Appendix III dated ....

As part of the research I further understand and agree to the following:	INITIAL
That extracts from my recorded therapy sessions may be used as part of conference presentations, published or unpublished papers, books or articles.	
That my personal details and any identifying information will be kept confidential at all times and will not be disclosed to any third parties, apart from the researcher's Academic Supervisor.	
That I will not be identified in anything that is written or reported about the research.	
That I am free, at any time, to withdraw from the research project.	
That I am free, at any time, to withdraw my permission for any extracts from therapy sessions to be used in conference presentations, published or unpublished papers, books or articles.	
That, in the circumstances above, all extracts from my therapy sessions will be deleted from relevant presentations and unpublished papers, books and articles, and from any further editions of published material.	
That it has been explained to me that this project has been submitted to the UEL Ethics Committee and approved by it and also by the NHS Norfolk Research Ethics Committee.	
That Kirshen Rundle is bound by the Ethical Framework of the British Association for Counselling and Psychotherapy and that she will observe the strictest confidentiality at all times.	

My consent is informed and freely given

Name (Block capitals) ....

Signed (Participant)   ....

Date   ....

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[1] NHS mental health trust or UEL letter heading included as appropriate

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APPENDIX E

Independent assessor information

i   Appendix V - Confidentiality Agreement for Independent Assessors

ii   Notes for Independent Assessor with recording of therapy session - April 2010 – middle of therapy: male client

iii   Notes for Independent Assessor with recording of therapy session – March 2011 – beginning of therapy: female client

iv   Independent Assessor report - April 2015 – end of therapy: female client

NOTES:

Any information which may identify the participant has been redacted.

Samples have been chosen to give examples of

a) each time I sent recordings to assessors,

b) beginning, middle and end of therapeutic process and

c) both genders.

i   Appendix V – Confidentiality agreement for Independent Assessors

APPENDIX V – CONFIDENTIALITY AGREEMENT FOR INDEPENDENT ASSESSORS
ANONYMISED FOR THESIS

[1]Confidentiality agreement for independent assessors

I confirm that I am a qualified counsellor and member of the British Association of Counselling and Psychotherapy.

I have read the research protocol for Kirshen Rundle's PhD thesis entitled *'People who hear voices: their lived experiences of person-centred therapy'* and have agreed to review a random selection of taped therapy sessions. I will consider these tapes in the light of Carl Roger's (1959) paper which outlines the conditions he suggests are necessary and sufficient to bring about constructive personality change.

I will report back my view on whether or not the therapy being offered in these sessions could reasonably be considered to be person-centred therapy as discussed in that paper.

If, at any stage, I believe I am aware of the identity of the research participant I undertake to stop listening to the tape immediately and to inform the Chief Investigator so that another tape can be allocated to me.

Signed ....

Print Name ....

BACP Membership Number ....

Date ....

_____

[1] UEL letter heading included

ii   Notes for Independent Assessor with recording of therapy session - April 2010 –
middle of therapy: male client

NOTES FOR INDEPENDENT ASSESSORS April 2010

PEOPLE WHO HEAR VOICES: THEIR LIVED EXPERIENCES OF PERSON-CENTRED THERAPY

Thank you for agreeing to help me in my research.

Your first recorded session has been mailed and will be with you shortly. It is about an hour long and I have written background notes on it below. You might prefer not to read these but they are included in case you wish to know a little context. Once you have heard the session, I would be grateful if you could let me have your views, via email, on the extent to which the therapy offered could be described as person-centred therapy.

In line with what I put in my submission for ethical approval, I am particularly interested in your observations of the following:

- Evidence of the therapeutic conditions
- Evidence of my non-directive attitude
- Evidence of a developing therapeutic relationship
- Evidence of the session operating from within the client's frame of reference
- Any specific instances, or phases, which could be considered as demonstrating relational depth or working with particular configurations of self.
- I stress that it is as important to highlight what goes wrong, or what would not be considered appropriate in a person-centred therapy session, as what matches the approach. I think that could form an interesting part of the later discussion of people's accounts of their experiences of the therapy process. (I am very aware, now I listen to the recordings, that there were times when I could have responded differently or more helpfully!)

If you feel this is too vague and would like me to specify things in more detail, please do let me know.

Note on ███████████

This was our sixteenth session. The client referred himself to me after attending a research day run by the mental health trust I work for. He has been a psychiatric service user for many years but considers his experiences to be spiritual or mystical happenings rather than signs of mental illness. I see him at a counselling agency, not through the trust. This is his first experience of talking therapy and he is trying to get it funded through the health service, but is currently paying for it himself.

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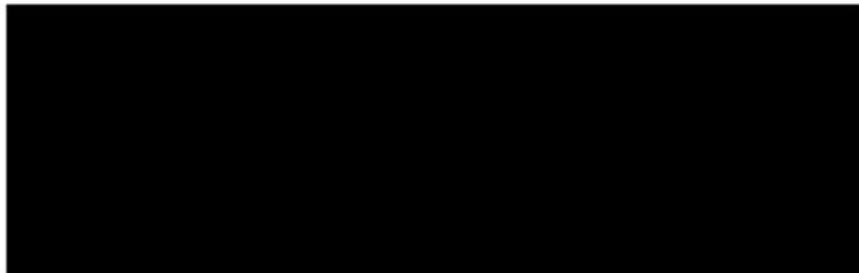
Appendix Eii: cont'd.

NOTES FOR INDEPENDENT ASSESSORS April 2010

I think I made a mistake early on in this session to get drawn into a discussion over what my views were in relation to the client's way of thinking, instead of quickly enough putting things back to him. At the time, I was aware of being more concerned with re-establishing my equilibrium so that I could be back in his frame of reference. It seemed to get round eventually to what he wanted to bring that day and he said he uncovered some important things that he not looked at before; but I think I could have facilitated it better and earlier.

iii   Notes for Independent Assessor with recording of therapy session – March 2011 – beginning of therapy: female client

NOTES FOR INDEPENDENT ASSESSORS March 2011

PEOPLE WHO HEAR VOICES: THEIR LIVED EXPERIENCES OF PERSON-CENTRED THERAPY

Thank you for continuing agreeing to help me in my research.

The second recorded session has been mailed and will be with you shortly. It is about an hour long and a little background is included below. Once you have heard the session I would be grateful if you could let me have your views on the extent to which the therapy offered could be described as person-centred therapy.

In line with what I put in my submission for ethical approval, I am particularly interested in your observations of the following:

- Evidence of the therapeutic conditions
- Evidence of my non-directive attitude
- Evidence of a developing therapeutic relationship
- Evidence of the session operating from within the client's frame of reference
- Any specific instances, or phases, which could be considered as demonstrating relational depth or working with particular configurations of self.
- I stress that it is as important to highlight what goes wrong, or what would not be considered appropriate in a person-centred therapy session, as what matches the approach. I think that could form an interesting part of the later discussion of people's accounts of their experiences of the therapy process. (As before, my listening to the recordings has highlighted instances in these sessions where I could have responded in a more helpful way – or where it would have been more help if I had said nothing!)

If you feel these notes are too vague and would like me to specify things in more detail, please do let me know.

Notes on ██████████

This client is a ██████ woman who was referred to me when she was an inpatient under section on an acute psychiatric ward. She has been in touch with psychiatric services ████████████ ██ ██████████████

This was only our second session and the first time we had a full therapy session as we had spent much of the previous week completing the study consent form and questionnaires. So she had not discussed in detail the things that she felt counselling might help with.

██ ████████████████████████████████ She was wary at first of entering into counselling and took a week or so to decide to go ahead.

I sometimes found it difficult always to hear clearly what she said and so used reflection a great deal – not just to check my understanding of the nuances, but also to check I had heard what she said correctly.

iv   Independent Assessor report - April 2015 – end of therapy: female client

Independent assessor ███████████████

I have listened to the recording of this session, using the criteria provided as a guideline for my assessment.

The session has many features that fit the person-centred perspective on therapeutic work. The therapist follows the client's direction, listens carefully to her and joins her in her exploration of her experience through reflection and clarification, and seeks to stay within her frame of reference.
She takes the client seriously at all times and does not try to influence her towards a particular style of expression such as preferring 'feeling' over 'thought'. My impression was that there is a good relationship between client and therapist; they have worked together for some time and it felt like they were on 'familiar ground", exploring issues that they had touched on before, but there was a feeling of freshness rather than rehashing old material.
The client speaks freely and there appears to be a lot of trust between them. The client is in charge of the direction of the session; at some points the therapist appears to be tempted to over-emphasise the positive direction of the client's process, but the client brings it back to her own level of experiencing. This to me is a sign of the client's locus of evaluation being inside herself: she listens to the therapist, takes what is relevant and meaningful, and carries on following her own train of thought.

The therapist appears involved with the client, touched by the client's experience and very encouraging of her positive experience. I felt that at times there was a bit of 'praising' rather than 'prizing', but this can happen in a strong relationship that is moving towards greater mutuality. It fits the feeling of this being a relationship that is perhaps coming to an ending. It was interesting that the therapist raised this towards the end of the session, somewhat surprising the client- perhaps there is still more to come.….

The therapist's involvement, affection and delight in the client's new self-experience come through in her tone of voice and in some of her positive and encouraging comments. Again, this may fit the stage of the therapeutic relationship, but on the other hand. it could get in the way of new or perhaps contradictory experience coming to the surface. Reflecting on process (the therapist's, the client's and of the relationship) rather than content helps to keep things open and transparent and creates freedom in the relationship.

There was nice moment when the therapist expressed her appreciation of her experience with the client- who responded with a hint of surprise and delight. These fleeting moments of direct relating are what we might refer to as moments of relational depth- often so fleeting that neither party are aware of it. It was perhaps there in the client's voice when she said: 'I told you I would overcome'.….

Elke Lambers
20.04.2015

APPENDIX F

Data from thematic analysis

i   Extract from post-therapy interview transcript[35]

47   R   /So it's almost as if then those critical voices then started to get integrated into
48   you, but then they just went because you weren't critical of yourself either anymore. Is that an
49   accurate summary?

50   P   That's a very good summary of it. / It is kind of starting off with a hay bale curving
51   and you not knowing where the centre of it is. It starts with lots of little niggles, and thoughts, and
52   things being said and as you roll along life you pick up more negativity and you hear more people
53   saying bad things and cruel things and you lead yourself off into wrong choices and….and suddenly
54   there's more and more of a pile up on top until it got to a point where I couldn't distinguish any of it,
55   I absolutely couldn't, it was just a great big muffled ball straw with walls and all of this negativity
56   bouncing around and all these bad things being said and and, … it was … making choices that I
57   would've not … not wanted to make, you know, so I was being influenced by past decisions, maybe
58   from past highs of making a decision and having the excitement that came from it, or … being
59   expected to fail … so not really trying too hard, or having low self-esteem so not really wanting to do
60   those things/ … /so it was only by coming and slowly unravelling it week by week, that I was able to
61   roll it all away backwards until all that was left was those initial … things that actually I didn't need to
62   hold onto/

63   R   Yes

64   P   /They couldn't cling to anything … they couldn't cling if I didn't allow them to/

65   R   No so … um …almost as if then … / that hay bale, it's a brilliant image there, but
66   almost as if that's unravelling and getting back to those initial … statements? or elements of the
67   things that had upset you? You can actually… look at again and as you are now, rather than as that
68   little girl who was cut to the quick by it at the time. You didn't have to feel it any more, you could
69   just look at it and say "Yes, that was an unkind thing to say" and "I was a little girl and, you know
70   what, I'm not a little girl now and I don't have to hold on"

71   P   Yes, it's making that detachment of always being insecure and always seeking for
72   your mother's approval … um … and… and that can go on for years and years and years and um/ …
73   and /it's only now … you know it's kind of as if I've woken up, with new eyes and so I'm actually a
74   mother of a 14-year-old, you know, I'm actually a grown up and I'm actually a mother and wife … I
75   don't … I can choose my family, I can choose my decisions, I can make those choices properly/, and
76   … /I know from being a mother myself that those things were not acceptable and those things were
77   not right to be said or done/ … um … /but I can't hurt from that anymore and I can't judge her that
78   because I, because it was her mistake that's not mine. And I don't need to carry other people's
79   mistakes with me/

80   R   /That's interesting, yes, you don't have to do to … to sort of blame her …to sort of
81   hold on

82   P   No, …yes, I was really angry with her even up until a few weeks ago,

83   R   Yes

84   P   Really, really angry with her that she didn't do better, that she didn't try harder,
85   that she shouldn't have allowed these things to happen /and she is still very controlling, and she is

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[35] Breaks between individual meaning units marked by /

86   still quite manipulative and she's … you know, a bit bitter and twisted. But actually … I don't even

87   feel sorry for her. // I went through a stage of being really angry about her and why as a parent did

88   she do these things because it has caused all of this. She was the main headmess … to then feeling

89   really sorry for her and thinking "Ohh you know what … you know she never got any help with it"/

90   /so I felt really guilty about that

91   **R**   You felt guilty?

92   **P**   Mmm…yes … that I never helped her more, if I was helping her so much. And I felt

93   sorry for her then. When you feel sorry to someone you feel guilt and pain and … you know it's all

94   that … /

95   **R**   /So that's like taking responsibility for something that wasn't yours, you know

96   [Yes]"I should have helped her more"

97   **P**   Yes but got help for her, for what I could see that was still difficult for her. "How

98   could I have been so awful to her?" /

99   **R**   Ooh….

100   **P**   /Yeah and it actually … now I don't. It's her life, her decisions, it's her choices it's

101   her mistakes, her pain that she has to live with, not mine to carry for her, so … she…

102   **R**   She's a grown up too

103   **P**   Exactly, so much so

104   **R**   So she could take responsibility for her own life/

105   **P**   /She's not old and senile, she's not somebody that you have to look after that and

106   who is dependable *[sic]* she's not young and naive, she's only in her 50s, /you know, she's … /and I

107   know that in 20 years time I'm going to be the same age as her, and I'm sorry, but 20 years ago I was

108   a better woman than she was at that time/ … so um … yeah, / I'm in a good place and I'm really

109   pleased to have got rid of that because … it was… it was … suffocating me through life … through

110   everything, through every decision I made. It was almost like that voice in my head, //not my inner

111   instinct, it was different from that, you have a gut instinct and you have that little voice inside you

112   that says "Ooh no, that's a little bit dangerous or that's exciting, go for it" but you know it wasn't

113   that, it was completely different, it wasn't in … it was in your main thought process; //these voices

114   were at the forefront of your mind all of the time, every decision I was making, things I was cooking,

115   things I was wearing places I was going on … Critical, judgemental, with preconceived ideas of what

116   was going to happen and it took up a lot of my thinking// … umm… and to be rid of that … it's

117   amazing, it really is amazing.

118   **R**   So it sounds as if all this space has been created

119   **P**   Yes, and I've now got the freedom to enjoy life

120   **R**   Yeah

121   **P**   And to move on and do things that I was held back from doing/

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Appendix Fi: cont'd.

| 122 | R | That's very interesting isn't it because there's all … /so what you're saying is there |
| 123 | | was always this sense of it being separate or different from you, not you, is that what you're saying? |

| 124 | P | Yes |

| 125 | R | You knew at some level that it was something else /but … it was so … it … it |
| 126 | | crowded out your own voice … |

| 127 | P | Yes/ |

| 128 | R | It crowded out your ability to listen to yourself and to listen to your own gut |
| 129 | | instinct, although that instinct was always there |

130	P	Yeah … you couldn't hear it you couldn't, you know you couldn't hear it; you could
131		shout and shout and shout but you couldn't hear your own instinct; / and it was exhausting and it
132		was draining and … and … it was really heavy … and it's interesting to have such a lightness

| 133 | R | And it's a lightness that it feels… |

134	P	A real lightness and/ … um … /and these sessions have been amazing in getting
135		rid of it. I know it's been long, and it's been working through and it's been quite difficult, but … it
136		hasn't been as hard as living with it has been.

137	R	Right, so it's … even the pain that you went through in those hours a week, plus
138		the processing you did in between times, that was difficult but it was wasn't as bad, you knew at
139		some level you need to do that because it was going to be easier … /

| 140 | P | /Yes … peeling back that onion |

| 141 | R | Yes |

142	P	Yeah you know and the layers are coming off … you know, until you get back, until
143		you've just got left that nice sweet bit in the middle, and you know you can't put an onion back
144		together/

| 145 | R | No…no you can't… |

146	P	/You know … so it's just kind of … that middle bit and that bit was me… and if you
147		imagine you can't get that little bit out when you've got all of that, all that skin, all the wrapping and
148		you can't get through, just putting that slice in, like you did, this therapy that allows me to see into it
149		and dig in to peel it back. And as I peeled it back, I got rid of it because I'm old enough to, because I
150		got support to do that … /

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ii   Extract from transcript showing meaning units and coding, Summer 2012

■■■ MEANING UNITS FROM TRANSCRIPT AND INITIAL CODING

Unit number	Meaning unit from transcript	Coding
64.	P Yes but I do think it was the right time I think it was a case that I had scared myself to such a point R Ah, you had to go so low, P Oh very much so. I got to the point where I was going to kill the love of my life; the person who has cared more about me in my whole life than anyone else, um, or kill myself which would have left my children without a mother which was the most painful thought you could ever have, um, to get that low and to be so close to doing it, to end up in a place, when all you had was your own thoughts, it was terrifying and it got to that point where that was absolutely it, it doesn't matter how painful; it doesn't matter what I'm faced with. I'm not skimming around; I'm not forgetting about it;	Got so low, and time right to address difficult things
65.	I don't know you, you don't know me I can just tell you anything and it doesn't matter, you're not going to judge me; you're not going to say "Oooh", you know you're not going to look at my kids, look at my house or, or anything like that, um, I'm just thought it's got to be done.	Not judged. No personal relationship. Needs to be done.
66.	If it's not done, then, in two or five years' time, when I break next time it's going to be much worse. And I, I'm not even going to tell anyone I'm going to kill myself, I'm not going to tell anyone that I'm going to cause hurt to someone. R That unpredictability is frightening is it P It's terrifying [R: Yes]	Fear. Unpredictability scary.
67.	P Absolutely, I couldn't speak to people. And I just thought what the point it's not right it really isn't right so I, so that made me work really hard at it because it needed working	Made her work hard
68.	I have skimmed it; I'd got therapy; I'd got CBT and, you know, laughed and joked about it R But that was putting a plaster over it was it, it didn't fix it? P No R Because until you look at it you can't fix it? P No	Previous therapy didn't work because didn't look at it properly
69.	I've had some good therapists but not, R Yeah, it doesn't mean they're not good therapists is that it, I mean CBT helps a lot of people but for you it sounds like you need to look at different things P Yes I needed to take it right back and that's what I did	Needed to take it right back and hadn't done that in other therapy

■■■ MEANING UNITS FROM TRANSCRIPT AND INITIAL CODING

Unit number	Meaning unit from transcript	Coding
70.	R What went on for you during those hours that was helpful - and I want to talk about what was not helpful - but I want to talk about what was helpful first P It was completely safe R Safe P Yes it was completely safe and separate, it wasn't in my home; it wasn't familiar and it wasn't your office. It was a room that could be used by anyone. I used this room to meet my children when I was in [psychiatric hospital], R Did you P Yes I have used this room for relaxation and for other types of therapy, this is just a safe room that is used by lots of people, and there's no stickers on the wall, there's no posters, there is no leaflets do you know, um, R So the anonymity of the room was part of what made it feel safe; part of what led you to feel you could bring whatever you needed to bring here P Yes	Safe, separate. Safe room. Used by others. Anonymity of room
71.	The fact that you're not suited and booted. [Laughs] Do you know I find that very difficult when I, [R: Do you?] yes, when I go and see someone and they're there in a pencil skirt and a shirt and a jacket, and I just think "You've got no idea. I'm not opening up to somebody who sits there in a suit and a collar, I'm not going to". I can't take them seriously	Not suited and booted. Can't open up or take seriously to them
72.	R Something about professionalism or presenting oneself as an expert or something? P Yes the specialist and very much so. Because you are just a number then, just a statistic. I know this is numbers that you don't look at me as if I'm a number, you know R I'm not doing numbers either. Let me just stop you there because I am not doing a statistical analysis, I'm doing a qualitative analysis, I'm looking at themes that come out of things that people say. I'm not going to add anything up because I don't think statistics gave a feel for people's experience P But that's what you get from professionals.	Not seen as number here unlike with other professionals
73.	I've loved it. Do you know, the fact that you come rushing in, with a pencil in your hair and you've been, you've been really busy and, it's, but you just, it's like talking to a friend, it's like talking to someone on the same level. You're not sat there in your prim and proper suit, and your back arched up and your body language is just natural, and, you know, you're talking to me like a person, as if you know, that's completely different, that's completely separate, there's no big desk in front of us and there's no piles of books and there's no stiff collars, you're not looking at me up your glasses and	Talking on same level as person. No barriers Relaxed, calm, friendly

Appendix Fii: cont'd.

