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**Portfolio for Professional Doctorate in  
Counselling Psychology (DPsych)**

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## Table of Contents

<b>Table of Contents</b> .....	2
<b>List of tables and figures</b> .....	7
<b>Acknowledgements</b> .....	8
<b>City University Declaration</b> .....	9
<b>Preface</b> .....	10
<b>Part 1 - Doctoral Research</b> .....	13
<b>Abstract</b> .....	14
<b>Introduction</b> .....	15
What are voices that tell you what to do? .....	15
Terminology.....	15
Prevalence .....	16
Compliance with command hallucinations .....	17
Command hallucinations and risk .....	22
Command hallucinations and distress .....	23
Relationship with voices .....	25
Stigma .....	28
Psychological interventions .....	30
Personal reflexivity .....	32
Study rationale .....	34
Aims of the study.....	36
<b>Method</b> .....	37
Study design.....	37
Rationale for adopting a qualitative research design .....	37
Epistemological standpoint.....	38
Choosing which methodology .....	40

Interpretative Phenomenological Analysis .....	41
Rationale for adopting IPA .....	45
Reflexivity .....	46
Validity .....	48
Sampling.....	51
Inclusion criteria .....	51
Recruitment .....	52
Participants.....	54
Interview procedure.....	54
Ethical considerations .....	56
Analysis .....	58
Methodological reflexivity .....	60
<b>Results and Analysis .....</b>	<b>63</b>
Overview.....	63
<b>Super-ordinate theme one: Unwanted experience .....</b>	<b>65</b>
Sub-theme one: Emotional impact.....	65
Sub-theme two: Impact on quality of life .....	67
Sub-theme three: Coping .....	69
<b>Super-ordinate theme two: Engagement .....</b>	<b>72</b>
Sub-theme one: Voice as negative/positive .....	72
Sub-theme two: Identity of voice .....	74
Sub-theme three: Response to voice content.....	77
Sub-theme four: Power .....	80
<b>Super-ordinate theme three: Relationship with others .....</b>	<b>82</b>
Sub-theme one: Impact on social relationships .....	82
Sub-theme two: Relationship with professionals .....	85
<b>Super-ordinate theme four: Sense-making .....</b>	<b>87</b>
Sub-theme one: Purpose .....	88

Sub-theme two: Time .....	90
Sub-theme three: Confusion .....	93
Sub-theme four: Questioning self.....	95
Summary .....	97
Reflexivity .....	98
<b>Discussion .....</b>	<b>100</b>
Theoretical insights .....	100
Implications for practice.....	110
Implications for policy .....	115
Critique of methodology and suggestions for future research .....	117
Conclusion.....	120
<b>References and Appendices .....</b>	<b>124</b>
References .....	124
Appendix A: Recruitment presentation.....	136
Appendix B: Health professionals flyer .....	141
Appendix C: Participant flyer .....	142
Appendix D: Participant information sheet .....	143
Appendix E: Consent form .....	146
Appendix F: Participant vignettes.....	147
Appendix G: Interview schedule.....	149
Appendix H: De-brief document .....	150
Appendix I: City University ethical approval .....	151
Appendix J: NHS ethical approval.....	155
Appendix K: Analysis of transcript (Holly) .....	158
Appendix L: Table 1: Emergent themes (Louise).....	162
Appendix M: Mind map of super-ordinate themes (Fred) .....	166
Appendix N: Table 2: Super-ordinate table of themes (Jack) .....	167
Appendix O: Photograph - analysing across cases .....	168

Appendix P: Table 3: Over-arching themes, super-ordinate themes, sub-themes and quote locations .....	169
<b>Part 2 - Professional Practice: Advanced Case Study .....</b>	170
<b>Introduction and the start of therapy .....</b>	171
Rationale for the choice of the case.....	171
Summary of theoretical orientation .....	171
The referral and context for the work .....	173
Biographical information.....	173
Convening the first session .....	174
The presenting problem .....	174
Initial assessment and formulation.....	174
The contract and therapeutic aims.....	176
<b>The development of the therapy.....</b>	176
The pattern of therapy.....	176
The therapeutic plan, key content issues and main techniques used .....	177
The therapeutic process.....	179
Difficulties in the work and how they were addressed .....	181
Changes in the therapeutic process over time.....	183
<b>The conclusion of the therapy and the review.....</b>	184
The therapeutic ending.....	184
Evaluation of the work .....	185
Liaison with other professionals .....	185
What I learnt about psychotherapeutic practice and theory.....	185
Learning from the case about myself as a therapist .....	186
<b>References and Appendices .....</b>	188
References .....	188
Appendix A: Figure 1: Formulation diagram.....	193
Appendix B: James's fear hierarchy.....	194

Appendix C: The therapeutic plan and main techniques used .....	195
<b>Part 3 - Critical Literature Review.....</b>	<b>196</b>
<b>Introduction .....</b>	<b>197</b>
<b>Reviewing the literature .....</b>	<b>200</b>
Overlap between psychosis and ‘normality’ .....	200
Overlap between psychosis and other mental health difficulties .....	203
Alternative classification systems arising from the continuum theory .....	205
Criticisms of the continuum theory .....	208
Summary .....	210
<b>Conclusion.....</b>	<b>210</b>
<b>References .....</b>	<b>215</b>

## **List of tables and figures**

### **Part 1: Doctoral Research**

Figure 1: Map of themes.....	64
Table 1: Emergent themes (Louise).....	162
Table 2: Example of super-ordinate table of themes for Jack .....	167
Table 3: Over-arching themes, super-ordinate themes, sub-themes and quote locations .....	169

### **Part 2: Professional Practice: Advanced Case Study**

Figure 1: Formulation diagram.....	193
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**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR  
DATA PROTECTION REASONS:**

**Appendix K:** Analysis of transcript (Holly) ..... 158-161

**Part 2 - Professional Practice:** Advanced Case Study ..... 170-186

## Acknowledgements

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## **City University Declaration**

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## Preface

This portfolio represents the culmination of many years spent working to become a Counselling Psychologist. Along this journey, an area that has particularly captured my curiosity and fuelled my passion to practice has been psychosis. Psychosis is a somewhat elusive phenomenon and yet it often leaves destruction and distress in its wake. Those affected by it frequently seek support from mental health services, bringing them into contact with Counselling Psychologists. What has always struck me about these clients is their strength and commitment to life; how despite facing what appears to be extreme torment, they can manage to find fight within them that I find inspiring and a testament to the human spirit. The stories of people who have experienced psychosis or psychotic features are complex and therefore in order to really appreciate the richness of this phenomenon, careful attention needs to be paid to it within research, theory and practice. This portfolio attempts to tell some of their stories.

This portfolio is comprised of three different pieces of work, all focusing on the topic of psychosis in relation to the practice of Counselling Psychology. The first piece is a research study qualitatively exploring the experiences of people who hear voices that tell them what to do. Secondly, an advanced case study illustrating a reflexive exploration of the work undertaken with a client struggling to manage the legacy of a psychotic episode is presented. Finally, there is a critical review of the literature exploring the continuum theory of psychosis. The first piece to be written was the critical literature review, followed by the client study and then the research. This order mirrors my development as a Counselling Psychologist working with psychosis: beginning at attempting to understand what psychosis was and how it related to everyday experiences, learning more about it and how to work with it therapeutically, to wanting more in-depth knowledge of what it is really like for the individual experiencing it to enable me to be the best practitioner I can be. An overview of each piece of work is now presented providing a more thorough explanation of what it consists of, as well as its intentions.

### **Part 1 - Doctoral Research**

This section presents an original piece of research intended to explore, in-depth, the lived experience of people who hear voices that tell them what to do (or 'command voices'). This experience is often referred to as 'command hallucinations' within the literature and refers to a specific type of auditory experience whereby the voices heard issue commands to the

voice hearer. Work began for this study at the end of my first year of training, although the idea and initial questions that brought about this study arose a few years earlier when working with this specific client group. What emerged from this previous work was a feeling that the perspectives of the people who knew most about this experience, the clients themselves, were somehow, unwittingly being overlooked within the research. Within this study, data were gathered from semi-structured interviews conducted with seven participants who were all currently hearing command voices. These participants all shared their experiences of living with voices that told them what to do. Particular focus was placed on exploring their lived experience, as well as their relationships with the voices and possible stigma encountered as a result of their experiences. The data were analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). The analysis focused on the meaning-making participants attributed to their experiences and several themes emerged across participants. The observations made are discussed in terms of the implications for clinical practice and policies. In addition, implications for theory are considered in relation to novel observations and confirmation of existing theories. The report also details a reflexive account throughout of the journey undertaken with the research. It is hoped that the findings from this study may be helpful for Counselling Psychologists working with this client group.

### **Part 2 - Professional Practice: Advanced Case Study**

This section consists of an example of clinical work in the form of an advanced case study, which was conducted and written up in my final year of training. This piece summarises the therapeutic journey of the collaborative work I conducted with a client recovering from an acute psychotic episode. Although not currently experiencing signs of psychosis, the client was experiencing social anxiety as a result of the legacy of his psychotic episode and the fear that he would be judged "crazy" by others. Cognitive Behavioural Therapy (CBT) was used as the model in which to formulate the client's problem as well as the therapeutic approach adopted to help address the presenting difficulties. The piece follows the work through to completion and highlights the key interventions used and the rationale for doing so. A reflexive stance is adopted to explore the therapeutic process as well as difficulties in the work and how they were overcome. The case study concludes by evaluating the work and reflecting on how it has impacted upon my practice and my growth as a Counselling Psychologist. The work highlighted a need that in order to be an effective evidence-based practitioner, one must be able to think about and challenge where necessary the empirical recommendations available. The case study aims to document my clinical skills, my

awareness of and ability to use theoretical knowledge to guide my practice, as well as my reflexive skills. In particular, the aim was to demonstrate competency in my chosen therapeutic model.

### **Part 3 - Critical Literature Review**

This section is comprised of a systematic and comprehensive critical appraisal of the existing literature on the 'continuum theory of psychosis' from a Counselling Psychology perspective. The piece was originally written in the first year of my training, although it has since been updated. The continuum theory of psychosis postulates that psychosis is not a discrete entity that some people have and others don't, but instead that it is an inevitable part of the human condition and as such, lies on a continuum with 'normality'. The review explores what led up to the creation of this theory and the evidence both for and against it. Areas such as the overlap between psychosis and 'normality' and between psychosis and other mental health difficulties, as well as more recent developments of the original theory and criticisms of it are discussed. This piece adopts an original stance by synthesising and critiquing this material in order to explore the current status of the debate surrounding the theory and highlight areas for future development. The main aim of this review is to examine whether or not the continuum theory of psychosis is a help or hindrance for the clinical practice of a Counselling Psychologist. Evidence is presented for both sides of the argument, and in reviewing this evidence, a position is taken that the continuum theory can be considered a help to clinical practice.

## **Part 1 - Doctoral Research**

**The experience of hearing voices that tell you  
what to do**

**Supervised by Dr Courtney Raspin**

## **Abstract**

Voices that tell you what to do, or ‘command voices’, are often distressing and disabling. Despite this, our understanding of them is somewhat limited and currently there are few effective treatment options available. Research into this phenomenon has been largely quantitative and researcher-led, investigating the link between command voices and violence/risk, what motivates compliance with the commands and more recently, how to improve treatment options. Qualitative exploration of what it is like for the individual to have this experience has been neglected. The present study explored the experiences of 7 participants who heard command voices. Semi-structured interviews were conducted and the data analysed using Interpretative Phenomenological Analysis (IPA). Four super-ordinate themes emerged: ‘Unwanted experience’, ‘Engagement’, ‘Relationship with others’ and ‘Sense-making’. Nestled within these themes were sub-themes that explored a variety of different facets. The data revealed that hearing command voices was a distressing and unwanted experience that negatively impacted upon the participant’s quality of life, emotional wellbeing and social relating. It also appeared that participants had formed relationships with their voices. Despite finding hearing command voices confusing, all strove to try to make-sense of their experiences. The observations made are discussed in terms of implications to clinical practice, theoretical understanding and policy. It is proposed that the insights gained into the lived experience of this phenomenon may be helpful for Counselling Psychologists working with this client group.

## Introduction

### What are voices that tell you what to do?

Voices that tell the person what to do are usually referred to in the existing literature as 'command hallucinations'. They are distinguished from other types of what the literature refers to as 'auditory hallucinations' by the presence of a voice instructing the individual to engage in a particular action, and are claimed to be the most prevalent form of auditory hallucination (Nayani & David, 1996; Reynolds & Scragg, 2010).

Command hallucinations have recently gained more attention as they are often considered to be potentially harmful to the individual/others, and indeed are claimed by some to be the most dangerous symptom of schizophrenia (Braham, Trower & Birchwood, 2004).

There are three generally agreed upon types of command hallucinations: commands that are benign in content (often referred to as 'innocuous'), commands to harm the self, and commands to harm others (Reynolds & Scragg, 2010).

### Terminology

In the existing literature, voices that tell you what to do are most frequently referred to as 'command hallucinations'. In order to accurately reflect the current research in this field, I felt it necessary to adopt this term in the literature review. However, it is important to acknowledge that the word 'hallucination' makes an assumption that the voice is *not* real. Generally, hallucinations are thought of as perceptual experiences that are not the result of actual stimulation of the relevant sensory organ and so are believed to be distinguishable from real perceptions (Colman, 2009). However, studies have indicated that to the voice-hearer, the voice can feel very real (Beavan, 2011). Indeed, my preferred definition of 'hallucination' is provided by David (2004), as it highlights the subjective nature of them and the fact that for the individual concerned, the experience can feel completely real:

*A sensory experience which occurs in the absence of corresponding external stimulations of the relevant sensory organ, has a sufficient sense of reality to resemble a veridical perception, over which the subject does not feel s/he has direct and voluntary control, and which occurs in the awake state. (p.110)*

As the epistemological stance of the present study does not subscribe to the notion of a single objective reality, but rather in many subjective realities (please see ‘Epistemological standpoint’ within ‘Method’ for further details), use of the term ‘command hallucination’ felt inappropriate and misleading. In addition, its use could be perceived, especially by individuals who do not consider their experiences to be unreal, as pathologising and labelling.

Counselling Psychology places an emphasis on the therapeutic relationship and the importance of taking a non-judgemental stance towards a client’s own reality. In order to remain in keeping with this approach and to adopt a more client-led position through mirroring their own language choice, use of the word ‘hallucination’ and therefore the term ‘command hallucination’ was restricted only to where it was deemed necessary and the terms ‘voices that tell you what to do’ or ‘command/commanding voices’ were used instead. In addition, any other assumptions concerning whether the experience was ‘real’ or not, were avoided wherever possible.

Similarly, the available literature was predominantly quantitative, adopting a realist position. Although I endeavoured to convey the key findings in the field, at the same time I tried to stay close to my own epistemological stance of not assuming a generic truth. I therefore have presented the findings reported by each researcher in an attempt to convey their experience of their work rather than to lay claim to an absolute truth.

## **Prevalence**

The prevalence rate of command hallucinations varies extensively across the existing literature, leading to a somewhat unclear status. For example, Barrowcliff and Haddock (2006) claimed that 30-50% of psychiatric inpatients reported experiencing some form of command hallucinations, whereas Buccheri, Trygstad and Dowling (2007) quoted prevalence rates from 18-89% but lowered this to 7-70% for harmful commands.

This extreme in variation at times renders the figures confusing and raises many questions. Buccheri et al. (2007) astutely pointed out that these rates may have varied due to under-reporting by patients reluctant to disclose the occurrence of command voices to clinical staff and forensic patients fearful of being detained for longer, as well as over-reporting by malingering forensic patients. Despite the variation, there appears to be a consensus that the occurrence of command hallucinations is relatively common.

However, it is worth noting that these prevalence rates pertain to clinical and/or forensic populations as to my knowledge, there has been no research into this in a non-clinical population<sup>1</sup>. However, it is well known that voice-hearing is common in the general population (McCarthy-Jones, 2012; Romme & Escher, 1989). Indeed, Davies, Griffin and Vice (2001) claimed to find that in a study of 29 members of an evangelical Christian church with no history of receiving treatment for mental illness, 59% reported hearing voices.

### **Compliance with command hallucinations**

Research to date has largely directed its attention to the matter of whether or not a person complies with command hallucinations. Although the rate of compliance varies across studies, overall, fairly high rates were reported. For instance, Chadwick and Birchwood (1994) reported rates of 89% whereas Bucci et al. (2013) reported a more moderate rate of 62% and 31% for compliance with commands containing a benign content and self-harming commands, respectively. This focus on rates is likely to be due to perceived social implications, as compliance with commands to harm can pose serious threat to the individual or others (Braham et al., 2004). In their comprehensive review of the compliance with command hallucinations literature, Braham et al. (2004) drew attention to the mixed findings across studies and pointed to the idea that compliance with commands was likely for some individuals. Efforts have therefore been made to try to understand what motivates compliance in an attempt to help devise ways to reduce it. While some studies showed high rates of compliance, others showed little to no compliance. However, all implied command hallucinations could exert some influence over behaviour. The authors suggested the variation in findings may be accountable by methodological difficulties that occurred within particular studies. They also proposed that the concept of compliance may be more complex than researchers had initially assumed and that compliance was likely to be mediated by psychological processes.

Although the reasons for complying with command hallucinations may be complex and differ from person to person, common mediating factors have emerged across the literature (see Braham et al., 2004 for a full review). In a ground-breaking move, Chadwick and Birchwood (1994) proposed that voices could be understood in terms of a cognitive formulation inspired by Beck's cognitive model of depression (Beck, Rush, Shaw & Emery, 1979) which

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<sup>1</sup> Similarly, as far as I am aware, the entire body of literature on command hallucinations focuses on clinical/forensic populations.

postulated that an individual's behaviour and affect are the result of negative beliefs. Birchwood and Chadwick (1997) went on to suggest that it was the beliefs held about the voice that acted as mediating factors in the behavioural and emotional response to it, rather than the voice activity per se. Similarly, Mawson, Cohen and Berry (2010) reviewed 26 studies investigating the relationship between appraisals of voices and different emotional reactions. They concluded that appraisals linked to greater distress were those where voices were perceived to be malevolent, powerful or dominant, personally acquainted with the voice-hearer and where the individual disapproved of/rejected the voice.

The shift in perspective offered a welcomed re-focusing from research based solely on voice topography and content, and has since fuelled exploration into the beliefs held about voices, particularly within compliance research. This shift is particularly pleasing within the field of Counselling Psychology, as focusing on the meaning behind behaviour and distress is concordant with the traditions of the profession. Within the research exploring beliefs about voices, two particularly dominant factors emerge: beliefs about the power of the voice and beliefs about its malevolence/benevolence. Both these areas shall now be discussed in more detail.

### **Power**

One of the most widely researched mediating factors for whether a person complies with their command hallucinations is the perceived power of the voice. Indeed, it has been argued by Hayward, Berry and Ashton (2011) that command hallucinations are the most disempowering type of voices. Chadwick and Birchwood (1994) defined power as the beliefs the person holds concerning how much control they can exert over the voice and how much they feel they need to comply. In their study, they found that all of the participants reported their voices were extraordinarily powerful.

This has been supported by further research. Beck-Sander, Birchwood and Chadwick (1997) set out to examine the influencing factors of compliance with command hallucinations. Participants had diagnoses of schizophrenia and related disorders and had all experienced auditory hallucinations, including commands, for at least one year. Their findings suggested that the more powerful the voice was perceived to be, the more likely the individual was to comply with commands given. Similarly, the more an individual believed they could exert control over the voices, the less likely they were to comply. Further support for a link between compliance and perceived voice power came from a randomised controlled trial

(RCT) of cognitive therapy for command hallucinations (Trower et al., 2004). In this study, a course of cognitive therapy, specifically designed to target the perceived power of the voice, was delivered to half the participants. The remaining half received 'treatment as usual'. The study found large reductions in the level of compliance with commands in the therapy group. In addition, there were significant improvements reported in the degree of conviction in the power of the voice, its superiority, and the need to comply. These latter findings were only seen in the therapy arm of the trial, leading the authors to claim an association between perceived voice power and compliance behaviour.

Milgram's classic study on obedience in 1974 provides an illuminating explanation for why power may influence compliance. In his study, Milgram claimed that whether an individual could be persuaded to administer a lethal electric shock to another participant depended on the perceived power of the experimenter, their own degree of control and the assumed consequences of non-compliance. Chadwick and Birchwood (1994) suggested that Milgram's findings were transferable to command hallucinations (with the voice taking on the role of the experimenter) and offered an intriguing insight into why the perceived power of the voice may influence compliance with commands.

Birchwood and colleagues continued to explore the role of power in compliance with commands and have developed a highly intuitive and leading theory. It is based on social rank theory (Allan & Gilbert, 1995; Gilbert et al., 2001), which postulates that individuals compare themselves to those around them in terms of relative strength, power, social attractiveness, talent and sense of belonging to the social group and that this is done to gain an appreciation of where the individual fits in terms of being more or less inferior to others (Allan & Gilbert, 1995). If an individual perceives themselves to be inferior to a powerful and threatening other, they are likely to engage in escape or submission behaviours (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000). Applied to the experience of voice hearing, it is postulated that an individual may encounter a voice they consider to be more powerful and threatening than themselves, in which case they deploy strategies to protect themselves such as escaping, submitting or complying with commands in order to reduce the threat (Reynolds & Scragg, 2010). Indeed feeling trapped with a desire to escape was found to be particularly prevalent when the voice was perceived as powerful (Gilbert et al., 2001).

Perceived power of the voice has also been claimed to be the strongest determinant in the level of distress experienced by the individual (Peters, Williams, Cooke & Kuipers, 2012).

This study by Peters et al. (2012) extended earlier findings of an association between voice-power and distress (eg Birchwood et al., 2004; Birchwood et al., 2000). They used a wide range of measures assessing distress in individuals currently hearing voices and found that beliefs of voice omnipotence were associated with both voice-specific as well as general distress such as depression, anxiety, low self-esteem and suicide ideation. However, it is worth noting that this study was correlational in design, meaning causality could not be inferred for the relationship found, and did not refer exclusively to command hallucinations.

Birchwood et al. (2004) shrewdly proposed that in the same way hostile social relationships have the ability to negatively impact upon physiological and psychological processes, so too could internal relationships with voices. Fox, Gray and Lewis (2004) suggested this may be related to self-perceptions of low social rank leading to subsequent feelings of helplessness and hopelessness.

Power perception was also an emerging theme within a qualitative study by Mawson, Berry, Murray and Hayward (2011). This interesting study set out to explore the experience of hearing voices within the context of the individual's social environment. The study analysed data from 10 voice-hearing participants using Interpretative Phenomenological Analysis and observed that the relationship formed with the voice was often viewed as controlling and powerful.

### **Malevolence/benevolence**

In addition to power, the perceived malevolence/benevolence of the voice is also considered to be a significant mediating factor throughout the literature. Chadwick and Birchwood (1994) proposed that individuals formed opinions about whether their voices were malevolent or benevolent based on beliefs about identity, omnipotence and purpose. Voices perceived to be malevolent were more likely to be resisted whereas voices perceived to be benevolent were more likely to be courted. This finding was supported by other studies (e.g. Beck-Sander et al., 1997). Chadwick and Birchwood (1994) found that the primary mediating factor for compliance was how much the command violated a social boundary; with increased resistance if the command involved major social transgression or self-harm. However, one could argue that voices issuing commands involving major social transgressions are likely to be perceived as malevolent. The findings from Chadwick and Birchwood's (1994) study were based on structured interviews with 26 voice-hearing individuals diagnosed with schizophrenia/schizoaffective disorder. Participants were

questioned about a range of factors including beliefs about voice power, content, compliance, control and behavioural responses. The authors acknowledged the preliminary nature of this early study and the need for replication, as well as the lack of clear definitions and measurements of aspects such as malevolence.

While the above research supports the notion that perceptions of malevolence or benevolence influence compliance with commands, it has also been argued they have no impact on compliance (Fox et al., 2004). Fox et al. (2004) recruited 32 participants from forensic and non-forensic services who had received a diagnosis of schizophrenia and reported having heard harmful command hallucinations. Interviews were conducted that focused on the principal voice heard by the individuals within a 3-6 month period prior to their most recent admittance to hospital. Participants were questioned with measures designed to examine beliefs about the voice power and malevolence/benevolence, as well as their sense of inferiority/superiority within social relationships. The authors concluded no significant differences between those who complied and those who did not in terms of beliefs regarding malevolence/benevolence. However, the authors highlighted a distinct lack of beliefs of benevolence within their sample. It may be that the lack of any significant effect for voice malevolence could be accounted for by the lack of variability in the data as well as a relatively small sample size. It is also worth noting that the study employed a retrospective design which left it vulnerable to memory biases, especially as participants were being asked to recall information from up to a year ago.

Further support for the presence of beliefs surrounding malevolence/benevolence comes from the qualitative study by Mawson et al. (2011) who found participants appeared to perceive the voice as negative or positive, which in itself influenced their emotional responses.

In addition to beliefs about the voices, other areas have been explored that may influence compliance with commands, such as command content, presence of delusional beliefs concurrent with the command (Braham et al., 2004) as well as the perceived consequences of non-compliance and the individual's mood (Chadwick & Birchwood, 1994). A more recent study has also shown an association between levels of compliance and anger, anger regulation and impulsivity (Bucci et al., 2013). In this study, impulsivity appeared to be a reliable independent predictor of compliance. Although this was a preliminary study with a

modest sample size, it offered another promising line of enquiry into the mediators of compliance and demonstrated how understanding in this area continues to evolve.

The compliance literature is fraught with limitations such as the use of retrospective designs and self-report measures, which can increase recall biases. Moreover, self-reporting is susceptible to motivational influences such as a wish for discharge from hospital. In addition, it is worth considering the unavoidable limitation of compliance studies: that the individuals most likely to participate in research are those more likely to comply generally, therefore introducing an inevitable sample bias.

### **Command hallucinations and risk**

As discussed, the interest behind compliance studies appears to be driven by the idea that compliance can lead to major social transgressions. However, this assumption seems to be based on limited empirical evidence. McNeil, Eisner and Binder (2000) assessed 103 psychiatric inpatients for the presence of command hallucinations, violent behaviour, other psychotic symptoms and social desirability responses. They found that 30% reported having experienced commands to harm others within the last year, with 22% reporting having complied with such commands. Based on their findings, the authors stated that individuals experiencing command hallucinations are more than twice as likely to behave violently as those not experiencing commands. However, the authors highlighted that the relationship between commands and violence occurred in the context of other psychotic symptoms linked to violence such as paranoia. When these other factors were considered, commands did not appear to be uniquely associated with violence. Although the design of this study could be considered robust, it did employ a retrospective design as well as the use of self-report measures. This may have impacted upon validity although the analysis did attempt to control for propensities towards a social desirability response bias.

Interestingly, these findings were not replicated in a forensic sample. Rogers, Watt, Gray, MacCulloch and Gournay (2002) examined the relationship between harmful commands and incidents of violence in forensic inpatients. Patients were divided into two groups: those who heard commands, and those who did not. Data were analysed for incidences of observed violence (including self-harm) and the presence and content of commands. The findings suggested that harmful commands and violence were unrelated, although self-harming commands were claimed to be linked to self-harming behaviour. The authors cited a number of possible explanations for failing to replicate the findings of McNeil et al.'s (2000) study.

These included differences in methodology (case-notes versus participant interviews), limitations in the available data from case-notes, as well as differences between the two study environments (forensic versus non-forensic). An important limitation of this study was that the researchers were not able to determine whether the participants were hearing harmful commands at the time of their violence/self-harm. Therefore, the findings of this study can only be viewed as correlational and not causal.

Currently, our understanding of the relationship between commands and violence/risk is problematic due to conflicting findings across the literature. It has been reported that the rates of compliance with dangerous commands ranges from 0-90% depending on the definition and methodology used (Barrowcliff & Haddock, 2006). This again appears to be due to methodological variation across studies, a lack of clear definition and measurement of terms such as 'command hallucinations' and 'violence' as well as little focus on the content of commands (Rogers et al., 2002).

### **Command hallucinations and distress**

It is mentioned throughout the literature that voices are often distressing to those who experience them. Indeed voice power and malevolence/benevolence, as previously discussed, have been linked to distress. Birchwood et al. (2000) found that over 60% of individuals who heard voices felt 'severely depressed', and over 75% described their experience as 'highly distressing'. Close and Garety (1998) conducted a highly influential study investigating the emotional impact of voices. They assessed 30 voice-hearing patients using a semi-structured interview and questionnaires. Ninety-three percent reported experiencing a negative affect in relation to the voice, quoting emotional responses such as depression, anger, anxiety and fear. In addition, they found the majority also displayed poor self-esteem and a propensity to negatively appraise the self. A particularly interesting finding was that voices with positive content were viewed as benevolent whereas those with negative content were perceived to be malevolent. Participants were found to respond to malevolent voices with a more negative affect. However, the authors poignantly concluded that the very experience of voice-hearing seemed enough to produce a negative affect, even when the voice content was benevolent. They also highlighted the important consideration that many people hear voices with no negative affect and are not under the support of services (e.g. Romme & Escher, 1989). They therefore proposed that psychiatric diagnosis may be a confounding variable in voice distress.

Close and Garety (1998) suggested negative affect may in part be related to the perception of controllability over when the voice starts and stops. Indeed, Larøi et al. (2012) argued that the perception of not being able to control onset or offset of the experience could be a crucial determinant in the development of distress and transition from a non-clinical to clinical experience. Close and Garety (1998) also proposed a reciprocal relationship where the voice triggers negative affect and beliefs about the self, which in turn influences the individual's behaviour, acting to reinforce the negative views held about the self. Although this study focused on auditory hallucinations in general rather than solely on command hallucinations, the results are likely to be transferable, especially as some of the voices reported were commanding in nature.

What emerges from the literature is further support for a cognitive model of voices; where it is not the voice per se that causes distress, but the beliefs associated with it. This was nicely captured by Birchwood and Chadwick (1997) who concluded that it is the individual's meaning and interpretation of the voice that mediates distress. This is an important idea as it again highlights the subjectivity of voice-hearing, and suggests that understanding the individual's meaning-making is imperative in facilitating our understanding of the phenomenon.

It has also been suggested that distress caused by voices may also be associated with a lack of coping strategies (Nayani & David, 1996). In their study, 100 participants who had heard voices within the last 3 months were assessed using a semi-structured interview. The authors reported that participants regularly attempted to avoid hearing their voices through the use of various coping strategies. They noted high levels of distress were reported by those who felt they had little control over the voice and few means of coping. Furthermore, they claimed that individuals who regularly used coping strategies tended to report less distress. This study was an important illustration of how voice-hearers attempt to alleviate distress and go about doing so. It built upon the landmark study by Romme and Escher (1989) in which 20 participants were asked to describe their experiences of hearing voices. Within this study, participants discussed the use of coping strategies and it seemed that those who used them managed their experiences better than those that did not. The main types of coping mechanisms reported involved rejecting, ignoring and controlling the voice, with accepting the voice (described as a form of controlling) being particularly effective.

A recent study has also suggested command content may influence distress as instructions to harm or kill the self were positively associated with levels of depression (Hartley, Haddock & Barrowclough, 2012).

The topic of voice distress also emerged in a qualitative study by Beavan (2011), which adopted a phenomenological perspective to explore how 50 participants described the experience of hearing voices. Participants were recruited from the general population with some being service-users and some not. Through the use of thematic analysis one of the emerging themes captured the emotional impact of the experience, with some participants viewing it as positive whilst others viewed it as negative. However, due to the qualitative methodological approach, these findings cannot be generalised to all voice-hearers.

Although 'distress' is documented as a common feature of the voice-hearing experience, and indeed the word itself may be defined as extreme anxiety, sorrow or pain (Oxford Dictionary, 2014), it would appear that what this term may mean to the individual remains somewhat elusive. It has been discussed how distress may be mediated by factors such as voice content, the perception held of the voice and control over the voice. However, the variation in these factors highlights that despite 'distress' seeming to be a universally understood phenomenon, it actually may mean something very different to each person reporting upon it. If this is the case, then measuring distress becomes difficult as what a particular measure of distress may be able to capture may not truly represent what that individual's distress means to them. This is an important consideration as it is possible that current measures of distress may well be too crude to detect what is really meant by the term. This highlights the need for further clarification of what distress means to the individual and for caution to be paid when distress as an outcome is discussed.

## **Relationship with voices**

A growing body of literature has emerged exploring the nature of the relationship between the individual and their voice, and it has been proposed that the experience of voices can be understood within interpersonal frameworks (e.g. Hayward et al., 2011). Although there have been significant developments within this area more recently, this is not a new concept. Benjamin's (1989) seminal study explored the relationship between 30 psychiatric inpatients and their voices using both a quantitative and qualitative methodology. She summarised that all had integrated and interpersonally coherent relationships with their voices, as seen through features such as perceiving the voice to be hostile or friendly.

Researchers have since embraced the concept of there being a relationship between the individual and their voice as can be seen from the following quote from Chadwick, Birchwood and Trower (1996):

*Individuals experience their voices not as their own thoughts, but attribute them to others. Consequently, it is possible to view an individual's relationship with a voice as interpersonal, and indeed the relationship shows many of the dynamics common to ordinary relationships (p. 106)*

The tendency to personify and identify voices is prevalent across the literature (e.g. Mawson et al., 2011) and demonstrates the presence of a relationship between the individual and the voice. Close and Garety (1998) stated 70% of their participants were able to identify their voice. Romme and Escher (2000) proposed that identifying the voice may be important in helping the individual to make sense of it by connecting present and past experiences. Similarly, it has been proposed that personification may help the individual to achieve a more balanced relationship with their voice (Jackson, Hayward & Cooke, 2010). It has also been put forward that recognising the voice may influence compliance with commands as individuals may feel more inclined to follow the instructions of someone they know and trust (Braham et al., 2004).

The literature concerning the application of social rank theory to voices has frequently been cited as demonstrating a relational dimension between the individual and the voice. This seems an appropriate interpretation as the individual must first assess the nature of the relationship they have with their voice before assigning a rank to themselves. Indeed the very concept of voice power could arguably denote the presence of a relationship given the voice is only perceived to be powerful in *relation* to the individual.

Using Birtchnell's (1996) theory of relating, which proposed that relating occurs on two intersecting axes of 'proximity' and 'power', Hayward (2003) has expanded the concept of relating to the voice. Hayward's (2003) study set out to explore whether individuals hearing voices had a similar relating style with their voices as they did with others in their social environment. Twenty-seven people who had heard voices for 6 months or longer were assessed using measures designed to investigate relating to voices as well as relating to others. The study reported that individuals did relate to the voice in similar ways to how they

related socially. The author argued that instead of attempting to manage a new relationship with the voice, the person's relating may be influenced by pre-existing pervasive patterns of social relating. This study may have been limited by a modest sample size and low internal consistency of subscales on some of the measures. However, later studies have addressed some of these limitations and found similar results (Hayward et al., 2011). Other researchers have also reported a mirroring between voice relating and social relating (e.g. Birchwood et al., 2000). In fact it has been proposed that interpersonal schema may underlie all forms of relating irrespective of whether the relationship is with another individual or a voice (Birchwood et al., 2004).

Several qualitative studies have acted as a welcome addition to the literature on the nature of the relationship between the individual and their voice. Chin, Hayward and Drinnan (2009) explored the voice-hearer's perspective on relating to their voice. Their astute rationale was the uncertainty of whether this concept made any sense to the individuals themselves. Participants were interviewed using a semi-structured interview that asked questions exploring both the relationships the individual had with their voices and with other social contacts. Participants had all heard voices for the last year, and were involved in mental health services. The data from 9 participants were analysed using Interpretative Phenomenological Analysis. Three themes were discussed, which captured how the participants attempted to define the voices, how they viewed themselves in battle with the voice for control and power, and how they engaged with the voice to create an intimate link with it. A particularly interesting finding was the way in which the participants attempted to define the voice, which included describing it as sounding real, naming it, and personifying it.

Complimenting quantitative findings, the study also found participants readily described feeling subjugated and controlled by the voice. However, in striking contrast to the existing literature, which focuses on hearer-powerlessness and voice-dominance, the study found power and control were bidirectional as individuals were unclear how much power they themselves possessed and reported battling for more. One way in which participants appeared to feel the voice maintained its position of power was through issuing commands.

Interestingly, although most rejected the idea of a relationship, making it clear they just wanted their voice to go away, participants seemed to form a union with their voice. The authors highlighted that the rejection of this concept may have been related to participants' perceptions of what a relationship was, as many viewed it as being something positive. They

also felt the voice-hearing experience could be described as an evolving process. Overall, it was concluded that the concept of a relationship was both accepted and refuted by the participants.

Another influential qualitative study to further explore the concept of relating to voices focused on those who viewed their experience positively (Jackson et al., 2010). This study used Grounded Theory to analyse data from 12 participants (5 in receipt of mental health services and 7 who were not). The findings suggested that sense of control and reduced fear enabled the individual to assert themselves and have a better relationship quality with the voice. Three areas were considered to contribute to this process: the relationship between the individual and the voice, connection to a community, and development of a personally meaningful account of the experience. It was suggested that personifying the voice, engaging with it, asserting boundaries and creating a stronger sense of self all acted to improve the relationship between the person and their voice. Connection to a community could be seen through seeking understanding and guidance from others as well as spending time with people in a similar position. Finally, creating a meaningful account appeared to be influenced by various factors such as integrating and accepting the voice.

Further support for the concept of a relationship with voices can be seen from claims that voices can provide companionship (Romme & Escher, 2000) as well as guidance for the individual (Nayani & David, 1996). Similarly, other themes to emerge in Beavan's (2011) study were the tendency for voices to say personally meaningful things to the individual, the person's inclination to assign an identity to their voice achieved through recognising the voice or naming it, and the development of a relationship between the individual and their voice. The author drew attention to how voices perceived to be well-meaning usually had a positive content and the individual described the relationship with that voice, as well as the overall experience, as positive. Conversely, believing the voice had unpleasant content, led the individual to describe the relationship with the voice, as well as the overall experience, as negative. Furthermore, it was proposed that the voice could fulfil an adaptive function, for instance by providing a loving relationship that could not be found elsewhere. Altogether, the research in this area appears highly compelling and worthy of further exploration.

## **Stigma**

Stigma appears to be a common, yet unwanted bedfellow of mental illness (Time to change, 2013) and studies suggest this is something people experiencing voices often worry about

(Intervoice, 2013). Stigma is believed to lower self-esteem as well as hinder recovery of mental illness (Knight, Wykes & Hayward, 2003). In a qualitative study exploring stigma in schizophrenia (Knight et al., 2003), three interesting themes emerged: participants felt judged due to people's lack of knowledge, they compared their current life to how it was previously, and attempted to conceptualise and cope with their situation. The authors reported that through comparison, some of the participants felt abnormal, unhappy and no longer part of society, but others saw the experience as an opportunity for personal growth. Key coping mechanisms employed to manage stigma included social withdrawal and choosing not to disclose the experience to others due to fear of the effects of doing so.

Support for the idea that voice-hearers are concerned about stigma can be seen within the Jackson et al. (2010) study as both service users and non-service users discussed the fear and stigma surrounding voice hearing. Similarly, Beavan (2011) reported that participants were troubled by the stigma around hearing voices, causing them to feel confused, vulnerable and afraid to discuss their experience with others. Furthermore, Chin et al. (2009) found a tendency for participants to try to normalise their relationship with the voice. The authors argued this may have been a response to negative perceptions towards voice-hearing and therefore an attempt to retain an acceptable social identity. Similarly, they proposed the reluctance to accept the presence of a relationship with the voice may have been to protect the participant's 'normal' identity under the pressure of the stigma attached to hearing voices.

Mawson et al.'s (2011) study also supports findings on stigma, as participants spoke about how stigma negatively impacted on their self-worth. Participants also discussed how voice-hearing had a detrimental effect on how they perceived themselves socially and created a boundary between themselves and others in their social world. It appeared that one way this boundary was maintained was again through the participant withdrawing from social interactions. One other intriguing finding was that although maintaining a social identity was perceived to be difficult, social relationships appeared to facilitate the ability to cope.

The ways in which hearing voices, particularly command hallucinations are portrayed to the general public through media may well influence stigma. Newspaper headlines concerning command hallucinations are often highly evocative and fear inducing, as can be seen from the following headlines that detailed acts of compliance with commands: "Man hacked off neighbour's head after hearing voices" (The Guardian, 2009), "Voices in his head told driver

to kill a stranger, murder trial told" (Wales Online, 2012) and "Man murdered pregnant woman 'after hearing voices'" (The Telegraph, 2010).

The portrayal of hearing voices across the internet appears to be a mixture of informative resources and harrowing accounts of the experience. Seldom voice-hearing celebrities are known, although a few have openly discussed their voice-hearing experience such as Anthony Hopkins (Actor) and Zoe Wannamaker (Actress) (Hearing Voices Network, 2013a). Similarly, within film and television, there is limited exposure, all of which may in itself contribute to a lack of understanding. Films that do attempt to depict what it is like hearing voices include 'A Beautiful Mind' (Grazer & Howard, 2001) and 'The Soloist' (Foster, Krasnoff & Wright, 2009), which are adaptations of the true stories of John Nash (Nobel Laureate in Economics) and Nathaniel Ayers (Musician) respectively, who both experienced schizophrenia and heard voices. A recent dramatic documentary ('The doctor who hears voices': Regan, 2008) with the Clinical Psychologist, Rufus May, looked at a doctor who heard command hallucinations and the stigma associated with it. These media portrayals may provide an insight into the experience of voice-hearing, but it is worth noting that they all appear to depict the experience as a battle with an unwanted illness. Although this may be an accurate reflection of the experiences of many, the negative impact this may have on public perception and fear of the experience is worth considering. Furthermore, it may act to marginalise individuals who have a more positive experience of hearing voices.

## **Psychological interventions**

As previously discussed, some people who hear command hallucinations may not need or want psychological intervention. However, the role of a Counselling Psychologist would include being able to provide psychological therapy for those who find the experience distressing and disabling. To my knowledge, NICE has not issued any guidance on the recommended treatment for hearing voices, let alone command hallucinations. However in its guidance for schizophrenia (NICE, 2009), it stated that CBT and family work should be offered in addition to pharmacological interventions. The same recommendations are made in the draft guideline for psychosis, due for publication in 2014 (NICE, 2013). Command hallucinations are often considered to be medication-resistant (Braham et al., 2004) and many have argued that there are few effective treatments available (e.g. Trower et al., 2004). As a result of this, effort has gone into devising more effective psychological interventions.

An exciting new therapy has been proposed that uses cognitive therapy to specifically target command hallucinations (Trower et al., 2004). This therapy was informed by the cognitive model of voices and social rank theory and aimed to reduce the perceived power of the voice (see Meaden, Keen, Aston, Barton & Buccii (2013) for full therapy content details). In a pilot RCT of the therapy, participants were randomly allocated to either a 'treatment' or 'treatment as usual' control group and were followed up at 6 and 12 months. The authors reported significant reductions in compliance for those in the therapy arm compared to the control arm. In addition, they found the degree of conviction in the power of the voices and the need to comply had also fallen in the treatment arm, as well as distress and depression. These changes were maintained at the 12 month follow-up. There were several limitations to this study such as not having enough participants in each arm to satisfy the desired power calculations, as well as not being able to show that it was specifically this therapy rather than therapy in general that led to the differences seen. However the authors went on to conduct a major trial across the UK ('COMMAND Trial') to replicate these findings on a larger-scale (Birchwood et al., 2013; Birchwood et al., 2011). Currently under review, Birchwood et al. (2013) reported significant reductions in compliance and power beliefs, which were maintained at an 18-month follow-up. Interestingly, although these factors reduced, no significant results were found in the reduction of distress. It is possible that although the individual no longer felt a need to comply, they were still hearing the commands just as regularly and intensely. If this was the case and the commands were unwanted, this may account for why distress levels stayed the same. The findings of this study may lead one to ask who the therapy is truly for, as the work of a Counselling Psychologist is focused on improving the client's psychological functioning and well-being (Division of Counselling Psychology, 2013).

'Relating Therapy' may also be a promising therapeutic approach for those with command voices (Hayward, Overton, Dorey & Denney, 2009). Based upon Birtchnell's relating theory (1996) highlighting the importance of the nature of the voice-hearer relationship, it aims to modify the distressing relationship with voices (Hayward & Fuller, 2010). An initial pilot study was conducted with 5 participants who heard distressing voices and 4 out of the 5 reported some improvement in distress and/or level of perceived control. Hayward and Fuller's (2010) study explored the experiences of those involved in the Hayward et al. (2009) study (such as participants and relatives). They reported that most participants appeared to find the therapy helpful and positive. However, although participants may have heard command

hallucinations, the Hayward et al. (2009) study was not specifically targeted at this population.

Interest is growing into the possible application of Acceptance and Commitment Therapy (ACT) for voices. This may be on account of its focus on acceptance and tolerance, which as previously discussed, has been found to aid the coping of voices (e.g. Romme & Escher, 1989). Following initial positive findings from studies investigating the utility of ACT for people with psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006), one study investigated the effectiveness of CBT combined with acceptance-based approaches from ACT for people experiencing command hallucinations (Shawyer et al., 2012). Although the therapy was found to be more effective than not having any treatment, it was not found to be significantly different to befriending in terms of confidence to resist complying and in coping. The authors highlighted that this may be due to small sample sizes and insufficient qualitative difference between therapy and befriending in the short-term.

There have been some preliminary findings in support of a behavioural management course designed to help outpatients manage persistent command voices (Buccheri et al., 2007). This study found a 10-week specifically-designed course appeared to reduce harmful commands whilst improving other features of voice topography and overall distress. These effects were seen immediately after the course as well as at a 1-year follow-up. This study was replicated with inpatients (Buccheri, Trygstad, Buffum, Lytle & Dowling, 2010) but as yet no outcome data is available.

## **Personal reflexivity**

Prior to commencing the Counselling Psychology Doctorate, I was employed as a Research Worker on the ‘COMMAND Trial’ (Birchwood et al., 2013). My role involved interviewing participants and administering a number of assessment measures. This experience was one of the most eye-opening of my career. Whenever I explained my job to others, I was frequently met with curiosity and fear for my safety, a response that if I were to be completely honest, mirrored my own feelings when I first started the post. However, as time passed, I came to believe that those most “at risk” were the individuals themselves. Moreover, time and time again I was able to form strong and rewarding relationships with these participants and I quickly moved from a position of fear to one of admiration for their strength and commitment to search for a better quality of life. However, I became frustrated that although my perceptions had changed, those of the people around me had not. I soon found myself

trying to share my views in an attempt to open up other people's eyes. It was this quest to promote an alternative story about hearing command voices that acted as a major motivator for the current study.

Whilst working on the COMMAND Trial, I had a number of participants tell me they just wanted the opportunity to tell their story. Due to the focus of the trial and the quantitative approach taken, this was not possible and I often found myself having to close down communications that elaborated on their experiences, something I found disheartening. The present study provided me with an opportunity to rectify this situation to some extent, by giving a voice to others in a similar situation.

Another important aspect to highlight was that in my experiences as a Research Worker, I rarely came across individuals who perceived their experiences positively. Instead, the overriding impression I had was that the experience was highly distressing, something that is well supported within the literature (Birchwood et al., 2000; Close & Garety, 1998; Hartley, Haddock & Barrowclough, 2012). This impression has undoubtedly shaped my opinion of what it is like to hear command voices. This potential bias needs highlighting as despite my best attempts to 'bracket off' these assumptions (Husserl, 1927) and approach the participants and data with an open mind, I acknowledge that to some extent, this may not have been entirely possible.

In thinking about my drive to conduct the present study, I began to reflect on my own experiences of hearing voices that tell you what to do. Although I had no personal experience of this within a mental health context, I was aware of my own internal voice and the impact it had. My internal voice has the ability to be highly critical and when it has been in the past, I viewed it as unwanted and inescapable. However, through examining the relationship I had with it, I began to gain a greater level of understanding towards it, which helped me through times when it dominated. It is my hope that the current study may go some way in helping those who experience distressing command voices to do the same. This may be achieved through increasing the understanding of Counselling Psychologists and therefore helping them to help their clients.

It was hoped that providing an insight into my own experiences and the motivations behind the research would allow the reader to become aware of the lens through which the present

study was viewed. In doing so, transparency is offered, with the aim to increase the validity of the study (Yardley, 2000).

## **Study rationale**

Various important themes emerged from the literature review such as the beliefs a person holds about their voice, the emotional impact of the voice experience, the relationship between the individual and their voice, as well as the impact of the experience on social relationships. While much of this work has pursued the interests of the researcher, little attention has been placed on the subjective account of the individuals themselves. There are exceptions to this, as demonstrated by the comparatively few qualitative studies already discussed.

Many people experiencing command voices appear to find it highly distressing and disabling. Furthermore, the potential for compliance with harmful commands is quite rightly a significant concern not only for the individuals themselves, but for all those who work with and may come into contact with them. In 2004, Trower et al. suggested that despite the high prevalence rate of command voices, our understanding of this phenomenon is somewhat limited and few evidence-based effective treatments are available. After exploring the current existing literature, I feel this statement is still applicable.

Chin et al. (2009) stated that the literature exploring voice-hearing has tended to focus on the researcher's account of the experience at the expense of the individual's viewpoint and explanations. This is particularly the case within the literature on command voices. To date, research into command voices has been solely quantitative using questionnaire-based assessments. Research in the field has predominately investigated the link between command voices and violence/risk, as well as what motivates compliance with the commands. More recently, focus has begun to move towards improving available treatment options. Much of this existing literature has been researcher-orientated, focusing on what they felt was important to explore. Although this has provided an important insight into the experience of hearing command voices, the available findings may not be capable of capturing the depth of the experience and risk analyses being made that are not aligned with the understanding of the individual (Yardley, 2000). Focusing on the experience of the individual has been a welcomed recent addition in the hearing voices literature (Mawson et al., 2011) and a movement I intended to continue within the field of command voices. As far as I am aware, no qualitative study exploring command voices has been conducted, and in

particular, no qualitative research exploring what it is like for the individual to have this experience. This was a gap I hoped to bridge with the present study: the experience of hearing voices that tell you what to do.

It has been claimed that a detailed knowledge of the phenomenology of voices helps ensure explanatory models accurately reflect the experiences of voice-hearers as well as provide insight into what underpins it (McCarthy-Jones, Krueger, Larøi, Broome & Fernyhough, 2013a). Similarly, Garcia-Montes, Perez-Alvarez and Perona-Garcelan (2012) argued that participants should be given a chance to share their subjective stories and that by doing so, existing concepts can be refined. I particularly agree with the view of Knight et al. (2003):

*In order to provide holistic investigation into the experience of mental illness, the ‘expertise’ of the mental health consumer must be recognised as both valid and integral to increasing knowledge and understanding. (p218)*

Overall, there is only a relatively small amount of literature specifically focused on command hallucinations. The present study's literature review included some studies that provide leading theories in the more generic voice-hearing field. As command hallucinations are considered a sub-set of auditory hallucinations, I thought it was imperative that these studies be included, particularly as in many cases it was unclear whether some of the voices referred to were at times commanding in nature. It would be interesting to see whether some of the areas highlighted in the voice-hearing literature are as prominent within a command voices specific population. This is another gap the present study hoped to bridge. A particular area of interest in this respect was the work conducted exploring the nature of the relationship between the individual and the voice (e.g. Benjamin, 1989; Chin et al., 2009; Hayward, 2003), as to my knowledge this is yet to be explored specifically within the field of command voices.

With the prevalence rate of command voices appearing to be as high as 89% among psychiatric inpatients (Buccheri et al., 2007) and it often being considered a distressing experience that is resistant to medication (Trower et al., 2004), it is likely that Counselling Psychologists will come into contact with this client group. Therefore, one would hope that any information providing insight into the experience of hearing this type of voice would be a desirable addition in clinical practice. It was hoped this may enhance therapeutic engagement as well as guide the Counselling Psychologist in potential areas to consider.

Furthermore, as few effective treatments appear to be available, gaining knowledge about what the experience is like for the individual may well go some way in improving treatment interventions so that they can focus on what really matters to the client.

### **Aims of the study**

The present study aimed to gain in-depth understanding of the experiences of people who hear voices that tell them what to do through exploring the lived experience of this phenomenon. Additional focus was placed on the relationships the person had with their voices as well as possible stigma encountered as these appeared to be particularly pertinent areas within the existing literature on voices. As well as providing a platform for experiences to be heard, it was hoped that the insight gained from this research would lead to an increase in the knowledge and understanding of this phenomenon, which could potentially help improve treatment options. Moreover, it was hoped the study findings could have implications for Counselling Psychologists working with clients who hear command voices, in relation to providing a window into what this experience may be like from their perspective.

It was not intended that the research provide an explanation for the processes underpinning command voices as a qualitative study with small sample size would not allow the findings to be generalised. However, it was hoped that the provision of a detailed description of the experience could go some way in achieving this goal indirectly (McCarthy-Jones et al., 2013a).

## **Method**

### **Study design**

The study adopted a qualitative methodology of Interpretative Phenomenological Analysis (IPA). Data were obtained through semi-structured interviews which were later analysed in keeping with the methodological procedures of IPA.

### **Rationale for adopting a qualitative research design**

The present research emerged from a gap in the literature. To my knowledge, there was no previous qualitative research exploring command voices, and in particular, no qualitative research exploring what it is like for the individual to hear these commands.

Given the lack of knowledge in this area and in order to address the research question and build a better understanding, it was paramount that the research methodology used in the present study was exploratory in nature. Morrow (2007) states that due to the focus on process within qualitative methodology, it lends itself to enabling in-depth analysis and can be a useful approach for generating knowledge for a less-well understood phenomenon.

Qualitative methodology seeks to explore the subjective experience of the individual (Willig, 2008). As the present study aimed to gain an in-depth understanding of the experiences of people who hear voices that tell them what to do, a qualitative methodology seemed the most appropriate as this approach is generally regarded as providing a richer description of human phenomena whilst focusing on the individual meaning ascribed to it (Dallos & Vetere, 2005).

It was assumed that each individual who experiences voices that tell them what to do would experience them in a unique and personally meaningful way. Therefore it was felt that by adopting a qualitative rather than a quantitative approach, it would better capture the rich quality and texture of the individual experience, thereby allowing differences and similarities between individuals to be seen and embraced (Willig, 2008).

In order to bridge the gap in the current literature and to be able to provide a rich, detailed exploration of an individual's experience, a qualitative methodological approach was adopted for the present study. Although an aim for the research was for the knowledge generated to go on to inform clinical practice and help improve the treatment options available for this

client group, another aim was to provide a platform where individuals could share their accounts and be heard. It was hoped that by adopting a qualitative approach, both these aims could be achieved.

Furthermore, adopting a qualitative approach was more personally appealing as it appeared to be better aligned with my own epistemological stance (please see 'Epistemological standpoint' below) as well as my own preferences and values for conducting meaningful research (please see 'Reflexivity' later in this chapter for further elaboration). Moreover, being a Trainee Counselling Psychologist, the stance adopted within qualitative approaches, such as conducting in-depth interviews with people and acting in a highly collaborative manner appealed to me as they were familiar from my clinical practice. I therefore hoped that being able to draw upon a skill-set already well established would both aid the course of the research and be enjoyable to do.

### **Epistemological standpoint**

Epistemology is concerned with how knowledge is acquired and the relationship between the person who knows (in research this is the participant) and the person who wishes to know (the researcher) (Ponterotto, 2005). It is essential to adopt an epistemological position within a research study as this not only guides the objectives of the study but also provides an insight into what type of knowledge will be generated (Willig, 2008). As Willig (2012) highlights, it is only through knowing the type of knowledge the researcher hoped to produce that the research can be meaningfully evaluated. The researcher therefore has a responsibility to not only state explicitly their epistemological stance but also to use this stance to guide the conduct of the research and the presentation of findings (Madill, Jordan & Shirley, 2000).

In attempting to establish my own epistemological stance, I resonated with the views of Willig (2012) who stated that this can be a challenging task as our assumptions about the world are often unacknowledged and implicit. In an attempt to try to uncover my own stance, I reflected on my therapeutic practice and what I considered to be of importance when a client reports their experiences. Through this I realised that I was guided by the subjective nature of a client's account rather than an objective truth. For instance, when working with clients with unusual beliefs, I was not concerned by whether or not their beliefs "made sense" or were "accurate" but by the impact the beliefs had on them. This highlighted that I believed in

the existence of some form of reality but felt each individual had their own version of reality due to their subjective experiences of the world.

Although I felt instinctively that I knew my own epistemological stance and what I hoped to achieve from the research, making this overt and in line with the terminology within the literature was a somewhat daunting task. In order to achieve this, I focused on answering the following questions as advised by Willig (2012): What type of knowledge did I hope to create? What were my assumptions about the world I studied? And what was the relationship between myself and the knowledge I hoped to create?

In addressing these questions, I realised that through capturing the subjective experience of the participant, I was not concerned with whether their accounts were an accurate reflection of 'reality'. Instead, I wanted to produce knowledge on what it was really like for the participants by attempting to get as close to their experiences as possible. I therefore was setting out to produce 'phenomenological knowledge'. Due to the lack of concern for whether information was 'factual', this type of knowledge generated would not be considered purely realist. However, it was neither purely relativist as there was believed to be a connection between the subjective experience and the person's account of it (Harper, 2012).

In thinking about my own assumptions about the world I studied and the knowledge that could be known (ontology), I reflected on the consequence of believing in subjective experience and found myself in agreement with Willig's (2012) comment that phenomenological knowledge posits that there are as many 'worlds' as there are individuals. Although I believed experience could be captured and hence there was some form of reality, I realised I felt the data could only come to life and illustrate meaning through being interpreted. It was felt that only through placing an experience within context, albeit existing theories or knowledge, could the data reveal an understanding. This again was conceived through reflection on my own practice, for example, disparities that can occur between a client's narrative and the transference or counter-transference I have observed in the room. This approach would occupy a more critical realist position towards ontology (Willig, 2012).

Phenomenological knowledge varies from 'descriptive' to 'interpretative'. As the intention was not just to take the data as an account in its own right and avoid imposing my own views on it, as occurs with 'descriptive phenomenological' knowledge, it was hoped that a move beyond this could be made to find meaning through interpretation. The knowledge produced

was therefore intended to be my interpretation of the participants' experiences of hearing voices that tell them what to do. I therefore intended to create 'interpretative phenomenological' knowledge. Willig (2012) highlights that interpretative phenomenologists deny that it is even possible to be purely descriptive when describing an experience as it is inevitable that some level of interpretation would be applied to the data. This view was in accordance with my own beliefs that every individual's reality was coloured by their own subjective experiences and drew my attention to the relationship between myself and the knowledge I hoped to generate. It highlighted that it was not possible to remove myself completely from the interpretations made and therefore the need to pay attention to the impact my own beliefs and experience had on the analysis (Willig, 2012).

In my journey to establish my own epistemological stance, I acknowledged that I held a political agenda within the research, to provide a platform to be heard for a group of people I considered to be under-represented.

I was mindful of Willig's (2012) argument that epistemological stances are merely angles by which to view human experience and that it is more important to understand the dimensions within an epistemological stance than to be stalled by attempts to label it. I have attempted to detail my own stance towards knowledge and its creation whilst avoiding becoming entangled in and overly ascribing to the vast array of epistemological terminology. However, if pushed to subscribe to one category, I would describe my stance as interpretative phenomenological.

### **Choosing which methodology**

When considering which qualitative methodology would be the most appropriate, three approaches were considered: Narrative analysis, Discourse analysis and IPA. Narrative analysis is concerned with the stories people tell about their experiences, which are believed to represent interpretations of reality (Murray & Sargeant, 2012) and I therefore felt this approach could capture the essence of what it was like for the individual to experience command voices.

There are different approaches within the 'Narrative analysis' umbrella. Some forms of Narrative analysis focus on the content of people's stories and this overlaps significantly with IPA, particularly where the focus is on interpretative meaning making. However, other forms focus on the structure of the stories (Smith, Flowers & Larkin, 2009) and I did not feel this

latter stance would sufficiently address the research question. I was also concerned that the data could be limited by the strong focus on the social aspects of narratives within narrative analysis (Griffin & May, 2012).

I was aware of the need for researchers using Narrative analysis to be cautious when inquiring about perceived crises, due to the depth of the interview and associated potential for distress (Murray & Sargeant, 2012). Given the nature of the present research, it was a concern that the use of Narrative analysis may prompt unnecessary distress in the participants.

Discourse analysis was considered as it explores the subjective use of language in describing experiences (Georgaca & Avdi, 2012). Its focus is on *how* a person's story is told and the use of language in achieving objectives (Starks & Brown Trinidad, 2007). However, as the aim of the research was to provide an understanding of what it is like to live through and make sense of the experience of hearing command voices, it was felt that Discourse analysis would not address the research question as well as IPA, which as Smith et al. (2009) highlight, is primarily focused on meaning-making and the lived experience. Furthermore, Discourse analysis takes a sceptical stance towards being able to link narratives to underlying cognitions (Chapman & Smith, 2002), which is in contrast to IPA. My own view is that an understanding of an individual's beliefs and feelings can be accessed through what they discuss, and therefore IPA seemed a more complimentary approach.

Fundamentally, I felt Narrative analysis and Discourse analysis moved away from the primary focus of the present study which was the subjective experiences and associated meaning-making of what it was like to hear command voices. IPA appeared to be able to more appropriately address the research question.

### **Interpretative Phenomenological Analysis**

IPA was developed in the mid 1990s by Jonathan Smith who stated that it was born from a need for an approach that was capable of capturing the experiential and qualitative, whilst working alongside and informing quantitative psychological research (Smith, 1996). Of primary importance to Smith was to have a research method, qualitative in approach, that was centred in Psychology. Much of the early work with IPA was in health psychology, but there is now growing application in Clinical, Counselling, Social and Educational Psychology.

More recently, IPA has begun to spread to other disciplines within human, health and social sciences (Smith et al., 2009).

IPA aims to promote a detailed exploration of a person's lived experience and the sense the person makes of this (Smith, 2004). It is both phenomenological in as far as it concerns itself with the participant's perception of events or objects, but also interpretative in its concern with the researcher making sense of the experience (Smith et al., 2009). These features stem from its theoretical underpinning which is primarily concerned with phenomenology, hermeneutics and idiography (Smith et al., 2009).

Phenomenological philosophy, initiated by Husserl (1927), provides a body of ideas on how to explore and understand lived experience. Husserl stated in order to meaningfully explore an experience, it was essential to put aside our 'natural attitude', in other words our everyday, taken-for granted experience, and adopt a phenomenological attitude whereby each and every thing is attended to in its own right. Husserl proposed that through 'bracketing', a technique whereby the taken-for-granted world can be placed to one side, it was possible to move away from the distraction of our own assumptions and focus on the underlying properties of an experience. Husserl's work has informed IPA by establishing the importance of focusing on experience and its perception, and by placing an emphasis on the process of reflection on the everyday lived experience (Smith et al., 2009).

IPA has also been influenced by contributions in phenomenology from Heidegger (1962), Merleau-Ponty (1962) and Satre (1956). Heidegger questioned whether it was possible to gain knowledge without an interpretative stance, taking the view that a person is always a person in context. He proposed that it is not possible to move away from our inner world to attend to aspects of the outer world as fundamentally, we exist only in terms of relatedness-to-the-world (Smith et al., 2009). Merleau-Ponty and Satre also believed knowledge was influenced by both contextual and interpretative aspects. However, where Heidegger placed emphasis on the worldliness of our experience, Merleau-Ponty emphasised the embodied nature of the relationship between a person and the world and Satre, the importance of considering experiences in the context of relationships with others. The over-riding message from Heidegger, Merleau-Ponty and Satre was of the person as embedded and immersed in a world of objects and relationships. This marked a move in phenomenology to a more interpretative position with the view that in order to attempt to understand experience, one must consider the complexity of perspectives and meanings and appreciate that these

belong uniquely to the relationship the individual has with the world (Smith et al., 2009). IPA recognises that experiences cannot be directly accessed and therefore encourages the researcher to explore how it is experienced and the meaning ascribed by the individual in order to gain a sense of understanding (Eatough & Smith, 2008).

Hermeneutics relates to the theory of interpretation, focusing on how people make sense of their experience. Heidegger (1962) defined phenomenology as being hermeneutic, stating that it is through interpretation that an understanding can be reached for a lived experience. Schleiermacher (1998) controversially claimed that if a sufficiently detailed and holistic analysis of an individual's account of their experience is conducted, the interpreter can reach a better understanding of the individual than the individual has of themselves. However, this has been disputed and correctly so in my mind. In line with the criticisms levelled against Schleiermacher's claim (Smith et al., 2009), I believe that although it may be possible to gain a clearer insight into an individual's meaning than they have themselves, I do not feel this equates to a better understanding of that person overall.

Heidegger (1962) raises the important issue that it is not possible for an interpretation to be made in the absence of the interpreter's pre-conceptions. He posits that these pre-conceptions may block interpretation and therefore priority should be given to attending to the new objects rather than to the pre-conceived ideas. Heidegger's suggestion implies that pre-conceptions can be made sense of in terms of the new object, but it has been argued that understanding may indeed occur the other way around, so that it is only through exploring the new object that we become aware of our pre-conceptions. Therefore the phenomenon influences the interpretation, and this can influence the pre-conceptions, which can then influence the interpretation. This draws on the idea of the hermeneutic circle in that to understand the parts one needs to look at the whole and vice versa (Smith et al., 2009).

IPA draws on the ideas of hermeneutics by being concerned with a phenomenon and enlists the role of the researcher to help make sense of it. It incorporates the notion of the hermeneutic circle by insisting that the analysis be iterative and therefore that the researcher constantly move back and forth through the data using a variety of different ways of thinking about it (Smith et al., 2009). IPA can also be said to represent a double hermeneutic as the researcher is attempting to make sense of the participant attempting to make sense of their experience (Smith, 2004).

IPA is also underpinned by the theory of idiography. This emphasis on the particular manifests itself through the level of detail expected from the analysis. For instance, each case is examined in detail before moving on to the next and the researcher strives towards understanding a particular experience as experienced by a particular person in a particular context. This is in contrast to a nomothetic approach, which focuses on aggregated data to make universal claims, and underpins the majority of current psychological research.

One of the most frequent criticisms of qualitative research compared to quantitative approaches is its use of small sample size and this has been a criticism levelled at IPA (Smith et al., 2009). The argument put forward is that small sample sizes do not allow the results to be generalised. However, many qualitative researchers have responded to these claims by arguing that quantitative research merely converts the rich complexities of life into statistical values of pre-defined categories, which cannot attempt to be truly representative. Instead Smith et al. (2009) astutely proposed that through the detail of the particular comes an insight in to the general. They therefore argued for the use of small sample sizes within IPA in order to achieve the richness in data required, and even went as far as to encourage the use of the single case-study.

IPA seeks to explore the diversity of lived experiences and does this not only through a detailed analysis of each case but also through a rich comparison across cases. IPA then discusses these findings in relation to existing psychological knowledge in the literature in order to gain a full appreciation of the phenomenon (Smith, 2004).

Further criticisms levelled at IPA centre around whether it meets the standards necessary to be classed as ‘scientific’ due to concerns around its lack of prescriptive nature and the resultant ability to replicate findings, as well doubts whether it is truly grounded in the philosophy of phenomenology and hermeneutics (Giorgi, 2010). However, in line with Smith’s (2010) fierce rebuttal of these claims, it was felt that these accusations were unjustified as Smith draws attention to Giorgi’s selectivity in resources used to substantiate his claims as well as a lack of rigour in his critique and a difference in opinion between the two on what constitutes ‘science’.

IPA is a relatively new qualitative approach and therefore its application is still in its infancy. As with many new ideas, an air of scepticism is almost inevitable and time must elapse for sufficient empirical support to be produced. However, it could be argued that given the

growing body of IPA research available (Smith, 2011) and its ever-increasing popularity (Hefferon & Gil-Rodriguez, 2011), IPA is fast becoming more widely accepted.

### **Rationale for adopting IPA**

In reviewing my own epistemological stance and that of the current research, IPA appeared to be a somewhat obvious complimentary methodological approach. However, in evaluating IPA's epistemological stance and the various available qualitative methodologies, I felt that IPA was not simply a 'best fit' but indeed an approach that seemed to echo my own beliefs and hopes for the study.

In determining the epistemological stance of IPA, the same three questions suggested by Willig (2012) were used: What type of knowledge does IPA hope to create? What are IPA's assumptions about the world it studies? And what is the relationship between the researcher and the knowledge generated? Turning first to what type of knowledge IPA hopes to create, it is known that IPA seeks to generate a detailed understanding of experiences as perceived by participants. This could be considered to be adopting the epistemological stance of 'constructivism-interpretivism' which as Ponterotto (2005) highlights, aims to understand phenomena from the viewpoint of those experiencing it.

It is argued that through the researcher engaging with the data, they are able to gain an insight into the world of the participant and produce knowledge surrounding what and how an individual thinks. This type of knowledge could be classed as more 'realist' knowledge as it assumes it reflects an accurate account of what is going on (Willig, 2008). However, IPA also posits that in order for meaning to be understood, the data must first be interpreted and that interpretation cannot avoid being influenced by the experiences and beliefs of the researcher. As IPA embraces the influence of the researcher on the interpretations made and attempts to make these explicit, the knowledge generated can also be considered to be reflexive (Willig, 2008).

IPA assumes that each person brings their own subjectivity to an experience and that each experience is unique to the person who has perceived it. This assumption contrasts with a positivist epistemological position, which presumes an objective reality can be captured (Ponterotto, 2005). Indeed, IPA is not interested in whether a person reports an experience in line with what may be considered 'reality', instead it is interested in the meaning making behind a person's experience. This is in line with my own epistemological position of

adopting a more relativist approach towards the data and aspiring to produce phenomenological knowledge. However, Willig (2008) argued that IPA in its recognition that a person's interpretation is inevitably affected by social interaction and processes also adopts a 'symbolic interactionist' perspective.

As IPA posits that meaning can only be understood through interpretations made by the researcher, IPA positions itself with an interpretative phenomenological stance towards its analysis. This again highlights the importance of the researcher incorporating a reflexive attitude. However, as Willig (2008) pointed out, IPA does not inform the researcher on how to include their reflexivity or highlight how their conceptions may affect the analysis. Ponterotto (2005) also highlighted that the constructivism-interpretivism approach stipulates that meaning behind a phenomenon lies hidden but can be unearthed through reflection, which can occur through the discussions between the researcher and the participant. This approach can also be seen within IPA.

Another aspect of IPA that appealed as a research methodology was its compatibility with Counselling Psychology. In the Division of Counselling Psychology's apt definition of Counselling Psychology, it draws attention to aspects such as its interest in phenomenological models as well as a more scientific approach, its endeavour to work with subjectivity and to respect the idiosyncratic nature of an individual's account, as well as the importance of not assuming a correct way of experiencing (Division of Counselling Psychology, 2013). These values are clearly mirrored within IPA, something I found attractive as I felt it supported the ethos of the Counselling Psychology profession and would suit my natural way of working.

As well as this, due to the nature of the bottom-up and inductive approach of IPA, I hoped that being involved in the research would help participants to feel heard, thereby addressing an important aim of the study. Indeed giving voice to participants is a fundamental element of IPA (Larkin & Thompson, 2012).

## **Reflexivity**

Qualitative research accepts that the researcher is enmeshed with the research process and therefore will in some way impact the findings. Reflexivity provides a way of gaining insight into how the researcher may shape the research and is therefore an essential component of qualitative work (Willig, 2008).

I do not believe that it is possible for a researcher not to be implicated in their research. I am aware that my motivation for conducting this study evolved from a personal interest in the phenomenon of hearing commanding voices and am therefore mindful that my own experiences and associated beliefs in this area will have impacted in some way on the current study and its observations. As the findings of this research are the interpretations I have drawn, my own contribution to the construction of meaning cannot be ignored.

Willig (2012) highlighted how reflexivity is used in different ways and for different purposes, depending on the epistemological orientation of the researcher. She argued that reflexivity could not only help to cast light on researcher biases, but for an interpretative phenomenological researcher, it actively facilitated the process of uncovering meaning.

Willig (2008) suggested that there are two types of reflexivity: personal and epistemological. Personal reflexivity is concerned with how various aspects of the researcher, such as their own experiences, may have shaped the research, as well as how the research may have shaped the researcher. Epistemological reflexivity is concerned with the assumptions that have been made in the research process about the world and about knowledge, and the ways in which this may have impacted on the research and its findings. Willig (2012) has argued that epistemological reflexivity is of central importance in evaluating the quality of a piece of research as it forms the foundation of all further evaluation. I have included my own epistemological reflexivity (see 'Epistemological standpoint' in the Method) as well as a detailed personal reflexive account (see 'Personal reflexivity' in the Introduction).

I felt it was important to provide a reflexive account of my experiences of working with people who heard commanding voices as I hoped this would increase my awareness of my own beliefs, thereby encouraging me to remain open to the experiences of the participants during the interviews and analysis, particularly when the topic touched upon my personal biases. In addition, by including this account, I hoped to provide the reader with an insight into the lens through which I viewed the participants and their experiences.

I attempted to reflect on my own position to the research throughout the study through the use of a reflexive diary. In each chapter of this report, I have summarised the relevant key points from this diary so there is transparency for the reader in the background processes occurring within the study. I hoped that by doing this and through directly detailing my own

epistemological standpoint, my inclusion of reflexivity within this research would be evident to the reader.

In addition to this, I endeavoured to write the entire report in the first person to help illustrate my involvement with every aspect of the study and how at no point was I kept at a distance from it.

## **Validity**

There has been growing discussion surrounding the manner in which qualitative research be assessed to ensure its quality (Elliott, Fischer & Rennie, 1999; Yardley, 2000). This is often regarded as a controversial topic due to the novelty of this methodological approach (Yardley, 2000). Yardley highlighted that unlike quantitative methods, the ways in which to assess validity within qualitative research are not well established and are at present, difficult to define. She proposed that one reason for this may be on account of the rich diversity of qualitative methodologies available and their associated epistemologies. She claimed that due to the reluctance of qualitative researchers to employ universally agreed methods, assumptions and objectives, a cloud of confusion and scepticism envelops their work.

With the rise in popularity of qualitative methodologies, there appears to be a consensus that despite the difficulty in formulating an effective approach to assess validity, an approach is needed in order for it to gain the credibility it deserves.

Several guidelines have been produced attempting to detail how qualitative research should be assessed for validity. Of these, two stood out as being the most widely accepted: that by Elliott et al. (1999), and that by Yardley (2000). Smith et al. (2009) rightly pointed out that these two approaches distance themselves from other more prescriptive and 'checklist' methods, to offer a more sophisticated and general guideline for assessing quality that could be used regardless of the theoretical stance of the study.

Of the two guidelines, Yardley's appears to be the most highly regarded in the literature and therefore the current study attempted to be in accordance with these principles in order to demonstrate quality and validity. However, as Yardley (2008) pointed outs, simply following guidelines does not guarantee good quality research and therefore I attempted to embed the principles within the entire methodology of the study.

Yardley presented four core principles for assessing quality within qualitative research, which I will outline and summarise how they have been addressed in the present study. The first principle was ‘sensitivity to context’. This can be established in three main ways: through sensitivity to existing theory, to the socio-cultural context of the study and to the participants (Yardley, 2000). The choice of IPA in the present study demonstrated sensitivity to context as it was chosen specifically because of its commitment to exploring the idiographic. The research was born from a gap in the existing literature, which was discovered through an extensive review of this material.

In addition, the present study used a purposive sample with a client group often difficult to locate and engage. This inevitably meant I had to work closely with mental health services in order to generate referrals for participants, a skill that I believe demonstrated sensitivity to context.

Similarly, sensitivity to context was employed during all interactions with participants. This could be seen from attempting to make them feel as comfortable as possible by conducting interviews at a time convenient to them and in a quiet room within a familiar setting, to showing warmth and empathy where appropriate in order to convey an appreciation of their situation and help encourage them to feel at ease discussing their experiences.

Furthermore, the interview schedule used was comprised of open-ended questions and was used in a flexible manner, with the intention of promoting the participant to lead and therefore discuss the issues that most mattered to them. It was hoped that the attention paid to negotiating and navigating the interview process led to the production of successful interviews, which in turn demonstrated sensitivity to context.

Sensitivity to context continued through the analysis, through the care and attention to detail in analysing the data. I hoped to convey this through the inclusion of a number of verbatim extracts from the participant’s material, which aimed to facilitate the reader in getting into the mind of the participant and assess the interpretations being made. In addition, I endeavoured to ensure interpretations were presented as possible arguments and related only to the sample used. And finally, the findings of the study were presented in relation to the existing literature within the Discussion chapter.

The second principle is ‘commitment and rigor’. This can be established through thorough engagement with the topic of the research and immersion in the data, as well as through the meticulous and diligent manner in which data is collected and analysed (Yardley, 2000). It was hoped that through the in-depth analysis and insights gained I was able to demonstrate my commitment both to the participant and in turn to the data collected. Smith et al. (2009) stated that conducting IPA well involves considerable skills on the part of the researcher, and a commitment to realise these. In an attempt to enhance my IPA skills, I not only conducted a thorough review of the existing IPA literature, but attended a workshop on how to carry out a good IPA study and practised interviewing techniques during pilot interviews.

Furthermore, I attempted to demonstrate rigour through the participants recruited, who formed a purposive sample in order to both address the research focus, and create homogeneity. I have included a detailed section on the rationale for the sample used and sampling techniques, which Meyrick (2006) believes is a key element to good quality research. Again I hoped that through the depth of analysis and insights gained from the data, as well as the idiographic content and interpretations made, rigor would be conveyed.