MEANING UNITS FROM TRANSCRIPT AND INITIAL CODING

	writing things down as we speak, um. That I always found very, very difficult, very difficult, um, but the fact that you always were so relaxed, that you were always so calm, yet you had a very friendly persona and energy and body language [R: Right] made me really able to open up and talk to you, um,	
74.	along with the simple surroundings and, and, and, it being, it's not, this isn't your space, it's not my space; you don't come to my house; you. I don't come to your office, it's some, it's just a space to sit and talk	Simple surroundings, neutral space
75.	Well I trust you, I still don't know your name, I know it's Kirshen but I remember it every time I come in here someone tells me. I don't see you as somebody I will depend on, that I need to have in my life. I don't need to have your every week, that's completely separate, its professional and that aspect, um, I like the fact you've got a difficult name to remember R Do you? [Laughs] P Yes [Laughs] really because it sounds something, you know, like my [support worker], [support worker] is such an easily remembered name and, and you can over familiarise yourself to having a relationship with, which is slightly less professional, where you take her home you know R Right, yes so the boundaries are really different there. Our relationship is very boundaried isn't it P Yes	Trust. Professional relationship. Not dependent.
76.	I love talking to you and I find you very easy to talk to and I find you very comfortable, comforting, um, and all the rest of it and I'm able to talk to you about anything but I wouldn't, wouldn't, be desperately upset. In fact, I hope we don't have to see each other again. You know that it's [Laughs] it's been lovely meeting you, lovely talking with you and thank you so much for everything that you've helped me understand, um, and for that I'll be eternally grateful. But I hope I never have to see you again and if I do ever see you again I hope it will be on a professional level, but I don't ever want to see you at this level again, no. So the relationship for me has had its purpose, has done its role, but has ended with a clean cut. At the end of this therapy session, it will be clean cut and finished and then, if I see you again then obviously it's meant to be in a different time or place	Easy to talk to. Comfortable. No need to continue. Inappropriate to continue relationship. Served its purpose
77.	You probably know more about me than a lot of my friends, you certainly know more about me than my mother does and, um, so I do trust you and it's strange to have that trust in a stranger. But I think it's valuable and it has to be that way	Strange but valuable to have that trust with stranger
78.	I know I don't think I could ever go out in a social sense. I could work with you, very much I could work with you and I would like to work with you because I think that we could communicate well	Boundaries

MEANING UNITS FROM TRANSCRIPT AND INITIAL CODING

	together but I don't think we could ever go out together for drinks because you know too much about me on a personal level R No, it's just not appropriate P No there is issues, and,	
79.	I know there are issues with therapists because people become reliant on every Wednesday. This time slot I'm going to see that person, and it's going to be really like that. It was like that with [support worker]. She was like my mum, she was like my mum, she's older, she is in her 60s, she comes round, she kicks my butt, she tells me to get dressed and helps me with my house work, tells me I'm special, gives me cuddles, do you know. But she is my carer	Different from other relationships
80.	R That's not therapy is it P No. So to talk to her about the things I've talked to you about, that's one of the reasons, that was one of the reasons after all, that's why therapy, why I've still got it, that's it. I've never had the therapist to talk it through	Different from other relationships
81.	I've had the therapists behind the desks or the one I've looked at as my mother… R Yes P That I loved, R Either the expert or the person that actually… P That really cares for me, [R: Yes], that loves you and thinks you're a wonderful person and I didn't want to hurt her or upset her fact telling her I felt like that R That's it P And I didn't want to tell the therapist behind the desk that I had done these terrible things and I had these crazy thoughts.	Different from other relationships
82.	But I've had to say it out loud to understand it. So that's why, that's what led me here R Saying those things out helped P Yes	Had to say it out loud to help

iii   Initial coding for one participant, September 2012

INITIAL CODING 24.09.12

Initial coding 24.09.12
Voices in control
Voices and distress linked
Voices stem from mother criticism
Self-acceptance led to voices going
Hay-bale gathering negativity
Hay-bale unravelling; letting go; nothing to cling to
Making own choices without seeking M approval
Understands mother wrong but doesn't judge her
Voices suffocated her before
Critical voices always at forefront of mind
Freedom to enjoy life; not held back
Couldn't hear own voice or instinct
Exhausting; draining; heavy
Now lightness because of therapy
Long process, difficult to work through
Harder to continue to live with it
Peeling back the onion to find sweet bit in middle – her
Can't put onion back as it was
Therapy put slice in to allow her to dig in and peel back
More you listen to own voice, the more you get confirmation of self as right
Starting and planning new things
Confident and able to do things. Not scared
Worthy of being with people
Letting go of things that upset her or made angry
Can't fix everything; not responsible for everything/one
Wanted love/approval/fix things – doormat
Don't dislike self; moving forward
Risk and responsibility
Trust self as responsible adult
Getting rid of voices as motivation for therapy
Angry/low self-esteem/scared of harming loved ones/unable to cope
Therapy as different from other help which did not address real/underlying issues
Wanted to understand why/what happening
Therapy – freedom to do it her way. No expectation
Done gradually; no big changes; steady; unaware of it till reflect on it
Become more loving of self
Got so low, and time right to address difficult things
Not judged. No personal relationship. Needs to be done.
Fear. Unpredictability scary.
Made her work hard
Previous therapy didn't work because didn't look at it properly
Needed to take it right back and hadn't done that in other therapy
Safe, separate. Safe room. Used by others. Anonymity of room
Not suited and booted. Can't open up or take seriously to them
Not seen as number here unlike with other professionals
Talking on same level as person. No barriers. Relaxed, calm, friendly.
Simple surroundings, neutral space

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Appendix Fiii: cont'd.

INITIAL CODING 24.09.12
Trust. Professional relationship. Not dependent.
Easy to talk to. Comfortable. Inappropriate to continue relationship. Served its purpose.
Strange but valuable to have that trust with stranger
Boundaries.
Different from other relationships
Had to say it out loud to help
Her agenda; interpret/understand for self; structure/other understandings imposed in past
Need me to be separate from her own painful experiences; to get what she was going through.
She unravelled, I picked up what was going on; gentle prompts helped her take it further herself
Not clear what happened or what talked about but felt lighter and better
Not scared of feelings anymore; life normal now with ups and downs; happy to wait to feel; not looking for extremes
Never fitted in; only remembers negative stuff; low self-esteem; no good at things
Voices made feel powerful and special at first; became negative; retreated into anger/hatred
Negativity from parents/others; negative voices increased; low SE; bad choices confirmed it all
Psychiatrist and other professionals distant; didn't make effort to understand
Mentally ill; black sheep; negativity as symptom of mental illness. Made sense
Competition and anxiety about getting approval from mother; about being good mother
Deserved the rape; her fault; scared; stayed in house; to do with MI and low self-esteem
Therapy helped see behaviour because of trauma, not MI; gave insight into why things go wrong
Voices didn't go after CBT; decided had to live with them; taught to use distraction
Therapy helped her understand voices; sick of being controlled by them and scared of them
Relapse meant didn't believe therapy worked
CBT addressed physical not mental issues
Therapy helped her unpick and peel back
Engaged with voices and considered what they might be about; no attempt to get rid of them; didn't address them as such
Allowed her privacy to address voices on own
Freedom to talk about anything allowed her to make connections and sort out messiness; able to backtrack and sort things out
Carry on in between sessions and set her own agenda
Previously had too much structure and pushing from others
Pushed herself and set own direction
Understanding from past helped free her
Doesn't hurt from story now; has let it go; and the voices have gone too
Can now wait for feelings to come instead of forcing extreme feelings to happen
Wanted a diagnosis so could get right meds
Thought responsibility with me to tell doctor so professionals could control her with drugs
She would have had no responsibility for life or behaviour because of MI
Has waited years and wanted it so badly. Now wants to be responsible for self as adult
Strong part of her always been there but hidden
Getting better is living and moving on; dealing with life
Feels positive; found self; got her life
100% because of therapy
Come off meds; doesn't want to be drugged; can deal with life better if not drugged

2

iv   Examples of initial themes for individual participants, September 2012

UEL07 Initial themes 26.09.12

Got so low/scared
- frightened
- don't want to live like this any more
- time is right
- need to work

Therapeutic rel'p
- different from other help
- *no pushing or answers from others*
- *no aim of distraction/ elimination*
- *no tick boxes*
- *listen and value*
- non-directive/unstructured
- trust/understanding /acceptance/openness
- treat as person on same level
- own pace
- gentle prompts/not suggestions/ not answers

Kickstart own process
- unravelling hay-bale/ peeling the onion
- can't be put back in same way
- get back to underlying issues
- understanding what was happening
- process in between sessions
- felt lighter

Changing rel'p (Before ≠ after)
- with self - Increasing self-acceptance
- with others
- with voices
- responsible adult with choices
- MI not a reason or excuse
- trust own voice - cumulative

Appendix Fiv: cont'd.

UEL02 Initial themes 28.09.12

Experience of voices	Experience of therapy
Lack of trust/betrayal	Trust
Not safe/dangerous/fear/terror	Safe/no fear
Pushed/controlled/powerless/no choice	Not pushed/in control/choices
Unease/discomfort/distress/stress	Ease/comfort/relief
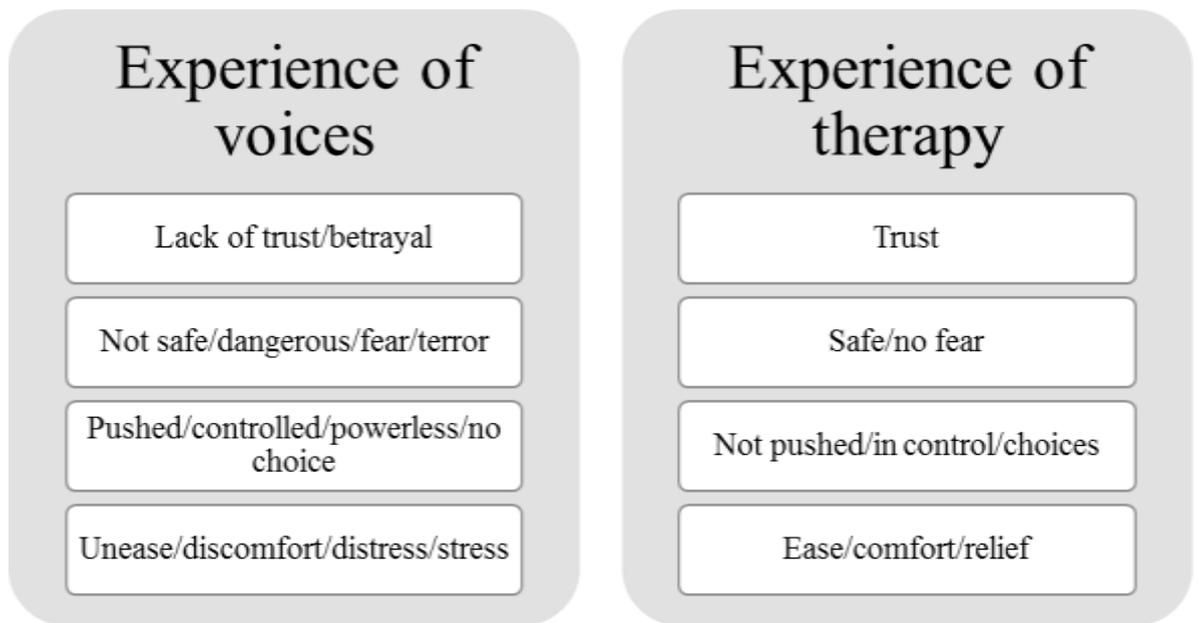
UEL09 Initial themes 05.10.12

Voices & Events				
distress	exhaustion	anger	negativity	low self-esteem

Tried to ignore

Therapy explored and facilitated				
Knowledge	compassion	openness	engagement	respect

Acceptance & healing		
voices positive	others - compassion & forgiveness	self - respect & love

v   Initial codes and themes across all participants, Autumn 2012

INITIAL THEMES - ALL PARTICIPANTS 10.10.12

Participant	Theme	Theme	Theme	Theme
■	surprise	intertwined but different	trust in self	
■	trust	safety	ease	choice
■	unpicking, untangling	being valued and free	to integration and partnership	
■	unravelling the hay-bale	kick-start own process	changing relationships	
■	hard to do	prefer guidance	made no difference	
■	facilitating compassion and respect	distress and anger to joy and love	confront not run away	
■	drug induced psychosis	just another case	bouncing board	
■	from denial and confusion to acceptance and understanding	finding the right words	less worry and thinking	
■	surprise and scepticism	understood	no big difference	
■	getting control, not getting rid of voices	repair job	giving time to talk it out	

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Appendix Fv: cont'd.

INITIAL THEMES - ALL PARTICIPANTS 10.10.12

Being valued and free
bouncing board
changing relationships
choice
confront not run away
distress and anger to joy and love
drug induced psychosis
ease
facilitating compassion and respect
finding the right words
from denial and confusion to acceptance and understanding
getting control, not getting rid of voices
giving time to talk it out
hard to do
to integration and partnership
intertwined but different
just another case
Kick-start own process
less worry and thinking
made no difference
no big difference
prefer guidance
repair job
safety
surprise
surprise and scepticism
trust
trust in self
understood
unpicking, untangling the mess
unravelling the hay-bale

CHANGE/PROCESS - Unravelling hay-bales and seeing things differently –SURPRISE/CHANGE IN VOICES/SELF/REPAIR JOB/DIFF CHANGES FROM INITIAL WISHES/NO CHANGE/UEL02 STILL GOT S.THING

SOMETHING ABOUT REL'P - You listen and I could talk openly and you knew where I was coming from; you can know exactly what I mean sometimes – RANGE – NOT ACCEPTED FULLY/FINDING RIGHT WORDS/DEPTH OF REL'P ACCORDING TO CHANGE OR WILLINGNESS TO ENGAGE

WHAT ITS LIKE TO DO - It's hard but... RANGE OF EXP – WORTH IT/NO DIFF/WANT MORE GUIDANCE/SURPRISE WHAT GOT/DIFF FROM OTHER SERVICES (dies this go here or should it be separate theme?)

VOICES??- do I need separate theme? It is so interlinked with most people's change/no change. Maybe it is worth separating for that reason – so I can comment on it being interlinked with process and that change/no change was according to depth of engagement and that the change was idiosyncratic

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vi   Interim themes and clusters of meaning across all participants Summer 2013

SUMMARY OF INITIAL THEMES AND CLUSTERS OF MEANING 07.08.13

What it felt like - different		What happened -
It's not like that with anyone else	*It's not what I expected*	*From chaos.com to a repair job in the Last Chance Saloon*
I did it in my own way, at my own pace/You didn't push me to talk about the voices/I've had too much structure in my life so it really helped	I thought you would talk more and tell me what to do	Chaos.com/Desperate/Last chance saloon/Losing self/Out of control
You got where I was coming from/You stayed with me when I was scared/You helped me find the right word when I was struggling/You knew how important those things were to me	I thought we would talk about the voices and you would tell me what to do to get rid of them	Unravelling hay-bale/Untangling big ball of string/Putting building bricks in place/Filling in the gaps/Looking at things differently/Confronting, not ignoring or pushing away
You gave me the time and let me talk/They just say it's my illness and give me tablets/They just tell me to ignore the voices/	I didn't know what to expect	Seeing things differently/Learning to accept self/Doing a repair job/Organised thoughts/ Understands things/Making sense of things
You treated me as a normal person/You accepted it was valuable just because it was my experience	I didn't expect this to happen/I don't want to lose them now, they are part of me and there've been good times/The voices are positive now/I know I'm not ill and it is the just the way I am and that's ok	In control/ Calm/Relief/Eased pressure/Organised thoughts/Integrated self/Found self/Self reliant/Trust self/ Strength to cope
Offer to engage with/reflect on voices	Reflected on voices and made connections/Or didn't	[No] Change in voices/relationships

List of analysed themes and clusters of meaning	
Dealing with voices	Voices in therapy-engagement/discussion of
Feelings about voices	Last chance saloon
Reasons for starting therapy	I didn't know what to expect
It's not what I expected	Understanding empathy
But then I'd come in here, and you were here, and...	You got where I was coming from
Summary of relationship themes 28.05.13	Quality of presence
Trust, closeness, mutuality, professionalism, boundaries	I did it my own way, at my own pace
Unravelling the hay-bale/untangling big ball of string/filling in the gaps/putting building blocks in place/doing a repair job	You helped me through in those ways...just not in the way we set out to
Outcomes	Therapy as an add-on to treatment for mental illness/subsidiary
Worldviews	**Differences**

IS A KEY THEME UNDER DIFFERENCE THAT WE WERE OPEN TO VOICE –DISCUSSION & ENGAGMENT?

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Appendix Fvi: cont'd.

SUMMARY OF INITIAL THEMES AND CLUSTERS OF MEANING 07.08.13

Chaos.com/Desperate/Out of Control/Losing self

Into the Last Chance Saloon

To get rid of voices	To confront things	To do reflective analysis	To help in coping with illness

What is was like

I did it my own way at my pace	You knew where I was coming from	You gave me time and let me ...	You treated me as a normal person	You stayed with me when I was scared	Openness to voices

How we did it

Unravelling hay-bale/ Untangling big ball of string	Filling in gaps/ Putting building bricks in place	Confronting issues never addressed before	Making sense of things	Looking at things differently	Getting to know voices

What happened

Order/ Integration	Calm/ Relief/ Pressure eased	Repair job/Find, Accept, Trust, Rely on self	Strength to cope	Under-standing/ Acceptance	Change to do with voices	Just the same

DIFFERENT – from other treatment, relationships and expectations

Understanding and meaning of voices before therapy

They're a symptom of mental illness I have because : • I was born with it • My weakness • I'm evil • I'm being punished • My head injury • I don't understand why and it's unfair	The voices are separate from me	They are spirits in distress	It is a supernatural entity; my higher self and he was in control	They are part of psychosis brought on by heavy drug use

Understanding and meaning of voices after therapy

I'm more able to manage the voices	I don't want to lose them anymore; they are part of me and there've been good times	They're positive now. I talk to them as if they are people	I am now integrated with my higher self. It's a partnership now	I came to see they were parts of me that I don't need any more	Voices are the same	Voices are gone

2

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vii   Description of interim themes, Summer 2013[36]

INTRODUCTION TO THEMATIC ANALYSIS

Themes

The following five main themes seem to encapsulate the experience of therapy and of hearing voices for the ten people in this study. Each theme will be introduced briefly then will be discussed in more detail using Ashworth's (2003, 2006) fractions of the lifeworld as a research heuristic. (See pp and Appendix ?? for more detail). Not all fractions will be evoked to the same degree in every theme.

I was desperate and would have tried anything (Katie) this was to do with people feeling desperate, out of control and as if their lives were chaotic at the start of therapy.

I didn't expect it to be like that (Rhiannon); - this was to do with a sense of surprise that people felt about the format of sessions, what they chose to focus on and what they got out of therapy

You're talking to me like a person ... that's completely different (Paula); - there was a strong sense of this therapy being different from any other relationship people experienced. It referred especially to contact with other people working in the field of mental health, but also to personal relationships.

It was like untangling a big ball of string (Fabien); – the process of therapy was described in terms of a move from chaos to order, from confusion to clarity; from lack of understanding to making sense of things. It meant things had to be taken apart before they were put back together in a way that made sense or was organised in a different way.

I'm more compassionate towards [my voices and] others, and I've learnt to love myself (Tina); - the final part of the experience was the development of new relationships with their voices, with others and with themselves. This did not always involve changed circumstances but was often about looking at things differently, and lead to feelings of relief, calmness, solidity and control.

I was desperate and would have tried anything

It does not appear to matter how people viewed their voices or what their understandings of the causes were, all felt a sense of desperation when they came into therapy. People talked of feeling *out of control*, that their *life was Chaos.com*, and that *nothing was helping* – therapy was described as *Last Chance Saloon*. They did not feel they had the *strength to cope* and some talked of feeling they were *lost*, that they were *getting smaller*, that the parts of themselves that coped were *being suffocated*. Alongside this was a sense *of weakness, exhaustion* and *feeling drained* and, in many cases, *fear* that they might hurt themselves or other people, sometimes because that was what their voices were telling them to do.

Some people talked of being desperate to get rid of – or, at least, control - their voices. Others wanted to explore longstanding issues that had never been addressed or which re-surfaced when they were feeling particularly vulnerable and increased their suffering.

Participants struggled to understand the meanings and reasons for their experiences, which felt confusing and threatening. They were fearful about what was going to happen to them, of how they were going to be treated. People believed that others did not understand them or what they were going through. They experienced powerfully the negative judgments passed on them by others because of their connection with mental health services and/or because they heard voices. Indeed they often passed those same judgements onto themselves. People talked of feeling *isolated, rejected, very lonesome*. They felt they were considered to be *a loony, a nutter, a black sheep, a freak*.

For most people there was a sense of needing to make sense of things, to make things change and get back in control, whilst not knowing how to go about it. For others there was a resignation to things staying as they were.

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[36] This document shows my attempt to describe some interim themes I identified. The format of the final themes has changed substantially because the question of HV was not, originally, sufficiently represented. But I think the initial overall sense permeates the final analysis.

Appendix Fvii: cont'd.

INTRODUCTION TO THEMATIC ANALYSIS

I didn't expect it to be like that

There was an element of surprise about people's experiences of therapy. This was partly to do with the form it took; but also to do with the work they ended up doing and what they got out of it.

The way therapy was encountered and engaged with varied from those for whom the freedom to direct the process of therapy was a welcome relief, to those for whom it was scary, confusing and too different from the way in which they were normally treated by 'professionals'.

Some participants had clear aims for therapy and were either surprised at what they ended up working on or at the things their exploration affected. This was sometimes connected with their voices, but the confidentiality of sessions also affected what they discovered they could do in therapy and the things that came up for them. Furthermore, some people found that a) they were able to talk about things they had previously felt it would be better to avoid and b) that it helped to do so or that those things were not as bad as they had previously feared.

People's expectations of outcome varied. Some were surprised that it had had any effect at all and said that they had been *cynical, sceptical,* that they knew *that therapy didn't work* beforehand. Although two people felt disappointed that they had not experienced any change and therapy had not helped, this did not appear to be a surprise and they had not really believed that anything could be done to help and were sceptical that any therapy could help, let alone one that relied on them, as patients, to lead the sessions. Only one person said she had found it helpful before so wanted to try again. One other person was expecting his therapy *to be different from psychiatric services* and, so, a more positive experience for him, though he did not know what that might be.

You're talking to me like a person ... that's completely different

People found that their experiences of therapy were very different from their relationships with other professionals working in mental health services and from the way they felt they were treated or regarded by society as a whole.

In therapy, they were offered *the chance to talk*, they were *listened to* but *not pushed* and *could do it in [their] own way.* Furthermore, it was a new and positive experience for people's experiences to be accepted as they were without denial, distortion or dismissal. It felt humanising and one said it made him *feel like a normal person.* It was very different from the usual sense of negative judgements being passed on them by others, including mental health professionals and, even, by themselves.

The clinical team were focussed on symptom elimination via medication; EIS focussed on practical skills for re-engaging with life after hospital; the roles of care workers and CPNs were to help people cope with day to day at home. The focus of therapy, conversely, was on the person herself and it was seen as separate from other care. Also, information gleaned in clinical consultations was usually shared amongst large teams of people so the *safety, confidentiality, privacy* of what we talked about in therapy was something that was treasured.

The counselling space, although part of the hospital, was seen as being different from *cold, clinical rooms* that they went to for other treatments – even if they regarded hospital as a place of retreat or refuge. People felt it was a place of security, *calm* and *relief* from the *pressure cooker outside; separate from the outside world,* a place where they could be who they wanted to be.

Some people, however, found the contrast between person-centred therapy and other aspects of care disconcerting and unwelcome. They preferred the role of patient being treated by an expert who would make the voices go away. The experience was, thus, in many ways for them, a disappointment. Even these people, though, still valued the opportunity of spending time with someone prepared to stay with them and listen to them.

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Appendix Fvii: cont'd.

INTRODUCTION TO THEMATIC ANALYSIS

It was like untangling a big ball of string

The process of therapy was seen as one of *unravelling, untangling, unpicking, looking at things differently, getting a second look at things*. The next step was one of *putting blocks in place, filling in the gaps, of getting more solid, of self growing back, of getting back in control, of doing a repair job*.

For many this involved making connections between things that had happened and what they had previously thought those things to signify. It was about sorting through distressing issues and coming to a new understanding about them. This was usually to do with how people felt about themselves, events and relationships. People talked of having the time, and feeling able to make sense of things which led to an easing of their chaos, confusion and desperation.

The way it happened was through a sense of feeling safe and secure in therapy sessions, such that they could explore deeply distressing and difficult things in a way they had not done before. That experience of being offered, and becoming able to receive, a respectful, accepting and reliable relationship was often a new experience for many of these people. Boundaries were also an important part of that as many people had experienced a lack of boundaries which led to unreliability and inconsistency in previous relationships. In learning how to be in such a relationship people found they were able to make sense of their experiences and come to feel differently about themselves, their voices and other people.

It was seen as a difficult process but one which was necessary. It was also seen as being led by them and focussed on what they needed to do. It was accompanied by a sense of tiredness, yet lightness and relief after each session. The overall feeling was of a move from chaos to order, from disintegration to integration and from confusion to understanding.

I'm more compassionate towards [voices and] others, and I've learnt to love myself

The final part of the experience for most people was the development of new relationships with their voices, with others and with themselves. Often, this did not involve changed circumstances but was about *looking at things differently, getting a second look at things* so they could be re-assessed, *making connections, finding solutions, learning to love, respect or accept self*. It led to feelings of *relief, calmness, solidity, of finding self again, of self growing back*. It was reflected in the way people felt they could relate to others. People felt more *understanding, compassionate and empathetic towards others*; that they *wanted to, and were worthy of, spending time with other people*; that they could *value family*; that they could *connect with* others; that they could *start a new life and make plans*.

Similar feelings attached to voices, if still present. People talked of feeling they *could relate to, or negotiate with*, voices; they felt *able to manage* or *control* voices; they felt the voice *became integrated into* or was *part of* self; that voices were *positive, beneficial or unthreatening*; that they were *in partnership* with their voice.

This was not the case for all participants. Two people valued the *chance to talk*, to *offload [my] thoughts* and that *someone was prepared to listen, to stay with [me] when [I was] scared*, and said it made them *feel normal*. But they did not experience any changes in their understandings of the voices or in terms of how they felt about the voices or themselves. They said there had been no change in the way they experienced the voices, or there felt different in the session but that it didn't last. One person just did not feel any differently about herself as she had decided therapy was not relevant to her and did not need to make any changes.

3

viii   Themes and sub-themes, Spring 2014

Themes and sub-themes identified in thematic analysis			
ADDITIONAL THEME PRESENT THROUGHOUT Surprise at what happens and at the effects			
THEME	Wanting things to be different	Being treated like a person	Therapy as work	Changing relationships
Sub-theme	Feeling life's too hard	Feeling valued, not being judged	Confronting distress, examining mess	(Re-)discovering qualities of myself
Sub-theme	Voices causing distress	Having someone to accept, understand, bear witness	Making connections, making sense	Coming to know myself differently
Sub-theme	Impact of medical explanation	Being able to talk about anything	Finding personal solutions in my own way	Changing relationships with others
Sub-theme	Knowing it's time to act	Working from my frame of reference	Comparing outcome with original aims	Changing relationship with voices

ix   Summary of themes across fractions of the lifeworld, Spring 2014

Table of fraction summaries across all themes 02.04.2014

Fraction	Wanting things to be different	Therapy as unique way of relating	Therapy as practical work	Changing relationships
Selfhood	Voices in control Not in control; unable to change things Unable to rely on self Lack of self-respect or self-esteem Losing sense of self; unable to hear own voice	Allowing agency = positive/ scary Too much structure elsewhere	Helped to have someone there – working out why Only by thinking and engaging could work out what it was about. Never thought about who voices were before – helped Muddle, needed to untangle mess. Used session as focus to rationalise, organise, filing cabinet Carry on between sessions – paula and tina Feedback and reflection helped – aisha, tina, Rhiannon, Fabien, paula (without words) Tired after session, hard work Feel lighter, calmer, - contrast with heaviness before. DIFF TYPE OF EXHAUSTION Learn to listen to self and meanings for self – lessen the fear, see as minor prob	Trust in self Stronger, more able to cope with life/voices Likes self/compassion for self More able to stand up for self and protect self Aware of what lies in realm of responsibility Confidence More in control of life/voices Ok to have sadness or negativity at times – realistic – don't all have to be perfect Still fearful of future because of scz – though now has understanding and knows how to look after self Pleased with self for working so hard and successfully at problems – all adds to feeling positive about self – sense of achievement? No change
Sociality	Feeling isolated Feeling like a freak, different Feeling judged, misunderstood, unsupported, rejected Wanting to be in relationship but scared	Treated as person not number Listened to, valued, respected, trust In control	Not being pushed. Work out why. Opp to talk made feel better and think about things not thought of before (Olivia). Second look, fill in gaps, building blocks, look at it differently, -ABOUT FEEDBACK Making sense by unravelling TO DO WITH ABILITY TO STAY WITH IT BECAUSE FELT SAFE. NOT PUSHED. NOT THREATENED SO MUCH. FEEDBACK REINFORCED OR	Able to be self in relationship with others – not people pleaser Not responsible for others Making connections and sorting out muddle Now able to make friendships freely – worthy of being around people Feeling connections with people after isolation

1

Table of fraction summaries across all themes 02.04.2014

	Wanting things to be different		Therapy as practical work	Changing relationships
	Difficult to establish or protect relationships		CHALLENGED TO RIGHT DEGREE. ENABLED TO CONTINUE TO PUSH SELF. Talk of cllr as help but they did work selves Ability to say anything helped aisha to bring things out she needed to look at and then find own solutions – same with Olivia and others Second look for Robert whereas before had only own thoughts and feelings – witness and additional reflection and someone there accompanying them into dark places Fears not realised when was brave enough to look at things	Still isolated because of scz but understands what to do to keep self safe and well Things the same but think of them differently – Olivia family/Paula mother/Tina voices/ Robert and Fabien – want to keep voices but now more in partnership rather than controlled by them No change with voices or lives and relationship Learning to trust therapist helps person feel stronger and gives sense of achievement – helps to feel good about self and more able to cope Sense of achievement from therapy helps towards feeling worthy of being with people and avoids people taking advantage
Embodiment	Scared; sad; angry; weak; confused Heaviness; exhaustion; feeling drained Disorientating; unable to concentrate Painful without any reason Feeling stuck; unable to move or change	Calm, secure, safe, in control, trust	Sessions with boundaries as focus and not going off at tangent; and motivation to proceed and push further Talking out loud effects - Relief when did say it out loud – Katie/fears not realised Robert/ able to feel more loving to self after accepting therapist feedback Tine/reassured by therapist presence Katie and Elaine/relieved pressure Robert, Fabien, paula Lightness after peeling away layers – tina, paula Unravelling meant could see things more clearly	Stronger, lighter More in control More confident, assertive Think differently about things though things the same – more understanding that is is scz so doesn't have to be so scared. But brings with it other fears eg how to be in intimate relationship with someone Feel safer and more able to cope – even with difficulties and scary voices More trusting of self Likes self More empathic and compassionate of self and others

2

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Appendix Fix: cont'd.

Table of fraction summaries across all themes 02.04.2014

			Calmer so can see things more clearly – fabien. Not muddled. Helped to organise by reflecting in structured way Fabien – analysis with someone to help and listen and understand to help him get clarity – KR ahead of him in analysis Ack of awfulness or importance of things for Katie and Fabien helped them re-assess Tina- talk it out and look more closely. Same as aisha and paula – envt allowed to look at things previously avoided as too scary – like Robert. Also Olivia who came to look at things differently even tho situation the same Struggling and negative before. Cllg helped to reflect and see self as better. Voices lose power as 'just' symptom-aisha. Robert – fill in gaps help self get stronger and help self to control voices and start to feel diff about voices so no longer want them to go Katie – easier to manage by having strength to explore them with me/paula they lost power as she started to question introjects and relp with mother; Fabien explored personal things which confirmed deep experience of them that had been blocked. As felt less muddled he had more space to engage differently with voice that lead to partnership; tina confront rape and her part in it. Felt better about self; able to offer self, voices others compassion and empathy Talking/reflected back/thinking about things – help focus better and get self thru	More aware of limits to responsibility Less scared Sense of achievement thru doing difficult work. More sociable – more in connection with others

3

Table of fraction summaries across all themes 02.04.2014

			difficulties. (illness for aisha). Help positive things or how to overcome diffs	
Temporality	Variation in duration of suffering Crisis leading to other problems resurfacing Desperation as catalyst for therapy Resignation of living in desperate state	Never treated like that before	Timing – right or not varied Session time – set by cllr; want longer; gave focus Process according to client timescale – not pushed	Change or not change according to work done and changed relationships
Spatiality	Hospital as place of refuge or forced imprisonment and restraint Appropriateness of hospital care for needs Contrast with therapy room Different therapy rooms	Calm in cllg room Private safe	Anonymous space/separate from ward/enclosed from world	Cllg room – safe and separate space to explore new way of being and then to practice relationship based on respect and trust and care – for me and for self – as well as voices Effects on space of new way of being – able to go shopping, engage with people Brave, confident, lack of fear, Organised, not chaotic or muddled Sure of self and limits of responsibility – as well as what is right for them – be true o self in all areas Impact of new way of being intertwined with space in sense of noticing what is around her eg Katie with husband, new house, animals; Rhiannon with new flat and job showing her that old issues were not important – but she had needed the retreat while in crisis. when she was better she could leave it behind

4

Appendix Fix: cont'd

Table of fraction summaries across all themes 02.04.2014

				Also a space to 'leave things in' that were scary or unpleasant. Not all did this – Paula used it as a kick start tho did like anonymity of room – more to do with me having no associations for her so a new blank sheet or relationship to work on or to use to explore what she needed to explore?
Project	Urge to regain control over life vs reliance on professional help Want to establish order, gain understanding Desire to address issues Need to manage or control voices Cynicism or fear about therapy	Not helped/ T not expert = +ve/-ve Cynical at first Confront not ignore	Organise thoughts, sort out muddle, clarify, help to push self/ needed to do it/see things diff/look at things not looked at before Previously too scary – avoided/ignored Could offload and leave in room Focus on what most pressing/not pushed/did in own way/decided what to talk about Talking about unrelated things made connections impact feeling about self and others Helps to see what don't need to hold Focus on client; structure of weekly session help keep focus – right time so had strength Do in own way and not pushed Make sense and make connections – affects feelings about self and others	Project sometimes different at the start Often to do with getting better or getting rid of voices What they ended up talking about gave them something else- often to do with new relationships with self, voices, others. Regarded as much, much more Or no change – no discussion of relationships Or not a massive impact – initial aim to work on old stuff – no longer important. No talk of relationships as such for Rhiannon
Discourse	Voices are real Understanding of voices as symptom or spiritual Impact of conflicting views Impact of HV on identity & relationships	Person not number/patient. No focus on symptoms Chance to offer own view Voices welcomed/engaged with	discuss 'allowing' by therapist cf session boundaries too – Katie/Fabien/tina/paula/Robert/ Easier/not to cope if symptom – varied – Olivia/aisha/Rhiannon/paula/Robert Increasing strength to address voices or discuss them – Katie and Robert scared at first Metaphors – lots here Making connections – lots of egs	Project sometimes different at the start Often to do with getting better or getting rid of voices What they ended up talking about gave them something else- often to do with new relationships with self, voices, others. Regarded as much much more Or no change – no discussion of relationships

5

Table of fraction summaries across all themes 02.04.2014

	Connections between voices and distress			Or not a massive impact – initial aim to work on old stuff – no longer important. No talk of relationships as such for Rhiannon
Mood-as-atmosphere	Sense of chaos; out of control Inability to rely on self or to trust others Isolation; rejection Effects on self, family, others Ways in which feel received, accepted, judged	Valued, respected, safe, private, humanising	Relp enabled to talk about things that surprised them and effects surprised them too Relief/difficult/exhausting but felt better Carried on between session Intertwined with other help for Olivia/all therapy for paula	Exploration in trusting and accepting environment enables increase in positive self-regard. This builds belief in ability to cope even with difficulties. Also enables realistic take on life – its ok to be sad or for things not to be perfect. Exploration also brings clarity and order out of chaos. Needs bravery and courage to do it. Hard work too. New relationship with self also enable new relationship with others. Realising you don't have to accept things that do/did you harm. Don't have to accept others' narratives. Thinking differently about things even if situation remains the same Getting better about relationships not getting rid of voices

6

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x   Extracts allocated to 'Project' fraction – 'Difference' theme, Spring 2014

PROJECT

P Um ... I think it's had a big impact. I've had a lot of support which has really helped. Um ... yeah, I just think it's been really really helpful, what's been offered to me/ 19.The early intervention people They've been great they've been really really good they've been really really supportive. / 20. Um ... I meet up with my caseworker once a week just to have someone to talk to Um ... I've been seeing the psychologist with them and am I've seen the consultant a couple of times .../ 21. Um ... from when I first came to [home city], yeah right so then nearly a year/ 22. R /the psychologist, how often do you see her? P At the moment I'm seeing her once a week/ R /Right and what sort of stuff does she do with you? P it tends to be more focused on ... um ... ways in which to move forward and sort of coping strategies and things like that 23. R And the caseworker ... what does she do with you? P Um...well we do things like... um ... will go out running or will go swimming/ 24. R /okay so that's alongside any medical treatment is it? P Yeah/ 25. Yeah they referred me onto the team in [university city] and take it from there really. It depends what they think is appropriate/ 26. Um ... I'd like to still have contact with with them. I'd like to still see a psychologist if possible	OLIVIA
this is the only place where I talked about how I feel really. (Right) Um ... and where I talked about the past that's something I haven't done anywhere else/ 29. it's been really helpful... um ... it's been ... it's just ... it's been difficult but it's helped to have the opportunity to talk/ 30. Um ... (long pause) it's pretty hard to describe ...um ... (long pause) I suppose it's helped me to have the opportunity to talk about how I feel because I haven't had that opportunity anywhere else/ 34. yeah yeah it does... um ... it has been hard but um ... there have been times when I have made myself do it rather than do it because I wanted to do it 35. /Um... but I don't regret doing it/ 38. Um ... there have been times that I felt I didn't really want to answer questions... it was just too... too difficult	