The third principle is ‘transparency and coherence’. Transparency can be measured in how clearly the reader is able to view what has been conducted and the rationale behind this, whilst coherence can be seen in whether a piece of research makes sense as a whole as well as whether it is in line with the theoretical stance underpinning it (Yardley, 2000). I attempted to ensure these two aspects were adhered to throughout the design, conduct and write-up of the study. In particular I endeavoured to provide a detailed account of the research design and procedures used. I made an effort to convey my understanding of the theoretical and epistemological standpoint of IPA, and adopted a hermeneutic and phenomenological stance throughout the write-up.

The present research is supported by a paper trail that maps the steps taken from the conception of the research idea to the final report written. Parts of this paper trail were reviewed by my research supervisor, which may be considered a form of independent audit (Smith et al., 2009). It was hoped this paper trail would represent both rigor and transparency.

One final way in which I tried to demonstrate transparency was through reflexivity. I attempted to detail my own position in relation to the research throughout, from stating my

epistemological stance to how my own experiences and perceptions may have affected the process and findings, which as Meyrick (2006) stated, is essential for quality in research.

The fourth principle is ‘impact and importance’ which can be measured by assessing how well a piece of research informs the reader and how useful it is (Yardley, 2000). The present study set out to explore the individual experiences of people who hear voices that tell them what to do. From the interviews, rich interpretative descriptions were obtained that produced an insight into this subjective phenomenon. My hope was that from this, a better understanding of this client group would become available, which would go on to not only improve clinical practice, but help inform new treatment interventions. As well as this, I hoped that the findings would help to reduce the stigma that this client group often receives through promoting practitioners to adopt a more compassionate and empathic attitude to working with these clients.

## **Sampling**

Seven participants were recruited: 5 male and 2 female, all between the ages of 18-65. All participants spoke English as their first language. Semi-structured interviews were carried out with all seven participants in accordance with the recommendation that between four and ten interviews be conducted for a professional doctorate IPA study (Smith et al., 2009). Smith et al. (2009) stress the importance of using a small sample size, highlighting that in order for an IPA study to be successful it requires a detailed analysis, which becomes difficult to achieve with larger sample sizes. The sample was purposive and homogenous in order to facilitate a detailed analysis of what it is like for people who experience the particular phenomenon of hearing command voices.

## **Inclusion criteria**

All participants complied with the following inclusion criteria in order to create a homogeneous group: aged 18-65, recommended for the study by a mental health professional, currently hearing voices that told them what to do (and had been for six months or longer), not currently in need of acute mental health care, had no history of acting out in response to stress/anxiety, and had not experienced any suicidal ideation within the last three months.

The age range of 18-65 was chosen to ensure only working age adults were recruited. As the present study formed part of a doctorate specialising in working with adults, this inclusion criteria seemed appropriate. I chose to limit the age range to working age adults as I feared interviews with older age adults had the potential to stray into more age related concerns rather than purely focus on the phenomenon of interest. This was particularly so if age-related conditions such as dementia were linked to the phenomenon of hearing command voices.

As people can hear command voices without having a formal psychiatric diagnosis and as it is a feature across a number of different diagnoses, it was decided to not make diagnosis an inclusion criterion. It was hoped that this would be less restrictive but also the use of diagnosis was felt to not be in keeping with the subjective, phenomenological stance of the study. It was therefore unknown what diagnosis the participant had. In order to ensure that extreme variations in presentations (e.g. prodromal cases) were not included and thereby increase homogeneity, as well as to ensure the group were purposive, it was a requirement that the individual be referred by a mental health professional.

The inclusion criterion of currently hearing voices and having heard them for the last six months or longer was added to ensure information given was current and therefore increase its accuracy by limiting the possibility of distortions in memory over time. It was also intended to increase homogeneity by filtering out people who were having transient experiences.

It was anticipated that participants might find the process of discussing their experiences with voices distressing. As this client group is often considered 'high risk', the final three inclusion criteria (not currently in need of acute mental health care, had no history of acting out in response to stress/anxiety, and had not experienced any suicidal ideation within the last three months) were incorporated to reduce the likelihood of participants responding in a harmful way to any stress generated as a result of participation in the study.

## **Recruitment**

Participants were recruited from the National Health Service (NHS). It was felt this was the most appropriate source for locating participants as they belong to a group that can often be acutely unwell and in need of mental health provisions. In addition, from my research experience, I found this client group quite hard to reach and at times high risk, and therefore

being able to enlist the help of a Care-Coordinator already involved in their care, seemed necessary.

The first step of recruitment involved making contact with the team manager at each mental health team involved, to seek approval to recruit from their team and arrange access to their facilities (e.g. rooms for interviewing). Following consent, I visited the team to give a presentation about the study. The presentation (Appendix A) provided information about the aims of the study and what would be required of the referrer and participant. At the presentation, flyers for the study aimed at mental health professionals (Appendix B) and aimed at participants (Appendix C) were distributed among the team. Following this, I asked the team to generate referrals from their caseload, adhering to the criteria of the study. Copies of study recruitment material were also disseminated via email to the teams.

I discussed referrals with the client's Care-Coordinator, with issues of risk and mental health history being the primary focus. If the referral appeared appropriate, the referrer passed on the participant information sheet (Appendix D) and the participant flyer to the potential participant and sought permission for me to contact them. Once verbal permission had been gained, the referrer provided me with the participant contact details and I contacted them via telephone.

In total, nine mental health teams were used for recruitment. From these teams, fifteen participants were referred: two refused to take part, six did not meet all of the inclusion criteria and the remaining seven were recruited. Given the large caseloads of these teams, these figures represent the difficulty in recruiting this population, which may be due to under-reporting of the experience of command voices by the clients themselves.

The initial phone contact with potential participants consisted of introducing myself and detailing the aims of the study, what would be required in participating, the benefits of participating and asking whether the individual wished to take part. If the potential participant agreed to take part, a date for the interview was arranged and they were sent the participant information sheet and consent form (Appendix E). Participants were contacted a week later and if they were still content to participate, were offered a choice of one of five £10 high-street vouchers, which would be given to them upon completion of the interview. It was felt that the offer of a voucher rather than cash would be more appropriate as it was important it was perceived as a thank-you for their time, rather than a coercive gesture to participate.

All recruitment material and the recruitment procedure had ethical approval from both City University and the NHS.

## **Participants**

A brief vignette for all participants can be found in Appendix F with the aim to familiarise the reader with the participants and act as an orientation point for when participants are referred to in later chapters.

The data used in the vignettes came up naturally in conversation during the interviews, no formal demographic collection method was used. I felt the use of a demographics form would be more appropriate to a study taking a positivist stance, and that its use might impact on the nature of the interview by implicitly conveying to the participant the sense of right or wrong answers. I also felt its use could affect the power balance between us because they would be giving me highly personally identifiable information that might not seem relevant to the study. Overall, I did not believe any additional information useful for addressing the research question would be gleaned from completing a demographics form.

## **Interview procedure**

The data were collected through semi-structured interviews. These interviews were conducted at the participant's mental health service at a time convenient for them and lasted approximately one hour. The interviews were recorded.

Prior to commencing the interview, pertinent information from the participant information sheet was reiterated, and participants were given the opportunity to ask questions before informed consent was obtained to take part in the research and have the interview recorded. Participants were also asked to provide a pseudonym by which their data would be referred.

Semi-structured interviews were conducted, which are generally considered to be the most effective approach within IPA (Smith & Osborn, 2008). The interview schedule (Appendix G) provided the framework for the interviews but in accordance with Smith et al. (2009), the schedule was used as a guide and questions were adapted depending on the response of the participant. This enabled the interview the flexibility to capture the areas most salient to the participant and therefore respected the ethos of IPA that the participant is the

experiential expert on the topic. In line with Smith and Dunworth's (2003) recommendations, this also allowed me to pursue the priorities of the participant at a deeper level.

The interview schedule was designed to encourage an exploration of areas I felt were pertinent in addressing the research question and were inspired by the relevant literature. These areas involved the participant's lived experience of hearing command voices, the relationship they had with their voices, and any stigma they may have encountered. Questions and prompts were aimed at being open-ended and non-leading, yet specific enough to encourage the participant to discuss the topic (Smith et al., 2009).

Prior to commencing interviews with participants, informal pilot interviews were conducted with two colleagues who had worked therapeutically with this client group as it was anticipated that it would be difficult to recruit enough participants to allow some to be pilot cases. Barrett (2006) suggested that pilot work helps establish whether there is clarity in the questions being asked and provides the opportunity to practice being a researcher. Particular focus was placed on the wording and order of the questions. Following these interviews, feedback was gained regarding the impact of the interview, its content and likely timeframe. From this feedback, the order of questions was adjusted. A more generic and open question was positioned at the beginning in order to encourage rapport as well as encourage from the outset, the participant to take the lead. Similarly, a question deemed more light-hearted and more abstract than the other questions was positioned half-way through the schedule to help relieve any distress or tension that may have built up from the first half of questions. The pilot interviews, as well as helping to improve the structure of the interview schedule, also provided reassurance that the questions obtained information that addressed the research question.

I anticipated the interview process might be distressing to participants due to the nature of the topics being discussed. For this reason, a de-brief opportunity was provided after the interview. Participants were asked how they found the interview, given the opportunity to ask any questions, and were provided with a de-brief document (Appendix H). Following the debrief, participants were given a £10 voucher and were encouraged to remain with me for a few minutes to discuss a topic other than their voices. This was intended to act as a distraction exercise to reduce any distress they may have been experiencing. The interview recordings were then transferred to a password-protected computer for analysis, and deleted from the digital recorder.

## **Ethical considerations**

The proposal for this study received ethical approval from the Department of Psychology at City University (Appendix I). Full care and consideration was paid to the ethical implications of the study throughout its progress in accordance with the BPS Code of Ethics and Conduct (2009) and the HCPC Guidance on Conduct and Ethics for Students (2009). Ethical approval was also sought and granted from the NHS (Appendix J).

To avoid intrusion and to respect the participants' privacy within their own homes, the participants were first introduced to the study by their mental health team Care-Coordinator and I did not make contact with them until they had agreed for me to do so. All participants were provided with a copy of the participant information sheet and consent form prior to the interview. The participant information sheet provided details of the project aims and what participation involved and the consent form reiterated pertinent information from the participant information sheet such as confidentiality, the use of the data collected, ethical procedural adherence and the use of an audio recorder in the interview. Participants were then given approximately one week before they were contacted again to confirm whether they wished to participate. It was felt that this approach would allow sufficient time for them to read and digest the information and thereby ensure they were giving informed consent.

At the interview, it was established that the participant had read and understood the information provided and any questions were answered. The participant completed and signed two copies of the consent form and kept one copy. Participants were reminded of their right to withdraw at any time from the study.

As highlighted in the Introduction chapter, the client group from which the participants were recruited are often considered 'high risk'. In order to prioritise my own safety, initial discussions with health professionals involved in the participant's care were conducted to ensure it was safe for me to carry out the interview. To reduce risk further, I adhered to the safety protocols of the NHS Trust/teams and interviews were conducted at the team base during working hours when members of staff were in the building.

It was anticipated that participants might find discussing their experiences distressing. To safeguard this, it was explicitly stated that they could withdraw at any time, that they should not discuss anything they felt too uncomfortable to discuss and that if they felt distressed by the interview to tell me immediately. If I felt a participant was becoming distressed or if the

participant reported feeling distressed, this was discussed and either a break offered or the interview stopped.

Following the interview, to further consider the possibility of any adverse emotional reactions occurring for the participant, a verbal de-brief was conducted, which intended to allow the participant to discuss and process their experience of the interview. Participants were also provided with a written de-brief sheet, detailing the nature of the study and providing a list of resources that could be accessed should the distress remain after the interview.

Following the de-brief, participants were encouraged to stay for another 5-10 minutes to discuss subjects other than the voices. It was explained that this was designed to help them be distracted from the interview material, which was intended to further reduce any distress. It was felt the combination of the de-brief and the distraction opportunity would act as an appropriate closure and safeguard the participant from leaving the interview distressed. Should they have felt they required support, participants were encouraged in the first instance to contact their mental health team during working hours or to follow the procedures in place through the team for an out of hours service. The participants were also encouraged to contact either myself or my research supervisor, should they have had any questions or concerns about the study. Prior to the interview, the mental health team were notified when the interview was due to take place and it was ensured that members of the team would be present at this time. Therefore, if the participant was still distressed at the end of the interview, I would have encouraged them to speak to a member of the team before leaving to go home.

The participant's mental health team were contacted following the interview and notified of their client's participation in the interview and of any information that emerged placing either the participant or others at risk.

Confidentiality was ensured by not discussing any material outside of the interview and by keeping the data anonymous at all times. Participants were informed that the only exception to this rule was in sharing information with my research supervisor where necessary and the mental health team should an issue of risk arise. Participants were given a participant number and asked to supply a gender-appropriate pseudonym by which they wished their data to be referred in the final report.

On the consent form, participants were asked to provide a correspondence address should they wish to receive details of the outcome of the study, providing an opportunity to find out how their experiences had informed the research.

The participant information sheet highlighted the right to request a copy of the transcript or audio file, thereby allowing participants access to their data. In accordance with the Data Protection Act (1998), BPS Code of Ethics and Conduct (2009) and HCPC Guidance on Conduct and Ethics for students (2010), the audio recordings of the interviews and typed transcripts were labelled according to the participant number and pseudonym provided (and any other identifiable names or demographic details made anonymous) and stored on a password-protected computer. Hard copies of audio recordings and printed transcripts were stored in a locked filing box. Consent forms, a list containing the matched participant number, pseudonym and the participant's real name, as well as the participant's contact details and referrer were kept in a different locked filing box. The use of different boxes ensured participants' details could not be paired with the content of their interview.

Upon completion of the study, all audio-recordings will be erased. In accordance with the Data Protection Act (1998) and the BPS good practice guidelines for the conduct of psychological research within NHS organisations (2005), as the data is intended to be published, all original data is required to be kept for 5 years post-publication and then be destroyed. In the event that a participant chose to withdraw from the study, all their data would be destroyed.

## **Analysis**

There is no one way to analyse data within IPA, but from reviewing the literature, there do appear to be common steps across variations. I used the procedural recommendations of Smith et al. (2009) as a guide for the present study. Each participant's data was treated as separate until the final stage of analysing across cases in keeping with the ideographic nature of IPA (Smith et al., 2009).

The interviews were transcribed verbatim from the audio recordings. In accordance with Smith et al. (2009) who stated that IPA transcriptions do not require detailed prosodic aspects of speech; only significant non-verbal utterances, gestures, broken sentences and pauses were included. The aim of the transcription was to produce a written account of the interview that resembled as closely as possible, the original dialogue. During the writing of

the transcripts, all identifiable information, such as names of people, places and individual mental health services were changed to retain anonymity. Completed transcripts were checked against the audio recording a final time to ensure accuracy, before moving on to the next step.

Prior to reading through the transcript, I listened to the audio recording once more, in an attempt to bring me closer to the participant at the time of the interview, and recorded any initial thoughts I had. The first transcript was read several times in order to gain familiarity with it and to enable the part to be considered within the whole, (Smith et al. 2009) before exploratory comments were noted in the left-hand margin of the transcript. These comments consisted of initial notes and as Smith and Osborn (2008) suggested, featured anything I found interesting or thought may be significant. Although there was no rule about what should be commented on (Smith & Osborn, 2008), the comments made roughly adhered to Smith et al.'s (2009) recommended areas of focus: linguistics, description and interpretation. This stage was conducted twice and any interpretations were kept very simple in order to stay close to the text.

The next stage consisted of noting emergent themes in the right-hand margin of the transcripts, which attempted to summarise the exploratory comments for discrete chunks of data. However, although the task was to capture what was important at specific points, it had been influenced by familiarity with the whole text (Smith et al., 2009). My aim was for each emergent theme to reflect an understanding (Smith et al., 2009). This stage involved the use of more psychological language and was more interpretative, but none-the-less I endeavoured to remain grounded in the text. If similar themes occurred, following Smith and Osborn's (2008) suggestion, the same theme label was used. An extract from Holly's transcript can be seen in Appendix K, which illustrates this process. A table was then produced (see Table 1, Appendix L for an example) capturing each emergent theme and associated quote, so as to preserve the idiographic contribution of each participant. If any themes in this table were deemed to be the same but with a different label, it was changed so labelling was consistent.

The next step involved searching for connections across emergent themes (Smith et al., 2009). This was achieved by writing all of the emergent themes for one case on to individual post-it notes and then arranging these on to a large sheet of paper in connecting clusters. The main approaches used to cluster in this way were 'abstraction', 'subsumption' and

'polarization'. Abstraction is where similar themes are placed together and a new label is assigned to describe the cluster. Subsumption is where a theme takes a higher status and is used as an over-arching label to help bring other themes within in, and polarization is where opposing themes may be clustered together. Smith et al. (2009) used these terms to describe ways in which themes could be connected and recommended the use of two or more in order to improve the level of the analysis. During this stage, some emergent themes were reduced by combining them with overlapping ones. Before every decision was made, I reviewed the quote in the table and where necessary, went back to the original transcript in order to ensure the participant's meaning was not lost. Each decision was also documented in the reflexive diary. Eventually each cluster was given its own label ('super-ordinate theme'; Smith et al., 2009) and a graphical representation was produced in the form of a mind map (see Appendix M for an example). A table was also produced for each participant, listing the super-ordinate themes, sub-themes and location for key illustrating quotes (see Table 2, Appendix N for an example)

The final step consisted of identifying patterns across all of the seven cases. To achieve this, each mind map was laid out on the floor and examined for connections in a similar manner to the previous step (Appendix O). Due to the similarity between cases and re-occurrence of many of the themes, no themes were discarded, but some were again reduced by merging overlapping ones and then relabeling them. The final result showing the connections for the group as a whole was illustrated in a mind map. In addition, a table was produced (Table 3, Appendix P), detailing the super-ordinate themes and how each sub-theme nestled within it, as well as key illustrating quote locations from participants.

### **Methodological reflexivity**

Part of the appeal of IPA was its epistemological stance as I felt it mirrored my approach within therapeutic practice. However, I was also drawn to its somewhat prescriptive nature. Being new to qualitative research, I found this helped contain my anxiety, but was aware that rigidly sticking to guidelines may have clipped my creative wings. It is likely that with greater experience and associated confidence, I would have been better able to access the participants' meaning-making processes. Indeed Smith et al. (2009) have highlighted that novice researchers often produce an analysis that is too descriptive. Although this is something I tried to be mindful of, it will ultimately be the reader who shall decide how well I met this challenge.

From my own experiences of working with this client group for research, I was concerned I would struggle to recruit. To overcome this, I invested a significant amount of time and effort in the recruitment by visiting and liaising with teams. At times I found this a frustrating and anxiety-provoking phase of the study, particularly when having to continually chase referrals that were few and far between. However, in hindsight, I feel this was a necessary process, without which I would almost undoubtedly have struggled to recruit sufficient participants.

There were a number of process issues present in the interviews worth consideration. The interviews often appeared difficult and distressing for the participants and in order to adhere to the ethical obligations of the study, this had to be addressed. This was achieved through checking the participant was happy to continue, moving on to a less distressing topic as well as shortening the length of the interview. In one case, it appeared that the participant's voice was active during the interview and influencing how much they were allowed to discuss certain aspects. It was therefore difficult at times to get the participants to lead the interviews and for me to occupy a more background position of curious listening (Smith et al., 2009). These factors made the interview more challenging and may well have limited the data obtained. Related to this, it sometimes felt difficult to be clear in my role. I often wanted to fluctuate from researcher to therapist, particularly when participants became distressed, something I was reassured others had experienced within their research (Finlay, 2003).

There may also have been a power imbalance present between the participants and myself. I was aware that I had no personal experience of what it was like to hear voices that tell you what to do, and was not a client accessing mental health services. Instead, I was a young woman who the participants knew worked within the NHS and was conducting research as part of a doctoral qualification. They were also aware that I would break confidentiality if I felt I needed to and that I was currently in contact with their Care-Coordinator. Potentially, the participants could have viewed me as yet another professional within mental health services to whom they were detailing their voices. Although I worked to build rapport and emphasised my role as an interested listener, to what extent this potential power imbalance was present behind the scenes and whether it affected the data, remains unclear.

Although I attempted to be explicit in my assumptions and beliefs regarding hearing command voices, I found I did not actually become aware of many of them until I was in the interview or even until I began the analysis. I took comfort from Finlay (2003) who stated that this is often the case as a source of new understanding can emerge from the engagement

between the researcher's known assumptions and the research process. This reinforced the notion that I would not have been able to fully bracket off my assumptions as some of them I was yet to become aware of, again highlighting the idea that I was unavoidably enmeshed in the study. I also found it challenging at times to bracket assumptions I was aware I had. For instance, although I was aware I believed hearing command voices was more often than not a distressing experience, I sometimes noticed myself unwittingly feeling in agreement when participants described it as distressing, and surprised when they didn't. I was mindful of Wall's (2004) claim that bracketing should be a continuous process and therefore attempted to do this throughout the study.

Finally, most of the participants visibly showed signs of finding the interview challenging and on occasion, distressing. Indeed, most openly shared this discomfort with me. Despite anticipating this may be the case and feeling able to contain negative emotions through the robust ethical procedures put in place, I was struck by the immense sense of gratitude I was left with. From my perspective, the participants had volunteered without much in the way of an obvious gain, to face something simply for me, my research and the possibility of what the study may go on to change. I found this a humbling yet highly motivating experience.

## **Results and Analysis**

### **Overview**

Through a detailed analysis of each case and then across cases, common themes emerge that provide insight into what it is like to experience voices that tell you what to do. Due to the vast quantity of material gathered and the need to prioritise, not every aspect of the participants' stories can be told. The aim of this chapter is therefore to guide the reader through the areas deemed the most pertinent in relation to answering the research question. I have chosen to write this chapter predominately in the present tense, which is intentional to re-create the unfolding nature of the analysis for the reader.

A striking finding of the study is that the participants all give very similar accounts of their experiences. Four super-ordinate themes emerge from the data. These are labelled 'Unwanted experience', 'Engagement', 'Relationship with others' and 'Sense-making'. Nestled within each super-ordinate theme are up to four sub-themes that highlight its different dimensions. These themes can be seen in Figure 1, below. Some overlap between sub-themes occurs, which is to be expected as one of the aims of IPA analysis is to be aware of convergences and divergences in the data (Smith & Osborn, 2008). I was mindful that these sub-themes may need to be combined if they were not fundamentally different; a concern shared by other IPA researchers (Storey, 2007). However, upon close examination, each sub-theme is sufficiently distinctive to be worthy of separate inclusion, and has been placed within the super-ordinate theme most appropriate in relating the interpreted meaning of the participant. It should therefore be noted that themes are not necessarily completely disparate.

The first super-ordinate theme, 'Unwanted experience', captures how the participants perceive the experience of hearing voices as unwanted, due to the impact it has on their emotional wellbeing and overall quality of life. In addition, this theme explores the participants' need to cope with their experience and the ways in which they go about doing so.

The next super-ordinate theme, 'Engagement', aims to describe a relational aspect between the participant and their voices. Within this theme, there is an exploration of the identity of the voices, the negative and positive attributes of them, how the participants respond to what they say and the perception of power between the participants and their voices.

The third super-ordinate theme, 'Relationship with others', considers how relationships between the participants and people from their social world and mental health professionals are affected as a result of their experience with voices.

Finally, the super-ordinate theme of 'Sense-making' aims to present the desire of the participants to better understand their experience with the voices as well as the ways in which they go about doing so. These ways include exploring the reason why they hear voices, their general sense of confusion towards their experience and how they embed it within a sense of time, as well as their questioning of who they are as a result of the phenomenon.

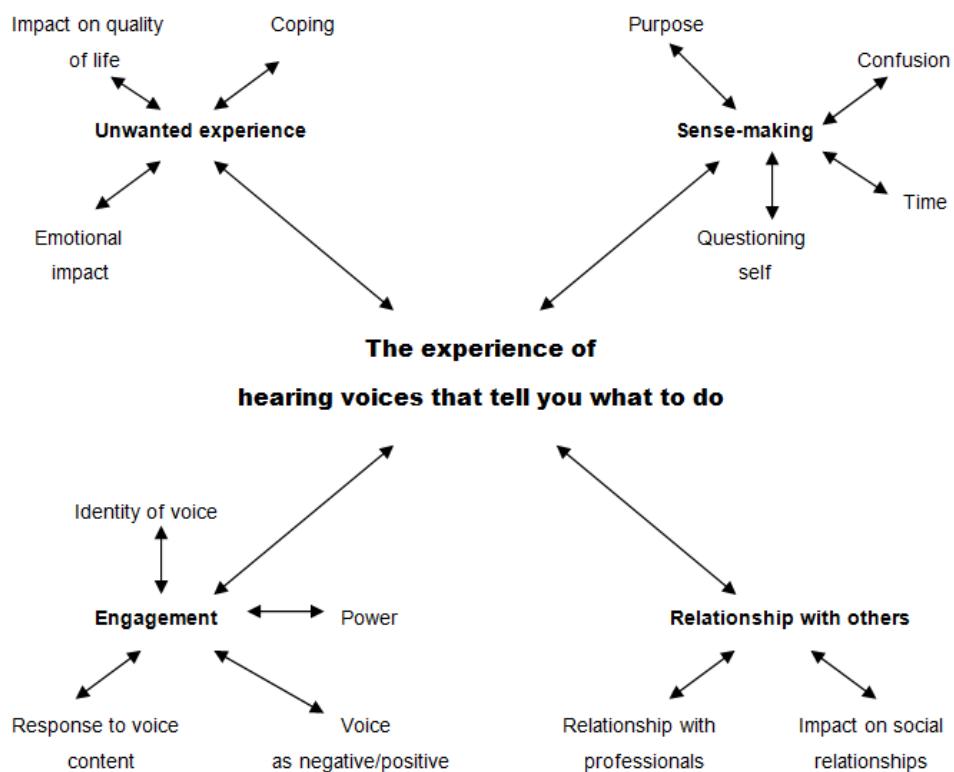


Figure 1: Map of themes<sup>2</sup>

<sup>2</sup> Super-ordinate themes are shown in bold font and sub-themes in regular font. Arrows indicating the connection between super-ordinate themes and sub-themes are bidirectional to depict a reciprocal relationship between them as it is felt they both influence and reinforce each other.

## **Super-ordinate theme one: Unwanted experience**

When asked to describe what it is like to hear voices that tell you what to do, all of the participants describe it as an unwanted experience. This super-ordinate theme attempts to capture this and the reasons behind it. Three sub-themes are presented. The first examines the negative emotional impact of hearing these voices on the participants. The second explores the impact of their experiences with the voices on their overall quality of life, and the third considers the ways in which the participants feel a need to cope with their unwanted experience and the ways they go about doing so. It should be noted that although these three sub-themes are presented separately, they are all subtly interwoven with each other, which shall be discussed.

### **Sub-theme one: Emotional impact**

One of the most striking findings is that a majority express that the experience of hearing command voices has a significantly negative impact on their mood. No participant mentions any positive impact, although the way in which their mood is affected does appear to vary. Several speak about feelings of anger, as illustrated by both Gary and Dylan:

*I think I've got a lot of anger, it's built up, I saw a psychoanalyst once who said I was very angry, pent up anger, and I'm sure it's, I've lost my point now (laughs)<sup>3</sup>, it makes me, I think it's [the voice]<sup>4</sup> making me crosser and crosser as I go on with my life, but probably one day I'll end up just shouting at it (Gary, p12<sup>5</sup>)*

*I worry about waking up in the morning now and what I've got to deal with, um, my ...<sup>6</sup> I feel my life has changed a lot, I, I get, I get angry and I get easily agitated now as well, like if we go shopping or something and there's someone there walking slowly in front of us or, or cuts, cuts across then I'll rare up (Dylan, p13)*

These quotes illustrate how the participants see themselves as having changed since hearing command voices and that this experience has caused them to be angrier than they

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<sup>3</sup> (text) indicates non-verbal data

<sup>4</sup> [text] indicates explanatory material added by researcher

<sup>5</sup> Key: Participant pseudonym, transcript page number

<sup>6</sup> ... indicates significant pause

were previously. This anger also appears to feel uncontainable for Gary as he anticipates that one day he will release it on the voice, and for Dylan, there is a sense that he regularly has outbursts of anger and frustration.

As well as anger, there are many different emotions mentioned, such as anxiety, fear, feeling overwhelmed and instability in mood. Regardless of the specific emotion, there is an overall impression of distress caused by the experience as Dylan illustrates:

*I had a situation where I was at a train platform and the voice was telling me to jump in front of the train, but I had a dog with me that stopped me from doing it but ... that was so distressing, and that was scary and it scares, it scares me to think that I could actually do that. And I don't ... I don't like it, I just don't want to feel like this anymore, it's ... it's looking for an easy way out really to stop me feeling this way. (Dylan, p3)*

For Dylan, hearing his voices is not just distressing, it has an almost unbearable impact on his mood as indicated by his desire to escape it, which as he goes on to discuss further, would be through taking the significant step of ending his life. The distress caused appears to be as a result of the content of what the voices say, as participants speak about their low mood in relation to critical comments the voices make about them or harmful commands given.

It also appears that hearing these voices lowers self-esteem. Participants discuss how the voices make them feel badly about themselves and at times worthless. This can be seen in Arthur's account where he describes his feelings towards himself after having attacked a doctor whilst hearing his voice:

*Well, I'm horrified. I mean I'm genuinely horrified, I mean it makes me look like a loose cannon. (Arthur, p11)*

There could be a social element to this narrative, as Arthur may be concerned about how others perceive him, but at the same time, his perception of himself has clearly been altered as he appears to feel ashamed of himself for his behaviour in response to the voice.

Feelings of worthlessness can be seen in Jack's and Arthur's account:

*the bad voice makes you feel worthless really (Jack, p8)*

*it's something trying to influence what I'm doing or being in my life and to me, I just get absolutely drained and I do feel, I do feel like I'm absolutely useless, I've got no value to anybody (Arthur, p7)*

These extracts again show the different ways in which self-esteem is impacted. For Jack, he holds the voice accountable for his sense of worthlessness, claiming it is the voice that makes him feel the way he does. However, for Arthur, it is his response to the voice, or his inability to cope that leaves him feeling of "no value", and he therefore holds himself accountable.

### **Sub-theme two: Impact on quality of life**

Another factor contributing to why the experience of hearing command voices is perceived as unwanted is due to its impact on the participants' quality of life. All of the participants speak about their experience negatively impacting on various aspects of their life quality. However, two also discuss how it is not currently impacting on them, suggesting a temporal and judgement based component to this sub-theme. Fred describes how it impacts on the quality of his life:

*my sleeping's all over the place, some days I just feel that I'm all over the place, I feel like I'm ... I just can't seem to get everything together (Fred, p14)*

Fred highlights how his sleeping is affected, which has a knock-on effect on his functioning. The repetition of "all over the place" suggests his sense of functioning directly mirrors his sleeping. "I just can't seem to get everything together" could be interpreted as a demonstration of how Fred struggles to live his life as he would like. He also highlights a temporal element in his account by suggesting the impact on his functioning only occurs "some days".

Arthur provides an insight into the impact his experience has on his quality of life through the way in which his opportunities and daily activities are restricted:

*I don't travel, I'd like to travel. One of the main reasons is I don't really, um when I was on an aeroplane before, Dean [voice] was telling me to open the door on the plane and I um, I had to be restrained on the aircraft because I was trying to open the door, which Dean was telling me to do, this was after hours, and then uh, the plane was landed and I was taken off by medical people in an ambulance and driven off to hospital. I'd like to be able to travel without having the incidents like that you know, and my brother lives in [country abroad], I've never been, I've never been there because I worry about the flying (Arthur, p40)*

Here we can see that Arthur, although he would like to, has decided not to travel due to a past experience with his voice that he perceives to be negative. His desire to be able to travel is evident and although the impact this has on his social network with his brother living abroad is unclear, it is likely to be restrictive. This demonstrates his perceived need to have to alter his way of living because of his experiences and the limitations in his opportunities and activities that occur as a result of these alterations.

The notion that hearing these voices has a negative impact on the overall quality of life is also poignantly conveyed by Gary:

*I'm in purgatory (Gary, p22)*

*It's just hell really (Gary, p22)*

Gary's use of the word "purgatory" and "hell" implies his life is one of suffering and conveys a sense of being trapped in his current situation, with no means to escape. Similarly, one could interpret the choice of the word "purgatory" to suggest he feels to some extent to blame for his suffering, as purgatory can be considered a place where sinners go to repent their sins.

In contrast to these accounts, Holly and Louise present the idea that their quality of life is relatively unaffected by their experiences.

*Everything's like I say a lot quieter, um, it's not constant, it's usually when I've let my guard down a bit so falling asleep, waking up or if I'm day-dreaming at work like if I've lost concentration and I'm day-dreaming then that's normally when I sort of get the odd flash of "you should do this, do this that and the other", um, but it's really not causing me any bother in my life, like I say when it does happen I'm really good at saying "no, I'm not listening" and it doesn't happen all that often so it kind of works for me. I'd rather not have it but at the same time it's nothing like I can't deal with when it happens and forget about when it doesn't, and it is less and less like definitely less and less, the anxiety that I had because of it is just non-existent now, so, little things like that. (Holly, p20)*

Here, the impact of the voices upon Holly's quality of life appears to be mediated by her ability to say "no" to the voices, suggesting lack of control may underpin a negative perception towards the impact on quality of life. Holly is able to reflect on the change that has occurred in terms of the frequency in which she hears her voices. She appears to use frequency as a gauge to measure the impact on her quality of life as can be seen from the comment "*it doesn't happen all that often so it kind of works for me*". She stresses a change in how she experiences the voices through the use of comparatives such as "*quieter*" and "*less and less*" as well as giving an overall sense of past and present. This acts to emphasise a temporal aspect to how quality of life is perceived. Indeed her phrase "*and it is less and less*", implies a sense that the experience is still not static and that she may have an expectation that it will continue to change.

However, although Holly currently feels the voices are not negatively impacting upon her quality of life, throughout her account, she recognises that they have done in the past. The unified opinion across participants is that although it may vary, the impact on quality of life is perceived to be negative. Although for some, the impact changes to become more neutral, none of the participants report the impact to be positive.

### **Sub-theme three: Coping**

Throughout the accounts, the theme of coping emerges. This incorporates the idea of both a need to cope with the experience of hearing voices as well as the ways to do so. Due to the impact on the person's emotional wellbeing as well as on their quality of life, the participants feel a need to try to cope with the experience in order to maintain functioning. However, at

times, it appears that reflecting on their need to cope reinforces the perception that the voices are having a negative impact upon their emotional wellbeing and quality of life, thereby potentially creating a vicious cycle. This can be seen with Fred:

*I've tried techniques and things and bits and pieces which do help sometimes, sometimes they do and sometimes they don't. I try my headphones but like I say sometimes even that doesn't help now because they come through one, I don't know how that happens really, I can't work it out, how you get it through one ear and not through the other ear, you get the voices in one and the music in the other. (Fred, p16)*

This extract highlights Fred's use of different strategies to try to manage the voices, with varying success. It is clear that these strategies at times help, and at other times do not. His use of the phrase "even that doesn't help now" emphasises his sense of despair and confusion around why the technique of listening to music through headphones no longer helps him. It is possible that when he uses coping strategies for the voices and they fail to work, it adds to the overall negative impact on his emotional state and quality of life. For Fred, his strategies involve trying to avoid hearing the voices, something that Arthur also attempts:

*I used to drink beer or gin and tonic or vodka, because I found (coughs) I could, um, blot him [the voice] out of my head and sort of pass out, he would go. But I found, the doctors told me that that only is making the situation worse, because he said to me "if you get more, more depressed in any way and alcohol makes you depressed, that will extend the time that you are actually hearing Dean talking to you". So I've knocked that on the head and that's why this medication was introduced, to use that rather than going to use drink as a, as a medium to, to get rid of it. (Arthur, p6)*

Arthur's coping strategies also centre on trying to avoid hearing the voice. He firstly mentions drinking as a strategy and then goes on to discuss medication as an alternative. His ultimate goal is to "get rid of it", demonstrating how his experience is an unwanted one. Arthur's use of the word "depressed" also indicates the impact of this experience on his emotional wellbeing and his quality of life, again providing evidence for these sub-themes as well as demonstrating how the three sub-themes are all interwoven with one another.

Another strategy employed by participants is the use of the performing self, as discussed by Gary and Fred:

*Well it's just a permanent trying to act normal, I would have said it's perfecting the art of normality to make people perceive that you're ok, helps (laughs), I have a tendency you know people ask how you are, it's very hard to, the best answer is just to say "yeah, yeah yeah, I'm fine" I have a tendency to want to answer them by saying "no, I feel like crap" (Gary, p19)*

*I mean when it first used to happen I used to be quite anxious outwardly and people used to notice here and there, now I can sort of mask it (Fred, p22)*

Gary and Fred both discuss pretending they are fine in order to convince others of this. In this way we can see them using the self as a means of performance for other people. For Gary, he has a sense of not being “normal” as a result of his experience, which leads him to engage in trying to act as normal as he can in order to cope, despite this feeling uncomfortable for him.

One of the most poignant strategies of coping with the voices is a belief in the self:

*it's the fact that I'm still here, um, there were a lot of points where I thought I wouldn't still be here and the fact that I am is proof to me that I'm bigger and stronger and badder than anything going on sort of inside my head. I can shout it down if I have to or I can use any technique that I've learnt, mindfulness has been really useful to me to sort of get myself away from that, I sort of got safe playlist music, my friend helped me put them together, I have no negative associations with the music at all, so I've learnt a lot through the coping skills (Holly, p5)*

Holly demonstrates a sense of pride in herself for surviving and managing to cope with her experiences. Her phrase “bigger and stronger and badder” suggests her voices are a force to be reckoned with and something she has had to struggle to cope with. This excerpt again describes the use of coping skills and techniques in order to help the participant to manage their experience. Holly’s need to use these techniques draws attention to the fact that

regardless of what strategy is employed, the participants all feel a need to use them; a need to have to cope.

### **Super-ordinate theme two: Engagement**

Engagement here refers to how the participants' attention is involved with their voices and the relationships created between them. Engagement is demonstrated through four sub-themes. The first involves the participants' opinions about whether they perceive the voices to be negative or positive. The second sub-theme concerns their attempts to identify the voices and the third, their responses to what the voices say. The final sub-theme examines the power dynamics between the participants and their voices and links this to a sense of control.

All of these sub-themes can be viewed as relational as their existence is determined by the presence of some form of relationship between the participants and their voices.