You're talking to me like a person...that's completely different 1

PROJECT

I suppose I saw you as something separate Um ... [long pause] I didn't see you as being part of the same team that the doctors....that the doctors are working on and stuff/ 193 ... It's ... it's different [Pause] there is ... there's a different focus 194. [Pause] their focus is more about ... medication and ... things like that. whereas yours is more about the person. / R rather than ... the ... symptoms of the person I suppose? P Yes exactly 195. R /what is the focus of the early intervention team? P Very much on the symptoms	
well it gives me more opportunity to explore the voices. Whereas my other counselling has been based on the rape at the rape crisis Centre and ......I know but sitting with you, you know, sometimes it is a comfort. Because I know that when I am hearing them, I feel safe	KATIE
if people push me to talk about the voices I won't talk about them.	
I wonder how much also the fact that we had started working on those files... P it was hard letting you in R go on...go on can you say some more? It was hard letting me in ... P ... on some really deep stuff R and that, for me, was such a privilege that you felt able to do that and it's something that was very important to you. It was a big deal that you were able to do that P yes R thank you that's wonderful for me. I wonder why it happened P I don't know there's not many people I do. It just felt safe	
What did they suggest you've getting rid of the voices? P Nothing they just kept increasing the tablets. R Right they just kept saying take more meds and you'll get rid of them P yes R did they work? P No R right um ... and previous counselling looked at the rape but didn't look at the voices? P No they weren't trained in that sort of thing and.... R right the fact that you heard voices as well P yeah so I had to stop my previous counselling	

You're talking to me like a person...that's completely different 2

Appendix Fx: cont'd.

had anything helped in the past? P Self harm … usually that 10 or 15 minutes of silence … it feels as if you're deaf …you can't hear anything R so it's a good feeling? P You get an adrenaline rush R right an adrenaline rush. So it's not peace that you get then? P Yeah well I get the rush but it's silent, it's calming … R okay … powerful? P Yeah it makes my heart pound R you feel you're back in charge of stuff? P Yeah but that 10 minutes goes past and they start again. That's why, in the past, two or three years ago all I ever used to do was self harm. All the time. Constantly. ….Constantly. At least every day I would stub a fag out, every day…. I think when I was admitted here once, I was sectioned, I was up at the [Name of general hospital] four or five times a week having staples … R an incredibly difficult time for you P but that kept my voices … quiet … even when I just stubbed a cigarette out	
no…it's just having someone sitting there and listening	
know …it happened before in counselling I have done that before in counselling … when I was at school where my counsellor was P I was talking and I got scared and I was only, what, 14 and I hid under a chair and she left the room and I got freaked out she went to get the doctor… and left me in there on my own and I was hallucinating so I just wrecked the room … I was petrified P yeah she just left me and went to get a Doctor… and that's about five or 10 minutes… and I was hiding under a chair … I was hiding under a chair at that point because the rape had only just stopped … and it was still going on with [Name of abuser] at the time … so I had seen [Name of abuser] the previous night and knew I was going again… I was terrified, I was hiding under the chair and she just left me … so that's why sometimes when I come here … I feel safe because I know you're not going to leave the room … so I feel like I can talk about it P it's because I'm so used to it from when I was younger … doors always closed as [Name of abuser] would come home … it's like when I was in that counselling that time … with my old counsellor when I was 14 and … because it was in the surgery I was scared … it was always in and out of doors and this door slammed really hard and I flew and hid under the chair … I just got under the chair and she just walked out… and that scared me … you know, being left alone … knowing that I hadn't even gone to court at that point and I … [Name of abuser] could see me whenever he wanted and I was … everytime I heard a door in foster care or counselling or … even at school when teachers come in and I'm not focusing … and I can hear it	
At my last hospital we had psychology and, you know, CBT and [IT WAS] Helpful … you learn different ways of coping …the counselling you can just talk about what you want to talk about really…yes I suppose CBT helped me more	ELAINE

You're talking to me like a person…that's completely different 3

P Yes … I didn't want everybody knowing my business	GARY
It fitted in all right… because one week I had was quite busy and the next it was a bit quiet. Because one week I was doing two days at the day centre and then I was coming to see you and get my drugs and then Thursday I would be out with the social worker and then the following week [Recording unclear]	
P Er I don't know… I probably talked moreUm … I don't know. It was more comfortable I don't know ….you sort of understood and knew where I was coming from and stuff	
had been previously offered help, yes. Um … Didn't find it helpful	RHIANNON
[THIS TIME] and because they were kind of more fresh and relevant as well so I thought it might be easier to connect with… and the relation of time between me feelings these feelings a gain and counselling this time was a lot shorter than it was before	
I think um … Particularly with friends who have kind of actually been there in the shitty times…um … They really have seen how it affected me and they can really have a greater understanding of it than probably any counsellor ever could	
I feel that mental health is generally quite … You kind of sit down five minutes and you talk to someone and then the doctor goes away and he decides what you've got and he gives you medicine for and it's so impersonal and it's so … And it's just … It … They don't really understand that every case is so dynamically different and what really needs to be done about it is kind of … For a counsellor to be sitting in talking through all of it, and I think probably a lot of medication wouldn't be needed if they'd provide counsellors instead.	
I mean a lot of mental health I think is triggered by stress and by um … I mean obviously it's … It's underlying in you but it's … It's brought to the surface by stress and difficult things that are happening in your life. I think if you are counselled over those um … Then you can overcome your episode	
and maybe occasionally to accept that medication … And pumping you full of medication is not the answer. And if you refuse … Like if you're sectioned and you refuse medication, you get it anyway. You understand this it's it is not the way to do things in my opinion, absolutely … Criminal … That drug pushing should be illegal on all levels …	
Well they [DRUGS] helped… I mean … They did the job, you know, they shutdown my Dopamine receptors and they… They um … Stopped all the paranoid thoughts and things like that so they actually worked but it's not the method to the outcome that I would have chosen	

You're talking to me like a person…that's completely different 4

Appendix Fx: cont'd.

PROJECT

Some people would choose to have the drugs, I just choose to have the meditation, you know,… And I think for mental health to accept that people have choices like that, and can make choices like that, and that there are other options than just pumping people full of drugs um …And yes, and she has meditated her way out of paranoia, she just went and did a retreat. She came out of here after three weeks and she just kind of threw the hat in and said "no … This is not helping me, this isn't working" so she went and did a buddhist retreat instead um … And after two days it … The paranoid thoughts had gone and she has come back and she's refreshed and she is bright and she's spritely…clinicians needing to take account of individual circumstances And their choices and their belief systems and all sorts that…. But they don't and they just think drugs are the answer when actually there are several more answers than just drugs	
Yes, yes I think it did actually … It did I think that the two experiences of counselling did work in similar ways. Um … In the way that it just wasn't really relevant. Um … Yet I felt I connected with you on other topics um … Far better … And … You helped me through in … In those ways, just not the way we initially set out to …	
… I think they dragged me back to the issues of abuse and it wasn't relevant so therefore the entire session of counselling wasn't relevant…Um … It's not that no one was … Well … Yes kinda um … It was that I just didn't have anything new or fresh to say about the issues that had happened and um … And yet week after week that's all they wanted to talk about. And yeah, I probably had more pressing issues in some kind of twisted scale of … Of importance at the time to deal with, other than .. Yes … Because actually, you know, it's quite important to … That you … … To work through … That you have been abused but, when that … That kind of lies alone and subsides for a while other things become more important that aren't actually, maybe in … A far-off view … More important, but at the time they seem more important.	
[COUNSELLING] It played a part, but not a massive part…Um … it's nice to have somebody to bounce ideas off of and to talk things through with, but, you know, I was … I had psychosis and counselling isn't going to fix that….medication is … or, you know, solutions are. I see counselling as an aid to um … to fixing a problem, not as the answer to fixing it….an extra added boost, but not … it's never going to be the sole solution	
yes, yes because if I was in your situation, or the situation that I thought you were in where you are employed, I'm just another case and another file, another piece of paper and as soon as you've got me out of the door then you can get another case is and then boom, boom…not quite as dramatically as that but that's generally what I think of people like … [name of staff member] from [name of housing association] or the early intervention team, I'm a case…I don't really believe truly that anywhere is without judgement…Truly, absolutely just nothing, no impressions are made, no thoughts are cast from things that I am saying … it's just absolutely kind of like, kind of going in one ear and out the other…I think I think I am accepted without judgement wherever I go but … in another case I think there is … every moment you move or do something, people are judging you for doing it the way you are doing it	

You're talking to me like a person…that's completely different 5

PROJECT

it doesn't really matter me either way, to me kind of it doesn't really bother me if I'm accepted or not. I mean it's quite nice when you're pouring out your heartfelt emotions that you are …, you know, that you are accepted for having these emotions out that you feel that way because of a certain ways, but kind of really doesn't bother me, the kind of really doesn't make a different situation or on me it's all from … it's like opinions are only from one person's side	
and then when you came and offered help … it just seemed like a blessing … like it was "well this is just exactly what I need and what I'm going through. / / [psychiatric hospital] hasn't fixed the voices, and changed my medication which wasn't wonderful, but it hasn't dealt with the issues and seeing [CPN] once a week or [support worker] once a week … I couldn't talk about all of this but it's not … it's not the same as somebody who has that knowledge or interest or insight into what I'm going through/./ I want to know what the voices are; I want to know how to make them go away and I want to know why they're still being here/	PAULA
I think if I had tried to do this five years ago it wouldn't have worked…um … and that's /what happened previously with [support worker] … she saw me for two years; every week for two years and I got better; really confident, strong, raring to go and I was out and I was meeting people and I got a job and … after three years on my own I did great and then I just crashed back down again um … because I hadn't addressed these other issue; because I took a job working with my mother!	
probably. I think if I had tried to do this five years ago it wouldn't have worked…um … and that's /what happened previously with [support worker] … she saw me for two years; every week for two years and I got better; really confident, strong, raring to go and I was out and I was meeting people and I got a job and … after three years on my own I did great and then I just crashed back down again um … because I hadn't addressed these other issue; because I took a job working with my mother!…can you imagine, having not addressed all those voices that would come and go in my head (whistles) and then suddenly having my mother there at breakfast time, at lunchtime, at dinner time, in the evening, all weekend, your whole working day ,my mother and then of course there's all the insecurities of when I've done things wrong at work she'd be "well…."all of the negative stuff was on show //yes I would sit there, but I didn't know then because I didn't understand what the voices were about I didn't … I just thought it was me I'd knew I had issues with my mum … they picked that up in my first lot of therapy when I was 21 years old/	
absolutely, I couldn't speak to people. / /And I just thought what the point it's not right it really isn't right so I … so that made me work really hard at it because it needed working/. /I have skimmed it; I'd got therapy; I'd got CBT and … you know … laughed and joked about it	
/The fact that you're not suited and booted…[Laughs] do you know I find that very difficult when I…yes// when I go and see someone and they're there in a pencil skirt and a shirt and a jacket …and I just think "You've got no idea. I'm not opening up to somebody who sits there in a suit and a collar, I'm not going to". I can't take them seriously/Yes the specialist and very much so. Because you are just a number then, just a statistic. I know this is numbers that you don't look at me as if I'm a number, you know	

You're talking to me like a person…that's completely different 6

Appendix Fx: cont'd.

PROJECT

made me really able to open up and talk to you um/ … /along with the simple surroundings and and and it being … it's not. This isn't your space, it's not my space; you don't come to my house; you.. I don't come to your office, it's some … it's just a space to sit and talk/	
I know I don't think I could ever go out in a social sense. I could work with you, very much I could work with you and I would like to work with you because I think that we could communicate well together but I don't think we could ever go out together for drinks because you know too much about me on a personal level/no there is issues, and/ I know there are issues with therapists because people become reliant on every Wednesday… this time slot I'm going to see that person … and it's going to be really like that … it was like that with [support worker] … she was like my mum, she was like my mum, she's older, she is in her 60s, she comes round, she kicks my butt, she tells me to get dressed and helps me with my house work, tells me I'm special, gives me cuddles, do you know…but she is my carer/no so to talk to her about the things I've talked to you about… that's one of the reasons ….that was one of the reasons after all…. that's why therapy, why I've still got it, that's it I've never had the therapist to talk it through; //I've had the therapists behind the desks or the one I've looked at as my mother…that I loved…C that really cares for me..that loves you and thinks you're a wonderful person and I didn't want to hurt her or upset her fact telling her I felt like that, and I didn't want to tell the therapist behind the desk that I had done these terrible things and I had these crazy thoughts. // But I've had to say it out loud to understand it …..so that's why, that's what led me here	
but that's what you've allowed me to do, that you've allowed me to do// and even just then in that brief bit then of … when you said how is it worked for you this time … it's because you haven't got the strict collar and I haven't got the … I've had to meet someone like you that I can trust and has good approachable body language/	
But it's never been about you I've never heard you speak once about what your thoughts are on anything I've said. //Whereas when I've spoken to other people, I speak to [support worker] or the therapist, Or [CPN], or anybody they tell me how they interpret things so I have never been able to interpret it myself	
because doctors, therapists, counsellors all of those people ….you say one thing and they jump in and tell you what you're thinking, why you're thinking that, where that process has come from. Actually, no we are all individuals and we all process things differently and … I have just been consumed with everybody else's ideas on why I'm this way	
It's like when I got diagnosed with um… postnatal depression um… I walked in there and I did have postnatal depression, but I looked at the little tick box … they give you a little sheet of paper to tick, and I knew that if I answered the questions and ticked at that end they were going to give me medication… and I was questioning whether they were going to take my children off me because I was depressed or something …um … so what I did was I just ticked everything the other end …when actually I was depressed and I was clever enough to see that … you know … do you feel tired, do you feel hurt and upset … and I thought that if I tick that yes box they are going to give me medication. So I'm going to take the no box…. So that … that way of doing it isn't going to be helpful. You've got people who will answer it honestly as I did …	

You're talking to me like a person…that's completely different 7

PROJECT

yes they could and um … and through previous counselling before they had done nothing but quiet them and um…Distractionsdistraction everytime I was having negative thought I was doing different things/, /I was developing my OCD a bit more and while I was doing that I wasn't listening, I was turning up the music and I was, I was distracting myself/ and didn't /then it was only at night time that I hurt real bad, when no one else was about	
yeah um … and … and … I didn't believe in therapy very much … I didn't believe … because it hadn't worked before um… //in fact when it hadn't worked and I'd got ill again it just reinforced the idea that… it's not working its … you know therapy doesn't work and um … /what it done, it dealt with the physical things, it dealt with the rape and it helped with low self-esteem and it dealt with sibling rivalry and it dealt with, you know, feeling a bit worthless. It was good in that sense ityes, it addressed the physical problems/, /it didn't address the mental problems, the … all of the stuff that had gone with it //	
previous help or support you'd had had been all about not focusing on them… P Yep R stop thinking about them/ P /yes, you need to get rid of the voices TRyeah/ R /but you can't get rid of the voices unless you find out what the voices are, where they come from and why they're there you know, and I've done that/	
I didn't, I've had too much structures	
when you are dealing with the supernatural on the level that I have and it is a knowledge not a belief system, then you've got a problem with the hierarchy and with the establishment, because they just think you're a heretic and shoot youwell you should be burnt at the stakes and that's the end of it, right so you've got a problem there and therefore your're rejection, rejection, rejectionyes because well because they're not where you are. But then you know more about it than they do and so you think they're a bunch of arseholes for not listening, and they think you're a completely loony, and think you should be locked up for not understanding what they do. Well that they think they do	FABIEN

You're talking to me like a person…that's completely different 8

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Appendix Fx: cont'd.

PROJECT

Right okay well you can understand with somebody who is er ... obviously on a different realm, because I thought that everybody else did what I did but they don't um ... but you don't know that they don't and it's only when you find yourself,... when you phone the palace to inform them of your rival because obviously if she is a spiritual lady, the head of the Church, she would know I was coming, right, or she should do, but then ... when I see two police cars, an ambulance and a doctor instead of a palace car arriving, it was a bit of a shock. So suddenly I'm faced with being taken out of um ... spiritual heaven, you know, seventh Heaven, up the Beanstalk, and being abducted, imprisoned, assaulted, tortured and abused. And not listened to. Now, it's all right once, and I realised the only way, because of listening to the voice, I had to tell them what they wanted to hear, but they didn't want to hear what I wanted to tell them which was true, they wanted to hear their lies in perpetuity that they had put out is the truth,. So I had to lie about my consciousness to tell them that I was unwell, to convince them that I was better to get out. And that told ...taught me everything, that moment of realisation with the voice inside my head saying "you'll have to tell them that you are unwell and then they will let you go"	
R and then decided, as you've just said, to come into counselling and you've got to pay, but you would have somebody ... P to listen and try ... because they were interested. Here was an opportunity that ... that London university was doing research to see whether counselling helped people who hear voices. Now the opportunity meant that one, I could influence a change ... in ... the ... the perception of schizophrenia vis a vis the medical model as opposed to the spiritual one which I am diametrically opposed to. And so ... here I had an opportunity, again, like I do in the colleges, like I did in the Institute, like I did ... all over the place um ... it was another opportunity to influence change. On ... you know, Cameron can say we're all in this together, we've got to have change, but at the end of the day we are not all in this together, we are in the system and everybody who was out of the system, and the system is trying to put me down because they don't want to change.	
Well, I'd ask every time, you see, I go to my GP and I say "can I have counselling?" And they'd say "ooh well you know" and she said "well you know there's a 3 to 5 year waiting list" and I said "well hang on a moment, I've been in the system 15, how long have I got to wait?" But no, no, I never got put to the front of the queue	
we've had a great journey... together. I mean it was difficult at first to understand the boundaries and where they were and I ... I was in trepidation really as ... as ... because I've never, well, to be quite frank anybody who works within the system has been totally an alien as far as I was concerned and there was, I knew I'd got to get something out of it because this was the last chance saloon in a way	
yes and ... and at the same time it was ... because it wasn't [name of psychiatric hospital], I felt better because it was one step removed to influence [name of psychiatric hospital] in a different way, to change their attitude, so I was happy with that so I could sort of think ... but then it was ... there was a sort of um ... how ... well I did challenge you over your belief system and ... are you going to be negative towards me ... and I because I didn't know how counselling was because I had never had it before so I didn't knowNo I didn't and so there was ... I can remember we had a very difficult session to sort of workout the boundaries and work out what was what	

You're talking to me like a person...that's completely different 9

PROJECT

well, the first thing is was you weren't a psychiatrist.It meant you didn't have a clinical model and that meant that I could have empathy with you because I find the clinical model disgusting. abhorrent. So therefore as a psychologist, ... so basically what you're saying is because I wasn't within the medical model that ... P yes that's right I felt I could ... expound where ... I didn't know where it was going to go ... I, I, I mean we're doing research aren't we? [Laughs]It's research by definition is that we are treading new ground ... R okay so that openness to new ground was important than P yes that was very important R and that ... that lack of direction ... was that important? P No ... I think we had a direction of where we were going ... ... R no I mean a lack of me directing I meant P yes, I think that was ... important ... to let it develop, see where it goes, I mean I had a logical, chronological order because everybody has, you know you start at nought and end up at death, you know, and there is a few years in between so we could go through it in some kind of chronological ... but the reason why I was here was because I went over there then is hard but that then I was always trying to get to where I've come from and I'm thinking yes, you know, um ...ere ... the last um .	
Because I was able to, because I felt free here, you know, it's like I can go and take my clothes and play wee willie winkie in town and get arrested. In [name of psychiatric hospital] I'm not. I'm locked up on the Ward and I can strip off and run round the block like a blooming loony and nobody gives a shit; they just stick another needle in your arm and take you back [laughs]. But here, this is structured, this is outside of the normal environment, it is encased, I feel enclosed, I feel I'm free here, to talk to...to talk how I want, to who I want and it's all recorded for me, for my own benefit, for the future, for [unclear], whether I do or not, I don't know but I would like a full transcript of everything and then what I'm going to do ... publish it on the web. Why not	
um ... it's been a wonderful experience for me. Because, I mean, it's been like the whole 20 years, you know, I'd come to see a psychiatrist and they'd spend five minutes with me, you know, and you actually think to yourself how can they know anything about you at all after only five minutes? And it's just ... it's just like they'd got all their questions written down or written down in their head because they've asked them so many times you know, and they ask the same questions over and over again, every time you go and see them, about five minutes, asking the same questions, you know, ... like are you taking alcohol and drugs? Are you still hearing voices? And you know ... I mean it's the same ones and they tick them off every time and I think well how can they possibly know anything about me at all?yes yes they will write things, you know, they would write things for other doctors as if they know you ... you know...you think well, you know, they don't know me at all, but like I just feel like you actually do know me, you do really know me but the doctors don't. Because they just don't ...you know, it's probably not their fault, they probably haven't got time, you know, to spend with patients that they only see ... how can they ... how can you say you know someone after five minutes, you know?	TINA

You're talking to me like a person...that's completely different 10

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Appendix Fx: cont'd.