#### **Sub-theme one: Voice as negative/positive**

This theme considers how the participants perceive the voices with which they engage. What emerges is that there are no neutral feelings towards the voices; the thinking appears to be quite dichotomous in that they are either described as being negative or positive. All participants describe the voices as being negative, but a few also reflect on some positive aspects.

There is similarity between viewing the voice as negative and viewing its impact on quality of life as negative. Therefore this sub-theme and the sub-theme of 'impact of quality of life' within the 'Unwanted experience' super-ordinate theme overlap to some extent. Indeed, the negative aspects of the voice detailed here could legitimately be placed in the previous super-ordinate theme. However, it is felt that the meaning behind the present sub-theme is more to provide information on the nature of the voice rather than the result of its nature on the participant's life. I therefore believe this sub-theme to be different and more to do with engagement with the voice than viewing it as an unwanted experience.

Dylan conveys his perception that the voices he hears are negative:

*it's destructive, it's being nasty isn't it, and saying bad things to me, you know, all you do is hurt that person and that person is me, it's hurting me, it's destroying me and (coughs) especially about what I told you earlier about the pregnant women, it's disgraceful, it's, it's just, it's sort of destroying my mind (Dylan, p15)*

Terms such as “destructive”, “nasty” and “destroying” that Dylan uses in relation to the voices illustrates his overall negative perception of them and excellently illustrates the sub-theme. The use of so many undesirable descriptions is interpreted to emphasise the extent to which he believes his voices to be negative. “It's hurting me” conveys a sense that Dylan adopts a victim position in relation to the voices, whilst they take on a perpetrator position. It could be interpreted that he experiences a sense of potential annihilation from his voices as he believes their intention is to destroy his mind and connected to this, his sense of self. Earlier on in Dylan's narrative, he discusses how his voices tell him to punch pregnant women in the stomach. From this extract it can be seen that this command appals him and goes against his sense of right and wrong. It would therefore seem that the content of the commands can be linked to why he holds a negative view of his voices.

Gary too appears to see his voice as negative:

*I got all this shit in my head (Gary, p16)*

Here Gary refers to the content of what the voice says to him. His use of the word “shit” brings to mind excrement and waste and therefore implies he views what the voice says as both unwanted and unpleasant, again illustrating a negative perception. Furthermore, as “shit” is often considered to be a swear-word, its use here can be interpreted as a means of stressing the strength of his feelings.

However, the voices are not seen as purely negative by all participants. For some, such as Holly and Louise, they report the presence of a distinctive “good” voice, whereas for other participants they view their voices as having both positive and negative traits. Here, Louise's “good” voice is discussed:

*maybe if I ever got together with this good voice it might all, all the rest of it might disappear, if um, the fairy angel waved her white magic wand. (Louise, p19)*

Louise implies she would like to form a romantic relationship with her good voice, demonstrating a very strong positive attitude towards it as well as her willingness to engage with it.

Holly explores the positive perspective she takes towards her voices by discussing her decision to stop taking her medication in compliance with its commands to do so:

*I stopped medication and I think when I told [mental health professional] that, he was very much that it is a very bad thing, but for me, that's become a positive, we didn't know necessarily how it was going to turn out, and I think I had a couple of weeks where it got a bit bad and then I've kind of accustomed to it so overall it's put, although the instruction might have been seen as a negative instruction, I think the long term outcome has been positive (Holly, p19)*

The instruction to stop taking medication is perceived to be negative by the mental health professional involved in Holly's care, although it is unclear to what extent Holly may share this view. Holly's ability to view her voices as both negative and positive can be seen in the way she is able to acknowledge that the command to stop taking medication was regarded as negative, but despite this something positive emerges from it. What motivates Holly's decision regarding whether the voices are deemed negative or positive appears to be based upon the "outcome" they have on her quality of life, again highlighting a degree of overlap between this sub-theme and that of impact on quality of life.

### **Sub-theme two: Identity of voice**

Another way in which the participants demonstrate engaging with their voice is through considering its identity. Thinking about who or what the voice may be highlights the relational component between the participant and their voice. For some of the participants, they appear to have clear insight into its possible identity, but for others, this is a source of great uncertainty. This sub-theme summarises the key ways in which the participants set about understanding their voices' identities.

One of the most striking ways in which the participants appear to gain insight into the identity is through visions they experience alongside their voices. This can be seen with Arthur:

*you see a trunk and the trunk comes, it extends out the bottom where you, visualise as the feet and then there's this round, uh, part of the trunk that has been uh, cut away as if a huge branch has been taken off and that's where his face is and then above that there are these two long branches that stand out like the arms and um, when he calls me to go there, you stand, stand in front of Dean (Arthur, p23)*

Arthur is describing how he sees a vision of his voice which closely resembles a tree. What stands out is the personification of this tree as it has feet, a face and arms, which could be perceived to provide support for the notion that there is a living, human-to-human relationship between them. Arthur has also named his voice "Dean", again hinting at a relational component and desire to know who his voice is. The level of detail in his account also demonstrates his engagement with this voice and perhaps his desire for others to also know its identity. Arthur appears to consider his voice to have a separate identity to his own, something that is echoed by Fred:

*Sometimes, the voices used to be, when I first used, when I first started getting the voices they were sort of like, sort of familiar voices, sounded like, they sounded like old family members that sort of died. (Fred, p8)*

Fred displays a lack of certainty around the identities of his voices, emphasised through his repetition of "like" and "sort of", but the fact he chooses to explore this topic implies a desire to seek clarity. It also appears that the identities of his voices are not static as they have changed over time, a factor that one could hypothesise may add to his lack of clarity. Fred describes how the voices at one point resembled deceased relatives, again highlighting the relationship aspect between himself and the voices. Following this excerpt, Fred continues to explain how he finds hearing these particular voices pleasant, which could be interpreted as evidence for his desire to engage with them.

Contrary to this, other participants are less certain that their voices are separate entities, as can be seen in the following excerpt from Gary:

*it's probably a manifestation of my own consciousness (Gary, p12)*

The use of the word “*probably*” conveys uncertainty, but it appears Gary does not rule out the idea that the voice he hears is actually a part of him. “Consciousness” could be interpreted to mean that he considers the voice to belong to a part of himself he is aware of and is not hidden, although “*manifestation*” suggests it may well be in a form he is less familiar with.

Jack, too, considers how his voices may be a part of himself:

*It's quite posh, it's like an older me (Jack, p23)*

This could be interpreted to mean that Jack believes his voice may be a part of himself, but perhaps a more unfamiliar part. Potentially, Jack’s voice in representing the future him, may depict a part of himself he hopes for or conversely, is fearful of. Although Jack hints that the voice may be a part of him, his use of the word “*it*” implies he still sees the voice as separate to himself and in fact, an entity with no gender, moving their relationship away from a human-to-human connection. However, earlier on, Jack discusses the name he gives to one of his voices:

*Jack is the good one (Jack, p6)*

Here we can see that not only does Jack assign his voice a name, demonstrating a sense of its gender and a desire to engage with and personalise their relationship, but in choosing to name the voice after himself, it could be argued that there is evidence for clear identification with his voice. The fact Jack’s account is rather contradictory could perhaps be an indication of his own lack of clarity around the identities of his voices.

Another common theme, relates to whether the voices are actually voices or the participants’ own thoughts. Holly nicely demonstrates this point:

*originally the bad thoughts kind of were the words of God giving me instructions and part of why I'd listen was because it's God, you kind of do what you're told when it's God (Holly, p19)*

Holly's use of the word "thoughts" when describing one of her voices (the voice of God) highlights her lack of certainty around whether what she hears originates from a part of her or an external source. Again Holly draws attention to the changeable nature of her voice's identity by describing how it was "originally". "It's God" also implies the voice has a separate identity to her own, but again one could postulate that the contradictory nature of her account mirrors the confusion within her understanding.

### **Sub-theme three: Response to voice content**

This sub-theme considers the way in which the participants respond to what the voices say. The range of responses varies, although the topic of complying with the commands stands out as a highly distressing yet important area that all participants make specific reference to. Participants describe the types of commands given as either potentially harmful to themselves or others, or as innocuous. More of the discussion focuses on harmful commands, which one could interpret as a sign that they are either more prevalent than innocuous, or more distressing and unacceptable to the individual. The impression gained from the participants' accounts is of the latter. As with other sub-themes, there is an area of overlap between the current sub-theme and the sub-theme of 'emotional impact' as in several cases, complying with commands elicits negative emotions such as shame. Jack explains about an instance where he complied with one of his voices:

*one of them told me to um, to go, to go into the sea and not come back, that was about a year ago now, I went into the sea for about forty minutes and then came out, I nearly died of hypothermia. I tried to drown myself but it just wouldn't happen. (Jack, p13)*

Jack demonstrates complete, almost unquestioning compliance with the command given to him by his voice. One could argue that a part of Jack did not want to fulfil the command and hence led to his decision to come out of the water. However, his comment "*I tried to drown myself but it just wouldn't happen*" implies external factors were responsible for his return to land as despite his best attempts to end his life, the sea just would not allow it. This suggests

that although he may fully engage with the voice and respond to its content, successful completion of commands is sometimes outside of his control.

There also appears to be a conflict between Jack's intentions. Explaining the reason why he was unsuccessful conveys that he feels a need to provide an explanation for a perceived failure, which implies he wanted to kill himself. However, "*I nearly died*" demonstrates a sense of surprise and distaste towards the idea of his death. It is therefore unclear whether Jack complied with this command because he was in agreement with the instruction.

Louise offers an insight into the rationale behind her compliance:

*I worry about being punished if I didn't do what they asked me to do. (Louise, p11)*

Louise believes she will be punished by her voices if she fails to comply with their demands. This is something Louise often thinks about, as she describes it as a source of worry. This concern supports the notion that she is motivated to comply with her voices in an attempt to remove the fear of punishment and therefore to mitigate the threat the voices present.

However, not all the participants comply with the commands given to them by their voices and even those that do comply choose not to comply at other times. Fred describes his non-compliance:

*I suppose I've decided that if I don't go out much I can't really, one it stops me sort of triggering this thought off in my head and two it, two it also means that I'm not hopefully ever going to come to, if the voices get worse or if they tell me to do something else, you know like, I wouldn't just go off and do it. So it's like, I feel in myself that it's my own little ... safe way really, I know that I would like to go out but I know that by not going out that if the voices and all the stuff that goes on comes in and it was to get worse or tell me to do something, I'm not very likely to do something if I'm not out (Fred, p12)*

Here Fred describes how he has altered his way of life to avoid going out in order to prevent himself being in a position where he may be commanded to do something he doesn't want to do and is able to act on these commands. He discusses how this technique helps to both

reduce the likelihood of him receiving these types of commands as well as his compliance with them. The use of the phrase “*just go off and do it*” again emphasises an unquestioning and direct nature to the compliance. Fred is not alone in the use of strategies to help avoid the possibility of complying with voices, as this can also be seen with other participants. As Fred chooses to employ this strategy to stop himself complying with commands, his behaviour can be viewed as non-direct non-compliance. However, it could also be seen as a means of coping with the voices. Non-compliance with commands is not always based upon the employment of specific strategies, for some, they simply choose not to comply with commands given to them.

Compliance with commands was by no means the only way in which participants reported responding to the voice content, as exemplified by Fred:

*you're sitting there volunteering, looking at the computer screen and staring off to space really sometimes. I'm getting the sort of whispery voices there sort of, that you can't make out, you know like you're straining to hear them or seeing what they're trying to tell you yeah and you're just not concentrating, you're not concentrating on the computer. (Fred, p6)*

Fred describes his difficulty in concentrating and in completing his work tasks due to being distracted by what the voices are saying. This distraction in itself highlights an unconscious or passive engagement with the voices, but Fred’s actions of “*straining to hear them*” emphasises his active positioning in this situation, and his choice not to concentrate on his work but instead to concentrate on what the voices have to say. This again highlights a perceived importance placed on the voice content.

Arthur, too, explains how his voice manages to distract him:

*Dean was actually bombarding me with this business about killing Jane and um, I then went to strangle the doctor who was actually giving me a consultation like this, because I was unable to really communicate with her because as I said to you before, the world outside of Dean seems to come to a halt, I'm not really listening to what she was saying, I wasn't really conscious of anyone around me (Arthur, p10)*

Arthur suggests that when he hears his voice, he feels engulfed by it and so distracted that he is completely unable to interact with and “communicate” with anyone else. This is apparent when he says “*world outside of Dean*”, which implies that when he hears his voice, he is in another place separate from everyone else.

### **Sub-theme four: Power**

Another striking theme to emerge from the data concerns the perception of power between the participant and the voice. This sub-theme illustrates the super-ordinate theme of engagement as without first engaging with the voice, a perception of power could not exist. Power appears to be defined by how much control is held, and this is in relation to how much control the participants have over the voices, as well as over themselves and their own behaviour in response to the voices.

Gary conveys his sense of lack of control by describing the relationship he has with his voice:

*it's like playing a game of chess with your own mind and it normally ends up with checkmate which is me following it because I can't defend it in any other way, whether it's because it's me thinking it's God and you can't say no to God*  
(Gary, p3)

Gary’s use of a chess metaphor implies the relationship between him and the voice is like playing a strategic game that he is rarely able to win. The idea that he feels unable to defend himself and that losing to the voice is considered normal highlights the perceived power of the voice. This draws on a relational aspect to the perception of power and emphasises that for Gary, his voice has more power than he does. This latter point is enhanced through his belief that the voice may be God, an omnipotent figure. If this is the case, then it could be hypothesised that Gary does not simply feel a lack of control, but in fact feels completely powerless. This notion is supported by the statement “*you can't say no*”, which demonstrates the complete removal of choice.

The idea of having no control is also well illustrated in the visual description of Arthur’s voice:

*it's as if you're fighting to pull away but you're being pulled by something very very powerful that makes you walk towards him and stand in front of him and then it's straight away the branch comes around or the arm comes around and um strangles you. And you stand, I mean I stand there and go (gasps) I can't breathe until I pass out. (Arthur, p25)*

Arthur demonstrates having some element of control over himself as he attempts to fight back and “pull away” from his voice. However, this has limited effect as he is not able to control the voice. This leads him to no longer feel in control of his own actions, which makes him behave in a way he does not wish. His vivid description of being strangled by the tree and being completely unable to escape until he passes out, as well as his use of the phrase “very very powerful”, highlights the extent to which he feels powerless. Furthermore, it suggests the voice’s power affects Arthur’s own sense of existence and potential mortality.

Lack of self-control is further highlighted by Jack:

*I tried to kill myself when I didn't want to (Jack, p19)*

Jack describes how he was made to perform an action again his will, demonstrating the lack of control he has over his own behaviour. The gravity of this power position is evident as not only does Jack comply with commands through a complete sense of lack of control, but should he have been successful, he would have caused his own annihilation. Once more this draws attention to the person’s sense of existence and own mortality and in Jack’s case, highlights the extremes he is willing to go to because of his own perceived position of powerlessness.

Conversely, some participants describe occasionally being able to shift the power imbalance to increase their own perceived level of power. This appears to be achievable through a sense of control and is most remarkable with Holly:

*I'm going to do what I want and I'm not going to be ruled by instructions that can't hurt me because they are just, they're just voices you know, they can't hurt me unless I actually act on it and I think coming to that understanding has really helped me (Holly, p12)*

Holly is the only participant to show this level of conviction in her ability to exert control over the voices and heightened position of power. Taking a holistic view of Holly's entire account provides a picture of someone who used to struggle with voices but has now managed to renegotiate the relationship, resulting in her feeling able to manage her experiences with limited distress. This extract supports the interpretation that her ability to now manage the voices could be a result of an increase in sense of control and power in response to them. Holly's statement "*they can't hurt me*" implies that at one point, she may have believed they could. This suggests that like Louise, her compliance may be motivated through a fear of the consequences of non-compliance. By realising the only person that can cause her harm is herself through choosing to comply with commands, Holly appears to have increased her sense of choice and control.

### **Super-ordinate theme three: Relationship with others**

This super-ordinate theme presents an account of the ways hearing command voices affects relationships between the participants and other people. This is illustrated through two sub-themes. The first explores how the experience of hearing voices impacts upon relationships in the participants' social worlds, and the second examines the relationships between the participants and professionals involved in their mental health care. This super-ordinate theme addresses the perceived overriding negative impact of experiences with these voices on relating socially, but also draws on exceptions to this negative experience.

This super-ordinate theme has some degree of overlap with the sub-theme of 'impact on quality of life'. However, the emphasis in this super-ordinate theme is on relationships and as this was such a dominant finding throughout the narratives, I feel it justifies its own super-ordinate theme.

### **Sub-theme one: Impact on social relationships**

A common theme concerns perceptions that social relationships are altered as a result of hearing command voices. All of the participants allude to finding social relationships problematic, which appears to stem from feeling it is difficult to discuss their voice-hearing experience. This seems to create a fear that sharing their experiences could result in damage to how others see them; a loss to their social self. One of the most poignant explanations to arise for this is due to a sense the outside world does not and would not understand their experiences, as Gary evocatively points out:

*It's one of the worst illnesses to have, for someone to go "ooooh" (laughs) I think that's slowly changing a bit, you get the odd media story don't you where they have chopped somebody up or gone on a rampage, not necessarily because they're schizophrenics but you just get bad press, even myself I feel like it's a, it's not a great thing to be called, you don't, something about the word I suppose, I mean "schizophrenic" but you can have like cancer and that's fine (laughs) but, you know what I mean it is quite stigmatised really. (Gary, p18)*

Gary appears to class his experiences as part of an illness, creating a sense of it being both unavoidable and not his fault, yet despite this, he feels it is not deemed socially acceptable. His use of the term "*ooooh*" suggests he feels people who become aware of his experiences would gape at him, implying a sense of being different to others; a difference that could potentially lead him to be reluctant to share his experiences with others in fear of being stigmatised. Gary's categorisation of "*schizophrenics*" emphasises a view that the illness is more noticeable than the individual, which could be interpreted as a loss of sense of self when in a social environment. Loss of a social self is illustrated well by Arthur:

*my main ambition from this thing is that I will be Dean [voice] free, that I could go month after month after month and not have any comeback, and really rejoin, rejoin um, society as it is. Because at the moment, I don't, as I say, I don't associate with a lot of people, I'm very very reserved about who I talk to about Dean (Arthur, p39)*

Arthur's haunting comment of "*rejoin society*" really stresses his belief that because of his experiences with his voice, he is not a part of the social world he previously belonged to. This loss of his social self is further elucidated in how he describes his limited social interactions. He also expresses a choice not to discuss his voice with others, a choice that again suggests a sense of it being problematic to do so, due to an implied fear that it would elicit a negative reaction. One could speculate that this is around a perceived fear of being judged and not understood. All of the participants have experience of sharing their story with others and indeed all of them speak about this experience as being problematic.

Dylan discusses how he, too, finds social relationships problematic:

*when I'm round my partner, I feel protected by her, and she's ... she's really been there for me, um, ... my brother and my mum have as well but they're not local to me, it's just telephone conversations. I haven't actually seen them since, since all this has happened, so, um, because I don't have much of a social, social life as well ... I'm not a sociable person anyway, but, the thing is I would probably be afraid to be in a social situation, um, too, just in case something like came inside my head, that I wanted to do, like bad and in front of people, in front of friends or whatever, it would be totally distressing to them, they would think, they would think I was a nut-job. (Dylan, p8)*

Like Arthur, Dylan describes a loss in his social self, with a reduced level of social interactions and willingness to be in social settings. For Dylan, this choice to withdraw from society appears to be triggered by a fear of what could happen; of what he may end up doing as a result of the voices and the fear that this would result in social condemnation. His use of "nut-job" further exemplifies this point and again suggests he feels aware of stigma towards experiences such as his. Another feature illuminated in this account is that although social relationships appear to be fraught with difficulties, they do also bring with them positive aspects. Dylan comments on the protection and support he receives from his girlfriend and family members, which seems to be important to him. His use of the word "protected" suggests his girlfriend is instrumental in helping him to manage his experience with the voices.

Holly also finds benefit in some social relationships:

*things like jump off bridges were easy to resist because I tended to get that at night and I would have woken up my husband so I never hugely acted on them because, because I would have woken him up and he would have stopped me so there was that kind of stopping me from going out (Holly, p9)*

Here Holly discusses how when she received commands to jump off bridges, she relied on her husband to cope and to keep her safe. Although Holly chose to wake her husband, the lack of any mention of her own ability to resist acting on these types of instructions implies a strong reliance on her husband in helping her to manage the situation and her experiences. This is indeed a recurrent notion across the narratives of the participants and suggests that

the difficulties encountered within social relationships are exclusive to certain relationships, as other relationships can be facilitative and supportive.

### **Sub-theme two: Relationship with professionals**

Another theme to emerge in discussing relationships with others concerns how the participants relate to mental health professionals. All of the participants have experience of receiving care from professionals and are all currently under the care of a mental health team. This theme explores the two areas that arise from the data; participants' satisfaction and dissatisfaction in the relationships they have formed with mental health professionals. As these relationships are what forms their care and treatment, this theme can also be used to illuminate information regarding the perceptions of service provisions.

Gary's dissatisfaction in the service he is currently receiving from his mental health team is evident:

*it doesn't seem to be a lot of help at the moment, I do feel a bit out there, as I say I've had a bad couple of weeks, um, even, I'm worse than I've ever been on tablets and I don't seem to be getting much help, they've increased the dose. I've asked to go into [accommodation designed as an alternative to hospital admission], but even my carer, you know, no, I'm not going to say anything about that (laughs) but I think they're so over, under-budgeted and over, under-staffed that there's not a lot of people that have a lot of time for you (Gary, p16)*

Gary appears to be experiencing a sense of both despair and frustration with the care he is receiving. He regards the service as a source of "help", but does not feel this is being delivered due to financial constraints and a lack of resources. Gary gives the impression that not only are his needs not being met or recognised ("not a lot of time for you") but that to some extent care is actually being withheld from him. His use of the term "out there" could be interpreted as him feeling alone with his struggles and his reference to "tablets" and "dose" suggests he feels the only help offered to him has been through medication, which he does not believe to be the answer.

Dylan also shares his dissatisfaction in the care he has received:

*Well, it's a kick in the balls really isn't it. You know, you go in on the trained doctor's word and he sits there and listens to what you've got to say and you spill your heart out about what's going on in your life and how you're finding it difficult and he's like here's, here's what I think is going to be the answer that's going to help you, and took the tablets and nothing's changed and so, yeah, just probably made me not really want to see him next time (Dylan, p20)*

Like Gary, Dylan relates his dissatisfaction with his doctor to discontentment in the affects of his medication. Again he views his doctor as having the ability to "help" him and to possess "*the answer*". It could be argued that Dylan places so much hope in his medication that when it fails to meet his expectations, he is so bitterly disappointed that he focuses this disappointment on to the origin of the hope, his doctor. The term "*kick in the balls*" could be interpreted as an act of aggression or something considered being extremely painful, humiliating and emasculating. The use of this term as well as his desire to protect himself from further distress by avoiding the doctor, gives an insight into the gravity of his distress. The level of his distress may also have been increased by feeling over-exposed through sharing his difficulties with the doctor, as one could potentially interpret through "*spill your heart out*". For Dylan, there appears little point in having to share his story with professionals if there is no obvious gain in doing so.

Both Dylan and Gary, and indeed other participants, demonstrate such a dependency on professionals for help, that at times it makes them appear to take quite a passive role in their own wellbeing. This is exemplified by Gary's description of how "*they've increased the dose*", suggesting this was a decision made without him. It is unclear whether they are choosing to adopt a passive position, but if they are not and indeed their agency is being reduced by professionals, one could anticipate this would enhance overall feelings of dissatisfaction.

Fred is the only participant who does not convey negative feelings towards health professionals, as illustrated in this touching extract:

*Well they were all very understanding, they listen and they know their stuff and they help to give you ways of dealing with it, strategies and leaflets and that kind of thing so, no they've been very good really. Like I say ... I wouldn't be here if it wasn't for them. No, very good, they deserve a bonus (laughs). (Fred, p20)*

Fred's satisfaction in the care he has received seems to stem from feeling heard and understood, which again highlights the fact that 'care' is relational, in that it is through the relationship formed with members of staff that it is delivered and received. This understanding is measurable by the way he has been offered solutions to help him manage his experiences. Fred's poignant remark "*I wouldn't be here if it wasn't for them*" emphasises his dependency on mental health professionals and passivity towards others, although in this case, it is something he appears grateful for. The extent of his satisfaction is conveyed by his notion that the staff "*deserve a bonus*", implying he feels they have gone beyond what was expected of them.

Although Fred is the only one to demonstrate satisfaction in the relationship with professionals, other participants speak of their positive experiences in addition to the negative. One example of this is from Louise:

*Oh they're [current mental health team] brilliant. Here they're brilliant. I've got a CPN [Community Psychiatric Nurse] and I've got a support worker and they're both brilliant and I've also got a doctor here who's very good as well, can't fault them here at all (Louise, p17)*

Louise's repetition of "*brilliant*" stresses her positive perception of the relationships she has with mental health professionals currently, although her use of "*here*" reminds us that this pleasure is as a result of comparing the care to other professionals she has worked with in the past. Louise appears to measure overall satisfaction through the resources she receives as well as the quality of the relationship she has with each professional.

#### **Super-ordinate theme four: Sense-making**

This super-ordinate theme explores the attempts made by the participants to make sense of their experience of hearing voices that tell them what to do. It draws on how they go about trying to understand their experiences as well as their desire to do so. Four sub-themes are

presented. The first concerns how the participants reflect upon the reasons they hear voices and the second how they embed their experiences within a sense of time in order to try to better understand the phenomenon. The third sub-theme conveys the overall sense of confusion participants feel about their experiences and therefore highlights the need for sense-making. The final sub-theme concerns how the participants turn their sense-making processes inwards to examine themselves and ultimately question who they are, who they have become and who they may turn out to be.

### **Sub-theme one: Purpose**

This theme captures the participants' attempts to make sense of hearing voices through their exploration of the meaning behind their experiences. The reasoning provided by each participant is idiosyncratic, with each participant demonstrating their own take on the possible reasons why they hear their voices. However, a unifying aspect is the importance placed on their sense-making process of establishing a rationale for their experiences; their need to not only know, but to understand *why*.

Arthur provides a moving account of his search to understand why he hears his voice:

*I don't understand why Dean is trying to get me to do something that really has no bearing on me, or doesn't appear to have any bearing on me, or why, why am I thinking about Daniel [friend], you know why then am I being choked and wanting to kill myself. There are loads of questions I would have, but I don't see, like I don't see, the end game, I don't see why Dean would want me to do these things, I don't know. Why do I want to do them, I don't know. Why, why would I go for a doctor? I don't know. (Arthur, p16)*

The many questions Arthur asks illustrates his lack of certainty and desire to understand why he experiences his voice, excellently demonstrating the sub-theme. Trying to understand why he hears his voice also brings him to question other aspects of his voice-hearing experience such as the motivation behind his voice's commands and overall behaviour towards him. Arthur appears to feel somewhat overwhelmed by the magnitude of his uncertainty, illustrated by his use of the future tense, "*loads of questions I would have*", almost implying that he dare not even begin to ask the questions that may bring about clarity. His reference to an "*end game*" could be interpreted to mean he views the voice as having an agenda for him to adhere to. Although Arthur appears to have many unanswered

questions, it is clear there is a sense-making process present where he is searching to comprehend his experience with his voice through trying to understand why he hears it.

Gary shares in Arthur's lack of clarity around why he hears his voice:

*I have lots of theories, I think it is, you wonder about, I don't know, whether I've been experimented on sometimes. (Gary, p6)*

This is one of many of the possible explanations Gary gives for why he may hear his voice. Another possibility includes:

*I don't know if I was supposed to listen to it, you know like Jesus listened to his father or whatever, I don't know, I don't think it is, I don't know if it is a higher spiritual power, it might be, there's evidence that I've experienced to say if it's a higher power, maybe it's all set out, but when it's nasty and bullying and tried to get me to do myself over, doesn't sound right to me really (Gary, p8)*

Gary seems to contradict himself in terms of his own conviction in how strongly he believes he understands why he hears his voice and what its purpose is, as on the one hand he appears to believe the voice may be part of an experiment but on the other he considers whether it may actually be a higher power. He openly admits to having "*lots of theories*" highlighting this lack of clarity in his own mind around the purpose of the voice. As with Arthur, in searching for the meaning behind why he hears his voice, other questions emerge such as whether he should engage in what the voice wants but this appears to cause an internal conflict as he has both supporting and non-supporting beliefs for each idea. Despite not knowing the voice's purpose, Gary does seem to believe it might have one, as illustrated through his description that it may all be "*set out*".

Holly, too, expresses a divided opinion around her perception of the voice's purpose:

*it's kind of like Jesus and his forty days in the desert and temptations and demons that he sees and all that, there's some level that I relate it to that, and my day-to-day head, my I'm going to work today and I'm going to be a manager at work head says that's absolutely ridiculous, but the thought stays and the thought is still there that that is, that it's some sort of trial that I have to go through to become a better person (Holly, p14)*

Holly's biblical reference implies she feels her voices have been sent to test her and that passing this test would transform her into a "better person". This highlights that although Holly perceives her voices to be a challenging experience, the outcome of hearing them is desirable to her. Throughout Holly's account, she makes several references to her faith, suggesting her meaning-making processes are entwined with her own experiences and beliefs.

Louise on the other hand, expresses a stronger conviction in her belief behind the purpose of the voices:

*I think they want my property and this is the way that they're trying to do it, for me to leave that property which I'm not going to, I've decorated it really nicely and it's my home and they're always saying to me, um, through all different sorts of means like um, the um, television, not the radio the radio's ok, but the television they're able to pull out um, not broadcast but programmes that really upset me (Louise, p3)*

Louise believes her voices are trying to get her to vacate her home so they can occupy it and are attempting to achieve this through upsetting her so much she chooses to leave. This again implies she considers the voices to have an agenda and highlights how she has formed a rationale as an attempt to try to make sense of her experiences. Unlike Holly, Louise does not see the purpose of her voices as something positive and this extract emphasises the bullying and unpleasant nature of her voices' agenda.

### **Sub-theme two: Time**

Embedded within the data is a subtle yet observable temporal component that runs throughout. Although present within all themes, a distinct temporal aspect emerges of particular significance to the participants' sense-making processes. This theme consists of a

macro view of the experience of hearing these voices in terms of it being a stage within their overall lifespan, as well as a micro view of the day-to-day details of the actual experience. Three main stages emerge within the macro analysis: a time when they did not hear voices, now, and the future with or without voices. The micro analysis is therefore situated within the 'now' stage. Arthur discusses the stages to his experience:

*it's something [voices] that's gone on for a number of years and ... this, uh, this sort of episode, I call them episodes, this episode with Dean um, is, um, it's it's it's new, new, new, because before I used to be trapped in a grave and I could hear voices in a box, in a coffin, and um, they weren't giving me instructions, they were just telling me things like how worthless you are, how you haven't achieved anything, this is the best place for you, but Dean, it's it's like a step on from that (Arthur, p7)*

Arthur draws attention to several stages to his voice-hearing experience. He mentions he has heard voices for a "number of years", suggesting there was a time when he did not hear them, highlighting a 'before voices' as well as a 'voices' stage. His use of the word "episode" also implies there are distinct stages to his experience and that perhaps there are times since he first started hearing voices that he has not heard them for a period of time. Alternatively, it could suggest that the experience feels qualitatively different, which would be supported by his description of how it has changed from hearing commanding voices whilst being trapped inside a grave, to commanding voices and not being inside a grave. It may be that Arthur uses the concept of stages, or 'steps', to help him to understand the changes that have occurred in his experience.

Fred also demonstrates thinking about the stages to his experience:

*I wonder where it's all going with the voices continuing and getting like they are, just, just sit there and think to yourself where is it all going to? You know, is there a point where it all goes to? Does it just carry on forever? (Fred, p23)*

Fred's questioning of how his experience with the voices may continue highlights uncertainty around whether or not he will continue to hear them in the future. Considering Fred's opinion of his voices, this extract could be interpreted as conveying his desire to be able to

categorise his experience into two distinct stages; now with the voices and the future without voices.

Holly considers a time before she heard voices:

*when this all started, because this has only been since February sort of thing, um, when they started they were hugely shocking, I've got used to it now sort of thing and um, when they started it was like the biggest, scariest thing I've ever sort of experienced because I had no control at all over when I heard them it was almost constant at some points, um, I couldn't focus on doing anything because all I'm hearing are these instructions (Holly, p1)*

Here Holly describes both macro and micro stages to the experience with her voices. She discusses a time when she did not hear voices, as well as the changes that have occurred within the lifecycle of her experience. For instance, she draws on her affect in relation to the voices as well as how the frequency of hearing them has altered over time. Taking into account Holly's current perception of feeling able to manage her voices it could be hypothesised that she has been helped to arrive at this perspective because she has been able to better understand her experiences through reflecting on the macro and micro aspects over time.

Arthur provides illumination into the lifecycle of his experience:

*his [voice] approach is, um what am I thinking about and it's it's like, it's like an opening move on a chess board, um, it always asks me what am I thinking about and I will always say "I'm not thinking about anything" and then the questions start coming out. I can hear this before, I can hear him before I can actually see him and it's, it's, it's um like a loop of questions that always return back to "what are you thinking about now?" And it builds up um, to the main issue that is going on in my head is to protect my friend (Arthur, p1)*

Arthur describes what his voice-hearing experience consists of in a step-by-step way. He gives the impression that it takes the form of a highly predictable and repetitive pattern. There is also a sense of permanence within this account as he offers no possibility of the experience differing in anyway, suggesting that for Arthur, there may not be any end in sight

for this stage in his life. Interestingly, throughout Arthur's interview, he repeatedly spoke of the repetitive nature of his voice. Arthur's repetition may have mirrored the voice's repetition, suggesting possible parallel-processing, giving an insight into how dominating this aspect is in his relationship with his voice. It also indicates a desire to further explore the nature of his experience, which is likely to be part of his sense-making process.

### **Sub-theme three: Confusion**

The whole experience of hearing voices that tell you what to do is described by all of the participants as highly confusing. This sense of confusion runs throughout their narratives and as well as overtly discussing a lack of understanding of the phenomenon, it is also conveyed through their struggle to describe the experience, which may represent internal confusion. For most of the participants, this mist of confusion remains, but for others, such as Holly, there appears to be a clearing in the mist. This sense of confusion provides a window into the participants' sense-making processes. Jack conveys his confusion:

*it's really weird. It's just, difficult because sometimes I don't know what's real and what's not real, there's like a middle that combines together, like a wall that disappears. (Jack, p3)*

Jack's use of the word "weird" communicates his own lack of understanding and appreciation for his voice experience. He describes there being a differentiation between what is real and what is not and implies that his voices interfere with that divide leaving him with a lack of clarity. In this extract, Jack cites a lack of certainty around his sense of reality as a contributing source of his confusion. However, the source of confusion differs for Dylan:

*It's because I'm not well, I don't know, I haven't, I haven't got, uh, I don't know ... I don't know if it's from like having a breakdown or, I, I, I ... don't know, I just ... (Dylan, p11)*

Here Dylan is attempting to make sense of what may have led to him hearing voices. Although he appears to think it may be related to him being unwell, his conviction in this idea is clearly weak, as is demonstrated not only through his repetition of "I don't know" but also through the way he expresses himself and his use of stuttering and false starts. Like Jack, Dylan appears to struggle with clarity over his experience with voices, which may be behind his apparent difficulties in describing it to others.

Fred also finds it difficult to communicate his experience to other people:

*Um ... it's difficult, it's difficult trying to explain how you feel to someone. I mean, well I've tried my best ... it's still hard to, it's hard to put in to words really. It's a shame they can't take your brain out like a car battery and say "yeah we know how you feel now, we can see" you know. (Fred, p26)*

His repetition of the words “*difficult*” and “*hard*” convey the severity of his struggle to share a description of his experience with other people as well as the fact that he has attempted to try his best to do so but has obviously been left feeling it was inadequate. Fred’s comment “*it's hard to put in to words*” could be interpreted to mean he knows what his experience is like experientially, but does not feel able to make sense of it verbally. This is supported by his wishful analogy that his brain could be a car battery, enabling others to bypass a purely verbal description. This again paints a picture of a situation that is experienced as highly confusing as a difficulty in verbalising the experience may well mirror an internal state of confusion.

Holly, too, finds her experience with voices confusing, but has managed to find some clarity:

*more recently I've come to kind of understand them as I have a sort of like a protective God voice type thing and then there's the devilish voice which is the bit that, and I think I was getting them muddled up so I think the things that were saying get closer to God were possibly getting a bit muddled with the things saying go kill yourself, go hurt yourself, um, but it's only recently I've started defining them if you like as that, it's just my own sort of categorisation of the different things, I've always, I had a religious upbringing and that's a big feature for me in my life and I started going to church regularly again so that I can sort of have a more structured understanding of things (Holly, p3)*

Holly describes how she previously felt quite confused and “*muddled*” but that she has found a way to reduce this lack of clarity through her desire for a “*more structured understanding of things*”. She appears to have achieved this sense of structure through reorganising her experience via categorising various aspects of it. This categorisation draws on her own faith,

and therefore it could be hypothesised that for Holly, being able to relate her experiences to something she already knows and understands well, has enabled her to feel less confused.

### **Sub-theme four: Questioning self**

The final theme involves how the participants' voice-hearing experiences have impacted upon their sense of self. The participants appear to try to make sense of their experiences through questioning themselves. Particular areas of self-reflection revolve around a belief they have lost the person they once were, concern for who they may become, and an uncomfortable awareness of their own mortality.

Holly questions herself in relation to whether her perceptions of the voices make any sense:

*it's weird, even as I'm saying it I'm thinking "you sound nuts" (laughs), "you sound like" it sounds completely fantasy and talking about it with people, it's good to be able to talk about it but I still have that doubt that I'm even going to be believed because it just sounds so, even to me saying it I'm like "what are you talking about?" even though it's my experience, I see it, especially in the cold light of day as an outsider going "what on earth is going through your head to be talking about this stuff?" (Holly, p22)*

Holly describes her difficulty in sharing her experience with others as being due to a concern about whether it makes any sense. On the one hand, she seems quite confident in what she believes, but on the other she conveys a strong sense of questioning her own beliefs, thereby nicely illustrating the sub-theme. Her repetition of self-doubting comments such as "*you sound nuts*" and "*what are you talking about?*" highlight the intensity of this questioning of the self and gives the impression she could not possibly be believed by others as she is unsure whether she believes it herself. Holly's self-doubt may stem from a difficulty she has in accepting that what she thinks could be believable and phrases such as "*weird*" and "*fantasy*" suggests she views her experience as unbelievable. This struggle illuminates Holly's attempts to make sense of her own experience and highlights how the perceptions of others play an important role in this process.