PROJECT

Well really I mean if I wanted to get any support or anything my only choice was to drastically start shouting down the phone to them "Oh this bad things happening or that bad things happening" and I didn't actually really want to go over the top and keeps saying these things but I felt like, if I didn't I wouldn't get anyone to help me, you know....yes, yes because if you like, if you are badly... you know if you're really suffering and you need some help, you know that's what I said about taking an overdose, you know, I think some people have to go down that route, you know, before any help before they get any help, before the doctors start taking any notice of what ... you know, you must have actually been suffering to take those that overdose, you	
I have suffered from mental illness for 20 years, but the issue I sought counselling for was for the rape that happened three years ago. This is the first time I had attended counselling for this issue.The only other help that had been previously offered was Lorazepam tablets and sleeping pills.	
I felt that this was the way forward. My problems were not properly addressed at all when I was an in-patient in psyche-hospital. Medications can help, but do not address the problem either.	
I decided, it was really good, I decided, you know, what was troubling me and then we would discuss it and and I kind of feel any clearer, in my mind	AISHA
R what was the reason for that... because you had medication, you had the doctors doing their bit, you had the early intervention team sometimes, your counselling ... what was it that affected the voices out of all of those things? P I think all of them	
um I could see reality um ... the real world which I was ...um.. I could say to myself "no, it is the voice which is saying this it's not really happening" yes, yes I ... having counselling helped me to reflect ...	
Yes I feel it's ... well, I was told to be you know, reassured that.... it ...as long as I take medication I will be fine but I am still scared about it. It's still worrying, you know, because they haven't gone totally and maybe they will be coming back and all the things that happened will be starting a day	

You're talking to me like a person...that's completely different 11

PROJECT

um ... yes ... yes I did direct the sessions because I would sit down and you would like ask me what I wanted to talk about, you know, what I wanted to discuss, so yeah ... I did feel that. And at one point ... yeah ....on the other hand I felt that ... because when the time comes to say okay it's time to go and that time is like ... is you [Laughs]well I kind of understand and I kind of got used to it so I said to myself it's one hour and at the end session will be ending soon ... I kind of actually looked at the time sometimes and I said yes it's near the end of the session and so yeah R right did that help you manage the stuff you talked about in a way? P Yes R I wonder how important it was you that it was boundaried session that it was an hour and no more kind of it. Was that a good thing or a bad thing for you? P Um ... well ... everything has to have a rule so ... yes ... one hour is enough to talk about a lot of things. Sometimes I do feel that I want to talk more and more [Laughs] and when I've really kind of opened up and talking about things, I just want to continue to talk R yes right when you get into it that you want to carry on P yes I wanted to continue exactly R right so it was kind of difficult for you to be cut off? P Yes that's it and I was cut off I was like "Ohhh [Tone of voice to suggest disappointment and sadness]"	
Well you listened to me. And you could give me a different view on things ...[Long pause] I think [Name of psychiatrist] ... he just says "they're bad thoughts" you know, "send them away" ... you gave me the chance to talk it out and I think that is where it has come from	ROBERT
I can talk to you and you give me time, whereas the nurses and the doctors ... they are ... write up me tablets, "take them and you'll get better" R okay what did you think I wanted out of the sessions? P To see if we could make sense of it	
what in the first place? Well I needed help because the voices were getting ...dangerously close to getting what they wanted and I knew that it was wrong. [Long pause] but ... I had to try something [ONLY OTHER]help that time tablets yes just tablets	
[Long pause] yes in a way...[Pause] but it wasn't really talking about the voices ... it was more a general counselling[Long pause] the other counsellor was more interested in the beginning of my troubles ... and the relationship I had with my parents [Long pause]	

You're talking to me like a person...that's completely different 12

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<u>xi   Extract from reflective notes</u>
27.09.12

One thing I want to make sure is that I take account of the comment in the Braun and Clarke paper about whether themes 'emerge' from the data. I am aware that I am the one who has made the decision to highlight and then develop a theme. How does this sit with the phenom approach which argues FOR the emergence of themes through maintaining the phenom attitude?

I have realised after doing Olivia and Paula that there is a difference to the ways in which the themes take shape. It makes me wonder what I am going to be left with when I try to integrate all P's into an overall analysis.

Paula: her process is very much a before/after with the therapy being the reason for the coming about of the after. For her, the therapeutic change is about herself primarily but, as a by-product almost, the voices and her relationship with them has changed. She puts this all down to the therapy and discusses richly what it is about it that has helped her bring about that change. She compares it with other help well too.

Olivia: she sees therapy as separate from her 'illness' and separate from 'getting better'. It is almost a happy by-product that she has experienced something helpful from it but she makes no connection to her recovery, although she does acknowledge that some of the changes in her relationships with self and others have reinforced the process of recovery that was going on anyway. She sees it as being her own strength and determination that brought about her recovery and does not make any connection between that and the process of therapy, or the relationship. She does, however, comment on what that relationship was like.

Katie: most of discussion around experience of voices. Discussion of therapy experience not that rich. Discusses what helped and why. Also, that it is different from other help. But she did interviews when at end of therapy because needed to take a break from the difficult stuff she was doing. Not really at end of therapy in usual sense. Still hearing voices and feeling distressed by that. Still seeing elimination as goal. But not feeling therapy has failed. Says it has given her strength to cope with the struggle of them being there. Also values the trust/listening/understanding/non-directive/consistent/staying with elements of therapy. These are what has enabled her to talk and feel safe enough to talk. Feeling held.

Trust and feeling safe enabled her to talk about why the voices were there and what they were saying. BUT this had a negative payback for her as the voices got angry with her and made her suffer more. This openness did not get a chance to establish itself as a source of power for her completely before the crisis that precipitated her deciding she needed a break. But she does acknowledge that it was beneficial overall.

Lots of talk about experience of voices rather than experience of therapy. Odd as we didn't talk that much specifically about them in therapy (though more so that with other P's?). It makes a big difference given that she was stopping at a vulnerable point cf other P's.

Appendix Fxi: cont'd.

28.09.12

Paula   one thing I am worried about is it is such a process – and such a quick process – that I wonder if I have led it to get the right answers. But then I think, for example, that when I was pressing about empathy she was adamant that there was no such thing and that was not what she wanted. So, I think it did all come from her rather than my looking for the right factors as it mentioned in that paper in the PCE works book (check ref). Given that we also discussed it just being the right time for her to do the work, and the fact that this admission had been so different as she was so desperate about the voices and them telling her to hurt her husband, I think it is support for the Bohart 'client as self-healer' thing.

Katie – last night i realised that there is a direct correlation between her experiences of therapy and voices. But it is direct opposites. The words she uses about therapy are the exact opposites of those she uses to describe exp of voices. It also feels as if the exp of voices is like a big enveloping dense cloud and that the exp of therapy is too little to cut through completely – also we had to stop before the process developed because it got too much I.e. maybe she could not receive the therapeutic conditions for long enough to make a difference or get to that self-acceptance stage.

Interesting about the direct comparison between therapy and voice hearing, though isn't it? Not had that with the others so far. Paula is much more of a process; Olivia is therapy as an add-on to other forms of support and runs in parallel to her recovery – no link to it at all, nor to the voice hearing.

02.10.12

Have just done coding for Elaine and Gary. They are just statements about not talking, being paranoid, CBT more helpful etc. but nothing v rich. Still they are accounts of experience so do I include them? I would like to have some stuff in there from people who have not been helped. I wonder if the amount of data is to do with the fact that they did not feel helped and did not ever really engage. And what is that about? I tried to see if it was me in the interviews but got nowhere with it.

They still talk about the relationship as the thing that was positive. It is just that it didn't help them get better in the way they wanted. That is important and something for me to discuss. Cf Paula who was so ready to change and so found it a helpful way of doing so. I.e. the initiative was coming from her and she was up for doing the work. These two were still in the position of needing help to manage and so wanted someone else to make them better cf Bohart yet again but from the other perspective to Paula. That is why I want to include but worry about the data not being rich enough.

<u>Appendix Fxi: cont'd.</u>

17.10.12

I've just realised i am trying to shoehorn everything to do with the relationship into different themes. Yet what actually is the case is that they all talked about the relationship without my asking specifically about it. That is what they cite when i ask what cllg was like. Therefore, it is a

theme in itself. I wonder if that will make it move more easily. Even those for whom cllg didn't bring about change, it still appears the rel'p was valuable and is what they did get out of it. For those who did experience change it was a key thing.

I have been so conscious of not wanting to see it there because i expect to see it there, that i have been overcompensating. What can i call it though? Maybe leave the actual title till it is done but include everything/every reference to the relationship into the same theme for now. That makes it easier to incorporate Katie where i felt all she said about her exp of therapy was a mirror of what she had experienced via the voices and the original trauma. I was wondering how to include all that she said as it was so little about the actual therapy. But what she did do was show me the diff bet our experience and that of the voices. That is more for the in-depth analysis though i think.

Fabien, Paula, Tina, Aisha – they were definitely in charge of directing us to where they wanted to go. They had made the decision, consciously or unconsciously, that they were going to bring about some changes. I was really only a witness to it, offering reflections which enabled them to go deeper or differently into the issues they were exploring. They did the work. I provided the environment which facilitated their processes. Maybe those issues weren't even explicitly known to them at the start of therapy but they were open enough to go wherever they needed to go. I.e. at a high stage of process.

APPENDIX G

Outcomes of psychotherapy

i   BAVQ-R measure (Chadwick, Lees et al., 2000)

ii   PSYRATS (AH) scale (Haddock et al., 1999)

iii   Other studies using BAVQ-R and PSYRATS to investigate talking therapies

iv   Other studies using BAVQ-R and PSYRATS with non-clinical samples

v   Graphs showing participant's changes across BAVQ-R scales and PSYRATS

<u>i   BAVQ-R measure (Chadwick, Lees et al., 2000)</u>

THE REVISED BELIEFS ABOUT VOICES QUESTIONNAIRE (BAVQ-R)

Appendix Gi cont'd.

Beliefs About Voices Questionnaire (BAVQ – R)

There are many people who hear voices. It would help us to find out how you are feeling about your voices by completing this questionnaire. Please read each statement and tick the box that best describes the way you have been feeling **in the past week.**

If you hear more than one voice then please complete the form for the voice that is dominant.

Thank you for your help.

Name: …………………………………………………………..

Age: ……………

		Disagree	Unsure	Slightly Agree	Strongly Agree
1	My voice is punishing me for something that I have done				
2	My voice wants to help me				
3	My voice is very powerful				
4	My voice is persecuting me for no good reason				
5	My voice wants to protect me				
6	My voice seems to know everything about me				
7	My voice is evil				
8	My voice is helping me to keep sane				
9	My voice makes me do things that I really don't want to do				
10	My voice wants to harm me				
11	My voice is helping me to develop my special powers or abilities				
12	I cannot control my voices				
13	My voice wants me to do bad things				
14	My voice is helping me to achieve my goal in life				
15	My voice will harm or kill me if I disobey or resist it				
16	My voice is trying to corrupt or destroy me				
17	I am grateful for my voice				
18	My voice rules my life				

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Appendix Gi cont'd.

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BAVQ-R QUESTIONNAIRE

		Disagree	Unsure	Slightly Agree	Strongly Agree
19	My voice reassures me				
20	My voice frightens me				
21	My voice makes me happy				
22	My voice makes me feel down				
23	My voice makes me feel angry				
24	My voice makes me feel calm				
25	My voice makes me feel anxious				
26	My voice makes me feel confident				

When I hear my voice, usually …

		Disagree	Unsure	Slightly Agree	Strongly Agree
27	I tell it to leave me alone				
28	I try and take my mind off it				
29	I try and stop it				
30	I do things to prevent it talking				
31	I am reluctant to obey it				
32	I listen to it because I want to				
33	I willingly follow what my voice tells me to do				
34	I have done things to start to get in contact with my voice				
35	I seek the advice of my voice				

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Appendix Gi cont'd.

Beliefs About Voices Questionnaire (BAVQ – R)
Scoring Sheet

KEY					
M	Malevolence	**B**	Benevolence	**O**	Omnipotence
E	Engagement	**R**	Resistance		

	BELIEFS ABOUT VOICES	Disagree	Unsure	Slightly Agree	Strongly Agree	
1	My voice is punishing me for something that I have done	0	1	2	3	**M**
2	My voice wants to help me	0	1	2	3	**B**
3	My voice is very powerful	0	1	2	3	**O**
4	My voice is persecuting me for no good reason	0	1	2	3	**M**
5	My voice wants to protect me	0	1	2	3	**B**
6	My voice seems to know everything about me	0	1	2	3	**O**
7	My voice is evil	0	1	2	3	**M**
8	My voice is helping me to keep sane	0	1	2	3	**B**
9	My voice makes me do things that I really don't want to do	0	1	2	3	**O**
10	My voice wants to harm me	0	1	2	3	**M**
11	My voice is helping me to develop my special powers or abilities	0	1	2	3	**B**
12	I cannot control my voices	0	1	2	3	**O**
13	My voice wants me to do bad things	0	1	2	3	**M**
14	My voice is helping me to achieve my goal in life	0	1	2	3	**B**
15	My voice will harm or kill me if I disobey or resist it	0	1	2	3	**O**

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Appendix Gi cont'd.

BAVQ-R QUESTIONNAIRE

16	My voice is trying to corrupt or destroy me	0	1	2	3	**M**
17	I am grateful for my voice	0	1	2	3	**B**
18	My voice rules my life	0	1	2	3	**O**
	EMOTIONAL REACTIONS	Disagree	Unsure	Slightly Agree	Strongly Agree	
19	My voice reassures me	0	1	2	3	**E**
20	My voice frightens me	0	1	2	3	**R**
21	My voice makes me happy	0	1	2	3	**E**
22	My voice makes me feel down	0	1	2	3	**R**
23	My voice makes me feel angry	0	1	2	3	**R**
24	My voice makes me feel calm	0	1	2	3	**E**
25	My voice makes me feel anxious	0	1	2	3	**R**
26	My voice makes me feel confident	0	1	2	3	**E**

When I hear my voice, usually …

	BEHAVIOURAL REACTIONS	Disagree	Unsure	Slightly Agree	Strongly Agree	
27	I tell it to leave me alone	0	1	2	3	**R**
28	I try and take my mind off it	0	1	2	3	**R**
29	I try and stop it	0	1	2	3	**R**
30	I do things to prevent it talking	0	1	2	3	**R**
31	I am reluctant to obey it	0	1	2	3	**R**
32	I listen to it because I want to	0	1	2	3	**E**
33	I willingly follow what my voice tells me to do	0	1	2	3	**E**
34	I have done things to start to get in contact with my voice	0	1	2	3	**E**
35	I seek the advice of my voice	0	1	2	3	**E**

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Appendix Gi cont'd.

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BAVQ-R QUESTIONNAIRE

Malevolence total	___	**(range - 0 – 18)**
Benevolence total	___	**(range- 0 – 18)**
Omnipotence total	___	**(range- 0 – 18)**
Resistance total	___	**(range 0 – 27)**
of which emotional -	___	(range 0 – 12)
of which behavioural -	___	(range 0 – 15)
Engagement total	___	**(range - 0 – 24)**
of which emotional -	___	(range 0 – 12)
of which behavioural -	___	(range 0 – 12)

6

PSYCHOTIC SYMPTOM RATING SCALES:

AUDITORY HALLUCINATIONS

GENERAL INSTRUCTIONS

The following structured interview is designed to elicit specific details regarding different dimensions of auditory hallucinations. When asking questions, the interview is designed to rate the patient's experiences <u>over the last week</u> for the majority of items. There are two exceptions to this e.g. when asking about beliefs regarding cause of voices, rate the patient's response based on what they believe at the time of the interview. Also loudness of voices should be rated according to the loudness of voices at the time of interview or the last time the patient experienced them.

Name: …………………………………………

Age: …………………….

Sex: M / F

Diagnosis: (if relevant)   …………………………………………

Length of time experiencing voices (years) : …………………………

Hallucinations in other modalities: visual / olfactory / gustatory / tactile

Appendix Gii cont'd.

AUDITORY HALLUCINATIONS: SCORING CRITERIA

1.   **FREQUENCY**

How often do you experience voices? e.g. every day, all day long etc.

0.   Voices not present or present less than once a week (specify frequency if present)

1.   Voices occur for at least once a week

2.   Voices occur at least once a day

3.   Voices occur at least once an hour

4.   Voices occur continuously or almost continuously i.e., stop for only a few seconds or minutes

2.   **DURATION**

When you hear your voices, how long do they last, e.g. for a few seconds, minutes, hours, all day long?

0.   Voices not present

1.   Voices last for a few seconds, fleeting voices

2.   Voices last for several minutes

3.   Voices last for at least one hour

4.   Voices last for hours at a time

3.   **LOCATION**

When you hear your voices, where do they sound like they're coming from?
-inside your head and/or outside your head?
-if voices sound like they are outside your head, whereabouts do they sound like they are coming from?

0. No voices present

1. Voices sound like they are inside head only

2. Voices outside the head, but close to ears or head. Voices inside the head may also be present.

3   Voices sound like they are inside or close to ears and outside head away from ears

4. Voices sound like they are from outside the head only

4.   **LOUDNESS**

How loud are your voices?
Are they louder than your voice, about the same loudness, quieter or just a whisper?

0. Voices not present

1. Quieter than own voice, whispers.

2. About same loudness as own voice

3   Louder than own voice

4. Extremely loud, shouting

Appendix Gii cont'd.

5. **BELIEFS RE-ORIGIN OF VOICES**

What do you think has caused your voices?
-Are the voices caused by factors related to yourself or solely due to other people or factors?
If patient expresses an external origin:
 - How much do you believe that your voices are caused by
…………………………………. (add patient's contribution) on an scale from 0-100 with 100 being that you are totally convinced, have no doubts and 0 being that it is completely untrue?

0. Voices not present

1. Believes voices to be solely internally generated and related to self

2. Holds a less than 50% conviction that voices originate from external causes

3 Holds 50% or more conviction (but less than 100%) that voices originate from external causes

4. Believes voices are solely due to external causes (100% conviction)

6. **AMOUNT OF NEGATIVE CONTENT OF VOICES**

Do your voices say unpleasant things or negative things?
- Can you give me some examples of what the voices say? (record these examples)
- How much of the time do the voices say these types of unpleasant or negative items?

0. No unpleasant content

1. Occasional unpleasant content

2. Minority of voice content is unpleasant or negative (less than 50%)

3 Majority of voice content is unpleasant or negative (50% or more)

4. All of voice content is unpleasant or negative

Appendix Gii cont'd.

7. **DEGREE OF NEGATIVE CONTENT**

(Rate using criteria on scale, asking patient for more detail if necessary)

0. Not unpleasant or negative

1. Some degree of negative content, but not personal comments relating to self or family e.g. swear words or comments not directed to self, e.g. "the milkman's ugly"

2. Personal verbal abuse, comments on behaviour e.g. "shouldn't do that or say that"

3 Personal verbal abuse relating to self-concept e.g. "you're lazy, ugly, mad, perverted"

4. Personal threats to self e.g. threats to harm self or family, extreme instructions or commands to harm self or others and personal verbal abuse as in (3)

8. **AMOUNT OF DISTRESS**

Are your voices distressing?
- How much of the time?