Another important factor within this sub-theme concerns how the participants question who they are and who they have become as a result of their voice-hearing experience. With this,

the notion of loss of the self emerges. This topic is highly prominent within the data and applies to every participant. Dylan provides an evocative account of this:

*I was dealing with a change in my body and dealing with a change in my mind, that, becoming a different person (Dylan, p17)*

Dylan's extract is a moving description of how he feels he has changed so substantially as a result of hearing his voices that he has lost his sense of who he is and has become "a different person". He relays how he feels the voices caused a change within him both physically and mentally and that these two things combined have caused a complete loss of the self. This notion is also demonstrated by Fred:

*I feel sad about it really, because ... I'm not the person I was ... I'm not the person I was about three or four years ago (Fred, p14)*

Again Fred describes how he feels he has lost his sense of self as a result of hearing the voices, and no longer feels like the person he once was. For Fred, this state has left him feeling "sad", highlighting the emotional impact this has on him. This questioning of the self can be viewed as a result of self-reflection and an attempt to make sense of their experiences as, in trying to understand themselves in relation to their voice experiences, the participants have concluded that at least a part of who they are has been lost.

Another example of questioning the self can again be seen with this extract from Dylan:

*one day I could cut a vein or something like that and I could, I could be dead on that sofa when she [girlfriend] walks through the door (Dylan, p7)*

Here Dylan presents another facet to his self-questioning as this time he is not questioning who he has become, but who he may become in the future. For Dylan, this possible future self appears to present a source of anxiety as he fears what impact this self may have upon others. When asked how he felt about what he had just said, Dylan replied:

*What dying? ... That's the easy way out at the moment, for me anyway, it would stop everything else that's going on in my head, and what's going on around me at the moment, it's just an easy way out, but it's other people that would have to pick the pieces up then, it wouldn't be me, no. (Dylan, p7)*

Again this illustrates his concern for the distress his future self may unintentionally cause other people and how he would leave them to have to “pick the pieces up”. As well as questioning his potential future actions, it is clear Dylan has become more aware of his own mortality. This shift to a more existential perspective again highlights his questioning of himself and his actions, as well as his overall attempt to try to make sense of his experience of hearing voices.

## **Summary**

To summarise, the analysis focused on four super-ordinate themes of ‘Unwanted experience’, ‘Engagement’, ‘Relationship with others’ and ‘Sense-making’. Within these themes were nestled sub-themes that explored a variety of different facets.

The first super-ordinate theme to be presented was ‘Unwanted experience’ and this explored the negative views towards having the voice-hearing experience. This looked into the perspective that both emotional wellbeing and quality of life were adversely impacted upon through hearing the voices. This super-ordinate theme also considered the participants’ need to cope with their experiences and the methods employed to do so.

The second super-ordinate theme was ‘Engagement’ and this looked at the way in which the participants formed relationships with their voices. The key ways in which this occurred were considered, such as attempting to determine the identities of the voices, perceiving them negatively and positively, responding to what was said and the power dynamics between the participants and their voices.

The third super-ordinate theme to be presented was ‘Relationship with others’. This considered the ways in which the relationships the participants formed, such as those with people from their social environment and mental health professionals, had been affected by the experience of hearing the voices.

The final theme discussed was that of ‘Sense-making’ and this explored how participants attempted to make-sense of their experiences with voices. The key ways in which they went about this consisted of examining the possible reasons behind hearing voices, acknowledging their confusion and associated desire to understand, considering the temporal aspect to their experiences and questioning themselves.

## **Reflexivity**

I found the analysis stage of the study a longer and more complex process than I had naively anticipated. I discovered that in immersing myself in the data, I soon found I was getting lost in my perceptions of the participants’ worlds, which at times felt overwhelming and confusing. Occasionally I found myself so immersed that I could no longer see an overview or feel confident to synthesise and process the data.

A particular hurdle I encountered was in regard to reducing the data. At times I felt paralysed to do this as I feared vital information would be lost forever and I would therefore not do justice to the participants’ accounts. Although this may have slowed my analytic progress, it resulted in me being hypervigilant in my cross-referencing of material and cautious in the decisions I made, which I hope helped to produce an accurate and meaningful account. One approach I found particularly helpful was to continually return to the text to check all my decisions made sense with the participants’ accounts before finalising anything (Smith & Osborne, 2008). This was made easy to do by having a print out of all the key quotes for each theme for each participant as well the full transcript. This technique allowed me to consistently take an iterative approach to the analysis as recommended for IPA (Smith & Osborne, 2008) and therefore ensured I was making sense of what the participants said as well as making sure my interpretations made sense with what the participants said.

Throughout the analysis I endeavoured to look at each participant’s data individually and in its own right but I soon began to notice reoccurring themes from previous participants. Initially I managed this by trying to work harder to bracket off my thoughts concerning previous cases and I employed techniques such as using previous labels where I could remember them but not allow myself to look back over the previous accounts. However, as the analysis progressed and I began to form the same super-ordinate themes across the cases I became extremely anxious that I was manipulating the data and seeing what I wanted to see. Consulting with my supervisor and peers proved essential at this point as they were able to cast their critical eyes over the data and corroborate the presence of the

themes. This was achieved through my supervisor checking sections of my work throughout the whole process. My supervisor not only checked the questions on my interview schedule to ensure they were appropriately focussed and non-leading, but also endeavoured to ensure my decisions and interpretations were grounded in the data at every stage of the analysis. As well as this, a peer independently analysed parts of my transcriptions for two participants, which revealed very similar themes.

As suggested by Smith and Osborne (2008), the analysis continued into the writing up phase of the study. Although I felt reasonably confident with my findings after I had completed the analysis, when I came to present them in the report, I continued to think about them and in a few cases re-organised themes. This came about when considering the overlap between sub-themes as each time I attempted to discuss this, I further explored whether it was actually an overlap or whether one of the themes could be a facet of the other.

Finally, throughout my analysis and particularly when I was writing it up, I was concerned about being able to do justice to the participants' accounts and represent their experiences in-line with how they would want it to be understood. I hope this desire and the care that went into the entire analytic process ensured this goal was met. One way this could be witnessed was in the order the super-ordinate themes were written up. This order was not random; I chose to write them up according to the sequence of my own understanding of the participants' experiences within the interviews and in the analysis. For example, the first realisation I had was that for the participants, hearing voices was a thoroughly unpleasant experience that was unwanted.

Although the analysis was a challenging task, it was a highly rewarding one. Once I was able to see light at the end of a, at times, rather dark tunnel, I felt pleased to be able to meet my goal of telling the participants' stories. To overcome the difficulties I encountered required stamina, 'time-outs' and the validation and second/third/fourth opinions of my peers and supervisor to help me see my blind spots and ensure I was making appropriate sense of the participants' sense-making.

## **Discussion**

This chapter discusses the theoretical insights gained from the present study and the implications these may have for practice, as well as offering a critique of the methodology and suggestions for future research.

### **Theoretical insights**

Most of the observations from the present study as well as supporting the existing command voices literature, also parallel many of the findings from more general voice-hearing studies. This was expected, given that command voices are a type of voice-hearing experience. Furthermore, in many of the more general voice-hearing studies, some of the voice content is said to contain an element of command. Indeed, it is possible that participants experienced some commands even in those studies that make no reference to command voices. Although the present study specifically applies to the experience of hearing command voices, it can be seen to add support to the existing literature on the voice-hearing experience through the super-ordinate themes that emerged from the data.

The four super-ordinate themes to emerge were: ‘Unwanted experience’, ‘Engagement’, ‘Relationship with others’ and ‘Sense-making’. Firstly, ‘Unwanted experience’ adds support by demonstrating that the experience of hearing command voices is unwanted, distressing and prompts the individual to employ coping strategies in order to reduce the distress associated with hearing voices. Secondly, ‘Engagement’ generated support for the idea that individuals form relationships with their voices, which was seen through attempts to identify the voice, judge its malevolence/benevolence and power, as well as through responding to the voice content. Finally, the present study supports the existing literature through the observations made in ‘Relationship with others’ that the voice-hearing experience has a negative impact on the relationships formed with other people. The present study also extends our current understanding through the observations made in ‘Sense-making’ by demonstrating that participants found hearing command voices highly confusing and endeavoured to try to make sense of them. Furthermore, by demonstrating that accepted aspects of voice-hearing are applicable to command voices, the study extends current understanding of hearing command voices by showing that consideration needs to be placed on more than simply compliance and risk. These areas shall now be explored in more detail.

### **Unwanted experience**

The present study demonstrated that hearing command voices was perceived to be an unwanted experience and this parallels the findings in the existing literature (Birchwood et al., 2000; Close & Garety, 1998; Peters et al., 2012). Overall, what particularly stood out was the level of distress present as a result of the participants' experiences. This high level of distress most likely accounts for why the experience was perceived to be unwanted. Distress was evident through the participants speaking about the negative impact hearing their voices had on their mood, and by them linking the experience to increased anger, anxiety, fear and mood instability. It could also be seen through how hearing the voices appeared to lower self-esteem, as participants spoke of feeling worthless and ashamed of their behaviour in response to commands. These observations are in line with Close and Garety's (1998) findings that the experience of hearing voices is associated with a range of undesirable emotional states as well as poor self-esteem and a tendency to negatively appraise the self.

Close and Garety (1998) suggest that not being able to exert control over the voices may be to some extent accountable for the levels of distress seen. Indeed, Larøi et al. (2012) claimed that this lack of control could determine the shift from a non-clinical experience to a clinical one. All of the participants in the present study discussed a sense of not being able to exert control over the voices and were all accessing mental health services. Not surprisingly, those participants who discussed having gained some control over their voices appeared to be less distressed and negatively affected by their experience.

Linked to a lack of control over the voice, most of the participants appeared to feel trapped with their experience, expressing a desire for things to improve and to be rid of their voices. Feeling trapped with a desire to escape is a theme that occurs within the current literature (Gilbert et al., 2001) and is likely to contribute to poor quality of life and distress. Gilbert et al. (2001) also highlighted that feeling trapped was more prevalent for those who considered their voice to be powerful. Each participant made frequent reference to the perceived power of their voices, thereby adding support to well established findings linking distress to perceived voice-power (Birchwood et al., 2004; Birchwood et al., 2000; Gilbert et al., 2001; Peters et al., 2012). It has been proposed that the effect of voice-power may be due to self-perceptions of low social rank compared to the voice, which may result in feelings of helplessness and hopelessness (Fox et al., 2004). This may provide some explanation for why the participants found their voice experience so distressing, although this was not explicitly discussed.

Another reason why command voices may be seen as distressing and therefore unwanted could be due to perceptions of voice malevolence. Close and Garety (1998) proposed that voices perceived to be malevolent were associated with greater distress. Indeed, those participants who viewed their voices as positive as well as negative, showed less distress. Mawson et al. (2010) claimed that in addition to malevolence, distress was increased when the voice was perceived to be powerful and when the individual felt personally acquainted with the voice and wanted it to go away. These factors may offer a further insight into why the experience of command voices was perceived to be distressing and therefore unwanted, as all participants viewed their voices as powerful, personally acquainted and stated they didn't want to hear them. The present study therefore provides support for the possibility that these attributes may be applicable to people who hear command voices.

It has also been proposed that voice distress may be due to impoverished coping strategies (Nayani & David, 1996). The authors found that participants employed various coping techniques to try to avoid hearing the voices, and that a lack of control over the voices and few means of coping were associated with greater levels of distress. Similarly, Romme and Escher (1989) found coping strategies were linked to improved management of the voice experience. Coping emerged as a sub-theme within the present study as participants readily spoke about both their need to cope and the techniques used to do so. The participants spoke about employing various coping strategies to avoid the voices such as drinking and taking medication. Several also discussed their attempts to perform in front of others to give the illusion of being "normal". Romme and Escher (1989) commented that accepting the voice appeared to be a particularly effective coping strategy. Indeed, the participants in the present study who demonstrated higher levels of acceptance towards their voices were those who appeared to cope better. Therefore Romme and Escher's (1989) claim may go some way to explain why these participants showed lower levels of distress. The use of coping strategies certainly appeared to be important for the participants and indeed when strategies failed to work, it appeared to have a significantly detrimental impact on quality of life. These observations add support for existing claims that coping strategies are imperative in helping people reduce the distress associated with hearing voices. The current study extends the existing literature on coping as participants described employing some novel strategies not before mentioned in the literature. Of particular note is 'the performing self'.

One final consideration worth noting in regards to voice distress and the experience of hearing command voices as being unwanted is that most of the participants received commands to harm or kill the self. Hartley et al. (2012) has previously linked these types of commands to higher distress levels, which may therefore provide another insight for the current participants.

The observations made in the current study again go some way to highlight the variation in what may cause distress and how 'distress' may mean something different to each individual. This is an important finding as it adds support to idea that 'distress' should not be taken as one unified outcome and that it is necessary to enhance understanding of this concept.

### **Engagement**

A large proportion of the existing literature places an importance on perceptions of voice malevolence/benevolence, linking it to behavioural responses as well as distress. Chadwick and Birchwood (1994) argued that perceptions regarding voice malevolence/benevolence were formed through beliefs about voice identity, omnipotence and purpose. In the present study, the theme of 'voice as negative/positive' emerged, which equated to malevolence/benevolence. Although beliefs around identity, omnipotence and purpose occurred in the present study, the participants also discussed voice content and impact on quality of life as determinants in their opinion of the voice. These observations support the finding of Close and Garety (1998), who argued that voices perceived to have a negative content were seen as malevolent. It also supports the findings of Beavan (2011) that voices perceived as well-meaning and having a positive impact on quality of life were usually those that had a positive content.

Perception of voice malevolence has also been linked to greater resistance in complying with voice commands (Beck-Sander et al., 1997). However, others have disputed this link (Fox et al., 2004). Most of the current participants described negative voices, although some simultaneously held positive beliefs. Despite considering their voices to be negative, all participants reported having complied at some point with commands given. It is possible that the reason the participants did not always comply with commands may be due to their perception of voice malevolence (Beck-Sander et al., 1997).

Why people comply with commands comprises a substantial component of the present literature on command voices due to the risk posed to the individual or those around them (Braham et al., 2004). Within the present study participants spoke of commands to harm themselves and others. Although all participants referred to times when they had complied with harmful commands, it was unclear how often this had occurred, and at the time of the interview, they spoke of resisting all commands other than innocuous ones. This is in keeping with Bucci et al.'s (2013) finding that participants were more likely to comply with benign commands rather than harmful ones. Similarly, it also supports Chadwick and Birchwood's (1994) finding that the most influential feature when considering compliance was the severity of the command itself; with lower-rates of compliance if major social transgression or self-harm were involved.

The most predominant reason put forward for why participants chose to comply with commands was a fear of the consequences of non-compliance. In particular, participants spoke about attempting to mitigate the threat posed by voices out of fear of being punished for not complying with commands. Chadwick and Birchwood (1994) proposed that Milgram's (1974) findings were applicable to command voices, whereby compliance was linked to the perceived power of the command issuer, the degree of own control and the assumed consequences on non-compliance. These aspects appear to be applicable to the current participants as fearing the consequences of non-compliance equates to fearing the voice, therefore implying the voice is more powerful and able to exert control. The findings from the present study are therefore also consistent with the proposal that compliance is more likely when the voice is perceived to be powerful (Beck-Sander et al., 1997; Trower et al., 2004).

As mentioned, literature on voice responding has focused on compliance. The present study not only supports this literature but extends it as there is currently little research exploring other ways people respond to their voices. In the present study, participants discussed difficulty in concentrating and a propensity to choose to listen to what the voice was saying. However, if the participants perceived the voice as highly powerful, this was likely to compel them to focus on the voice, perhaps out of a fear of not doing so.

Indeed, all the participants discussed perceiving the voice as more powerful than themselves and 'Power' was a dominant theme emerging from the data. Power appeared to be determined by lack of ability to exert control over the voice as well as to not comply, finding support for Chadwick and Birchwood (1994). The role of voice-power perceptions is well

documented (Beck-Sander et al., 1997; Chadwick & Birchwood, 1994) and when individuals consider a voice to be more powerful than themselves, they are likely to respond by attempting to escape, submit or comply with commands (Reynolds & Scragg, 2010).

While perceived voice-power may account for the responses to voices, a few participants also demonstrated being able to regain some power. As Chin et al. (2009) highlighted, the majority of the existing literature focuses on the powerlessness of the voice-hearer. In their study however, they found power and control could be bidirectional, with participants battling to take back control and that voices appeared to maintain their position of power through issuing commands. This finding may therefore offer an explanation for why most of the participants, and indeed all of them at one point or another, believed their voices to be so powerful.

As well as engaging with the voice through beliefs about its malevolence/benevolence and power, participants also demonstrated engaging with the voice through seeking to understand who or what the voices were. In particular, participants demonstrated having personified their voices through assigning a gender, name and personality, and in a few cases, describing the voice in terms of human physical characteristics. The propensity for individuals to personify and identify their voices is well documented in the current literature (Close & Garety, 1998). It has been proposed that identifying the voice may enable individuals to begin processing and making sense of their experience (Romme & Escher, 2000). Similarly, it was suggested that through personification, a person may achieve a more balanced relationship with the voice (Jackson et al., 2010). Although these claims were not substantiated directly by the current study, they may account for the tendency of the participants to engage with their voices in this way. However, contemplating whether the voice had a separate identity or was actually a part of the self stood out as a novel and therefore intriguing finding, not previously captured in the hearing-voices literature. In particular, a few participants appeared to battle with the notion that the voices may actually be their own thoughts. Similarly, the presence of voice-associated visions also appeared to aid the establishment of an identity. This, again, is not mentioned within the existing literature and suggests people may actually go through a confusing process of deciding whether or not the voice has a separate identity to their own.

The super-ordinate theme 'Engagement' attempted to capture how all participants chose, to some extent, to attend and relate to the voice. For this reason, all of the sub-themes of

'voices as negative/positive', 'identity of voice', 'response to voice content' and 'power' could be viewed as having a relational component as their very existence occurred only as a result of a voice-hearer relationship being present. Although the existing command voices literature has explored voice malevolence/benevolence, compliance and power, it is only really power that has been discussed within the growing body of work as demonstrating the presence of a relational component to voice-hearing (Chadwick et al., 1996; Chin et al., 2009; Hayward et al., 2011). It is my belief that all four of these sub-themes represent voice-relating and therefore the present study offers an opportunity to add to the existing theory on relating to voices to be meaningful for a command voices specific population.

An interesting claim in the work exploring relationships between the individual and their voice is that voices can provide companionship (Romme & Escher, 2000). Similarly, Beavan (2011) proposed voices could fulfil adaptive functions and even suggested that voices could provide a loving relationship that was not possible elsewhere. These characteristics were evident in the narratives of participants in the present study. The observations from the present study add support for both Romme and Escher's (2000) and Beavan's (2011) claims, as well as the overall concept that relationships can be present between an individual and their command voices.

### **Relationship with others**

In the present study, hearing command voices impacted upon social relationships, with most participants reporting a negative impact. Sadly this is well documented within the current literature (Intervoice, 2013) with voice-hearers often worrying about stigma (Jackson et al., 2010). In one study exploring stigma around schizophrenia, it was discovered that participants felt judged due to other people's lack of knowledge, compared their lives to how they were prior to hearing voices, and tried to conceptualise and manage their experiences (Knight et al., 2003). Interestingly, all three of these themes could be observed within the present study, thereby adding to the theory to make it applicable to hearing command voices. For instance, most of the participants spoke about finding it difficult to discuss their experiences with others due to a fear of not being understood and being negatively appraised. Indeed, some of the participants appeared to fear that complying with certain commands could prompt negative reactions from others. Another striking observation was that participants spoke of feeling abnormal and different to how they once were. It appeared that in order to manage these fears, participants employed techniques such as withdrawing from social contact and choosing not to discuss their experience with others; strategies also

mentioned in the Knight et al. (2003) study. Knight et al. (2003) also argued that stigma could hinder recovery, a concerning finding given its applicability to the present client group.

However, Knight et al. (2003) also found that some participants reported the experience of schizophrenia as an opportunity for personal growth. This echoes the experiences of some of the present participants who spoke of the experience as, for instance, a “force for good”, highlighting how Knight et al.’s (2003) findings are consistent with the more specific client group of people who hear command voices.

Another possible indication of perceived stigma was that participants spoke about their relationships with the voices in a rather conventional manner. This is in line with the findings of Chin et al. (2009) where participants attempted to normalise their relationships with voices. They proposed this may have been to retain social identity under a perceived fear of negative appraisal.

Interestingly, all participants spoke of stigma as if it were easy-to-understand and inevitable. Indeed, several seemed surprised when I asked them to explain further what they meant. There appeared to be an automatic assumption that others would undoubtedly view them as “crazy”, although none of them elaborated as to why this might be. Limited reference was made to how the experience of command voices was portrayed to the general public and it is therefore unclear what impact media presentations may have on stigma.

In addition to the fear of stigma, it appeared that the experience of hearing command voices also negatively impacted on the participant’s sense of self worth, which had a detrimental effect on social relating. Mawson et al.’s (2011) study highlighted how voice-hearing negatively influenced the views of the social self and acted as a barrier between the self and others. The present study found that participants generally perceived a dramatic sense of loss of the social self, which was maintained through social withdrawal and choosing not to share their experiences with others. It is important to note that although social interaction was viewed as problematic, in many cases it also appeared to facilitate coping. This was observed within the Mawson et al. (2011) study, and the present study demonstrates the applicability of their findings to the specific experience of hearing command voices.

This super-ordinate theme highlights the importance of socio-cultural factors in the experience of hearing command voices and therefore the need for the individual’s wider

context to be considered. The picture that emerged from the present study was complex in regard to relationships with others, with them being both problematic as well as beneficial. However, what stood out was that the participants' voice-hearing experiences were not independent of other people but instead were unavoidably entwined with those around them.

### **Sense-making**

There is very limited information in the literature about participants' attempts to make sense of their voice-hearing experiences and the present study provides new insights about this. Knight et al. (2003) mentioned participants' attempts to conceptualise their situation, but this has not been explored within voice-hearing literature, and particularly not in relation to hearing command voices. Similarly, some studies (e.g. Chadwick & Birchwood, 1994) mention the tendency for participants to consider the purpose of their voices, but this is generally in connection to exploring what motivates compliance with commands. However, within the current study, an attempt to make sense of the experience was a significantly dominant theme, and indeed to some extent was interwoven within all other themes. Purpose was a key feature as participants demonstrated a desire to know and understand why they heard the voices. For some, this was particularly confusing, but most appeared to believe the voice had an agenda even if they were unsure what it consisted of.

The idea that the use of time facilitates sense-making occurs within psychological theory and practice, such as narrative therapy (Payne, 2006), as well as within other disciplines such as Knowledge Management (Dervin, 1998). However, there appears to be no reference to this within the command voices literature. In the present study, participants not only compared past, present and future, they also spoke about discrete episodes of voice hearing. Chin et al. (2009) have highlighted how the experience of hearing voices was perceived by participants to evolve over time. They also drew attention to stages within the experience as well as individual features of the lifecycle of the experience, such as how the voice was perceived on a day-to-day basis.

Participants in the current study shared that they found their experience confusing and often struggled to understand it and describe it to others. Particular sources of confusion appeared to stem from questioning the reality of their experience as well as where the voices may have come from. Again, there is little mention of this confusion within the command voices literature, although Beavan (2011) does highlight how participants reported voices were felt to be real.

One way in which participants appeared to attempt to make sense of their voice-hearing experiences and relieve some of the confusion, was through questioning their sense of self. Participants discussed a loss of the person they once were as well as a concern for who they might become. Knight et al. (2003) found similar themes such as finding that participants compared themselves to how they were before hearing voices and drew conclusions that they were now abnormal, unhappy and no longer part of society. It is likely that a loss of sense of self may be another contributory factor to the distressing nature of the experience. Indeed, Mawson et al. (2011) proposed that improving sense-of-self may well reduce voice distress.

One final interesting comparison between the present study and the existing literature was the similarity in findings with Beavan's (2011) study. This study adopted a qualitative methodology to explore the experiences of hearing voices. Five themes emerged: voices said personally meaningful things, participants attempted to identify the voice, presence of a voice-hearer relationship, emotional impact of the experience, and realness of the experience. All of these themes appeared in the current study, therefore supporting Beavan's findings and demonstrating that they are applicable to command voices. Similarly, Mawson et al. (2011) conducted an IPA study exploring the experiences of hearing voices within a social environment context and found five themes: voices reflected the identity of social acquaintances, voices produced an inferior sense-of-self compared to others, battle for control with the voices, friendships facilitated coping, and voices led to social isolation. The present study supports all of these findings apart from that voices reflected the identity of social acquaintances. However, this theme may well have been present, but the participants did not discuss this in sufficient depth to explore it.

By looking across all the themes and considering how they may relate to one another, the analysis may be lifted to a further level. In this cross-examination, what stood out was an over-arching theme of re-negotiating one's lifestyle. This re-negotiation appeared to become applicable due to the individuals feeling they had moved away from a sense of 'normality' that they once shared with others. This shift saw them have to re-negotiate their relationship with themselves through attempting to make sense of their experience, what it may have meant for their sense of self, as well as how to manage the emotional impact of the experience and the impact on their quality of life. In addition, this move from 'normality' also saw them have to re-negotiate their relationship with others. This took place with the voices

themselves, such as by trying to understand them and how to engage with them, as well as through learning how to cope with them. It also occurred with others from their social world such as friends and family, as they attempted to adapt these relationships to better accommodate their new voice-hearing self. This re-negotiation of relationships with others in their social environments again highlights the importance of socio-cultural factors in the experience of hearing command voices.

Related to this re-negotiation of lifestyle seemed to be another over-arching theme of empowerment. 'Power' was a particularly dominant theme in relation to engaging with the voices and therefore it felt necessary to include it in its own right as a sub-theme of the super-ordinate theme 'Engagement'. However, a theme of empowerment appeared to play a more subtle, yet vital role across all themes and therefore can be seen as a further over-arching theme. It appeared that not only were the participants engaged in a continual battle for power over the voices but also over themselves and their sense of self. Furthermore, participants' sense of empowerment was aided through their relationships with others as well as through being able to make-sense of and cope with the voices.

### **Implications for practice**

The study revealed that for the participants interviewed, the experience of hearing command voices was distressing, confusing and unwanted. As demonstrated in the existing literature, this is an experience shared by others who hear voices that tell them what to do. Many of these individuals will seek support from mental health services and as the primary aim of a Counselling Psychologist is to improve the quality of life for their clients (Division of Counselling Psychology, 2013), it is likely that they will encounter this client group within their practice.

The observation that participants found the experience highly distressing has ramifications for how Counselling Psychologists may go about working with this client group. Although Counselling Psychologists are used to working with people who are distressed, there may be particular ways this can be more easily ameliorated for people who hear command voices. Hayward (2003) proposed that establishing how to offer the most effective therapeutic intervention could be achieved through developing an individual case formulation aimed at enhancing the understanding of the variables mediating distress. He suggested these variables may include beliefs about the voices, beliefs about the self and current coping techniques. In line with this proposal, the findings from the present study as well as the

existing literature suggest that effective therapeutic approaches may include exploring the beliefs the person holds about their voice, particularly in relation to power and control, promoting acceptance of the voice, and exploring the voice-hearer relationship as well as the beliefs the individual holds about themselves. There are therapies that incorporate these factors and therefore their application to command voices and implications will be explored.

Beliefs held about the voice appear to be a very important mediating factor in distress. Both the current study and existing literature support a cognitive model of voices, which suggests that it is the beliefs associated with voices that cause distress (Birchwood & Chadwick, 1997). This is concordant with Counselling Psychology practice, as the traditional stance adopted is to explore the individual meaning behind distress and behaviour. Accordingly, the present study adds strength to the theoretical and practical use of this. It also suggests it is imperative to understand the individual's meaning-making as this may be quite idiosyncratic.

The present study supports existing research in the importance placed on the perceived power of the voice and indeed this is one particular belief that has been addressed with cognitive therapy. Trower et al.'s (2004) command-specific therapy, as mentioned in the Introduction chapter, was aimed at reducing compliance with commands through reducing the perceived power of the voice. Although the initial pilot trial was found to reduce both compliance and distress (Trower et al., 2004), the larger, follow-up trial only produced reductions in compliance (Birchwood et al., 2013). However, a case study using the same therapy found that distress was lowered in addition to compliance (Singer & Addington, 2009). Although this therapy appears to be highly effective in reducing compliance rates, the mixed findings lead to questions regarding its effectiveness in reducing distress. However, as previously discussed, caution needs to be paid as this finding may possibly be accounted for by the distress measures used being too crude to measure the actual levels of distress present.

Although they haven't devised a specific therapeutic approach, Close and Garety (1998) have suggested that if distress is linked to voice power and a resultant feeling of lack of control, then initial interventions should focus on behavioural work to increase the person's sense of control. They argued this could potentially reduce a sense of helplessness and negative affect. As the present study could be seen to support an association between lack of control and distress, it also would support the application of this therapeutic strategy when working with this client group.

More recently, research has begun to explore the application of ‘third wave’ CBT approaches when working with command voices. Third wave CBT emphasises the relationship a person has with their cognitions rather than the content of them. It could be argued that voices are conceptually similar to thoughts, given the intimate relationship between the spoken voice and the hearer that was found in the present study. If this were the case, then a therapy based on working with the relationship between the person and their thought, or in this case voice, would seem promising. As well as being based on the cognitive model, third wave therapies also incorporate factors such as acceptance, which the present study and existing literature suggests is helpful in reducing distress (Romme & Escher, 1989). Shawyer et al. (2012) investigated the effectiveness of CBT combined with acceptance-based interventions from ACT. However, this research is still in its infancy and yet to produce convincing findings.

As well as exploring the use of acceptance in cognitive therapy, Mindfulness-Based Cognitive Therapy, a third wave therapy, has also been explored as a treatment option for people experiencing distressing voices (Chadwick, Hughes, Russell, Russell & Dagnan, 2009). This paper suggested that although the therapy appeared to be beneficial in helping manage other features of psychosis, it was not found to be effective for managing voices. However, more recent work has produced evidence to the contrary, demonstrating the benefits of mindfulness interventions such as improvements in well-being, distress and feelings of control in relation to the voice (Dannahy et al., 2011). Evaluation of the effectiveness of mindful-based interventions within the field of voice-hearing is in the very early stages of development and therefore further research is needed to empirically validate their usage. However, instinctively, if clients were able to turn their mind away from their voices, which could be taught through mindfulness-based interventions, this could have a significantly positive impact on their perceived power and control in relation to their voice. Given the existing literature and observations from the current study demonstrating the presence of a relationship between the individual and their voice, the use of third wave approaches seems to intuitively make sense. However, this is yet to be empirically supported.

Another therapeutic approach that has been explored is Relating Therapy (Hayward et al., 2009), which is specifically designed to modify the distressing relationship with the voice (Hayward & Fuller, 2010). The therapy combines factors supported by the current study as

well as existing literature, such as assuming the presence of a voice-hearer relationship, emphasising acceptance of the voice and challenging its perceived power (Hayward et al., 2009). By combining these factors that have individually been found to be effective in therapy, this therapeutic approach appears to be a potentially exciting new addition to clinical practice. Indeed, an initial pilot trial revealed the therapy was largely effective, but due to the infancy of this finding and therefore the current lack of replication, this approach is yet to be well supported empirically. Relating Therapy attempts to modify the relationship with the voice *directly* through addressing the nature of it. However, the voice-hearer relationship may also be able to be altered *indirectly* through assertiveness training to alter social relating (Birchwood et al., 2000), in line with the theory that voice-relating may mirror social relating (Birchwood et al., 2000; Hayward, 2003). Indeed, Mawson et al. (2011) proposed that individuals may well benefit from interventions that seek to empower their social abilities and confidence.

As well as considering what may form an effective therapeutic intervention when working with this client group, consideration should also be paid to possible obstacles that may occur in the therapy. For instance, all the participants in the present study appeared to find social relationships and relationships with health professionals challenging. In addition, they all reported finding it difficult to share their experiences with others. It is likely these difficulties could emerge in the therapeutic relationship, which may negatively impact upon engagement and ultimately the effectiveness of any therapy. It would therefore be helpful for Counselling Psychologists to be mindful of this potential difficulty and to use their therapeutic skills to attempt to overcome it. In line with Hayward's (2003) proposal, modelling successful relating within the therapeutic relationship may in itself be particularly therapeutically effective for this client group.

According to the current NICE guidelines for schizophrenia (NICE, 2009) and the proposed guideline for psychosis (NICE, 2013), CBT and family work should be offered in addition to pharmacological intervention. The present study found support for the application of a cognitive model for voices and therefore a recommendation of CBT seems appropriate for people experiencing command voices. However, as already discussed, 'CBT' should be considered broadly so as to include third wave approaches. Given the difficulties people hearing command voices appear to experience in social relating, which has been supported by the current study, a recommendation of family work also seems appropriate for this client group. However, these recommendations are based on fast-growing research and as much

of the work on therapeutic interventions is in its infancy, recommendations should be viewed as tentative at this point.

As it stands, there doesn't appear to be one approach that shines above the rest when working therapeutically with this client group. Certain aspects of the therapies available seem to hold more promise than others, but exactly what these aspects are still seems relatively unclear. For instance, the cognitive therapy for command voices devised by Trower et al. (2004) seems successful in reducing compliance and Romme and Escher (1989) have highlighted the effectiveness of showing acceptance towards the voice. Unfortunately, it appears that devising an overall effective treatment option is still very much 'work in progress', but it may well be that by combining aspects from different therapies, we may get there sooner. This suggests the use of an integrated pathway approach for clients, whereby they are offered therapeutic intervention that can target both compliance as well as other aspects leading to voice-distress. A recent novel intervention, 'Cognitive Behavioural Relating Therapy' (Paulik, Hayward & Birchwood, 2012), which is an amalgamation of cognitive therapy for command voices (Trower et al., 2004) and Relating therapy (Hayward et al., 2009) is an example of just this. This approach was used in a clinical case study. In this case, the individual did not report commands from her voices, but the use of this combined intervention led to changes in relating patterns, improved self-esteem and reduced voice-related distress. This approach therefore offers support for an integrated pathway approach.

However, it is worth highlighting the idiosyncrasies of people and the subjective nature of hearing voices, which means that a therapeutic approach that works for one person is unlikely to work for all. Therefore an integrated pathway would need to adopt a graded approach. For instance, for those for whom reducing compliance/risk is the most imperative, Trower et al.'s (2004) cognitive therapy for command voices should be the primary focus in the first instance. This is where a Counselling Psychologist's wide repertoire of skills may prove invaluable, enabling them to work according to the client's need. That said, it is imperative that research continues, in order to devise more evidence-based effective treatment options, so the Counselling Psychologist skill-set can be broadened for this population. The integration of approaches appears to offer the best chance of achieving this and therefore approaches such as Cognitive Behavioural Relating Therapy need to be explored further.

## **Implications for policy**

Participants in the present study all reported being afraid to share their experiences of voices due to a belief that others would not understand and negatively appraise them. Interestingly, as it stands, there is very limited information available to the public about command voices, and even on Psychology training courses there is often minimal information given regarding what this experience may be like and how to work with this client group. It is likely that this gives rise to professional anxiety. There is often an unspoken expectation that Counselling Psychologists are expected to be more understanding than the general public and elevated to a new level of non-judgement. However, this attitude neglects the more instinctive-side of the therapist and the idea that working with this client group, for some, may be a frightening experience. This is particularly pertinent when one considers how therapists are responsible for their own welfare, that of their clients as well as their own professional reputation and career. Given the current empirical evidence suggesting high associations within this client group with risk, and the limited information available on treatment options, some degree of professional anxiety would be understandable. Sadly however, this professional anxiety is likely to contribute to and act to maintain the distress of a client who hears command voices.

The present study therefore helps to highlight a need for the HCPC to take steps to ensure adequate training on command voices is included within training courses for Counselling Psychology in order to help reduce professional anxiety. This could be achieved through experiential learning and/or encouraging trainees to take placements where they may have the opportunity to work with people experiencing psychosis. By working within this type of placement, trainees are likely to encounter clients who hear voices, although working with clients specifically hearing command voices could not necessarily be guaranteed.

Due to available resources, however, it may not be realistic to think that all trainees would be able to undertake this type of placement. Alternatively, someone who has previously heard or currently hears command voices but feels able to discuss them could be invited as part of the training, to visit trainees and share their experiences. One possible source for these speakers could be from Hearing Voices groups, which are run across the UK (Hearing Voices Network, 2013b). During the recruitment phase of the present study, I encountered a gentleman who stated that he had already visited one University to speak of his experiences and would welcome further opportunities. The inclusion of these provisions would give trainees an opportunity to gain valuable insight into the experience first-hand, and to empathically relate with individuals who hear command voices. This type of training is likely

to improve a Counselling Psychologist's confidence in working with this client group, which in turn is likely to help them feel more relaxed and better able to form an effective therapeutic relationship, which in itself may provide a highly effective intervention.

Counselling Psychology training programmes should also encourage trainees to reflect on their own relevant experiences. For some, this may be thinking about their experiences with voices, but it is by no means limited to this. Relevant experience would also include times when the trainee has been criticised, when others have behaved in a hostile manner towards them, or may include thinking about their own internal critical voice. Counselling Psychologists are often highly reflective and the doctoral training courses stipulate the undertaking of personal therapy. Therefore, thinking about their own internal commentary, particularly when it is negative, should be something trainees are able and willing to engage with. Through this, the Counselling Psychologist may be helped to feel the experience is more understandable. Moreover, feeling able to draw on personal experiences when working with this client group may again aid confidence and the forming of an empathic connection with the client.

NICE has not yet issued any guidance on how best to treat hearing voices, let alone voices that are commanding in nature, although it is set to produce a guideline for psychosis in 2014. Although this future guideline may cover voices, the term 'psychosis' is a broad umbrella term and hearing voices is merely one aspect. As the experience of hearing command voices appears to be fairly prevalent, a dedicated 'voices' section within this new guideline would seem appropriate. This section should be informed by observations that participants found sharing their experiences difficult and showed an element of distrust towards others. This finding suggests potential difficulties in engagement with these clients. To enhance engagement, Meaden et al. (2013) have suggested that when working with people who hear command voices, therapists should be encouraged to offer flexibility in terms of time, location and length of sessions. They also recommended the use of joint sessions with other professionals involved in the client's care if required and that therapists show persistence in offering further appointments when clients do not attend. NICE (2013) similarly, recognises the importance of engagement with people with psychosis and encourages the use of therapist persistence and flexibility, but are vague as to how to achieve this. It would be advantageous if guidelines specifically for hearing voices were flexible in the number of sessions recommended. By not being overly restrictive, there is more possibility of successful engagement and therefore of effective therapy.

## **Critique of methodology and suggestions for future research**

There were a number of strengths and limitations to the present study, which shall now be discussed in addition to potential areas for further research. In order to achieve homogeneity and to improve the rigor of the study, the sample used was small and purposive. By adhering to the inclusion criteria, participants were all in receipt of support from mental health services and currently deemed to be low risk. This sample may not therefore be representative of the overall population of people who hear command voices. By the very nature of being involved in services, people who hear voices within a clinical population are more likely to be distressed by their experiences than those in the general population (Mawson et al., 2011). Therefore it is possible that the data were negatively biased towards command voices being perceived as unwanted. It therefore may have been wiser to include non-clinical participants in the sample. However, in addition to reducing the likelihood of negative bias, this would also have reduced the purposive nature to some extent. An interesting piece of future research could be to use the same interview schedule but with a non-clinical population to explore whether this has an impact on the data. It is also worth noting that the participants all chose to take part in the study. In doing so, it suggests they may well have had a desire to explore their voices. Again, not all clients within mental health services will share this desire or level of engagement and therefore the sample used represents a proportion of the overall population.

It was decided not to make diagnosis an inclusion criterion and therefore that there was no need to record any diagnosis the participant had. It was felt that by recording the diagnosis, it may have inadvertently biased the interpretations made and would move the analysis and the reader's appreciation of the findings away from the actual data. It was feared this would go against the subjective, phenomenological stance of the study. Upon reflection, I feel I also chose not to record this information in order to keep the participants safe from pre-conceptions and possible judgements surrounding any diagnosis. However, in hindsight, by not recording any information concerning diagnosis or other mental health difficulties, I feel I may have denied myself and the reader a line of curiosity and the ability to place certain findings (e.g. distress) into context. This idea is supported by the claim by Close and Garety (1998) that diagnosis may act as a confounding variable to voice distress.

It is possible that difficulties associated with the voice-hearing experience manifested during the interview, which again may have limited the data. For instance, participants sometimes struggled to concentrate and elucidate during the interview. For one participant, their voice

appeared to be actively interfering with the interview process by telling them what they could and could not disclose. Furthermore, as the data revealed, it may have been very difficult for participants to share their experiences with me. This draws on a fundamental limitation of IPA that participant's may not be able to communicate the richness of their experience to the researcher in the manner required by the method (Willig, 2008). The difficulties observed with the participants may have been less with non-clinical participants, but again this would have introduced more variation in the sample. To overcome this, it may have been beneficial to interview fewer participants but over two or three sessions. This would have facilitated the building of stronger rapport, which may well have led to greater-depth being achieved. This extra time would also have enabled further exploration into the nature of the relationship with the voice. However, due to the distress observed within the current interviews and the reluctance at times to discuss their experiences, it is questionable whether participants would have agreed to meet for more than one session. Alternatively, more time could have been spent at the beginning of the interview trying to engage the participant and put them at ease.

Another pertinent point in regards to the sample used was that two of the participants had only recently started hearing voices, where others had heard them for considerably longer. Mawson et al. (2011) suggested that people who have had longer to listen to their voices may have had greater opportunity to begin to understand and accommodate them, and therefore have a different relationship to them than someone who started to hear them more recently. Although it may have made recruitment more restrictive, this could have been avoided by ensuring participants had all been hearing their voices for approximately the same amount of time. Again, this highlights a potential area for further research.

During the analysis, I observed that participants' accounts were generally quite similar and that most themes were present across cases. This was an anxiety-provoking observation as I feared I had shoe-horned the data or led the interviews in some way. However, upon careful reflection, although the interviews were themselves fairly similar to one another, I do not believe the interview schedule was leading. Furthermore, I collaborated with my supervisor in devising the schedule and it was independently critiqued by peers. Similarly, the themes that emerged were all cross-referenced with the original data repeatedly and again reviewed by my supervisor and peers. In addition, my peers independently analysed parts of my transcripts and similar themes emerged. As already discussed, there was the potential for a negative bias in the data due to the purposive nature of the sample. Therefore,

given the independent audit (Smith et al., 2009) conducted by my supervisor and peers, the purposive sample used and the fact the existing literature supports the present study's observations, I feel confident that the findings were representative of the participants' experiences of the phenomenon.

That said, I do believe an important limitation of the study was the interview schedule. Having no personal experience of command voices, the schedule was constructed from a less knowledgeable position of the phenomenon. This may have led to areas being included that rather than being pertinent to the participant, were present due to my own assumptions. To some extent this went against the ethos of the study which was to be client-led rather than researcher-led. In hindsight, it would have been more appropriate to have co-constructed the schedule with people who hear command voices, asking them what they felt were the most important areas of focus. This could have been achieved with a participant focus group or by conducting pilot interviews with members of this client group. However, this would have required an extra set of participants and given the difficulties in recruiting, this was unlikely to have been feasible within the time constraints of the present study. This therefore presents an exciting opportunity for future research. Within the present study, it may have been helpful to start the interview with the question "what does voices that tell you what to do mean to you?", as this could have unearthed a deeper insight into the participants' views of the phenomenon.

In addition, several themes emerged that were worthy of further exploration. For instance, many of the participants alluded to a time before they heard voices, which would have been an interesting area to explore in more depth. Similarly, the present study observed the presence of a voice-hearer relationship, but did not obtain significant information into the nature of this relationship. Furthermore, Hayward (2003) and Birchwood et al. (2000) claimed that individuals related to their voices and to others in similar ways, but this was not explored in the present study. Exploring these themes further within future work would add fascinating further insight into the experience of hearing command voices.

Overall, the participants did not really deviate from the interview schedule and did not specify anything else they wished to discuss when asked directly. Therefore, although there was clear room for improvement within the schedule, I feel it did capture the phenomenon and allowed rich data to be obtained that addressed the research question.

Another important limitation of the study concerns a common criticism of IPA: that the observations made cannot be generalised. It has been argued that although IPA can provide a rich account of the experience of participants, it cannot attempt to explain the experience (Willig, 2008). This potentially limits the utility of the observations made in the present study, the study's impact overall and how much it can influence policy, theory and practice. To overcome this and to help prevent qualitative studies being marginalised, it has been suggested that this limitation can be addressed through meta-synthesis, whereby individual qualitative studies are amalgamated (McCarthy-Jones, Marriott, Knowles, Rowse, & Thompson, 2013b). McCarthy-Jones et al. (2013b) argued that this would allow overarching themes to emerge, which themselves can provide new knowledge for practical application. Future work may therefore benefit from adopting this approach and synthesising the findings of qualitative studies exploring voice-hearing. This approach could also be used, once the number of qualitative explorations grows, within the command voices literature.

Similarly, the present study may act as a starting point for further quantitative research. For instance, the observation that participants attempted to make-sense of their experiences and found this a confusing process is currently poorly understood within the present literature. Therefore future quantitative research in this area would be a welcomed addition in order to explore this on a greater scale.

Finally, the present study observed that the experience of hearing command voices impacted upon relationships socially and with mental health professionals. However, the mental health professionals discussed were Psychiatrists and Care-Coordinators. It would be interesting to explore the relationship between the individual and their therapist in future research. This would be particularly beneficial to Counselling Psychologists as it may help illuminate areas within their work with this client group that could be addressed and improved.

## **Conclusion**

The present study set out to explore the experience of hearing voices that tell you what to do. To my knowledge, no qualitative research had been conducted within the field of command voices. This left the existing literature adopting quite a realist position and potentially being led more by the interests of the researcher than what was relevant to the participant. The current study was aimed at redressing this balance by attempting to explore the lived experience of the participant from their perspective.

The observations made in the present study uncovered interesting and new aspects of the experience of hearing voices that tell you what to do. Most of the observations also acted to provide support for existing findings in the literature. Overall, the experience of hearing command voices appeared to be highly unwanted. Participants revealed how the experience had negatively impacted on their emotional wellbeing by inducing undesirable moods and lowering their self-esteem. This appeared to leave them with high levels of distress. Similarly, the experience appeared to negatively influence their quality of life by impairing functioning and restricting opportunities available to them. In order to cope with the unwanted experience, participants appeared to feel compelled to try to manage their situation and employed a number of coping strategies to help them. For some, they seemed to be coping well, to the point where it was no longer having such a negative impact on their mood or life quality.

All of the participants engaged with their voices, which resulted in the formation of a relationship between them. Engagement could be seen through the opinions formed about the voices, such as them being either negative or positive. It was also seen by participants endeavouring to identify their voices, responding to what they said and perceiving them to be highly powerful. All participants described their voices as being negative influences, although some also experienced positive voices or were able to see positive attributes in addition to the negative. When participants discussed the identities of their voices, they appeared to reflect on whether the voices were separate entities or in fact a part of the self, such as thoughts. The ways in which participants responded to their voices varied, although all of them spoke about a time when they had complied with commands. Some chose not to comply and some chose to take avoiding action to prevent the possibility of compliance. Others responded to their voices by choosing to listen to its content and by becoming completely absorbed in the voice experience. All participants described their voices as being very powerful, with some alluding to omnipotence. This perception appeared to arise from the individual feeling unable to exert control over the voices or over their own behaviour in response to them. However, again, some seemed to have regained a sense of control, leaving them feeling better able to manage and less distressed.

Participants also spoke about the ways in which their relationships with others, both socially and with mental health professionals, had been affected by their experiences with the voices. All participants alluded to finding social relationships problematic, which appeared to stem

from a fear of sharing their experiences with others due to concerns they would be judged and not understood. However, despite this, social relationships seemed important and often facilitated coping. There was an overwhelming impression of dissatisfaction with the relationships formed with mental health professions, stemming from a feeling that the help so desperately desired was not being delivered. However, conversely, some participants seemed pleased with the services provided and the relationships formed.

Finally, it was evident that participants attempted to make-sense of their experiences. One of the ways they went about doing this was through considering the purpose of the voice, with most giving the impression they felt their voices had an agenda, even if they were unsure about the nature of that agenda. Similarly, participants appeared to embed their experience within a sense of time to look at the minute details as well as its overall place in their lifespan. It seemed that trying to understand their experiences was a highly confusing process and one that left them with self-doubt and feelings they had lost the person they once were and the person they hoped to become.

From looking across themes, two over-arching themes appeared, which were that the experience of hearing voices not only forced the participant to have to re-negotiate their lifestyle through the relationships they had with other people as well as themselves, but also involved a continual battle for empowerment.

In conclusion, the present study has provided a rich and detailed picture of what it might be like to hear voices that tell you what to do. Although this picture is restricted to the participants within this study and therefore is only a piece of the jigsaw, it is hoped this piece may go on to help form the larger picture emerging within the current literature. This is nicely captured by Chin et al. (2009) who stated that qualitative research should not be seen as a definitive account, but as a contribution to an emerging scene. It is hoped this study may provide Counselling Psychologists with a valuable insight into the lived experience of this phenomenon, which stands to reduce professional anxiety as well as enhance therapeutic practice with this client group. In addition, the observations made may go some way in helping devise more effective treatment options. A final aim of the study was to allow participants the opportunity to have their stories heard. Although the first two aims are yet to be realised, I am delighted the final aim has been achieved.

The study arose from a desire to challenge common misconceptions by enabling people who hear command voices to tell their stories. Over the course of the last three years, this desire has not faded as I still feel as passionately now as I did then. However, the journey of this study has been a true roller-coaster. There have been hard times, anxiety-provoking times and times when I could not see where I was heading. However, for every low there has been a greater high and I am very grateful for the opportunity to have produced this piece of research. The willingness of the participants to take part in the study was overwhelming and something I shall always be immensely grateful for. I found listening to their stories both humbling and enlightening, and attempting to do justice to their accounts was an exciting challenge. Furthermore, this study reinforced to me the benefits of not making assumptions and endeavouring to see an individual's perspective, something articulated well by Harper Lee (1960):

*You never really understand a person until you consider things from his point of view — until you climb into his skin and walk around in it (To kill a mockingbird, p.33).*

## References and Appendices

### References

- Allan, S., & Gilbert, P. (1995). A social comparison scale: Psychometric properties and relationship to psychopathology. *Journal of Personality and Individual Differences*, 19, 293-299.
- Bach, P., & Hayes, S.C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: A randomised controlled trial. *Journal of Consulting and Clinical Psychology*, 70 (5), 1129-1139.
- Barrett, M. (2006). Practical and ethical issues in planning research. In G.M. Breakwell, S. Hammond, C. Fife-Schaw and J.A. Smith (Eds.), *Research methods in psychology*, 3<sup>rd</sup> Edition (pp. 24-48). London: Sage.
- Barrowcliff, A.L., & Haddock, G. (2006). The relationship between command hallucinations and factors of compliance: A critical review of the literature. *The Journal of Forensic Psychiatry & Psychology*, 17 (2), 266-298.
- Beavan, V. (2011). Towards a definition of "hearing voices": A phenomenological approach. *Psychosis*, 3 (1), 63-73.
- Beck, A.T., Rush, J.A., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy for depression*. New York: Guildford Press.
- Beck-Sander, A., Birchwood, M., & Chadwick, P. (1997). Acting on command hallucinations: A cognitive approach. *British Journal of Clinical Psychology*, 36, 139-148
- Benjamin, L.S. (1989). Is chronicity a function of the relationship between the person and the auditory hallucination? *Schizophrenia Bulletin*, 15 (2), 291-310.
- Birtchnell, J. (1996). *How humans relate: A new interpersonal theory*. Hove: Psychology Press.

Birchwood, M.J., & Chadwick, P. (1997) The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine*, 27, 1345-1353.

Birchwood, M., Gilbert, P., Gilbert, J., Trower, P., Meaden, A., Hay, J., Murray, E., & Miles, J.N.V. (2004). Interpersonal and role-related schema influence the relationship with the dominant 'voice' in schizophrenia: A comparison of three models. *Psychological Medicine*, 34, 1571-1580.

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: Subordination and entrapment by voices and significant others. *Psychological Medicine*, 30, 337-344.

Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L., Dunn, G., & Peters, E.R. (2013). The MRC COMMAND trial: results of a multi-centre, randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations. *Submitted to Lancet*.

Birchwood, M., Peters, E., Tarrier, N., Dunn, G., Lewis, S., Wykes, T., Davies, L., Lester, H., & Michail, M. (2011). A multi-centre, randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations. *BMC Psychiatry*, 11 (155), 1-6.

BPS Code of Ethics and Conduct (2009). Retrieved July 18, 2013 from [http://www.bps.org.uk/sites/default/files/documents/code\\_of\\_ethics\\_and\\_conduct.pdf](http://www.bps.org.uk/sites/default/files/documents/code_of_ethics_and_conduct.pdf).

BPS Good Practice Guidelines for the Conduct of Psychological Research within the NHS (2005). Retrieved July 18, 2013 from [http://www.psy.ed.ac.uk/psy\\_research/documents/BPS%20Guidelines%20for%20the%20Conduct%20of%20Research%20within%20the%20NHS.pdf](http://www.psy.ed.ac.uk/psy_research/documents/BPS%20Guidelines%20for%20the%20Conduct%20of%20Research%20within%20the%20NHS.pdf).

Braham, L.G., Trower, P., & Birchwood, M. (2004). Acting on command hallucinations and dangerous behaviour: A critique of the major findings in the last decade. *Clinical Psychology Review*, 24, 513-528.

- Buccheri, R.K., Trygstad, L.N., Buffum, M.D., Lyttle, K., & Dowling, G. (2010). Comprehensive evidence-based program teaching self-management of auditory hallucinations on inpatient psychiatric units. *Issues in Mental Health Nursing*, 31, 223-231.
- Buccheri, R., Trygstad, L., & Dowling, G. (2007). Behavioural management of command hallucinations to harm in schizophrenia. *Journal of Psychosocial Nursing*, 45 (9), 47-54.
- Bucci, S., Birchwood, M., Twist, L., Tarrier, N., Emsley, R., & Haddock, G. (2013). Predicting compliance with command hallucinations: Anger, impulsivity and appraisals of voices' power and intent. *Schizophrenia Research*, 147, 163-168.
- Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *British Journal of Psychiatry*, 164, 190-201.
- Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. Chichester: Wiley.
- Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy*, 37, 403-412.
- Chapman, E., & Smith, J.A. (2002). Interpretative phenomenological analysis and the new genetics. *Journal of Health Psychology*, 7 (2), 125-130.
- Chin, J.T., Hayward, M., & Drinnan, A. (2009). 'Relating' to voices: Exploring the relevance of this concept to people who hear voices. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 1-17.
- Close, H., & Garety, P. (1998). Cognitive assessment of voices: Further developments in understanding the emotional impact of voices. *British Journal of Clinical Psychology*, 37, 137-188.
- Colman, A. (2009). *Oxford dictionary of psychology*. New York: Oxford University Press.

Dallos, R., & Vetere, A. (2005). *Researching psychotherapy and counselling*. Maidenhead: Open University Press.

Dannahy, L., Hayward, M., Strauss, C., Turton, W., Harding, E., & Chadwick, P. (2011). Group person-based cognitive therapy for distressing voices: Pilot data from nine groups. *Journal of Behavior Therapy and Experimental Psychiatry*, 42 (1), 111-116.

Data Protection Act (1998). Retrieved August 31, 2012 from  
<http://www.legislation.gov.uk/ukpga/1998/29/contents>.

David, A. S. (2004). The cognitive neuropsychiatry of auditory verbal hallucinations: An overview. *Cognitive Neuropsychiatry*, 9, 107-124.

Davies, M.F., Griffin, M. & Vice, S. (2001). Affective reactions to auditory hallucinations in psychotic, evangelical and control groups. *British Journal of Clinical Psychology*, 40, 361-370.

Dervin, B. (1998). Sense-making theory and practice: An overview of user interests in knowledge seeking and use. *Journal of Knowledge Management*, 2 (2), 36-46.

Division of counselling psychology. (2013). What is Counselling Psychology? Retrieved May 17, 2013 from [http://dcop.bps.org.uk/dcop/home/about/about\\_home.cfm](http://dcop.bps.org.uk/dcop/home/about/about_home.cfm).

Eatough, V., & Smith, J. (2008). Interpretative Phenomenological Analysis. In C. Willig, & W. Stainton-Rogers (Eds.), *The sage handbook of qualitative research in psychology* (pp. 179-195). London: Sage.

Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Finlay, L. (2003). Through the looking glass: Intersubjectivity and hermeneutic reflection. In L. Finlay, & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences*. (pp. 105-119). Oxford: Blackwell Science.

Foster, G., & Krasnoff, R. (Producers) & Wright, J. (Director). (2009). *The Soloist* [Motion picture]. U.S.: StudioCanal.

Fox, J.R.E., Gray, N.S., & Lewis, H. (2004). Factors determining compliance with command hallucinations with violent content: The role of social rank, perceived power of the voice and voice malevolence. *The Journal of Forensic Psychiatry & Psychology*, 15 (3), 511-531.

Garcia-Montes, J., Perez-Alvarez, M., & Perona-Garcelan, S. (2012). Affinities in the phenomenological perspective of schizophrenia and recent cognitive research: Towards mutual enrichment. *Theory & Psychology*, 22 (6), 756-770.

Gaudiano, B.A., & Herbert, J.D. (2006). Acute treatment of inpatient with psychotic symptoms using acceptance and commitment therapy: Pilot results. *Behaviour Research and Therapy*, 44, 415-437.

Georgaca, E., & Avdi, E. (2012). Discourse analysis. In D. Harper, & A.R. Thompson (Eds), *Qualitative research methods in mental health and psychotherapy* (pp. 147-161). Oxford: Wiley-Blackwell.

Gilbert, P., Birchwood, M., Gilbert, J., Trower, P., Hay, J., Murray, B., Meaden, A., Olsen, K., & Miles, J.N.V. (2001). An exploration of evolved mental mechanism for dominant and subordinate behaviour in relation to auditory hallucinations in schizophrenia and critical thoughts in depression. *Psychological Medicine*, 31, 1117-1127.

Giorgi, A. (2010). Phenomenology and the practice of science. *Journal of the Society for Existential Analysis*, 21, 3-22.

Grazer, B. (Producer) & Howard, R. (Director). (2001). *A Beautiful Mind* [Motion picture]. U.S.: Universal Studios.

Griffin, A., & May, V. (2012). Narrative analysis and interpretative phenomenological analysis. In Seale, C. (Ed), *Researching society and culture (3<sup>rd</sup> Edition)*. (pp. 441-458). London: Sage.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper, & A.R. Thompson (Eds), *Qualitative research methods in mental health and psychotherapy* (pp. 83-99). Oxford: Wiley-Blackwell.

Hartley, S., Haddock, G., & Barrowclough, C. (2012). Anxiety and depression and their links with delusions and hallucinations in people with a dual diagnosis of psychosis and substance misuse: A study using data from a randomised controlled trial. *Behaviour Research and Therapy*, 50, 65-71.

Hayward, M. (2003). Interpersonal relating and voice hearing: To what extent does relating to the voice reflect social relating? *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 369-383.

Hayward, M., Berry, K., & Ashton, A. (2011). Applying interpersonal theories to the understanding of and therapy for auditory hallucinations: A review of the literature and directions for further research. *Clinical Psychology Review*, 31, 1313-1323.

Hayward, M., & Fuller, E. (2010). Relating therapy for people who hear voices: Perspectives from clients, family members, referrers and therapists. *Clinical Psychology and Psychotherapy*, 17, 363-373.

Hayward, M., Overton, J., Dorey, T., & Denney, J. (2009). Relating therapy for people who hear voices: A case series. *Clinical Psychology and Psychotherapy*, 16, 216-227.

HCPC Guidance on Conduct and Ethics for Students (2010). Retrieved July 18, 2013 from <http://www.hpc-uk.org/assets/documents/10002C16Guidanceonconductandethicsforstudents.pdf>.

Hearing Voices Network 'Famous people who hear voices' (2013a). Retrieved August 21, 2013 from <http://www.hearing-voices.org/about-voices/famous-people/>.

Hearing Voices Network 'Hearing Voices Groups' (2013b). Retrieved September 2, 2013 from <http://www.hearing-voices.org/hearing-voices-groups/>.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist*, 24 (10), 756-759.

Heidegger, M. (1962). *Being and time*. (J. MacQuarrie, & E. Robinson, Trans.). New York: Harper and Row.

Husserl, E. (1927). Phenomenology. For *Encyclopaedia Britannica*. Retrieved July 18, 2013 from <http://aleph0.clarku.edu/~achou/EncyBrit.pdf>.

Intervoice 'Home' (2013). Retrieved August 20, 2013 from <http://www.intervoiceonline.org/>.

Jackson, L.J., Hayward, M., & Cooke, A. (2010). Developing positive relationships with voices: A preliminary grounded theory. *International Journal of Social Psychiatry*, 57 (5), 487-495.

Knight, M.T.D., Wykes, T., & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health*, 12 (3), 209-222.

Larkin, M., & Thompson, A.R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper, & A.R. Thompson (Eds), *Qualitative research methods in mental health and psychotherapy* (pp. 101-116). Oxford: Wiley-Blackwell.

Larøi, F., Sommer, I.E., Blom, J.D., Fernyhough, C., Ffytche, D.H., Hugdahl, K., Johns, L.C., McCarthy-Jones, S., Preti, A., Raballo, A., Slotema, C.W., Stephane, M., Waters, F. (2012). Characteristic Features of Auditory Verbal Hallucinations in Clinical and Nonclinical Groups: State-of-the-Art Overview and Future Directions. *Schizophrenia Bulletin*, 38 (4), 724-733.

Lee, H. (1960). *To kill a mockingbird*. Great Britain: Arrow Books.

Madill, A., Jordan, A., & Shirley, C. (2000) Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.

- Mawson, A., Berry, K., Murray, C., & Hayward, M. (2011). Voice hearing within the context of hearers' social worlds: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 256-272.
- Mawson, A., Cohen, K., & Berry, K. (2010). Reviewing evidence for the cognitive model of auditory hallucinations: The relationship between cognitive voice appraisal and distress during psychosis. *Clinical Psychology Review*, 30, 248-258.
- McCarthy-Jones, S. (2012). *Hearing voices: The histories, causes and meaning of auditory verbal hallucinations*. New York: Cambridge University Press.
- McCarthy-Jones, S., Krueger, J., Larøi, F., Broome, M., & Fernyhough, C. (2013a). Stop, look, listen: The need for philosophical phenomenological perspectives on auditory verbal hallucinations. *Frontier in Human Neuroscience*, 7 (127), 1-9.
- McCarthy-Jones, S., Marriott, M., Knowles, R., Rowse, G., & Thompson, A.R. (2013b). What is psychosis? A meta-synthesis of inductive qualitative studies exploring the experience of psychosis. *Psychosis*, 5 (1), 1-16.
- McNiel, D.E., Eisner, J.P., Binder, R.L. (2000). The relationship between command hallucinations and violence. *Psychiatric Services*, 51 (10), 1288-1292.
- Meaden, A., Keen, N., Aston, R., Barton, K., & Bucci, S. (2013). *Cognitive therapy for command hallucinations: An advanced practical companion*. Hove: Routledge.
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. (C. Smith, Trans.). London: Routledge.
- Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigor/quality. *Journal of Health Psychology*, 11, 799-808.
- Milgram, S. (1974). *Obedience to authority*. New York: Harper & Row.

- Morrow, S.L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35, 209-235.
- Murray, M., & Sargeant, S. (2012). Narrative psychology. In D. Harper, & A.R. Thompson (Eds), *Qualitative research methods in mental health and psychotherapy* (pp. 163-176). Oxford: Wiley-Blackwell.
- Nayani, T.H., & David, A.S. (1996). The auditory hallucination: a phenomenological survey. *Psychological Medicine*, 26 (1), 177-189.
- NICE (2009). Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. Retrieved August 20, 2013 from <http://www.nice.org.uk/nicemedia/live/11786/43608/43608.pdf>.
- NICE (2013). Psychosis and schizophrenia in adults. Retrieved September 2, 2013 from <http://www.nice.org.uk/nicemedia/live/13569/64924/64924.pdf>.
- Oxford Dictionary (2014). Definition of distress. Retrieved January 22, 2014 from <http://www.oxforddictionaries.com/definition/english/distress>.
- Paulik, G., Hayward, M., & Birchwood, M. (2012). Cognitive behavioural relating therapy (CBRT) for voice hearers: A case study. *Behavioural and Cognitive Psychotherapy*, 41, 626-631.
- Payne, M. (2006). *Narrative therapy: An introduction for counsellors* (2<sup>nd</sup> Edition). London: Sage.
- Peters, E.R., Williams, S.L., Cooke, M.A., & Kuipers, E. (2012). It's not what you hear, it's the way you think about it: Appraisals as determinants of affect and behaviour in voice hearers. *Psychological Medicine*, 42, 1507-1514.
- Ponterotto, J. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52 (2), 126-136.

Regan, L. (Producer/Director). (2008). *The doctor who hears voices* [Motion picture]. UK: Channel4.

Reynolds, N., & Scragg, P. (2010). Compliance with command hallucinations: The role of power in relation to the voice, and social rank in relation to the voice and others. *The Journal of Forensic Psychology*, 21 (1), 121-138.

Rogers, P., Watt, A., Gray, N., MacCulloch, M., & Gournay, K. (2002). Content of command hallucinations predicts self-harm but not violence in a medium secure unit. *The Journal of Forensic Psychiatry*, 13 (2), 251-262.

Romme, M., & Escher, A. (1989). Hearing voices. *Schizophrenia Bulletin*, 15 (2), 209-216.

Romme, M., & Escher, S. (2000). *Making sense of voices: A guide for mental health professionals working with voice-hearers*. London: Mind.

Satre, J-P. (1956). *Being and nothingness*. (H. Barnes, Trans.). New York: Washington Square Press.

Schleiermacher, F. (1998). *Hermeneutics and criticism and other writings*. (A. Bowie, Trans.). Cambridge: CUP.

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

Singer, A.R., & Addington, D.E. (2009). The application of cognitive therapy for command hallucinations. *Cognitive and Behavioral Practice*, 16, 73-83.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261-271.

- Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1 (1), 39-54.
- Smith, J. A. (2010). Interpretative Phenomenological Analysis. *Journal of the Society for Existential Analysis*, 21 (2), 186-192.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5 (1), 9-27.
- Smith, J.A. & Dunworth, F. (2003). Qualitative methodology. In J. Valsiner and K. Connolly (Eds.), *Handbook of developmental psychology*. (pp. 603-621). London: Sage.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smith, J.A., and Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*, 2<sup>nd</sup> Edition (pp. 53-80). London: Sage.
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17, 1372-1380.
- Storey, L. (2007). Doing interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing data in psychology* (pp.51-64). London: Sage.
- The Guardian. (2009, July 6). Man hacked off neighbour's head after hearing voices. *The Guardian*. Retrieved from <http://www.theguardian.com/uk/2009/jul/27/eric-cruz-hacked-neighbour-head>.
- The Telegraph. (2010, May 19). Man murdered pregnant woman 'after hearing voices'. *The Telegraph*. Retrieved from <http://www.telegraph.co.uk/news/uknews/crime/7740805/Man-murdered-pregnant-woman-after-hearing-voices.html>.

Time to change (2013). Retrieved August 20, 2013 from <http://www.time-to-change.org.uk/about>.

Trower, P., Birchwood, M., Meaden, A., Byrne, S., Nelson, A., & Ross, K. (2004). Cognitive therapy for command hallucinations: Randomised controlled trial. *British Journal of Psychiatry*, 184, 312-320.

Wales Online. (2012, October 24). Voices in his head told driver to kill a stranger, murder trial told. *Wales Online*. Retrieved from <http://www.walesonline.co.uk/news/wales-news/voices-head-told-driver-kill-2022628>.

Wall, C. (2004). Using a reflective diary to develop bracketing skills during a phenomenological investigation. *Nurse researcher*, 11 (4), 20-29.

Willig, C. (2008). *Introducing qualitative research in psychology* (2<sup>nd</sup> Edition). Maidenhead: Open University Press.

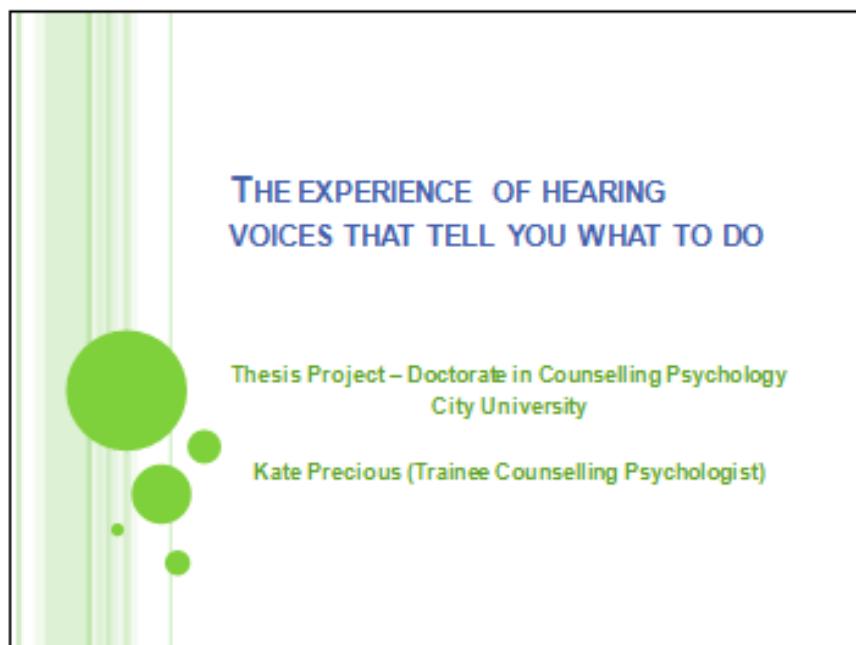
Willig, C. (2012) Perspectives on the epistemological basis for qualitative research. In C. Harris (Ed.), *APA handbook of research methods in psychology* (Vol 1) (pp.5-21). Washington, DC: APA.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15, 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (2<sup>nd</sup> edn) (pp.235-251). London: Sage.

## Appendix A

### Recruitment presentation



The slide has a light green vertical bar on the right side with one green circle. The title 'VOICES THAT TELL YOU WHAT TO DO' is at the top in blue. Below it is a bulleted list in green:

- Commonly referred to as 'command hallucinations'
- Particular type of auditory hallucination; often...
  - Harmful to the individual/others
  - 3 types: benign in content, to harm self, to harm others
- High prevalence rate yet little appears to be understood about it and few effective treatments are available
  - Often most persistent feature of psychosis - "treatment/drug resistant"
- Fear - Stigma and prejudice

## WHY DO THIS RESEARCH?

- Research so far focuses on what is of interest to the researcher (eg risk and compliance)
  - Distinct lack of client perspective
  - Lack of understanding what it is actually like for clients who live with this phenomenon
  - No-one has yet asked clients what it is like for them
- Redress the balance



## WHAT I SHALL BE DOING

- Contact clients
  - Explain study, invite for interview, send consent form and further information, re-contact a week later
- Carrying out interview (approx. 1 hour) exploring what it is like for them to hear voices that tell them what to do
  - Recorded and later analysed.
- Keep you informed about your client
  - Participation, date of interview and any important info arising from the interview.



## WHAT I WOULD LIKE YOUR HELP WITH

- Referrals of clients you think would be suitable and interested in taking part
- Inclusion Criteria:
  - Aged 18-65
  - Currently hearing voices that tell them what to do (>6 months)
  - Not in need of acute mental health care
  - No history of acting out in response to stress/anxiety
  - No suicidal ideation within last 3 months

## BENEFITS TO CLIENTS

- From own experience this client group often really value the opportunity to be able to talk freely about their voices to an impartial and non-judgemental listener
- An opportunity to share experiences in a relatively unrestricted manner - hopefully leave them feeling empowered and heard.
- Feeling that they are not alone with their experiences
- £10 gift voucher

## HOPES OF THE STUDY

- Improve knowledge and understanding
- Empower clients - give them a platform to have their experiences heard
- Devise better treatment options
- Reduce stigma

## ETHICAL APPROVAL

- Study has been approved by:
  - NHS ethics
  - SABP R&D
  - City University

## YOUR HELP PLEASE - REFERRALS

- Please discuss with me today any suitable referrals
- Or arrange a time for me to discuss with you
- My contact details and inclusion criteria on flyer



ANY QUESTIONS?



## Appendix B

### Health professionals flyer

 CITY UNIVERSITY LONDON

Surrey and Borders Partnership NHS  
NHS Foundation Trust

**What is it like to hear voices that tell you what to do?**

**Do you have clients that hear voices that tell them what to do (often referred to as 'command voices/command hallucinations')? Would they be willing to discuss their experiences? They would be given a £10 gift voucher**

My name is Kate Precious and I am a trainee Counselling Psychologist at City University. I am currently looking to talk to people for my research study: "The experience of hearing voices that tell you what to do".

I am looking to talk to people who...

- ✓ are aged 18-65
- ✓ currently hear voices that tell them what to do and have done for 6 months or longer
- ✓ are not currently in need of acute mental health care
- ✓ have no history of acting out in response to stress/anxiety
- ✓ have not experienced any suicidal ideation within the last 3 months

**What do you need to do?**

- If you know of someone who you think would be suitable and would agree to take part, then please let me know. My contact details are below.
- I will ask you whether they meet the criteria above and a few questions about whether they present with any risk.

**What do participants need to do?**

- If the participant agrees to take part in the study, then they will be invited to an interview where I shall ask them a few questions about their experiences of hearing voices that tell them what to do.
- The interview will take no more than 1 ½ hours and at the end they will be given a £10 gift voucher from a choice of five different shops.

If you would like to refer anyone or would like further information about the study, please contact me:

Email: [REDACTED]  
Telephone: [REDACTED]

Research is supervised by Dr Courtney Raspin, Department of Psychology, City University, Northampton Square, London EC1V 0HB; Email [REDACTED]

The research has obtained ethical approval from City University and the NHS

## Appendix C

### Participant flyer

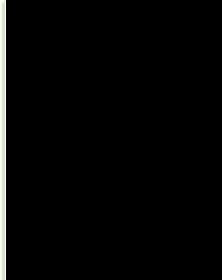
 CITY UNIVERSITY LONDON

Surrey and Borders Partnership   
NHS Foundation Trust

**What is it like to hear voices that tell you what to do?**

**Do you hear voices that tell you what to do?  
Would you be willing to discuss your experiences?**

**I'd be really interested in hearing about your experiences and to  
thank you for your time, you would be given a £10 gift voucher**



My name is Kate Precious and I am a trainee Counselling Psychologist at City University. I am interested in hearing about the experiences of people who hear voices that tell them what to do, for my research study. People often say that hearing voices that tell them what to do can be a distressing experience. Is this the case for you? Would you like the chance to share your story?

**What would you have to do?**

- \* Please ask someone within your mental health team or hearing voices group to refer you.
- \* If you would like to take part and are suitable, then you will be invited to an interview where I shall ask you a few questions about your experiences of hearing voices that tell you what to do.
- \* The interview will take no more than 1 ½ hours and at the end you will be given a £10 gift voucher from a choice of five different shops.

**If you are interested in taking part, please ask someone from your mental health team or hearing voices group to refer you.**

**If you would like further information about the study, please contact me:**  
Email: [REDACTED]  
Telephone: [REDACTED]

Research is supervised by Dr Courtney Raspin, Department of Psychology, City University, Northampton Square, London EC1V 0HB; Email: [REDACTED]

The research has obtained ethical approval from City University and the NHS

## **Appendix D**

### **Participant information sheet**

**City University**

Department of Psychology, Social Sciences Building, Northampton Square, London EC1V  
0HB

Website: [www.city.ac.uk](http://www.city.ac.uk)

**Researcher**

Kate Precious

Email: [REDACTED] Tel: [REDACTED]

**Supervisor**

Dr Courtney Raspin, City University

Email: [REDACTED] Tel: [REDACTED]

**Title of Research study**

The experience of hearing voices that tell you what to do

My name is Kate Precious and I am a trainee Counselling Psychologist at City University. I am carrying out this research study as part of my training. You have been invited to take part in this research study and this information sheet is designed to give you information about the study so that you can decide whether or not you would like to take part. Please read through the following information carefully and feel free to talk to other people about taking part in this study, if you would like to.

**What is the aim of the study?**

I am interested in what it is like to hear voices that tell you what to do and therefore the aim of the study is to explore these experiences. I believe it is very important to ask people about their own personal experiences of hearing voices that tell them what to do as it is something we don't currently know too much about. Some people like hearing their voices and some find them distressing. It is therefore important to carry out research into voices that tell you what to do, so that we can better understand what the experience is like for each person and be able to devise better treatment options for those people who find their voices distressing.

**Do I have to take part?**

You do NOT have to take part in this study. If you decide that you would like to take part in the study, you may keep this information sheet and we shall arrange a time to meet where I shall ask you to read and sign a consent form to say that you agree to take part. I shall ask you to sign two copies of the consent form so that you and I can both keep a copy.

Even if you sign the consent form, you are still free to withdraw from the study at any time, without having to give a reason, and without any disadvantage to you. If you do withdraw from the study after the interview has begun, all the information that I have collected for you, shall be erased.

**What will be involved?**

If you decide to take part in the study, you will be invited to meet with me for a face-to-face interview. This interview will take place at a convenient time, at the team base of your mental health service. The interview will last no longer than 1 ½ hours and I shall ask you a few questions about what hearing voices is like for you. However, you have the right to refuse to answer the questions I ask you.