0. Voices not distressing at all

1. Voices occasionally distressing, majority not distressing (<10%)

2. Minority of voices distressing (<50%)

3 Majority of voices distressing, minority not distressing ($\geq$ 50%)

4. Voices always distressing

9. **INTENSITY OF DISTRESS**

When voices are distressing, how distressing are they?
-Do they cause you minimal, moderate, severe distress?
-Are they the most distressing they have ever been ?

0. Voices not distressing at all

1. Voices slightly distressing

2. Voices are distressing to a moderate degree

3 Voices are very distressing, although subject could feel worse

4. Voices are extremely distressing, feel the worst he/she could possibly feel

10. **DISRUPTION TO LIFE CAUSED BY VOICES**

How much disruption do the voices cause to your life?
-Do the voices stop you from working or other daytime activity?
-Do they interfere with your relationships with friends and/or family?
- Do they prevent you from looking after yourself, e.g. bathing, changing clothes, etc?

0. No disruption to life, able to maintain social and family relationships (if present)

1. Voices cause minimal amount of disruption to life e.g. interferes with concentration although able to maintain daytime activity and social and family relationships and be able to maintain independent living without support.

2. Voices cause moderate amount of disruption to life causing some disturbance to daytime activity and/or family or social activities. The patient is not in hospital although may live in supported accommodation or receive additional help with daily living skills.

3 Voices cause severe disruption to life so that hospitalisation is usually necessary. The patient is able to maintain some daily activities, self-care and relationships whilst in hospital. The patient may also be in supported accommodation but experiencing severe disruption of life in terms of activities, daily living skills and/or relationships.

4. Voices cause complete disruption of daily life requiring hospitalisation. The patient is unable to maintain any daily activities and social relationships. Self-care is also severely disrupted.

11.   <u>**CONTROLLABILITY OF VOICES**</u>

     -Do you think you have any control over when your voices happen?
     -Can you dismiss or bring on your voices?

0.   Subject believes they can have control over the voices and can always bring on or dismiss them at will

1.   Subject believes they can have some control over the voices on the majority of occasions

2.   Subject believes they can have some control over their voices approximately half of the time

3   Subject believes they can have some control over their voices but only occasionally. The majority of the time the subject experiences voices which are uncontrollable

4.   Subject has no control over when the voices occur and cannot dismiss or bring them on at all.

Appendix Gii cont'd.

NUMBER OF VOICES

How many different voices have you heard over the last week?

No. of voices =

FORM OF VOICES

1st person	Yes/No	(n=)
2nd person	Yes/No	(n=)
3rd person	Yes/No	(n=)
Single words or phrases without pronouns	Yes/No	(n=)

Appendix Gii cont'd.

AUDITORY HALLUCINATIONS: SCORE SHEET

1. FREQUENCY

2. DURATION

3. LOCATION

4. LOUDNESS

5. BELIEFS RE-ORIGIN OF VOICES

6. AMOUNT OF NEGATIVE CONTENT OF VOICES

7. DEGREE OF NEGATIVE CONTENT

8. AMOUNT OF DISTRESS

9. INTENSITY OF DISTRESS

10. DISRUPTION

11. CONTROL

iii   Other studies using BAVQ-R and PSYRATS to investigate talking therapies

Study	Intervention *Measure Scale*	Pre-intervention			Post intervention		
		n	*mean*	*sd*	*n*	*mean*	*sd*
	CBT + Treatment as usual						
	PSYRATS TOTAL	95	32.27	4.49	82	29.10	7.57
	PSYRATS distress (amount)	97	3.22	0.83	82	2.83	1.26
	PSYRATS frequency	98	2.98	1.22	85	2.49	1.44
	PSYRATS negative content (amount)	97	3.41	0.81	83	3.06	1.17
	BAVQ-R						
	Malevolence	98	12.93	4.46	87	10.60	5.15
	Benevolence	97	3.22	3.82	87	3.18	4.52
	Omnipotence	98	13.23	3.77	87	10.29	4.46
	Resistance total	98	21.29	5.12	86	20.41	5.99
	- Emotional	98	9.48	2.48	86	8.77	2.95
	- Behavioural	98	11.81	3.63	86	11.64	3.87
	Engagement total	98	4.87	4.58	86	4.27	5.20
	- Emotional	98	1.82	2.57	86	1.80	3.12
Birchwood et al., (2014) CBT for command based hallucinations *(PSYRATS - total and selected items; BAVQ-R - scales and sub-scales)*	*- Behavioural*	98	3.05	2.84	86	2.47	2.82
	Treatment as usual						
	PSYRATS TOTAL	99	32.97	4.31	84	28.05	8.55
	PSYRATS distress (amount)	99	3.22	0.87	84	2.52	1.49
	PSYRATS frequency	99	2.91	1.21	89	2.42	1.50
	PSYRATS negative content (amount)	99	3.32	0.74	85	2.88	1.30
	BAVQ-R						
	Malevolence	99	13.17	4.22	86	11.41	4.93
	Benevolence	99	3.52	4.16	86	3.28	4.47
	Omnipotence	99	13.74	3.72	86	11.38	4.85
	Resistance total	99	21.47	4.60	86	19.95	6.09
	- Emotional	99	10.22	2.06	86	8.83	3.09
	- Behavioural	99	11.25	3.57	86	11.13	3.97
	Engagement total	99	5.25	5.25	86	4.70	5.28
	- Emotional	99	2.16	3.08	86	2.27	3.15
	-Behavioural	99	3.09	2.92	86	2.43	2.66

Appendix Giii: *cont'd.*

Gottlieb et al, (2013) Web-based self directed CBT. *(PSYRATS & BAVQ-R - total scores)*	**Coping with voices intervention**						
	PSYRATS (total score)	17	26.76	6.75	17	22.94	6.44
	BAVQ-R (total score)	17	39.88	14.20	17	39.47	13.74
Leff et al., (2013) Computer assisted therapy for medication resistant auditory hallucinations. *(PSYRATS & BAVQ-R total scores)*	**Immediate treatment**						
	PSYRATS (total score)	14	29.25	4.86	14	26.63	8.03
	BAVQ-R (total score	14	22.63	7.58	14	18.88	7.24
	Delayed treatment						
	PSYRATS (total score)	12	31.88	8.10	12	20.00	13.10
	BAVQ-R (total score)	12	21.00	11.33	12	12.37	12.61
Penn et al., (2009) Group CBT vs. Group enhanced supportive therapy for auditory hallucinations. *(PSYRATS - total score; BAVQ-R - scale)*	**Group CBT**						
	PSYRATS (total score)	32	26.5	5.5	32	25.4	7.4
	BAVQ-R SCALE (by scale)						
	Malevolence	32	7.3	5.5	32	8.0	5.8
	Benevolence	32	6.2	5.3	32	4.5	4.9
	Omnipotence	32	8.3	4.3	32	7.1	3.7
	Resistance	32	14.2	7.2	32	15.5	6.9
	Engagement	32	6.6	6.4	32	6.2	6.8
	Group supportive therapy						
	PSYRATS (total score)	33	28.8	5.1	33	26.3	6.8
	BAVQ-R SCALE (by scale)						
	Malevolence	33	9.5	4.9	33	7.6	5.1
	Benevolence	33	5.8	5.2	33	4.5	4.7
	Omnipotence	33	9.3	3.6	33	6.9	4.3
	Resistance	33	18.1	5.9	33	16.8	6.2
	Engagement	33	6.9	6.3	33	5.5	5.5
Durham et al., (2003) CBT for medication resistant psychosis. *(PSYRATS - total score)*	**CBT**	21	23.7	11.4	21	17.9	13.2
	Supportive psychotherapy	23	24.1	10.3	19	20.6	12.3
	TAU	21	20.9	10.5	19	19.3	11.3
Haddock et al., (2009) CBT v social activity therapy for history of violence. *(PSYRATS - total score)*	**CBT**	38	14.74	14.17	38	9.74	13.92
	Social activity therapy	39	14.61	14.10	39	11.38	15.13

Appendix Giii: *Cont'd.*

Lewis et al., (2002) CBT for acute phase in early psychosis. *(PSYRATS - total score)*	**CBT**	*60*	*29.38*	*6.69*	*47*	*6.15*	*10.31*
	Supportive counselling	*63*	*29.46*	*6.91*	*41*	*6.41*	*10.61*
	Routine care	*62*	*29.00*	*6.35*	*43*	*8.30*	*12.60*
Valmaggia et al., (2005) CBT for refractory symptoms resistant to medication. *(PSYRATS - factor)*	**CBT**						
	Physical characteristics	*35*	*5.57*	*5.02*	*35*	*4.26*	*4.34*
	Emotional characteristics	*35*	*6.17*	*5.61*	*35*	*5.48*	*5.80*
	Cognitive interpretations	*35*	*5.63*	*5.34*	*35*	*4.46*	*4.17*
	Supportive counselling						
	Physical characteristics	*23*	*7.52*	*4.74*	*23*	*7.91*	*5.53*
	Emotional characteristics	*23*	*9.26*	*5.52*	*23*	*7.81*	*4.98*
	Cognitive interpretations	*23*	*7.83*	*4.86*	*23*	*7.87*	*4.79*
Shawyer et al., (2012) Acceptance based CBT for command hallucinations. *(PSYRATS - selected items; BAVQ-R - selected scales)*	**TORCH**						
	PSYRATS (items relating to distress and disruption)						
	Disruption	*21*	*1.7*	*0.8*	*20*	*1.5*	*0.8*
	Distress	*21*	*5.1*	*2.5*	*20*	*4.5*	*2.5*
	BAVQ-R (selected scales)						
	Omnipotence	*21*	*18.1*	*0.9*	*20*	*17.1*	*0.7*
	Resistance	*21*	*28.4*	*4.4*	*20*	*27*	*4.5*
	Engagement	*21*	*13.1*	*6.8*	*20*	*12.2*	*5.5*
	Befriending						
	PSYRATS (items relating to distress and disruption)						
	Disruption	*22*	*1.7*	*0.6*	*20*	*1.1*	*0.8*
	Distress	*22*	*4.9*	*2.7*	*20*	*3.2*	*2.9*
	BAVQ-R (selected scales)						
	Omnipotence	*22*	*17.6*	*3.9*	*20*	*15.0*	*4.1*
	Resistance	*22*	*28.7*	*5.0*	*20*	*28.3*	*6.5*
	Engagement	*22*	*13.1*	*6.2*	*20*	*12.8*	*5.1*

iv   Other studies using BAVQ-R and PSYRATS with non-clinical samples

Study *(Measure)*	**Sample** *Scale/Measure*	*n*	*mean*	*sd*
	Clinical VH			
	Duration (0–4)	72	2.69	1.21
	Location (0–4)	72	2.13	1.16
	Loudness (0–4))	72	2.04	0.84
	Beliefs origin (0–4	72	2.25	1.22
	Amount negative content (0–4)	72	2.96	1.08
	Degree negative content (0–4)	72	2.96	1.01
	Amount distress (0–4)	72	3.04	1.00
	Intensity distress (0–4)	72	2.53	0.80
	Disruption life (0–4)	72	2.36	0.95
	Controllability (0–4)	72	3.15	1.11
	Emotional characteristics	72	11.99	2.64
Daalman et al., (2013) Clinical and non-clinical	*Cognitive interpretations*	72	7.76	2.26
VH *(PSYRATS – item (excluding Frequency) and*	**Non-clinical VH**			
factor (excluding physical characteristics))	*Duration (0–4)*	72	1.63	0.80
	Location (0–4)	72	2.38	1.23
	Loudness (0–4))	72	1.90	0.56
	Beliefs origin (0–4	72	3.01	1.07
	Amount negative content (0–4)	72	0.38	0.90
	Degree negative content (0–4)	72	0.39	0.93
	Amount distress (0–4)	72	0.46	0.92
	Intensity distress (0–4)	72	0.26	0.61
	Disruption life (0–4)	72	0.21	0.60
	Controllability (0–4)	72	2.03	1.66
	Emotional characteristics	72	9.38	1.95
	Cognitive interpretations	72	5.25	1.86
Hill et al., (2012) Clinical and non-clinical VH	**Clinical voice hearers**	20	30.1	7.4
metacognitive beliefs. *(PSYRATS - total score)*	**Non-clinical voice hearers**	20	15.3	4.5

Appendix Giv: *cont'd*

Morrison et al., (2004) Interpretation of voices by clinical and non-clinical VH. *(PSYRATS – factors with clinical VH only)*	**Clinical voice hearers**			
	Physical characteristics	*41*	*9.66*	*2.06*
	Emotional characteristics	*41*	*11.17*	*4.42*
	Cognitive interpretations	*41*	*9.69*	*2.27*
Andrew et al., (2008). Psychiatric and non-psychiatric VH. *(BAVQ-R - scale)*	**Psychiatric voice hearers (PVH)**	*22*	*10.77*	*5.24*
	Malevolence	*22*	*3.09*	*5.30*
	Benevolence	*22*	*13.00*	*3.75*
	Omnipotence	*22*	*17.86*	*8.39*
	Resistance	*22*	*7.09*	*8.71*
	Engagement			
	Non-psychiatric voice hearers (NPVH)	*21*	*0.10*	*0.44*
	Malevolence	*21*	*12.38*	*4.40*
	Benevolence	*21*	*3.33*	*2.10*
	Omnipotence	*21*	*0.62*	*1.66*
	Resistance	*21*	*15.62*	*5.34*
	Engagement			
Lawrence et al., (2010). HV in a non-psychiatric population. *(BAVQ-R - scale)*	*Malevolence*	*184*	*4.17*	*4.90*
	Benevolence	*184*	*6.09*	*5.34*
	Omnipotence	*184*	*6.40*	*4.51*
	Resistance	*184*	*10.49*	*8.06*
	Engagement	*184*	*6.86*	*6.75*

v   Graphs showing participant's changes across BAVQ-R scales and PSYRATS

Figure 1 RCI for BAVQ-R overall
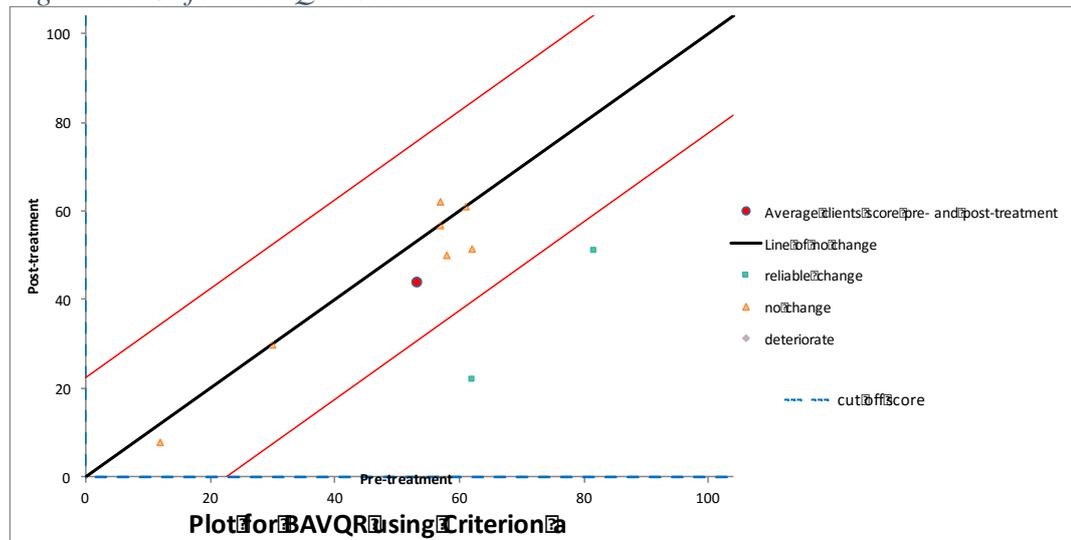

Figure 2 RCI for Malevolence scale on BAVQ-R
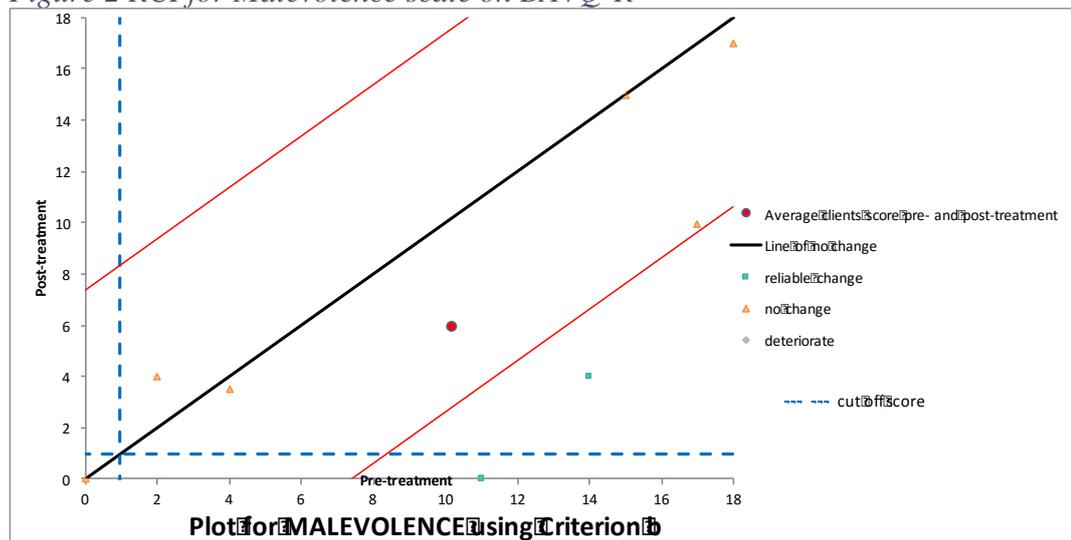
Figure 3 RCI for Benevolence scale on BAVQ-R
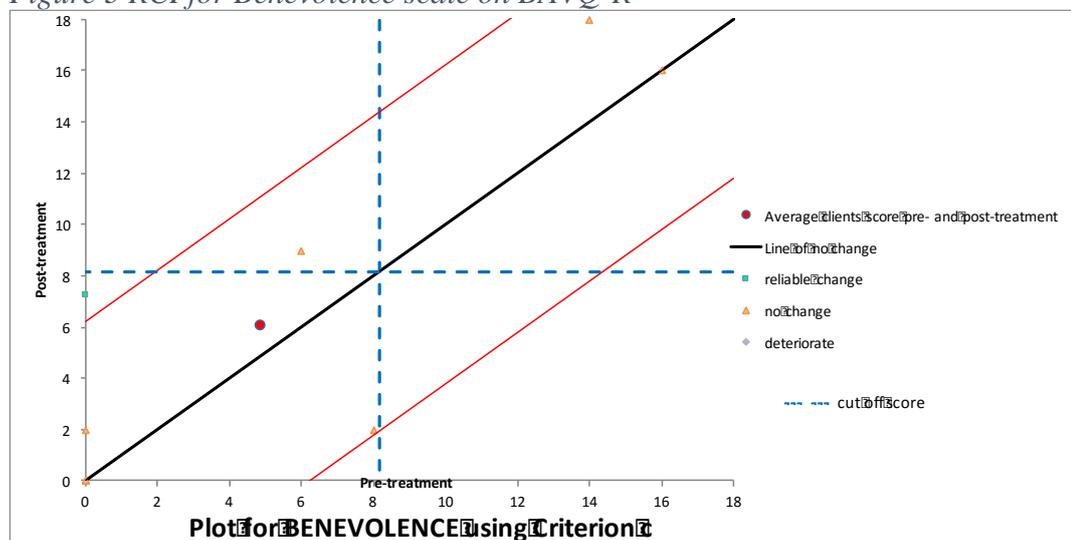
Appendix Gv: *cont'd.*