With your consent, I will audio-record our conversation. This is to help me remember exactly what you say. If you would like to have a copy of the interview, I would be able to provide you a copy on a CD, after the interview.

**What will happen to the information I provide?**

Using the recording made on the audio-recorder, I will type up the interview to provide an accurate account of what was said. You are entitled to ask for a copy of the written interview. Your interview, along with the interviews of other participants, will be analysed and the findings written up into a report that will contribute towards my Doctorate in Counselling Psychology. This report may also be published in professional journals.

**Will my participation be confidential?**

Your mental health team/GP will be contacted and notified of your participation in the study, should you decide to take part. All the information that you provide in the study will be kept confidential. However, should any information emerge in the interview which places the researcher, yourself, or others at risk, this information will be shared with your mental health team.

**Will other people be able to identify me?**

No they will not. Any information that is used in the report that could be personally identifiable will be removed so that you cannot be recognised from it. You will be given a participant number and in the report, you will be referred to by a pseudonym (false name) that you can choose. Quotes from your interview may be used in the written report, but these will be made anonymous.

**How will my information be kept safe?**

In accordance with the Data Protection Act (1998), BPS Code of Ethics and Conduct (2009) and HPC Guidance on Conduct and Ethics for students (2009), the audio recordings and written accounts of the interviews will be labelled according to participant number and pseudonym provided, and stored on a password protected computer. Hard copies of audio recordings and printed written accounts will be stored in a locked filing box. Your consent form and any other information that identifies you will be kept in a different locked filing box. Only the researcher will know the password to the computer and will own the key to the filing boxes. Only those directly involved in the study will have access to your data.

**What happens to my information once the study is complete?**

When the study has finished, your audio-recording will be erased. In accordance with the 'Data Protection Act' and the 'BPS good practice guidelines for the conduct of psychological research within NHS organisations', all original data is required to be kept for 5 years post-publication and then be destroyed.

**Is this study safe to take part in?**

This study has been given ethical approval by City University ethics committee and by the NHS ethics committee.

**What if I feel distressed after the interview?**

Hopefully you will not find the interview distressing. However, for some people, talking about their voices can leave them feeling distressed. You are encouraged not to discuss anything in the interview that you feel too uncomfortable to discuss and to tell the researcher immediately if you do feel distressed. You will be given time at the end of the interview to discuss how you found it and an opportunity to talk about any issues that came up for you. You will also be encouraged to stay for a few minutes at the end to talk with the researcher about something other than your voices. It is hoped that this will help distract you from what you have talked about in the interview and therefore reduce any distress you may be feeling. You may want to plan an activity following the interview to help you to take your mind off what you have discussed. However, if you do feel distressed when it is time to leave the interview, or if you notice any significant lowering in your mood or if you are worried about how you feel after the interview, please contact your mental health service for support and guidance. You will also be provided with details of telephone helplines should you wish to talk to somebody about how you are feeling.

**What are the benefits of taking part?**

By taking part in this research, you will be helping to improve the understanding of what it is like to hear voices that tell you what to do, something that we don't currently know very much about. Some people really like hearing their voices, but for others they find it distressing. It is hoped that by knowing more about what it is like for each person, we may be able to improve the treatments available for those people who seek help with their voices.

As a thank you for taking part and giving up your time, you will be offered a £10 gift voucher. There will be 5 different types of vouchers to choose from.

**Can I find out the results of the study?**

On the consent form that you will be asked to sign, you can ask to receive the results of the study. You will be asked for your contact details and you have the choice of receiving the results via email or by post.

Thank you for taking the time to read this information sheet.

This document is for you to keep. If you have any questions about the study or about what you have read on this sheet, please ask me.

## Appendix E

### Consent form

Consent Form	
CITY UNIVERSITY	
Title of Research study: <b>The experience of hearing voices that tell you what to do</b>	
Researcher: Kate precious (Trainee Counselling Psychologist)	
Please tick	
1. I confirm that I have read the Participant Information Sheet relating to the above research study, and agree to follow what it says. I have been given a copy to keep.	<input type="checkbox"/>
2. The purpose of the study has been explained to me and I have been given the opportunity to ask questions, and have had my questions answered.	<input type="checkbox"/>
3. I understand that the interview will be recorded and listened to by the researcher and research supervisor if necessary.	<input type="checkbox"/>
4. I understand that my involvement in this research will remain strictly confidential, and any personal identifying information will be changed to ensure my anonymity. However, if any information emerges in the interview, which places either myself or others at risk, the researcher will share this information with my mental health team.	<input type="checkbox"/>
5. I understand that people directly involved in conducting the study will have access to my data.	<input type="checkbox"/>
6. I understand that relevant sections of data collected during the study may be looked at by individuals from regulatory authorities, where it is relevant to my taking part in this research. I give my permission for these individuals to have access to my records.	<input type="checkbox"/>
7. I understand the researcher is compliant with the Data Protection Act and both the British Psychological Society and Health Professions Council codes of ethics.	<input type="checkbox"/>
8. I understand that the study will be written up into a report that contributes towards a Doctoral Degree in Counselling Psychology, and may be published in professional journals. I understand that quotes from my interview may be used with a pseudonym of my choice.	<input type="checkbox"/>
9. I understand that my participation in the above study is voluntary and I have the right to withdraw at any time, without giving a reason, and without any disadvantage to myself. I understand that if I withdraw, my audio-recording and transcript will be erased.	<input type="checkbox"/>
10. I agree to take part in the above named study.	<input type="checkbox"/>
Participant's Name (BLOCK CAPITALS) .....	
Participant's Signature .....	
Researcher's Name (BLOCK CAPITALS) ... KATE PRECIOUS .....	
Researcher's Signature .....	
Date: .....	
If you would like to receive information about the outcome of the study, please tick the box and provide contact details:	
I would like to receive information about the outcome of the study	<input type="checkbox"/>
Via email (please provide address) .....	
Via post (please provide address) .....	
.....	

## **Appendix F**

### **Participant vignettes**

#### Fred

- Middle-aged male.
- Lives with his wife and children.
- Voices: varies from one to several. However, he has two dominant voices that he likens to 'Darth-Vader' from 'Star Wars' and 'The Joker' from 'Batman' (both described as male, sinister and threatening).
- Predominant voice content: comments (e.g. "Your house is bugged", "you are being followed", "someone/something is going to get you"); harmful commands: "Find/get the person following you", commit suicide.
- Key behaviour in response to voices: checking around the house, looking out windows, not answering the phone, avoiding going out.

#### Jack

- Young male.
- Lives with his parents.
- Voices: hears two voices: "Jack" (male, "good voice"/voice of his grandfather – likened to a happy cartoon from 'Wacky Racers') and "Peter" (male, "bad voice" – likened to a posh, older version of himself).
- Predominant voice content: harmful commands: commit suicide (e.g. "jump off bridges" and "hang yourself"); innocuous commands (e.g. what to buy in the supermarket).
- Key behaviour in response to voices: attempts to commit suicide, attempts to resist harmful commands, compliance with most innocuous commands.
- Experiences visions associated with his voices.

#### Holly

- Young female.
- Lives with her husband.
- Voices: hears three voices: "God" (male, "good voice"), "Hum of the universe" (mainly indistinguishable sounds, but also makes positive comments) and "The Voiceless-Voice" (male, "bad voice" - likened to 'Brian Blessed').
- Predominant voice content: harmful commands: commit suicide or self-harm (graphic and detailed instructions of how to do it) in order to become closer to God and get to understand the ways of the Universe.
- Key behaviour in response to voices: self-harming behaviour as well as attempts to resist harmful commands.

### Louise

- Middle-aged female.
- Lives alone.
- Voices: one “good voice” (“the voice of encouragement” - male voice from the present) and several (believed to be up to eight) “bad voices” (male voices from the past).
- Predominant voice content: bad voices – harmful commands: commit suicide (e.g. “overdose”, “jump off the balcony”) and “abscond from hospital”; good voice – innocuous commands perceived to be helpful and encouraging (e.g. what to wear).
- Key behaviour in response to voices: attempts to commit suicide, compliance with the innocuous commands from the good voice.

### Dylan

- Middle-aged male.
- Lives with his girlfriend.
- Voices: unsure whether he hears one voice or more. Throughout the interview, he mostly described hearing “voices”. Likened the voice to ‘The Joker’ from ‘Batman’ (viewed as destructive and crazy).
- Predominant voice content: harmful commands: commit suicide (e.g. “jump in front of a train”), self-harm; comments: critical comments about him.
- Key behaviour in response to voices: self-harming behaviour as well as attempts to resist harmful commands.

### Gary

- Middle-aged male.
- Lives alone.
- Voice: only hears one voice – described as a dominant, masculine voice (possibly “God”).
- Predominant voice content: harmful commands: commit suicide; innocuous commands (e.g. “brush your teeth”).
- Key behaviour in response to voice: attempts to commit suicide, compliance with the innocuous commands as well as attempts to resist harmful commands.

### Arthur

- Older male.
- Lives alone.
- Voice: only hears one voice – described as a tree (named “Dean”).
- Predominant voice content: harmful commands: to kill his friend’s (Daniel) ex-girlfriend and if he can’t do that, then to attack other people.
- Key behaviour in response to voice: complies and attacks others, as well as attempts to resist harmful commands
- Experiences visions associated with his voice

## **Appendix G**

### **Interview schedule**

#### Lived Experience

- \* Please can you tell me about your voices
  - o How many
  - o What is it like – always felt this way?
- \* What sort of things do your voices tell you to do?
  - o Past commands?
- \* Why do you think you hear voices that tell you what to do?
- \* Do you ever do what the voices ask you?
  - o How do you feel about that?
  - o Have you ever done something the voice said that you didn't want to?
- \* How does hearing the voices affect your day-to-day life?

#### Relationship with the voice(s)

- \* If you could choose characters from a movie or cartoon to describe your voices, who would you choose?
  - o Why did you choose those characters?

#### Stigma

- \* Have you told other people you hear voices that tell you what to do?
  - o How have others responded?
  - o Have you spoken to other people who hear voices? What was that like?
- \* What are your experiences of accessing mental health services for support or treatment?
  - o What are your experiences of treatments?

#### General

- \* Is there anything else you would like to tell me that I haven't asked you about?
- \* How did you find the interview today

## **Appendix H**

### **De-brief document**

Thank you for taking part in my study. Your participation is very important because it has helped to provide an insight into what it is like to hear voices that tell you what to do. People who hear voices that tell them what to do often find them very distressing and sometimes these voices can lead them to do things that they might not want to do, or to do things that place themselves or other people in danger. It is therefore important to carry out research into voices that tell you what to do, so that we can better understand what it is like for the person. By doing this, we may be able to offer better treatments in the future. I believe it is very important to ask people about their own personal experiences of hearing voices that tell them what to do as this will hopefully help us to better understand what the experience is truly like.

I appreciate that talking about your experiences of voices that tell you what to do may have left you feeling a little distressed or uncomfortable. To help you with these feelings, you may want to do an activity after the interview (such as seeing a friend or watching the television), to help you to take your mind off what you have discussed.

If you notice any significant lowering in your mood or if you are worried about how you feel after the interview, please contact your mental health service for support and guidance.

I would like to provide you with the details of a few organisations that can provide you with emotional support:

#### **Helplines**

##### **Samaritans** - 08457 90 90 90; [www.samaritans.org](http://www.samaritans.org)

A telephone helpline offering emotional support for anyone in need. They are open anytime, night or day. They can also be contacted by email: [jo@samaritans.org](mailto:jo@samaritans.org)

Or by letter: **Freepost RSRB-KKBY-CYJK, Chris, P.O. Box 90 90, Stirling, FK8 2SA**

**Or you can speak to someone face-to-face at your local branch (see website - [www.samaritans.org](http://www.samaritans.org) to find your local branch or ask over the phone)**

##### **SANElne** - 0845 767 8000

An out-of hours telephone helpline offering emotional support and information to anyone affected by mental health difficulties. They are open everyday from 6pm-11pm.

#### **Other Organisations**

##### **Hearing Voices Network** - 0114 271 8210.

An organisation offering information, support and understanding to people who hear voices. They run over 180 self-help groups throughout the country. These groups are designed to allow people to share their experiences of hearing voices so that they can support and help each other. They offer a safe place to be where you can feel accepted and comfortable. To find out your nearest group, look on the website ([www.hearing-voices.org/groups.html](http://www.hearing-voices.org/groups.html)) or telephone.

Once again, thank you for giving up your time to take part in this study. I wish you all the best in the future.

Kate Precious (Researcher and Trainee Counselling Psychologist)

## Appendix I

### City University ethical approval

#### Ethics release form

<b>Section C: To be completed by the research supervisor</b> <i>(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)</i>	
Please mark the appropriate box below:	
Ethical approval granted	<input checked="" type="checkbox"/>
Refer to the Department's Research and Ethics Committee	<input type="checkbox"/>
Refer to the School's Research and Ethics Committee	<input type="checkbox"/>
Signature	
Date-----	
<b>Section D: To be completed by the 2<sup>nd</sup> Departmental staff member</b> <i>(Please read this ethics release form fully and pay particular attention to any answers on the form where <u>underlined bold</u> items have been circled and any relevant appendices.)</i>	
I agree with the decision of the research supervisor as indicated above	<input type="checkbox"/>
Signature	
Date-----	

## Data collection insurance form

### Insurance Data Collection form for Arts and Social Sciences Research Projects

All students planning to undertake any research activity in the Schools of Arts and Social Sciences are required to complete this Insurance Data Collection as part of their ethical approval application.

Researcher(s) Name(s)	Kate Precious
Supervisor(s) Name(s)	Dr Courtney Raspin
Degree Programme	Doctorate in Counselling Psychology
Project Title	The experience of hearing voices that tell you what to do
Abstract (maximum 100 words)	Command voices are types of auditory hallucinations that are common, often distressing and regarded as being high-risk due to their link to self-harm and violence. Current interventions are limited in efficacy, bringing this symptom a reputation for being 'treatment resistant'. To date, no qualitative studies have been conducted exploring command voices and little focus is given to clients' experiences. The researcher aims to conduct interviews with individuals hearing command voices, exploring their experiences of this phenomena. Data will be analysed with Interpretative Phenomenological Analysis. This research may provide knowledge which may influence treatment options available to this client group.
Brief descriptions of method of recruitment, procedures and participants	<p>Participants will meet the following inclusion criteria: aged 18-65, have been recommended for the study by a mental health professional, currently hearing command voices and have been for 6 months or longer, are not currently in need of acute mental health care, have no history of acting out in response to stress/anxiety, and have not experienced any suicidal ideation within the last 3 months.</p> <p>Participants would be recruited from the NHS or 'hearing voices groups'. Once ethical clearance has been granted to recruit from the NHS, the researcher would make contact with the relevant NHS Trust director and seek approval from them to conduct the research within their trust and to have access to the use of their services (eg rooms for interviews). Following consent, the researcher would make contact with the team managers of community mental health teams and arrange to visit the team to give a presentation about the study. Flyers for the study would</p>

	<p>also be distributed within the team. Following this, the researcher would ask for referrals from members of the team, adhering to the criteria of the study, and discuss the referral with the referrer. Next, the researcher would ask for the contact details of the potential participant and then make contact with them. A similar procedure would be taken with accessing participants from hearing voices groups (contacting organisation directors and then the group managers, giving a presentation, asking for referrals and their contact details and then contacting the potential participant). Participants would be screened over the phone for suitability (ensuring they meet the inclusion criteria).</p> <p>All suitable participants would be provided with a copy of the participant information sheet and consent form, and given a week to read through this information. This consent form would need to be signed by the participant prior to the interview being commenced. If after a week, the participant is still willing to participate in the study, a convenient time to meet would be arranged. The researcher will then meet with the participant to conduct a semi-structured interview. The interview will be recorded using a digital Dictaphone, later transcribed verbatim and then analysed using ‘Phenomenological Interpretative Analysis’ (IPA).</p> <p>At the end of the interview, all participants would be debriefed about the purpose of the study, provided with a debrief document detailing various professional bodies offering support, and asked how they found the procedure to determine if it was helpful. They will be thanked for taking part, have the opportunity to ask any questions about the research, and be given a £10 voucher.</p> <p>It is intended that interviews be conducted with 10 different participants.</p>
Expected end date of project	July 2013
Will the research involved involve children or vulnerable groups?	Yes. Participants will be adults who hear command voices. All of these individuals will be recruited from mental health services or hearing voices groups and therefore may be considered

	vulnerable adults.
Will the research take place abroad?	No

For office use only

Application reference	PSYETH(UPTD) 12/13 65
Application submission date	16 <sup>th</sup> July 2013
Application approval date	9 <sup>th</sup> August 2013
Approving body	Department of Psychology Research and Ethics Committee
External ethical approval sought?	NO
	Body (e.g. NRES):
School Stamp	 <p><b>CITY UNIVERSITY LONDON</b></p> <p>School of Arts and Social Sciences</p>

## Appendix J

### NHS ethical approval

**NHS**  
**Health Research Authority**

**NRES Committee London - Harrow**  
Level 7 Maternity, Room 019  
Northwick Park Hospital  
Watford Road  
Harrow  
HA1 3UJ

Telephone: 020 8869 3928  
Facsimile: 020 8869 5222

13 April 2012

[Redacted]

Dear Mrs Precious

**Study title:** The experience of hearing voices that tell you what to do(P)  
**REC reference:** 12/LO/0383

Thank you for your e-mail dated 27<sup>th</sup> March 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

**Confirmation of ethical opinion**

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

**Ethical review of research sites**

**NHS sites**

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

**Non-NHS sites**

**Conditions of the favourable opinion**

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

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

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

A Research Ethics Committee established by the Health Research Authority

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

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

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

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

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

#### Approved documents

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

Document	Version	Date
Advertisement	flyer for participants V2	27 March 2012
Covering Letter		15 February 2012
Evidence of insurance or indemnity		
GP/Consultant Information Sheets	participation letter to health professionals V1	06 February 2012
Interview Schedules/Topic Guides	2	27 March 2011
Investigator CV		
Other: flyer for health professionals	1	06 February 2012
Other: participant debrief sheet	1	06 February 2012
Participant Consent Form	2	27 March 2012
Participant Information Sheet	2	27 March 2012
Protocol	2	27 March 2012
REC application	1	15 February 2012
Referees or other scientific critique report		
Summary/Synopsis	recruitment timeline sheet	

#### Statement of compliance

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

#### After ethical review

##### Reporting requirements

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

- Notifying substantial amendments

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

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

Feedback

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

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

**12/LO/0383**

**Please quote this number on all correspondence**

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

Yours sincerely

[REDACTED]  
Dr Jan Downer  
Chair

Email: alison.okane@nwh.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Courtney Raspin  
Ms Dorrie Mystris, Surrey & Borders Partnership NHS Trust

**Transcripts have been removed for confidentiality purposes.**

**These can be consulted by Psychology researchers on application  
at the Library of City, University of London**

## Appendix L

**Table 1: Emergent themes (Louise)**

<b>Emergent Themes</b>	<b>Page / Line</b>	<b>Quote/Key words</b>
Inescapable	1.3	first awake until I go to sleep
	1.7	moment I get up until the moment I go to sleep
	6.107	then they come back again
	11.225	all around me
	19.401	when they're going to go, if ever
Dichotomy	1.4	good voices, bad voices
	1.12	good voice, bad voices
	2.39	past, present
	10.194	right or wrong, should or shouldn't, can or can't
	20.413	bad things, left with the good
Sense Making	1.8	telling me, not telling me
	1.17	well it could be a couple
	3.62	I think they want my property
	6.128	messages in a voicing form
	7.130	Well I hear them in my head so they've got to be
	8.155	it's as though they want to capitalise on it
	8.165	it could be jealousy
	9.181	don't know much about how
	9.184	doctor next week, think I'm going to ask her
	9.191	because I'm out of hospital
	10.202	I don't know
	16.333	that's what I'm wondering
	19.400	being there and not knowing where they come from
Difficulty describing experience	1.11	now you're asking, I don't know
	3.62	they're just, I mean...they think...I think
	7.135	No, I can't, that's a difficult one
	13.269	difficult to describe
	13.275	difficult to say
	14.288	I just can't think
Voice as facilitating coping	1.13	puts things right
	3.48	pulled me through
	5.100	wouldn't be able to function I don't think without
	5.103	stuck up for me, pulled me through
	9.176	good voice wouldn't even let me do that
	13.272	since this good voice, things are getting better

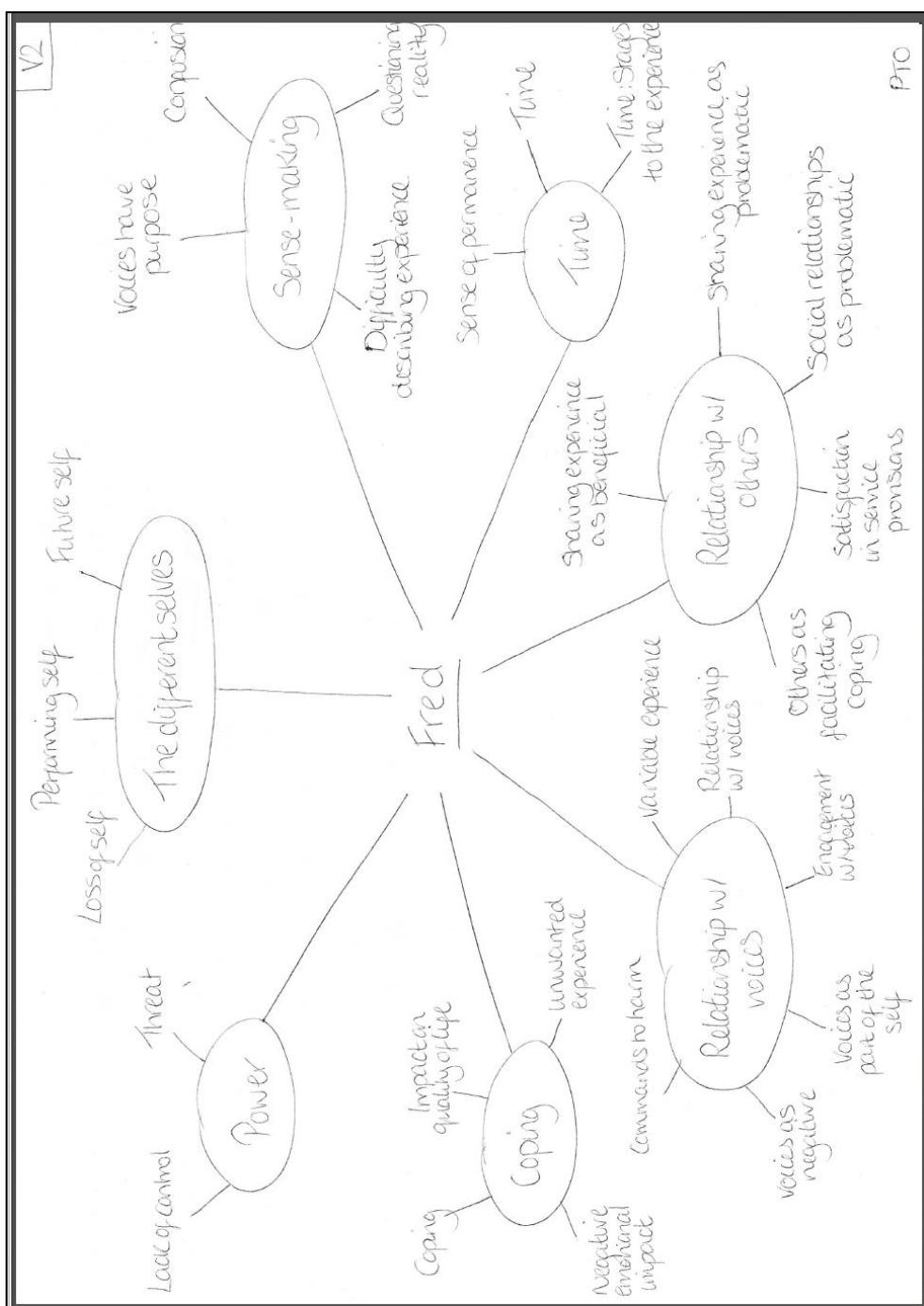
Negative impact on quality of life	1.15	I just get through the day
	10.200	gives you a purpose, something to look forward to
	19.408	quite tiring
Time: stages to the experience	1.19	it is improving
	2.28	what I used to be like
	2.32	at the time those voices told me
	9.188	before, I wasn't rational
	10.207	hasn't always been like this
	11.234	beating that now
	12.250	at the moment
	18.375	hope not to go there again
Coping	2.21	To cope
	16.323	had to cope
The self as performance	2.22	act normally
Voices as part of the self	2.23	in your head
	4.79	in my head
	19.396	inside your head
Work to manage voices	2.27	trying to see myself forward
	4.68	managed to avoid the television now
	4.72	since then, haven't watched it
	8.157	have to deal with the voices
Responding to the voices	2.32	Because, voices told me
	5.90	I've done that
	5.92	I was taking notice of the bad voices
	8.169	all down to them
	9.176	which I do
	9.188	just used to do them
	11.233	punished if I didn't do what they asked
Commands to harm	12.244	having to do it to save whatever I had to save
	2.34	jump off the balcony
Sense of own mortality	2.35	walked away and was fine
Relationship with voices	2.39	voice from the past
	5.94	we make like a joint decision
	5.98	it's like having a partner
	8.171	this good voice knows that
	12.254	we can have
	13.266	voice of encouragement
	19.404	got together with this good voice
Frequency	3.44	lots of times
	5.88	twice or three times

Passivity to others in own welfare	3.44	I've been driven to hospitals
Time	3.45	year and a half nearly been two years
	5.91	this last year and half
	6.113	in my past
	6.117	happened twenty years ago
	6.123	present, future
	7.132	It is, or it has been, it still is, but it was
	8.169	this last year
	14.296	reminds me of when I was a patient
	15.302	reminds me even now
	16.337	more than a year now
Voices as positive	3.47	positive good voice
	3.50	reassuring
	3.56	reassuring and un-provoking
	9.177	like a guardian
	12.254	funny joke
	13.258	fantastic sense of humour
	13.268	encouragement
	20.410	Be good...Very good
Voices as negative	3.59	horrible voices
	5.101	want to destroy me
	6.107	wish they'd go away
	6.126	dragging me over the coals
	8.151	very nasty
	8.153	call me the pot-bellied pig
	8.161	bad voices don't want me to be happy
	11.222	wanted, me to um, just be a goner
	12.236	something very nasty
	19.405	rest of it might disappear
Repetition	4.65	always saying to me
Variable experience	4.65	through all different sorts of means
	4.75	sometimes
	12.154	sometimes
Negative emotional impact	4.67	really upset me
	6.110	distressing, very distressing
	6.112	give me a guilt trip
	6.119	quite hard, it's very hard
	7.133	disconcerting
	8.156	distressing, very distressing
	11.215	guilty
	12.253	haven't cried for a long time

Loss of self	5.91	out of character
	8.169	crazy
	8.170	I'm not like that
	14.290	crazy
Sharing experience as problematic	7.140	I'm finding this quite difficult
	7.146	Let's see how it goes anyway
	11.221	tricky questions
	15.308	I think that's enough of that ...No, that will do
	15.311	as usual it's awkward for me
	15.317	I wouldn't tell other people
	17.347	No, enough said on that one, feeling exhausted
	19.395	quite hard, it's very difficult to try to put in words
Difficulty remembering	19.398	quite tricky in stages
	9.174	I can't remember a lot
Lack of control	9.187	they actually put it in my head
	12.242	I would have to do it regardless
Power	11.232	obey them
	12.239	perform but wouldn't actually um, be accused of
Neutral impact on quality of life	12.250	neither here nor there
Voices as separate to the self	13.257	whoever this is
	16.329	my doctor and nurses and good voice
Isolation	13.272	had to do it on my own
Negative response from others	15.320	people don't understand
Satisfaction in service provisions	17.358	they're brilliant
	17.364	doctor in psychiatry and she's very nice as well
	18.374	I think they're good
	18.380	she's very good, she listened
	18.383	I can always talk to her, she's very good
Others as facilitating coping	17.362	takes me out and helps me
Dissatisfaction in service provisions	18.367	horrible place
Powerlessness	19.402	the tablets can only help so much

## **Appendix M**

## Mind map of super-ordinate themes (Fred)



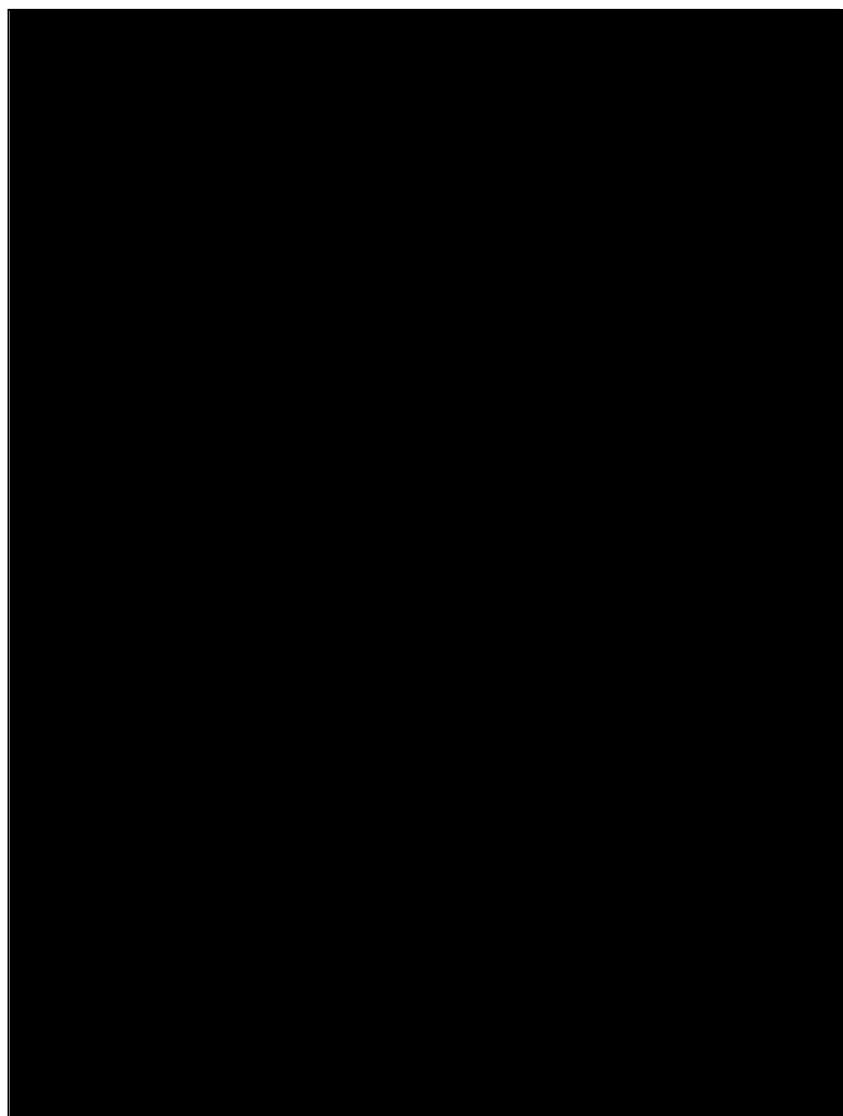
## Appendix N

**Table 2: Super-ordinate table of themes (Jack)**

<b>Super-ordinate theme</b>	<b>Sub-theme</b>	<b>Page number</b>
The different selves	Loss of self	7, 24, 26
Power	Lack of control	2, 3, 7, 10, 13, 14, 16, 17, 19, 23
Coping	Coping	2, 6, 8, 9, 11, 12, 16, 20
	Negative emotional impact	1, 2, 5, 6, 7, 8, 11, 13, 20, 24, 25, 26
Relationship with voices	Variable experience	1, 6, 10, 17
	Voice as part of the self	6, 22, 23, 27
	Engagement with voices	2, 3, 4, 5, 6, 13, 14, 16, 18, 19, 20
	Voices as negative	3, 5, 6, 8, 11
Relationship with others	Isolation	9, 24, 25
	Sharing experience as problematic	9, 12, 18, 23, 24
	Social relationships as problematic	4, 5, 8, 20, 24
	Others as facilitating coping	10, 13, 17, 20, 21, 25
	Dissatisfaction in service provisions	25, 26
Time	Time	12
	Time: stages to the experience	6, 7, 10, 11, 12, 13, 17, 19, 21
	Frequency	3, 10
	Sense of permanence	2, 11
Sense-making	Sense-making	2, 6, 18, 19
	Lack of understanding	3, 10, 14
	Difficulty describing experience	1, 2, 3, 5, 17, 18, 22, 23
	Confusion	2, 7, 27
	Visions associated with voices	1, 5, 14, 15, 16
	Questioning reality	4, 7, 27

**Appendix O**

**Photograph - analysing across cases**



## Appendix P

**Table 3: Over-arching themes, super-ordinate themes, sub-themes and quote locations**

Over-arching themes	Super-ordinate themes	Sub-themes	Quote location (Participant initial Page number)
Re-negotiation of Lifestyle	Empowerment	Unwanted experience	Emotional impact H2, H24, H28, G9, G8, G12, F3, F10, F15, L4, L6, L11, J1, J8, J20, A7, A11, A12, D3, D13, D14
			Impact on quality of life H20, H20, H27, G10, G11, G22, F14, F20, L1, L12, L19, A36, A37, A40, J6, J8, J20, D6, D17
			Coping H5, H6, H10, G1, G10, G19, F16, F22, F24, L2, L4, L16, A4, A6, A11, J9, J12, J20, D4, D5, D16
		Engagement	Voice as negative/positive H3, H13, H20, G9, G17, G19, F9, F21, F24, L1, L5, L19, A27, A32, A39, J2, J6, J8, D5, D15
			Identity of voice H11, H12, H19, G6, G9, G12, F7, F8, F9, L4, L13, L16, A1, A11, A23, J6, J23, J27, D1, D2, D14
			Response to voice content H2, H5, H11, G1, G10, G17, F2, F6, F11, L2, L5, L11, A5, A9, J13, J16, J19, D6, D13, D14
			Power H3, H6, H12, G4, G8, G9, F8, F9, F27, L9, L11, L12, A9, A16, A24, J2, J10, J19, D2, D3, D6
		Relationship with others	Impact on social relationships H9, H25, H26, G18, G19, G21, F4, F15, F25, L15, L17, L19, A20, A21, A39, J9, J10, J12, D8, D9, D22
			Relationships with professionals H10, H21, H28, G16, G17, F20, F21, F20, F21, L17, L18, A31, A32, J25, J26, D16, D17, D20
		Sense-making	Purpose H1, H13, H14, G2, G6, G11, F4, F7, F9, L3, L8, A1, A3, A16, D14,
			Time H1, H5, H27, G7, G12, G21, F8, F10, F23, L1, L2, L19, A1, A2, A7, J2, J11, J12, D2, D8, D16
			Questioning self H22, H23, H24, G8, G14, G21, F11, F14, F17, L2, L5, L8, A15, A1, A19, J24, D3, D6, D7
			Confusion H3, H13, H15, G4, G5, G8, F5, F8, F26, L9, L10, L19, A7, A16, A17, J4, J19, J27, D2, D3, D9

**Part 2 - Professional Practice: Advanced Case Study**

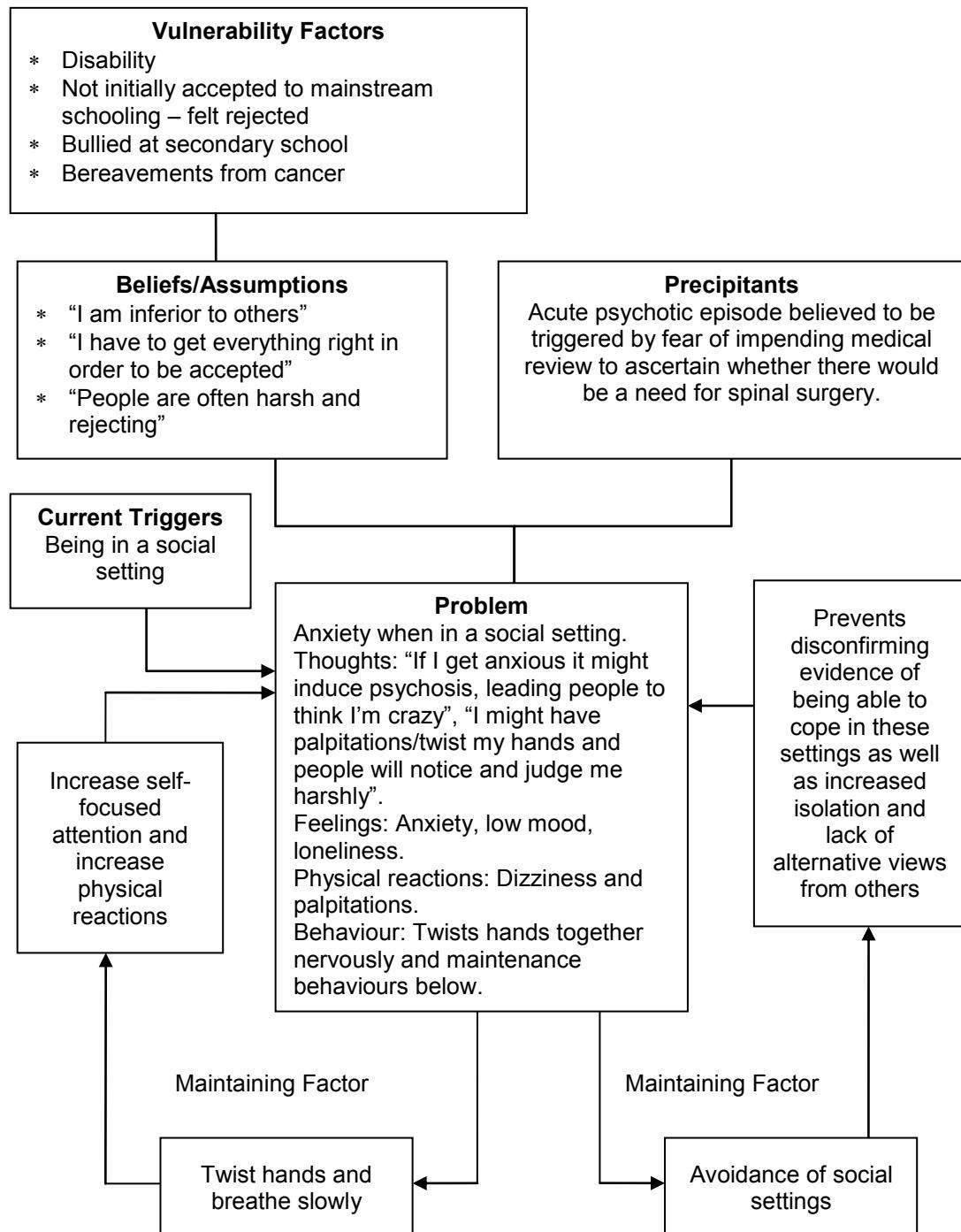
**Cognitive Behaviour Therapy to Manage the  
‘Secondary’ Effects of Psychosis**

**The Professional Practice Component of this thesis has been  
removed for confidentiality purposes.**

**It can be consulted by Psychology researchers on application at  
the Library of City, University of London.**

## Appendix A

**Figure 1: Formulation diagram**



## **Appendix B**

### **James's fear hierarchy**

**10.** Attending parties of my sister (without mum)

**9.** Attending parties of my sister (with mum)

**8.** Shopping with mum in local large supermarket

**7.** Shopping with mum in local small supermarket

**6.** Going to local high street alone

**5.** Going to local high street with someone

**4.** Talking to people at swimming club (without mum)

**3.** Talking to people at swimming club (with mum)

**2.** Not leaving swimming club early

**1.** Attending swimming club with mum

## **Appendix C**

### **The therapeutic plan and main techniques used**

#### **Sessions one to four:**

- \* Assessment (Dudley & Kuyken, 2006; Westbrook et al. 2007)
- \* Formulation – identifying key maintaining factors (Clark, 2001; Salkovskis, 1991); Shared with client (Dattilio and Hanna, 2012)
- \* Creation of therapeutic goals (Westbrook et al. 2007)
- \* Introduction to CBT (Westbrook et al. 2007)
- \* Psychoeducation - anxiety and the role of avoidance (Clark, 2001; Leahy & Holland, 2000)
- \* Homework: Consideration of therapeutic goals, reading of psychoeducational material

#### **Sessions five to eleven:**

- \* Challenging maintaining factors of anxiety
  - o Graded exposure - *in vivo* and imagery (Heimberg 2002; Leahy & Holland, 2000)
    - Creating fear hierarchy and gradually working up through fear ratings
  - o Cognitive restructuring (Beck & Emery, 1985)
    - Identifying negative automatic thoughts (Leahy & Holland, 2000) and searching for alternatives
    - Behavioural experiments undermining negative core assumptions/beliefs (Beck, Rush, Shaw & Emery, 1979)
  - o Social skills deficit considered
- \* Homework: *In vivo* graded exposure, cognitive restructuring, behavioural experiments

#### **Sessions twelve to fourteen:**

- \* Reviewing work so far - achievements made, techniques learnt
- \* Identifying future goals
- \* Encouragement to continue practicing newly acquired skills

N.B. The original plan involved ten sessions that would have consisted of the same content as above. However, as sessions progressed, it seemed appropriate to allow more time for the middle and end stages and therefore the overall plan was conducted over fourteen sessions.