Figure 4 RCI for Omnipotence scale on BAVQ-R

Plot for OMNIPOTENCE using Criterion b
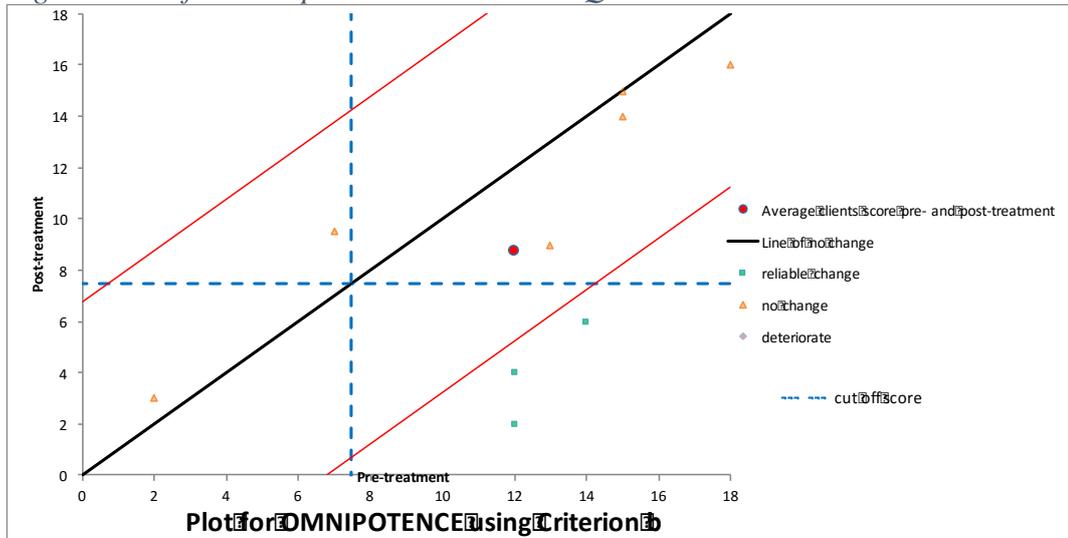
Figure 5 RCI for Resistance scale on BAVQ-R

Plot for RESISTANCE using Criterion b
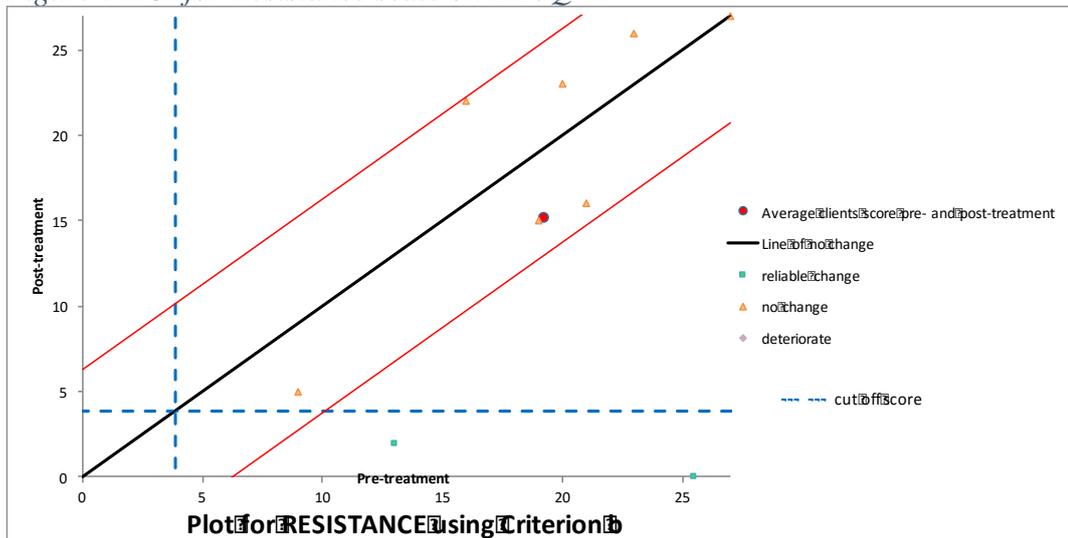
Figure 6 RCI for Resistance – emotional sub-scale on BAVQ-R

Plot for RESISTANCE EMOTIONAL using Criterion a
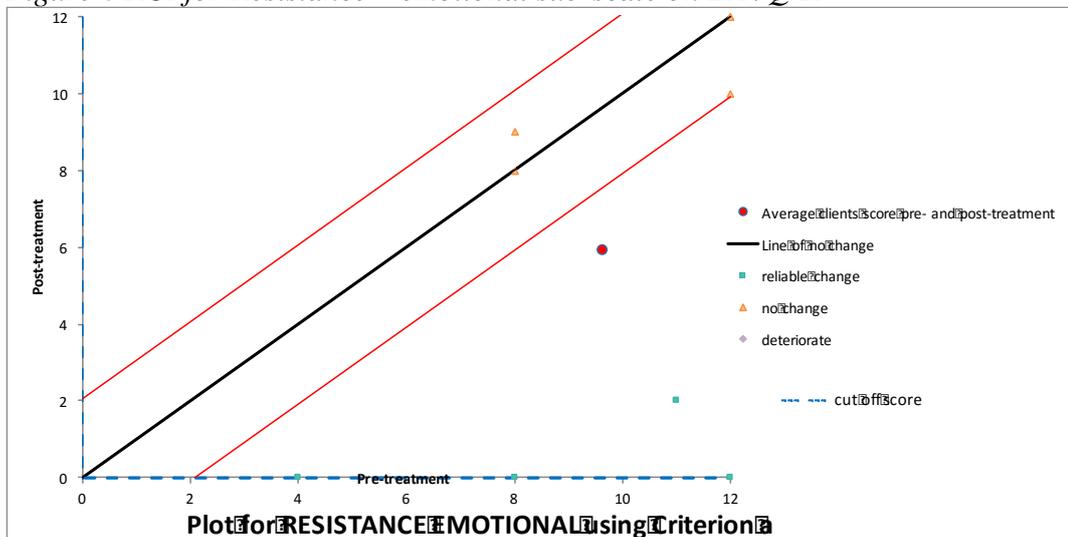
Appendix Gv: *cont'd*

Figure 7 RCI for Resistance – behavioural sub-scale on BAVQ-R

Plot for RESISTANCE BEHAVIOURAL using Criterion a
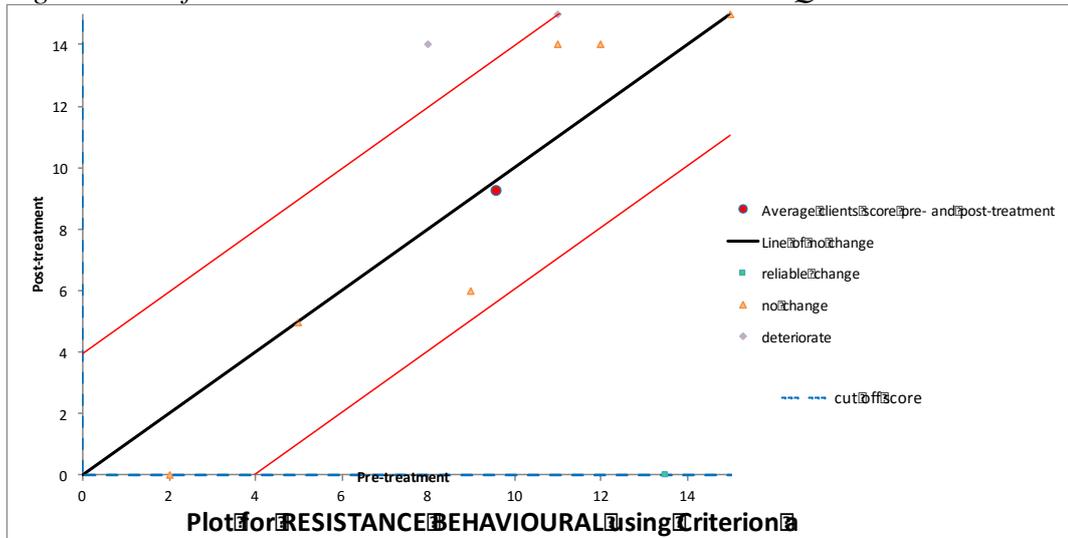
Figure 8 RCI for Engagement scale on BAVQ-R

Plot for ENGAGEMENT using Criterion c
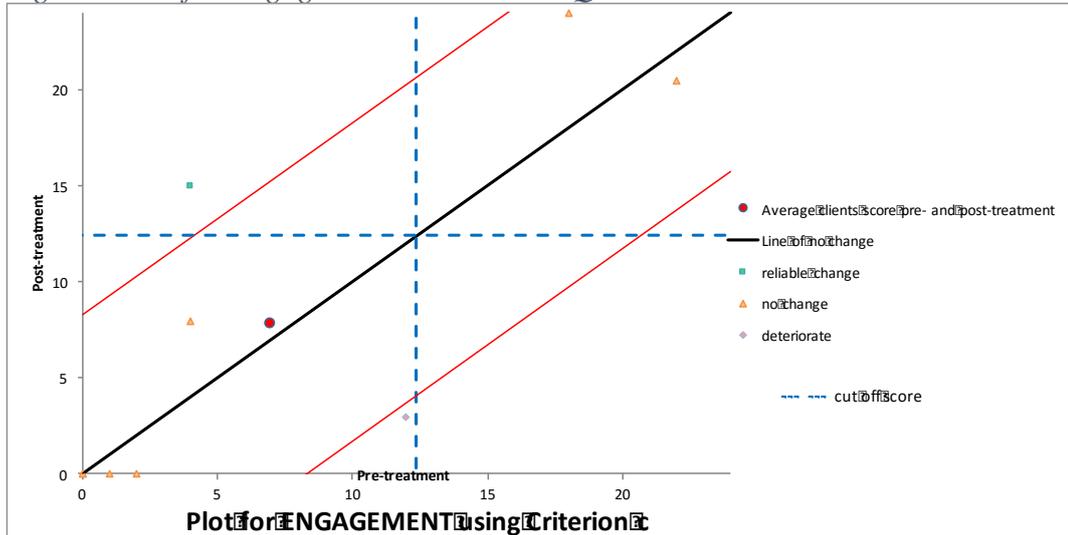
Figure 9 RCI for Engagement – emotional sub-scale on BAVQ-R

Plot for ENGAGEMENT EMOTIONAL using Criterion a
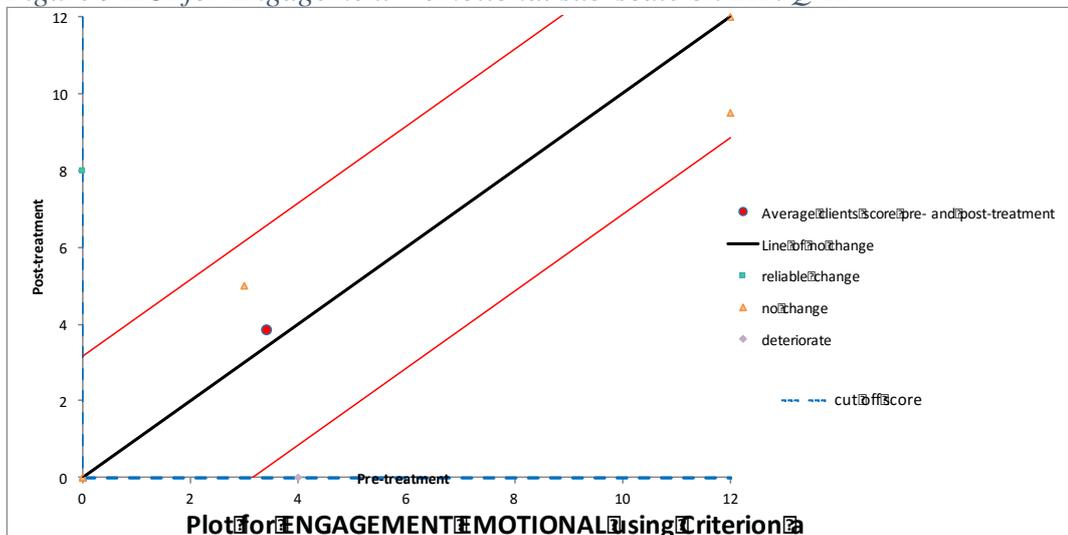
Appendix Gv: *cont'd.*

Figure 10 RCI for Engagement – behavioural sub-scale on BAVQ-R

Plot for ENGAGEMENT BEHVIOURAL using Criterion a
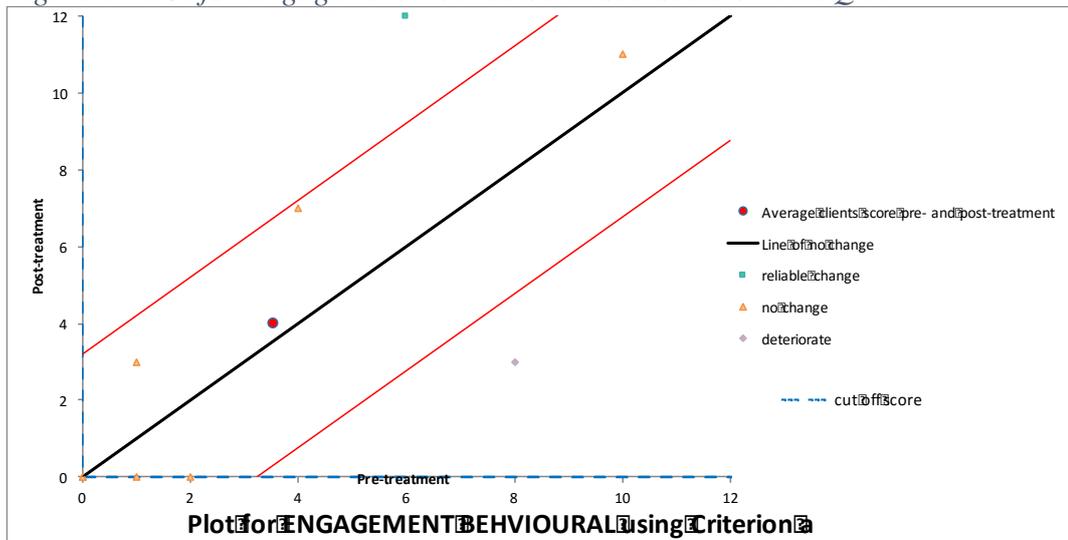
Figure 11 RCI for PSYRATS overall

Plot for PSYRATS using Criterion b
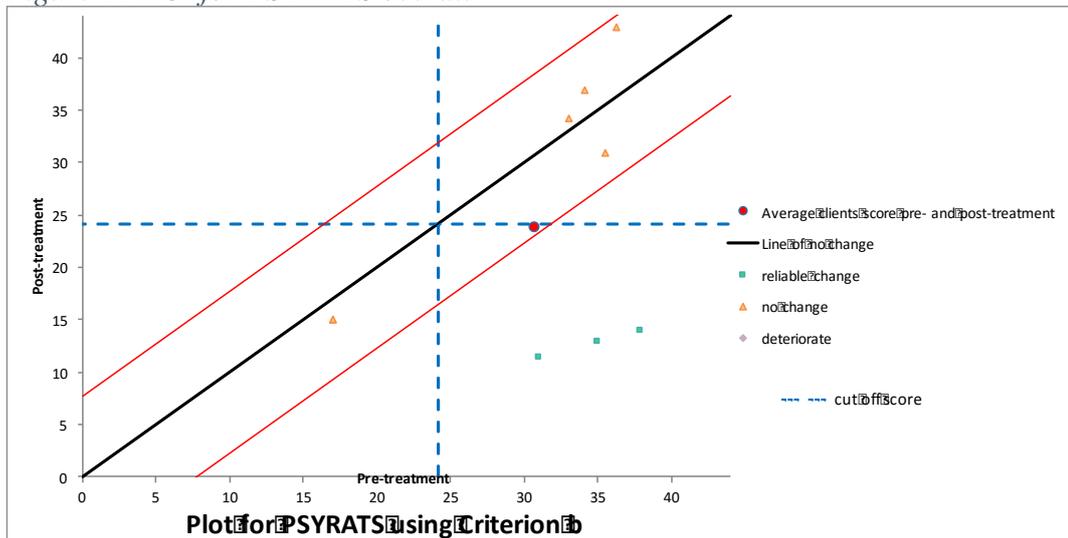
Figure 12 RCI for Physical characteristics factor on PSYRATS

Plot for PHYSICAL using Criterion a
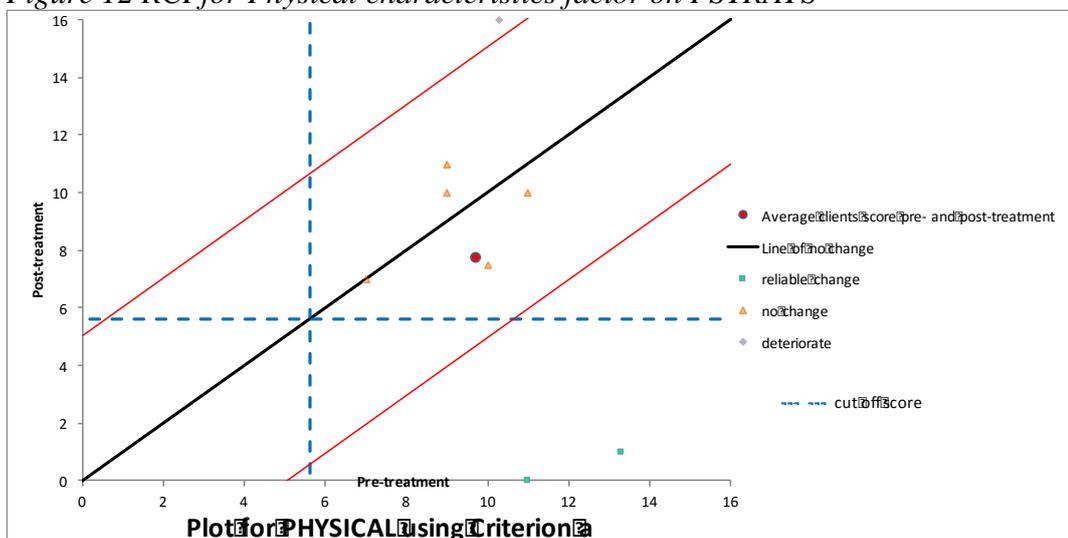
Appendix Gv: *cont'd.*

Figure 13 RCI for Emotional characteristics factor on PSYRATS

Plot for EMOTIONAL using Criterion b
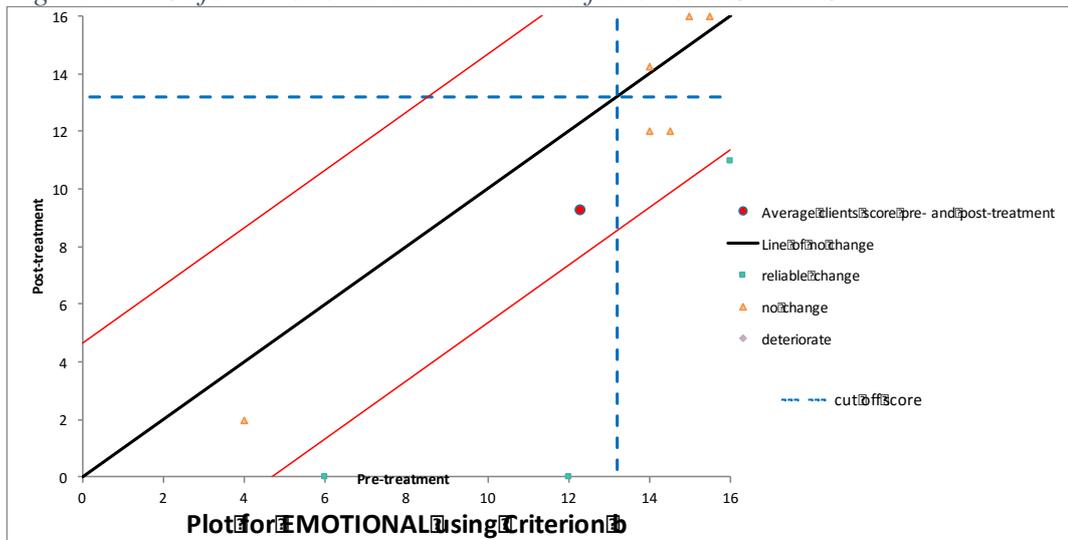
Figure 14 RCI for Cognitive interpretations factor on PSYRATS
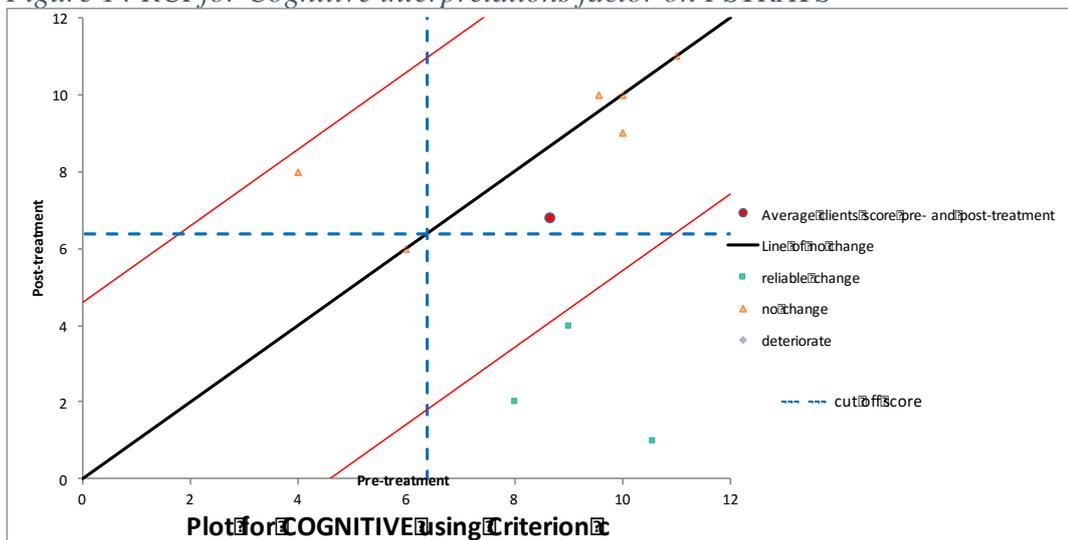
Plot for COGNITIVE using Criterion c

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APPENDIX H

Demonstration of rigour in study

APPENDIX H

Demonstration of rigour in study

i   Study documents - audit trail and reflections

Document	Operation	Reflections
Documents (included at Appendix D)	Information sheet for participants (Appendix Dii). Given to potential participants after they had decided to start therapy with me	Shared with 4 service users and edited taking account of their sugggestions on clarity and content before ethical approval sought. Participants reported that they appreciated the clarity of information it contained and it helped them decided whether or not to join the study.
	Information sheet for clinicians. (Appendix Di) Given to all staff who might be working with potential therapy clients and study participants. Outlined study and inclusion criteria and explained referral process	At the start of the study, psychiatrists and nurses at mental health trust read and discussed with me at a management meeting. As and when participants joined study, information was sent to clinicians again. Staff from independent low-secure psychiatric unit and counselling agents were given information as and when participants joined the study. In practice referrals were generated more from my attendance at management meetings and based on need for therapy than because clinicians had seen the leaflet in advance.
	Letter to clinicians requesting confirmation that they did not see any risk in participants joining study (Appendix Div)	No refusals received and responses received quickly. Copies of responses held on file kept in secure cabinet in my home office.
	Informed consent form (Appendix Dv) given to participants after they had agreed to join study	In practice this was at our second therapy session and was completed there and then. Copies held on file in secure cabinet in my home office.
	Supplementary consent form regarding use of recorded material at conferences (Appendix Dvi)	Checked with UEL ethics committee and NRES who agreed to its use. In practice only required for two participants where material was used at a conference and a lecture (Fabien and Paula). Participants concerned were happy to sign it. Copies held on file in secure cabinet in my home office.
	Question areas for post-therapy interviews (Appendix Diii) given to	Participants often read the sheet before the interviews and had their own questions that arose from it.

	participants at the end of therapy before interviews took place. Also discussed at start of study when participation being discussed	Some participants liked to refer to the sheet as we were going through the interview process eg Fabien, Rhiannon. One participant (Tina) wrote answers to all questions and brought them to our second interview. This information was added into her data set for use in the thematic analysis. In practice it seemed to be a useful aide-memoire for participants to help them stay focussed on what we were exploring and to remind them of things they wanted to raise. There are several examples in the interviews of people referring to the questions to add information (eg Rhiannon, Fabien, Robert).
	Confidentiality agreement for independent assessors (Appendix Ei)	Sent to Elke Lambers, Paul Wilkins and X to gain confirmation of qualifications, membership of professional bodies and that they would protect participant confidentiality. Copies held securely in my office.
Outcome measures (scores included at Appendix F)	BAVQ-R; PSYRATS; BPRS-E	I had originally intended to ask participants what they felt about these measures. I though it would be interedting to see if the measures often administered by mental health professionals had meaning or relevance to those completing them. BPRS-E is usually completed by a physician using observation and interviews; but I used it in collaboration with participants and they chose the most appropriate scores based on their experiences, not my observations. The other two measures are completed by VH themselves. As my research questions developed, I decided I would not have space to deal with this area. I decided, however, to continue with BAVQ-R and PSYRATS as they were quick to complete and participants seemed interested when I explained why I was doing it. As BPRS-E was more time-consuming, I decided not to continue with that and so I only actually gave it to three participants and, only then, pre-therapy. We talked briefly about their views on the measures at the start of the post-therapy interviews and they often felt that their experience did not 'fit' the available categories.

ii   Procedures – audit trail and reflections

Stage of study	Procedure	Reflections

Pre-data collection and data collection	Recording of therapy sessions	All participants except one, accepted the recording of their sessions and understood that sessions were not research data. The participant that declined had agreed to the recording of our post-therapy interviews but then withdrew from the study after ther therapy ended and before the interviews took place.
		
		At the start of each session I checked that the participant was happy for me to turn on the recorder.
		
		All sessions were recorded apart from the following:
		
		   Elaine requested that two sessions were not recorded, saying she felt particularly vulnerable those days. She also asked that one recording be deleted as she said she regretted what she had talked about in that session.
		
		   Katie asked that two sessions were not recorded, saying she felt particularly vulnerable those days. Also, the equipment was not available on one occasion (I had forgotten to recharge the batteries).
		
		   Fabien asked that one session was not recorded, saying her felt particularly vulnerable that day.
		
		This means that in total there were 194 recordings out of a total of 201 carried out.

	Use of independent assessors (Sample notes and report included at Appendix E)	Random selection of recordings of therapy sessions sent to all three assessors in April 2010 and March 2011. Notes giving brief information on the client, reason for referral, number of sessions attended and other relevant comments were also sent. Reports received back promptly from EL and PW, both confirming that the therapy being practised could be classified as person-centred therapy. I had further email discussion to clarify some points they made.
		The idea of exposing my work to people I respect, and who were very experienced, made me anxious. Once the sessions were selected, I listened to them again and was aware of how much I had 'done wrong'. It was a relief to read positive remarks and useful, but difficult, to read about 'errors'. The reports were useful supervision reports for me as much as useful for the study. They highlighted aspects where my practice could have been improved and where it was effective. They also showed how much is unavailable when a session is heard by a person who was not present at the time and did not know the overall context of the therapy. Further discussions helped me justify why I had reacted in certain ways, or made particular comments in the sessions. They also helped my further learning. I did not receive responses from X after April 2010 so wrote asking if she was still able to help the study. She replied that she was and asked me to send the session again, which I did. I still received no response so, before the second session was due, I checked again. Once again she said yes and asked me to send both sessions, which I did. I also saw her at a conference and she confirmed her willingness to be involved. Despite this, I still received no responses. After sending two further emails, I wrote asking her to destroy the discs. Randomly selected recordings of the remaining sessions were sent in April 2015, therefore, only to EL and PW. Again, they were accepted as being examples of person-centred therapy. It is unfortunate that I did not receive feedback from X who has been a significant figure in the development of person-centred therapy in this field. It meant I had checks on only ≈ 3% of the sessions instead of ≈ 5% as planned, which could have been classed as a 'significant' check.
	Attrition rate	My initial aim had been to collect 20 data sets. On reflection, however, the amount of data I had to work with proved sufficient to give a good breadth and depth of analysis.

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		I wonder how I would have I encapsulated individual stories within the general themes had there been more accounts to analyse. Indeed, phenomenological analysis is often conducted on individual cases or with only 3-5 participants (Giorgi, 2011). Smith recommends 8-12 participants for a PhD study using IPA (2012).

A major finding of the study was the importance of attending to individual accounts so more perspectives would have interesting and informative. Having said that, there was, perhaps, enough variation noted from the 10 stories here to make the point about the need to pay attention to individual perspectives.

Equally, there were a fair amount of general experiences noted by the 10 participants such that I suspect other accounts might have offered few further insights. |
| | Recruitment of participants | It was straightforward to ensure I recruited appropriate numbers of participants. I was present at least once a week at all sites and all staff there knew me and about my study. I managed the flow of participants myself, and was usually able to take on people for therapy as they required it. Occasionally, when I had spaces free, I would attend meetings to remind staff that I was seeking therapy clients who heard voices. That was always sufficient to generate new clients with whom I could discuss the study.

Only four people who satisfied the inclusion criteria and decided to start therapy declined to take part in the study. They received therapy as usual in accordance with the terms of the ethical approval. |
| | Post-therapy interview process | Most participants seemed happy and willing to take part in the post-therapy interviews. They were carried out in the same room as therapy had taken place.

During the interviews we often talked about the therapy space and it was then that Katie described how difficult she found it to come to the hospital because of negative associations for her, to say nothing of the long journey she had to make to get there and the stress she felt at travelling in hospital transport. |

		It was straightforward to arrange dates and times that were convenient for most participants and we tended to schedule the interviews for the two weeks following the end of therapy, at the same time as their appointments had been. The exceptions were Elaine, Gary and Rhiannon.

Elaine was about to move to a different hospital so our therapy had to end. She came to our first interview and assured me she was happy to take part. As noted in the text, however, I called a halt to the interview as she was finding it so distressin. I later got a message from the unit staff that she did not feel able to take part in a second interview. I made sure I spoke to her to reassure her that it was not a problem and to wish her well at her new hospital.

Elaine's distress highlights the need for sensitivity on the part of researchers when talking to people about difficult issues, especially if they are known to be vulnerable.

Gary had moved away so we had to conduct the interviews over the phone on loud speaker to enable recording.

Rhiannon was unavailable for some time. Once we were in the interviews, however, she seemed willing to take an active part and gave thoughtful answers to the questions. It did seem like an imposition for her though and she did not want to see her transcripts to ensure accuracy, nor review the resulting analysis. I got the impression from her and from Olivia that, once therapy had ended, they wanted to move on from it and did not want contact with anything that would remind them or connect them with that difficult time in their lives.

All participants apart from Elaine offered that they felt comfortable with the questions they were asked and enjoyed the process of reflecting on how they felt about their therapy, the voices they had, or still, heard and how they felt compared with how they had felt before therapy.

Several noted that they were also reflecting on things differently as part of the interviews. Paula, for example, noted that she had not realised how the |

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		process had worked for her until we came to be talking about it in the interviews.
	Recording of interviews	This was straightforward as it was what participants expected. When alerted to what would be involved in the process, several commented that they were surprised when they remembered that their therapy sessions had also been recorded as they had not been aware of the recorder there.
	Preparation of transcripts	Transcripts of the first post-therapy interviews were completed by me in advance of the second interviews in all cases. They were discussed with participants in second interviews apart from with Elaine (no second interview).
	Approval of transcripts and analysis	All participants agreed the transcripts were accurate and several commented on how interesting they were (Tina, Paula, Katie, Fabien) and how surprised they were at how much they had said (Tina, Fatima, Fabien). Transcripts of second post-therapy interviews were sent by email or post to those who requested them (Paula, Fabien, Tina). No feedback was received but I did receive an acknowledgment from Fabien. I had included the option for participants to receive copies of transcripts and draft analyses in the information sheet and on my applications for ethical approval. As it happened, however, there was such little feedback on transcripts, and so few people wanted to see the analysis, that it does not feature in this study. It seems that people appreciated being offered the option but did not want to pursue it. Another factor was the time delay between my final contact with participants and my completing the analysis in a form that could be sent to them. A draft of my overall impression of what two participants were trying to convey was sent to them in 2013. One responded very positively, both about the accuracy of my understanding and about the themes I had identified. No reply was received from the other participant who had requested it.

Data analysis (information included at Appendix G)	Thematic analysis	My original intention had been to carry out a reflexive-relational, phenomenological thematic analysis (Finlay & Evans, 2009). But I had so much data and was trying to answer two research questions. I found I could not, successfully, achieve this. It is, instead, informed by existential-phenemenology but does not analyse in as much depth as I had hoped. Those data are, however, available for further analysis later.
	Read transcripts	Transcripts were read and re-read to gain a sense of what each participant was saying. This enabled me to get a feel for the overall themes that might be emerging across all participants – both similarities and differences in experience. As with all other stages in the analysis, I tried to remain open to the meanings that participants were trying to convey, whilst remaining aware of how my own ideas might be affecting what I read. It involved monitoring that I had empathically grasped the participants' meaning or imposed meaning based on my own values, experiences, assumptions. I found it relatively straightforward as it is an attitude I have been trained in and developed through my work as a therapist. But it was sometimes difficult to separate myself as therapist from myself as researcher. It was a combination of a methodical and systematic reading with a more intuitive sensory dwelling-with to see what emerged This cannot, nor is intended to, offer a direct representation of what a participant meant, were such a thing even possible. Apart from the selection employed by the participant when answering questions, I could not be completely divorced from the process. However much I reined in my own prejudices, assumptions and experiences, however much I monitored the effect they still had, however empathic I remained to the participants accounts of their experiences, my resulting understanding has still just been one interpretation of what participants said refracted through my lens, through the distance from when the interview took place, and through the medium of reading a transcript of a face to face encounter. It was then

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		further refracted as it came to form a written part of an overall thematic analysis.
	Code data for meaning	I made notes about possible themes or sub-themes that each piece of relevant data might represent. Not all data appeared relevant to the research questions.
	Identify themes	Once data had been coded in this way, I was able to make a list or map of all the themes that data related to. There were many different ideas at this stage. I made several charts which linked all the themes in different ways to try and delineate which might be main themes or sub-themes and which fitted together.

This process involved going back and forth between transcripts, coded data and theme to see which pieces of data fitted best where and how best to structure the overall narrative to give a comprehensive account that covered all I wanted to convey in a coherent way.

I wrote notes on several different themes using quotations to support the ideas and I tried to ensure I captured the range of experience within each.

Sometimes it became clear that initial themes I had identified were better included as sub-themes elsewhere.

Again, this process involved a dwelling-with to try and get a feel for whether I had captured a coherent overall picture of what these accounts.

The themes I developed changed several times before the final analysis. |
| | Iterative between raw data and themes identified | This was a combination of a technical process of checking that what I had identified was supported by raw data from transcripts and a more sensory process of "does this convey the feel of what I construe participants to mean?"

It was interesting to note my sense of ease once I got to the stage of the themes presented here. I felt able to trust that I had managed to find a structure that encapsulated the feel of what all participants had said to me, the personal meanings they attached to hearing voices and to their person- |

		centred therapy and that I had captured the breadth and depth of those experiences.

It was a struggle to let go of some of the sub-themes I identified initially but I was also aware of the struggle I had previously felt to 'make sure' I fitted them in somewhere. Once I had got to the stage of working with the final themes here, I reflected that those initial themes were included anyway. That contributed to the feeling of comfort associated with reaching the final narrative. |
| | Code data for each theme using fractions of lifeworld

(See Appendix B) | This discipline enabled me to check again that the themes reflected the data and that I was working with a representative group of themes that provided an answer to the research questions.

It also demonstrated that the data could be investigated for each person according to those fractions and just how an overall lifeworld might be constituted of those interdependent elements. I found it extremely useful in highlighting similarities and idiosyncrasies which helped when I was trying to express the breadth of experiences and views in the final written analysis

Using the fractions as a framework helped me also to retain the phenomenological attitude of trying to capture participants' lived experiences in an empathic way. It enabled me to move between the data and different facets of each theme. Once again, technique, system and method facilitated the intuitive or sensory process.

It also grouped the data into sections that allowed me easily to select evocative quotations to illustrate different points and to ensure that I represented the full range of experiences and gave voice to all participants, especially those who were less articulate of where data was less rich. |
| | Write themes | This was straightforward in both analyses I completed (2014 and the final one presented here). Again, it involved returning to the raw data regularly. |

Glossary

Glossary

Abbreviation	Name	Description
APA	American Psychiatric Association	The main professional organization of psychiatrists and trainee psychiatrists in the United States, and the largest psychiatric organization in the world.
AVH	Auditory and Verbal Hallucinations	The medical terms for hearing voices
BACP	British Association for Counselling and Psychotherapy	A professional body for counselling and psychotherapy in the United Kingdom.
BPS	British Psychological Society	A representative body for psychologists and psychology in the United Kingdom
CBT	Cognitive Behavioural Therapy	A form of talking therapy that has been widely researched in the UK and elsewhere. Recommended treatment for a variety of mental health issues
CBTp	Cognitive Behavioural Therapy for Psychosis	A form of talking therapy developed from CBT for specific use with people suffering from psychosis
CMHT	Community Mental Health Team	Team co-ordinating care for out-patients of NHS mental health trust
DA	Discourse Analysis	A research method within Discursive Psychology that tends to operate from a social constructionist perspective, assuming there is 'nothing outside the text'. We construct our worlds through language and are constructed by it. The analysis examines the rhetorical devices by which we construct that world
DSM5	Diagnostic and Statistical Manual, fifth version (APA, 2013)	A manual produced by the APA that classifies 'mental illnesses' and 'disorders'. Widely used in USA especially for purposes of healthcare insurance,
EIS	Early Intervention Service	A team within a mental health trust which focuses on care of (usually young) people who are regarded as at risk of developing 'psychosis'.
FDA	Foucauldian Discourse Analysis	A research method within Discursive Psychology. But, unlike DA, it assumes that language affects and is affected by structures that are historically, culturally and socially situated. The method takes account of those structures in analysing what people say
HVM	Hearing Voices Movement	The name given to organisations and individuals who follow the approach to understanding HV and helping VHs that was developed from the work of Marius Romme and Sandra Escher.
HVN	Hearing Voices Network	A service user led, peer support organisation offering advice, support and information to VHs. Espouses the values of the HVM

ICD – 10	International Classification of Diseases, 10th version (WHO, 1992)	A manual produced by WHO that attempts to classify illnesses and diseases. Used widely, especially outside the USA. Chapter V deals with 'Mental and Behavioural Disorders'.
IPA	Interpretative Phenomenological Analysis	A research method used for exploring individual accounts of concrete lived experience. as the name suggests it offers an interpretation of what that meaning might be and usually offers a thematic analysis across a small number of participants that tries to identify commonalities and differences.
MHA	Mental Health Act, latest version 2007	UK legislation 'in relation to mentally disordered persons'. It amends the Mental Health Act 1983 and the Mental Capacity Act 2005. It applies to people in England and Wales.
NHS	National Health Service	The publicly funded healthcare system for the UK
NICE	National Institute for Health and Care Excellence	Provides national guidance and advice to improve health and social care. It makes recommendations on treatments and interventions that can be funded by the NHS
PCA	Person-centred approach	A humanistic approach to understanding people and what motivates them. It was developed by US psychologist, Carl Rogers and he advocated the application of its principles in many areas including education, conflict resolution and personal development. Person-centred therapy is the form of therapy associated with it.
PCT	Person-centred therapy	A form of non-directive talking therapy developed by US psychologist Carl Rogers
RCT	Randomised controlled trial	The 'Gold Standard' of research required by policy makers and funding bodies. Used to measure effectiveness of treatments, drugs etc.
WHO	World Health Organisation	A global health organisation set up under the aegis of the United Nations whose primary role is to direct and coordinate international health within the United Nations' system.