## **Part 3 - Critical Literature Review**

### **Continuum theory of psychosis: A help or a hindrance?**

## Introduction

There is an assumption within medicine that a doctor's capacity to understand and reduce illness relies upon the ability to distinguish between symptoms so a diagnosis can be made (Dean & Murray, 2003). Kraepelin and Bleuler are jointly credited with inventing the term 'schizophrenia' (Read, 2004a), which can be defined as a chronic mental health condition causing a range of unusual experiences such as hallucinations, delusions, confused thinking and changes in behaviour (NHS Choices, 2013a). Schizophrenia had previously been labelled 'dementia praecox' and distinguished from bipolar disorder, a distinction that offered a dichotomous view of psychiatric illness that quickly gained widespread acceptance (Dean & Murray, 2003). However, this distinction was simply a distinction, and in 1913, Kraepelin himself admitted that the causes of schizophrenia "are at the present time still wrapped in impenetrable darkness" (Kraepelin 1913, p224). This ignited a race to establish a neuropathological basis to the experience. However, by the 1960's, arguments had broken out stating that despite feverish attempts, a neuropathological basis had still not been found, leading people to ask: "does schizophrenia exist?"

The debate surrounding whether schizophrenia exists is an extensive and enduring one. Since its creation in the 1800's, the diagnostic criteria for schizophrenia have seen little change despite numerous studies questioning its reliability and validity (Lake & Hurwitz, 2006).

The question of whether schizophrenia existed was not raised to imply people with this diagnosis do not have unusual or difficult experiences, but instead to question whether the term was reliable and valid (Read, 2004b). Many claim that 'schizophrenia' is meaningless and only acts to identify individuals who are acutely unwell (Goel, 2007). An important issue raised was that fifty years after the creation of the term, experts could still not agree on who had it, meaning the proposed properties of the experience could not be evaluated (Read, 2004b). One line of attack against the existence of 'schizophrenia' came by challenging the notion that it is a specific 'brain disease' that an individual either has or does not have (categorical view). Boyle (2002) argued that schizophrenia as a brain disease is an illusion created and maintained by nothing more than sophisticated techniques such as assertion, to fool one into believing in its existence. Another line of argument within the debate centres around evidence that many individuals diagnosed with schizophrenia report mood disturbances where traditionally the experience was not believed to impact on affect. Furthermore, it has been claimed that the course and outcome of schizophrenia varies

between individuals, that there is inconsistent evidence suggesting any patterns of brain pathology and that genetic research has failed to identify any particular gene variance or combination unique to schizophrenia (Goel, 2007).

If 'schizophrenia' is indeed meaningless, invalid and unreliable, it has serious ramifications for clinical practice as it will inevitably lead to confusion for both professionals and clients. Furthermore, as Boyle (2002) highlights, as long as schizophrenia is perceived to be a 'brain disease', research and treatment interventions are likely to continue with an emphasis on genetics, neuro-imagery and neurobiology. In turn, recommended treatments are likely to remain psychopharmacological, with psychological interventions continuing to be viewed as 'adjunct' therapies (Tarrier et al., 2000). Given that 'adjunct' can be defined as something supplementary rather than essential, (Oxford Dictionary, 2013) the valuable contribution of a Counselling Psychologist may well be under-recognised.

One of the most persistent areas within the debate on the existence of schizophrenia is the notion that psychosis lies on a continuum with 'normality' ('continuum theory'). More recently, it has been argued that psychosis should be viewed as an inevitable part of human variation, rather than as an illness (Bentall, 2003). Psychosis describes mental health difficulties that affect an individual's thinking and behaviour, which may result in them experiencing a very different reality from that of others (NHS choices, 2013b). It is often considered to be a feature of certain diagnoses such as schizophrenia. The view that psychosis is not a discrete entity contrasts with the dichotomous view of schizophrenia. If it were true that psychotic symptoms lie on a continuum with 'normality', it threatens to undermine the very concept of schizophrenia.

Claridge (1997) referred to features of psychosis being expressed at sub-clinical levels throughout the general population as 'schizotypy'. Although this concept is not new (e.g. Meehl, 1962), over the last thirty years, significant evidence has accumulated supporting this view, leading many to conceptualise psychosis as the more complex expression of traits present in the general population (Claridge, 1972). In a survey of over 14,000 people, 8% of men and 12% of women admitted to having experienced hallucinations in their lifetime (Sedgewick, 1894). Similarly, in a study of 375 college students, 71% reported having experienced a hallucinated voice and 39% reported having heard thoughts spoken aloud (Posey & Losch, 1983). More recent studies have been conducted that continue to provide evidence that other symptoms of psychosis, such as delusions (Eaton, Romanoski, Anthony

& Nestadt, 1991; Peters, Joseph, & Garety, 1999b), language and communication difficulties (e.g. Szasz, 1993) and hypomania (e.g. Angst, 1998) can also be found in the general population.

Despite convincing research supporting the psychosis continuum theory, it is of course not without its sceptics. It appears the limitations to the current categorical diagnostic system are well recognised (e.g. Lawrie, Hall, McIntosh, Owens, & Johnstone, 2010) and therefore the 'other side of the debate' is not simply a contrasting view proclaiming the non-existence of psychosis continuum theory, but more a prompt for caution and to encourage further investigation into its existence. Concerns have been raised regarding the methodology used in continuum theory research, and it has been argued that sharing polygenic vulnerability does not necessitate that bipolar disorder and schizophrenia lie on a continuum, especially given findings they differ in terms of risk factors, pathology and treatment response (Lawrie et al., 2010). However, contrary findings have also been produced demonstrating no difference in genetic cause, pathology and treatment response between the two (Ketter, Wang, Becker, Nowakowska & Yang, 2004; Lichtenstein et al., 2009). It has also been argued that the presence of psychotic symptoms within the general population does not exclude the possibility there are underlying categories or subtypes of psychosis (Lawrie et al., 2010).

Traditionally, schizophrenia was thought of as a mental illness, or specific brain disease, that one either had or did not have. It was believed to have a neuropathological basis and therefore was treated solely psychopharmacologically. In contrast, the continuum theory posits that psychosis is not a discrete 'illness' but instead an inevitable part of human variation (Bentall, 2003), meaning that everyone experiences it to a greater or lesser degree. Leading on from this, the continuum theory does not suggest underlying neuropathology and therefore encourages exploration of psychological interventions. The difference in approach of the continuum theory therefore challenges the long withstanding view of schizophrenia and threatens to undermine it by suggesting that 'schizophrenia' (as it has been previously understood), does not exist. For this reason the following review focuses on the specific area of the continuum theory of psychosis. There is currently much confusion around the theory concerning its existence and utility in informing clinical practice. To date, research has tended to focus on either providing evidence for or against the theory, or to suggest particular ways in which it guides/hinders practice. The current review aims to take an original stance by synthesising this material, bringing together and critiquing key issues,

examining the current status of the debate and highlighting potential areas for future work. Above all, the review shall address the question of whether the continuum theory offers hope and promise or merely a hindrance for clinical practice. It is this author's belief that the continuum theory of psychosis has something to offer and therefore through this review, the author hopes to show that the continuum theory can be considered 'a help' to clinical practice.

The question of whether the continuum theory is a help or hindrance is important within the field of Counselling Psychology. If the consensus is that psychosis can be viewed as lying on a continuum, then this could significantly improve perceptions of the experience. Currently, the term schizophrenia brings with it fear and stigma and clients are often reluctant to accept it as a diagnosis (van Os, 2009). A reduction in stigma could therefore lead to greater acceptance of the diagnosis, and therefore the number of people accessing support. Furthermore, improving perceptions of psychosis and working with up-to-date information may open up the possibility of more informed and improved treatment options being available to individuals distressed by this experience.

Within this review, 'continuum theory' refers to the theory that psychosis lies on a continuum with 'normal' experiences. As psychosis is not a diagnosis in itself but a feature of experiences such as schizophrenia (NHS choices, 2013b), the terms 'schizophrenia' and psychosis both appear in the review. This was to ensure all relevant material was included as the two terms are used throughout the literature to indicate the same phenomenon being discussed within the continuum theory.

## **Reviewing the literature**

A thorough literature review was conducted using online databases 'Psycarticles' and 'Scopus'. Further searches were conducted for cited articles contained in the original search. Papers were reviewed both supporting and refuting the existence of the continuum theory.

### **Overlap between psychosis and 'normality'**

A number of studies have explored the overlap between 'normality' and psychosis and that they both lie on a continuum. One of the earliest and most influential papers to discuss the idea that psychotic experiences occur in the general population came from an experiment carried out by Romme and Escher (1989). Following a television performance where a client

diagnosed as having schizophrenia spoke about her experiences of hearing voices, 450 viewers identifying themselves as voice-hearers, contacted the television programme. One hundred and fifty of these individuals were identified as being able to 'cope' with their voices, and the remaining 300 as 'non-copers'. The researchers sent the 450 individuals a questionnaire asking about their experiences of coping with their voices. From comparing the two groups of participants ('copers' and 'non-copers') they concluded that a vital part of coping with voices appeared to be the frame of reference the person assigned to them and that by accepting the voice as "part of me", the person improved their chances of coping.

There were obvious limitations to this study. There was limited detail regarding the methodological approach taken. Although it appeared to adopt a qualitative approach, details of the questionnaire and of the analysis, such as whether the authors used a phenomenological or narrative approach, were absent, therefore bringing into question the validity and reliability of the findings. In addition, the conclusion that better coping was associated with viewing the voice as positive implies a causal interpretation (that thinking the voice is positive causes you to cope better) but this cannot be assumed as it is possible the voices were positive, allowing the person to feel more able to cope.

More recent studies have been conducted investigating the presence of auditory hallucinations in the general population (Posey & Losch, 1983; Sedgewick, 1894; Tien, 1991), one of the largest being by Sommer et al. (2008) who found further evidence of voice hearing in a study of 103 non-clinical individuals, therefore adding support for the idea that psychosis and 'normality' lie on a continuum.

Another study to investigate the overlap between psychosis and 'normality' was conducted by Peters, Day, McKenna and Orbach (1999a). This ground-breaking study investigated the incidence of delusions in two new religious movements (NRMs): Hare Krishnas ( $n=13$ ) and Druids ( $n=13$ ); compared to two control groups: one formed of non-religious ( $n=38$ ) and Christian participants ( $n=45$ ), and the other of inpatients experiencing psychosis ( $n=33$ ). Using a quantitative approach, participants were asked to complete questionnaires assessing delusional ideation and social desirability. It was found that NRMs members shared a number of less florid delusions with psychotic individuals, held an equal level of conviction in their ideas, but were not as preoccupied or distressed by their experiences. In addition, it was found that the NRMs members scored significantly lower on the social desirability measure, indicating that differences between the two groups could not be

accounted for by under-reporting by NRMs members. The researchers proposed that whether a person becomes 'deluded' depends on the extent to which delusional ideation is believed and how much it disrupts their life and causes an emotional impact, rather than simply on the presence of delusional ideation. It was suggested that psychotic experiences lie on a continuum with 'normality', and that above a particular threshold, a person may become 'deluded'.

This study added support for the continuum theory. The methodology used was strong, incorporating a control group and a large sample within all experimental groups, as well as exploring considerations such as desirability affecting findings and that religion itself can cause higher delusional ideation. However, no attempt was made to assess the content of religious and delusional beliefs and the manner in which participants were obtained may have led to a biasing of results. For instance, the Druid participants were selected by a contact of one of the researchers, which could have led to a selection bias. In addition, all 'deluded' participants were currently receiving medication, so it is unclear how affected by delusions their thinking may have been at the time of testing. Within this study, one of the delusional ideation measures was created by one of the researchers specifically to test the psychosis continuum theory. It has been suggested that measures devised for a psychosis population may not be suitable for the general population as they have been validated against a psychosis population. Therefore, when applied to the general population, what is measured may not be 'true delusions', which threatens to undermine the measure's validity (David, 2010).

A further study exploring whether psychosis and 'normality' lie on a continuum set out to estimate the incidence of self-reported psychotic symptoms and associated risk factors, in the general population of Great Britain (Wiles, Zammit, Bebbington, Meltzer & Lewis, 2006). The researchers carried out a follow-up assessment on participants ( $n=2413$ ) of an earlier survey (the British National Psychiatric Morbidity Survey (Singleton & Lewis, 2003)) who had no evidence of psychotic features at baseline. Participants were asked to complete a questionnaire aimed at identifying the occurrence of psychotic features (hypomania, thought insertion, paranoia, strange experiences and hallucinations) over the last 18 months. Four percent of the general population reported having experienced a psychotic experience over the previous 18 months. Six risk factors were also identified: living in a rural area, having a limited support network, experiencing more adverse life events, smoking tobacco, experiencing neurotic symptoms and engaging in harmful patterns of drinking. The

researchers concluded “a small but not insignificant percentage of the population of Great Britain reported incident psychotic symptoms over 18 months” (Wiles et al., 2006, p519).

This study added further evidence for the psychosis continuum theory by producing longitudinal data and by broadening the criteria for psychosis to measure paranoia, thought insertion, hypomania and strange experiences instead of simply delusions and hallucinations. A large sample was used but as the researchers highlighted, due to the low incidences of psychotic symptoms reported, the study may have been underpowered to detect associations with risk factors. Furthermore, the study used self-report measures, and although the researchers claimed in-depth psychiatric interviews are not possible with large surveys, it is possible this approach led to under/over-reporting thereby reducing reliability (van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009). However, a high correlation has been found between individuals endorsing items on the questionnaire used in this study, and those clinically diagnosed with psychotic symptoms (Johns, Nazroo, Bebbington, & Kuipers, 2002).

The studies mentioned are key papers in support of the existence of the continuum theory, but there are a vast number of others citing similar finding (e.g. van Os, Hanssen, Bijl, & Ravelli, 2000; Yung et al., 2003). It would appear there is considerable evidence suggesting a continuum may indeed exist between ‘normality’ and psychosis and therefore that the question of whether the continuum theory of psychosis is a help/hindrance is an important one.

### **Overlap between psychosis and other mental health difficulties**

Although schizophrenia was distinguished as being fundamentally separate to bipolar disorder, more recent work suggests they are manifestations of the same underlying condition (Lake & Hurwitz, 2007). This idea was strengthened by the introduction of the term ‘schizoaffective psychosis’, which described individuals experiencing both psychotic and mood disturbance features (Lake & Hurwitz, 2007). Over the last few decades, evidence has been generated enhancing the scepticism towards the concept of disease specificity between bipolar disorder and schizophrenia (e.g. Pope & Lipinski, 1978; Lake and Hurwitz, 2006) as well as between schizophrenia and other mental health difficulties (e.g. Ellason & Ross, 1995). The idea that schizophrenia may overlap with other mental health difficulties again brings into question whether psychosis lies on a continuum. Indeed, it has been

suggested that there are no behaviours and experiences specific to schizophrenia (Read 2004b).

One influential study that set out to investigate the overlap between psychosis and other mental health difficulties compared the pattern of positive and negative psychotic symptoms between patients diagnosed with Dissociative Identity Disorder (DID) and patients diagnosed with schizophrenia (Ellason & Ross, 1995). A sample of DID patients ( $n=108$ ) were assessed using the Positive and Negative Syndrome Scale (PANSS) (Kay, Fiszbein, & Opler, 1987) and their mean scores compared with the norms of patients diagnosed with schizophrenia ( $n=204$ ). The DID patients were all recruited and assessed by the researchers but data for the patients diagnosed with schizophrenia were obtained by using pre-existing data collected from Kay, Opler and Lindenmayer in their 1989 study. It was found that patients diagnosed with DID reported more severe positive symptoms and general psychopathology (particularly anxiety and depression) than patients diagnosed with schizophrenia and that conversely, patients diagnosed with schizophrenia reported more severe negative symptoms than those diagnosed with DID. The researchers suggested that focusing on the presence of positive symptoms when assessing patients may lead to incorrect diagnoses between schizophrenia and DID.

One important limitation of this study was that the researchers did not assess both groups. Although they took steps to ensure inter-rater reliability for their PANSS ratings in the DID sample, as different raters were used for the patients with schizophrenia, variability may have been introduced in the data. Additionally, certain details were missing for the schizophrenia data, preventing specific comparisons from being made. For instance, in the DID group, there were 10 males and 96 females, whereas the genders were not given in the schizophrenia group. Finally, none of the researchers were blind to the participants' diagnoses, which may have led to biased results, particularly on the side of the DID patients, who were assessed by the researchers of the paper.

In another influential study, Varghese et al. (2009) aimed to examine the prevalence of psychotic symptoms in individuals with affective and anxiety disorders. They used a large sample of participants ( $n=2405$ ) taken from a previous cohort study, and those identified as having either a lifetime diagnosis of major depression, an anxiety disorder or substance use/dependence were assessed using two independent measures for psychotic features. The authors concluded a significant number of individuals diagnosed as having a lifetime

diagnosis of major depression or an anxiety disorder also reported having psychotic experiences. The researchers suggested psychotic experiences are associated with a range of mental disorders, thus adding further evidence to the theory that psychosis lies on a continuum.

The reliability and validity of this study appeared to be strong. As mentioned, a large sample size was used and participants were assessed by trained professionals using two independent psychosis measures. The researchers presented clear hypotheses and the study design met the requirements to test these. An appropriate statistical method to analyse the data was used, logistic regression, and the researchers showed consideration of the possible confounding variable of trauma by excluding participants who met lifetime diagnosis of PTSD ( $n=153$ ) from the analysis. However, the assessors were not blind, thereby introducing a possible reporting bias, and there was no mention of inter-rater reliability testing between assessors. In addition, the diagnoses were not made using the main universally accepted diagnostic tools (DSM or ICD), potentially reducing validity.

The claim that there is no evidence demonstrating behaviours and experiences unique to schizophrenia (Read, 2004b) compared to other mental health difficulties, is supported by the above studies and many others (e.g. Crow, 1990; Johns et al., 2004; Kessler et al., 2005). These findings add strength to the argument that schizophrenia is not a definitive 'thing', but rather, that the symptoms of schizophrenia lie on a continuum, both with 'normality' and with other mental health difficulties. This suggests the continuum theory of psychosis provides a helpful and empirically-supported approach to the understanding of psychosis.

### **Alternative classification systems arising from the continuum theory**

In reviewing the literature on the continuum theory, several researchers have discussed and attempted to devise alternative classification systems for schizophrenia that incorporate the idea that psychosis lies on a continuum. One such study is that by Allardyce, Gaebel, Zielasek and van Os (2007a). In their paper, they review the psychometric literature exploring the evidence of discontinuity between schizophrenia and 'normality' as well as schizophrenia and other psychotic conditions. They drew on a wealth of studies indicating a continuum of psychotic experiences between 'normality' and psychosis and an overlap between schizophrenia and other psychotic illnesses and concluded the current validity of the diagnostic criteria for schizophrenia is insufficient. The researchers claimed these

findings support the theory schizophrenia is caused by genes that alone show a negligible effect, but upon interaction with each other and environmental risk factors, can lead to psychotic illness. In line with the findings, they proposed a diagnostic system combining both dimensional and categorical representations of schizophrenia offered more utility in terms of course and outcome information than either representation independently, a view supported by other studies (e.g. Allardyce, Suppes & van Os, 2007b). However, other research has challenged this representation and urged for further research to be completed before any firm view be made (Craddock & Owen, 2010; Lawrie et al., 2010). Although this research drew on a number of different supporting studies, the methodology surrounding the literature review was not detailed and alternative viewpoints were not well explored, thereby potentially creating a somewhat one-sided interpretation.

Another study to explore an alternative way to classify psychosis was by van Os (2009). The researcher reviewed the current literature to explore the validity, usefulness and acceptability of the current concept of schizophrenia in order to discuss key changes that have occurred and addressed how these may affect the future of DSM and ICD diagnoses. A number of studies were reviewed that have produced evidence supporting the continuum theory and it was concluded that "...psychotic disorders appear to be fuzzy in that they blur into normality. The evidence suggests a natural representation of psychotic disorders that is dimensional along a continuum from subclinical expression to psychotic disorder" (van Os, 2009, p365). In accordance with Allardyce et al. (2007a), the researcher suggested a combined categorical and dimensional approach to psychosis encourages greater information to be established regarding causes, treatment needs and outcome. In line with this claim and the evidence suggesting psychotic symptoms are a manifestation of the individual overly-focusing on attention-grabbing stimuli, the researcher proposed a new system whereby individuals are categorised as having: salience syndrome with affective expression, salience syndrome with developmental expression or salience syndrome not otherwise specified.

The researcher clearly set out his agenda and drew reference to various studies supporting his ideas. He approached the continuum theory of psychosis as factual, not questioning its validity and therefore proposed a new diagnostic system based upon it. However, within this article, there is little evidence reviewed to offer any alternatives, which at times left it feeling slightly blinkered, and there was no mention of how the literature review was conducted. Although the researcher did refer to studies supporting his claims, at times some of these

claims appeared unsubstantiated, therefore being reminiscent of Boyle's comments regarding how ideas can be converted to fact, simply through assertion (Boyle, 2002).

Van Os, in collaboration with other researchers, also produced one of the most influential studies written in support of the continuum theory (van Os et al., 2009). The researchers set out to review 'proof' for the existence of the continuum theory. They conducted a detailed and systematic review of the evidence for incident and prevalence rates of psychotic experiences and risk factors at a subclinical level. The researchers took a thorough and rigorous approach to reviewing the data by addressing over 2000 papers, leaving their findings and conclusions highly compelling. They concluded that there was a median prevalence and incident rate of approximately 5% and 3% respectively. The researchers inferred evidence for the theory of 'schizotypy' (Claridge, 1997) re-naming it 'psychosis proneness' and proposed a 'psychosis proneness-persistence-impairment model' of psychosis, whereby expressions of psychosis may become persistent and therefore clinically relevant if the environmental risk the individual is exposed to becomes too great. It was suggested this model offers a valid and realistic approach to psychosis and highlights the importance of further exploration into the factors leading to persistence of psychotic features, thereby demonstrating the essential nature of efforts at early detection and intervention.

Within the van Os et al. (2009) paper, the researchers admitted there was variation in the recorded prevalence and incident rates of psychotic features within the general population and explained this as being due to the use of differing methodologies. It has been suggested this variance stemming from methodological issues undermines the reliability of these findings (David, 2010). However, this criticism appears unfair given that van Os et al. (2009) specifically addressed this issue by looking at the overall prevalence and incident rates, which are far higher than the clinical presence of psychotic features, thereby concluding that whatever the methodology used, the rates support the theory of the psychosis continuum.

Reviewing the literature, it would appear the evidence supporting the continuum theory is coercive and therefore future developments for alternative classification systems stemming from it have begun to emerge. Both the 'salience syndrome' model (Van Os, 2009) and the 'psychosis proneness-persistence-impairment model' (Van Os et al., 2009) offer a current, de-stigmatising approach to diagnosing psychosis that appears to have higher validity than the existing model. It would therefore appear that again, the continuum theory offers a helpful presence in the understanding of psychosis and how it can be applied to clinical

practice. However, at present, these concepts are theoretical and therefore lack evidence supporting their utility.

### **Criticisms of the continuum theory**

Despite the evidence in support of the continuum theory, many have criticised it. Concerns have been raised surrounding its validity as well as its ability to help alternative approaches be devised that aid the understanding and management of psychosis. For instance, in a highly controversial article, Lawrie et al. (2010) attempted to argue that the support for the continuum theory of psychosis was limited and that this support did not indicate a need to change the present diagnostic approach. The researchers stated the current categorical representation of psychosis was well recognised and argued that despite its clinical validity being brought into question, it enables worldwide diagnoses and has facilitated the understanding of pathogenesis and what causes psychosis (Tandon, Keshavan, & Nasrallah, 2008). Despite the 'salience syndrome' model (Van Os, 2009) and the 'psychosis proneness-persistence-impairment model' (Van Os et al., 2009), the researchers claimed no specific proposals had been made for alternative approaches based on the continuum theory. Although these two models are at present, purely theoretical and lacking specificity, by not acknowledging them, Lawrie et al. (2010) presented a rather short-sighted view.

Lawrie et al. (2010) highlighted that despite the literature supporting an overlap between psychosis and bipolar disorder, there was also evidence showing these two experiences differ in risk factors, treatment response and pathology. They also acknowledged the findings showing that psychotic experiences occur in the general population, but suggested this did not necessarily substantiate the claim that psychotic symptoms occur on a continuum or that there are not underlying categories of psychosis. The researchers questioned the utility of a dimensional approach, stating there was little data detailing such an approach and that it was unclear how symptoms and outcomes should be measured and how this would be completed in clinical practice. The main concern was stated as being that an "over-enthusiastic and under-critical acceptance of the 'continuum of psychosis' will throw away something scientifically serviceable and clinically useful" (Lawrie et al., 2010, p424). They therefore highlighted the importance of further systematic studies to establish the specific details of any continuum theory-based approach. At times, the researchers appeared highly speculative, making little reference to studies supporting their claims. The counter-arguments were not well reviewed, leaving the paper rather biased in its viewpoint. For example the argument "why jeopardise the advances we have made for something of

unknown value?" (Lawrie et al., 2010, p424) appeared somewhat propagandistic and limiting in terms of scientific development.

Another paper to take a sceptical view towards the continuum theory argued that despite the psychosis continuum theory becoming widely accepted, there was confusion surrounding the exact nature of the continuum being discussed, potentially undermining the reliability of various studies (David, 2010). In this paper, research with supporting evidence for the presence of psychotic symptoms within the general population was reviewed and methodological concerns were raised. For instance, the researcher highlighted the approach taken (e.g. self-report measures or clinical interview) can affect the frequency of psychotic symptoms being reported and that altering the wording of the questions to make them suitable for the non-clinical population may lead to an increase in false-positive responses. The researcher also suggested there was a lack of clarity across studies as to exactly which continuum was being measured: whether they were measuring distribution of traits in the population (epidemiology) or a continuum of experiences (phenomenological) and that this distinction was important as the related findings would inform the understanding of psychosis in differing ways. The final point raised was that in searching for a more morally acceptable approach to psychosis, the continuum theory risks masking the seriousness of psychosis and may devalue people's experiences.

This theoretical paper took a systematic approach and drew on many studies to support its claims. The researcher suggested carrying out further studies exploring the idea of discontinuity between psychosis and 'normality' in an attempt to further question the utility of the continuum theory for psychosis. Although this would legitimately further understanding, it could also be argued that this is a rather one-sided and restricted view given that since the creation of the term 'schizophrenia', diagnosis has been based on a purely categorical system.

Although there is much support of the psychosis continuum theory, there are also concerns regarding its validity and utility in offering an alternative approach to the understanding and treatment of psychosis. These concerns have not yet been addressed and therefore presently, uncertainty surrounds the theory, leaving it exposed to the criticism that it actually could be causing more of a hindrance to the understanding of psychosis than a help.

## **Summary**

There is a strong body of evidence supporting the existence of the continuum theory of psychosis derived from studies demonstrating the overlap between psychosis and 'normality' (e.g. Peters et al., 1999a; Peters et al., 1999b; Romme & Escher, 1989) and between psychosis and other mental health difficulties (e.g. Ellason & Ross, 1995; Varghese et al., 2009). Building on this evidence, propositions have arisen for how the continuum theory of psychosis can be used to re-model the current diagnostic approach to psychosis. Two main models have been proposed: the 'salience syndrome' model (Van Os, 2009) and the 'psychosis proneness-persistence-impairment model' (Van Os et al., 2009). These models incorporate both a categorical and dimensional representation of psychosis, which recent studies suggest holds more utility than either representation alone (Allardyce et al, 2007b; Lawrie et al., 2010; Van Os, 2009; Van Os et al., 2009). These models appear to provide more validity than the current diagnostic categories for psychotic illnesses, whilst also being de-stigmatising and able to inform future research, for instance by highlighting the importance of early detection and intervention for individuals experiencing psychotic symptoms (van Os et al., 2009). However, there are a number of criticisms of the continuum theory, consisting of methodological concerns and anxiety around the lack of clarity of exactly which 'continuum' is being measured (David, 2010). Currently, despite much evidence supporting its existence, the continuum theory of psychosis still appears to be in its infancy in terms of impact towards clinical practice. Although models have been suggested of how the theory can be used in terms of a diagnostic approach, they are theoretical and therefore lack empirical evidence supporting their utility. There is also little description in the literature of how the continuum theory may improve general clinical practice and treatment outcomes.

## **Conclusion**

Numerous studies have concentrated on exploring the possibility of the existence of the continuum theory of psychosis and despite the queries raised regarding these studies' validities, it appears the theoretical approaches taken to date overwhelmingly support the existence of the continuum theory of psychosis. The question therefore should no longer be whether there is a continuum of psychosis, but instead, whether this theory adds to a clinician's understanding of psychosis and ultimately informs and improves treatment options. At present, the benefits of the continuum theory to clinical practice appear to be centred on providing a system that has a higher validity than the current diagnostic one (van Os, 2009) but the benefits of this validity appear to be weakly explored in terms of how this

will aid clinical practice. Indeed the main argument raised against the continuum theory is that there is presently a lack of clarity and specificity regarding how it would be applied to clinical practice, highlighted by a lack of empirical evidence of its utility (Lawrie et al., 2010). It would appear that currently, the continuum theory for psychosis is caught in a catch-22 situation: in order to be more widely accepted, it needs empirical evidence supporting its effectiveness within clinical practice, but it is not able to achieve this as its lack of empirical support prompts a reluctance to allow it to be tested within clinical practice.

Future developments of the continuum theory need to focus further on how it can be applied to clinical practice, making any proposal clear and specific in terms of methodology. For instance, proposals need to specifically address questions such as: with a dimensional approach, which symptoms would be rated within clinical practice and is it feasible to expect a busy clinician to find the time to rate all of these symptoms and establish reliability of ratings among colleagues (Lawrie et al., 2010). One way that this could be achieved is through clinical trials that aim to determine the therapeutic implications of approaches based on the continuum theory (Lawrie et al., 2010). It has been suggested that a better understanding of what causes the onset of 'need for care' would improve treatment options (van Os, 2009). Studies exploring methods to measure need for care could be conducted to achieve this aim. Peters et al. (1999a) suggested that what distinguishes the need for care is the level of distress caused. However, conviction and preoccupation have also been suggested as determinant factors (David, 2010). Drawing on these findings, studies could be conducted, such as randomised controlled trials, comparing the efficacy of various measures of distress, preoccupation and conviction with individuals from the clinical and non-clinical population who experience psychotic experiences, in order to establish a reliable measure for need for care.

It has been suggested that the presence of psychotic symptoms can predict the onset of clinical difficulties (Chapman, Chapman, Kwapil, Eckblad, & Zinser, 1994) and that certain risk factors can trigger the onset of a disorder (van Os, 2009). This highlights the possibility of identifying individuals who will go on to develop a need for care and suggests further research needs to focus on establishing these risk factors. This is particularly relevant for Counselling Psychologists in assisting them to spot potential signs of psychological decline in this client group. One well documented risk factor of schizophrenia is living in an urban area, although evidence to the contrary has also been established (Wiles et al., 2006), highlighting the need for clarity in documenting risk factors. If it is possible to identify

individuals at risk of developing a need for care, possibly through public health campaigns, then treatments may be able to be offered sooner, thereby reducing the duration of distress (Johns & van Os, 2001).

Further studies also need to be carried out to add additional support for the existence of the continuum theory as its existence is still questioned by a number of sources. One way this could be achieved is through further studies investigating whether schizophrenia and bipolar disorder are the same or separate conditions (Lake & Hurwitz, 2007). Similarly, it has been suggested that presently there is insufficient research into whether the most appropriate representation of psychosis is categorical, dimensional or a hybrid of the two (Lawrie et al., 2010), highlighting the need for further research within this area. This could potentially be explored by carrying out a clinical trial using the salience model (van Os, 2009) to test out treatment responses with individuals reporting psychotic experiences, thereby investigating the effectiveness of this hybrid approach.

The continuum theory of psychosis appears to be a promising approach to understanding psychotic experiences, which, providing the concerns surrounding it are addressed would provide a much welcomed presence within Counselling Psychology. By improving the understanding of psychosis, the continuum theory may transform clinical practice through aiding the detection of people at risk of developing clinical difficulties and highlighting the importance of early interventions (thereby adding support to the current emphasis placed for treatment on psychosis early intervention services (NICE, 2009)).

The continuum theory also provides a potentially de-stigmatising approach for clients within the professional field. Even amongst professionals, concepts that lead to ideas of 'them and us', such as the traditional categorical approach to psychosis, can lead professionals to feel an unhelpful distance from their clients, which can create difficulties in engaging and empathising. These difficulties will ultimately reduce the effectiveness of the therapeutic relationship and therefore psychological intervention. The continuum theory encourages the idea that there is no 'them and us'. This idea is strengthened through models arising from the continuum theory promoting the role of gene interaction with environmental risk factors in the formation of clinical psychosis, as these models may implicitly convey to professionals that they could become the client given the right context. Furthermore, breaking down the barrier between the professional and the client may encourage the professional to reflect on their

own relationship with psychosis, thereby becoming more aware of any prejudices, which can be challenged in order to improve the therapeutic relationship.

As well as reducing stigma amongst professionals, the continuum theory has the potential to challenge other more stigmatising approaches. For instance, the current diagnostic approach to psychosis often brings with it fear and judgement due to implying people experiencing psychosis are ‘different’ in some way. This can act to discourage clients from accepting their diagnosis as well as from accessing services for support. Using the continuum theory as an explanatory model with clients may well help them to see they are not ‘different’ to others, thereby aiding their engagement in services. Similarly, with the traditional diagnostic approach, the primary means of intervention involved the use of medication. Medication implies the notion of a disease of the brain, which can leave the client appearing impaired and not in control. This again can be stigmatising, but reduced with the continuum theory, which fights against the notion of a brain disease and encourages personal responsibility and sense of control through the employment of psychological intervention. Furthermore, the continuum theory may also inform therapeutic interventions used that are aimed at reducing stigma. For instance, Cognitive Behaviour Therapy (CBT) forms part of the recommendations for the treatment of schizophrenia (NICE, 2009) and the normalising approach used within CBT is based on a dimensional view of psychosis (Johns & van Os, 2001). Indeed it has been argued that cognitive models are built on the premise that features of psychosis lie on a continuum (Garety, Bebbington, Fowler, Freeman, & Kuipers, 2007). Therefore the continuum theory would complement existing psychological approaches aimed at reducing stigma, whereas other more categorical approaches do not. That said, it is worth noting that other Psychologists such as Morrison (2001) have proposed that psychotic features such as voices are mis-attributed intrusive thoughts, which goes against the continuum theory but is also still in line with cognitive models.

One could argue that the continuum theory simply maintains the status quo in regards to stigma but in a more politically acceptable way, for instance through the use of hybrid models that combine categorical and dimensional approaches. These types of models, by suggesting there is a threshold that must be reached before psychosis manifests itself, adopt a positivist ‘them and us’ stance, much like the more traditional categorical approach. Furthermore, the continuum theory does act to maintain the idea of ‘normalcy’ by having one end of the continuum being ‘normal’ and the other ‘psychosis’. Both of these aspects have the potential to encourage stigma amongst clients and professionals. However, despite

these points, it would still appear that the continuum theory's many benefits outweigh its negatives.

At this time, there is still much confusion and debate surrounding the continuum theory. The theory stands to contradict an approach that has stood the test of time, so further exploration of its validity and effectiveness must be conducted in order to strengthen its position. It would appear that the continuum theory for psychosis can be regarded as a 'help' rather than 'hindrance', as it holds the potential to further enlighten the understanding of psychosis and inform clinical practice. Counselling Psychologists should review all of the available information and be cautious before fully embracing the theory. However, in agreement with Craddock and Owen (2010, p95): "at the end of the 19<sup>th</sup> century it was logical to use a simple diagnostic approach that offered reasonable prognostic validity. At the beginning of the 21<sup>st</sup> century, we must set our sights higher".

## References

- Allardyce, J., Gaebel, W., Zielasek, J., & van Os, J. (2007a). Deconstructing psychosis conference February 2006: The validity of schizophrenia and alternative approaches to the classification of psychosis. *Schizophrenia Bulletin*, 33 (4), 863-867.
- Allardyce, J., Suppes, T., & van Os, J. (2007b). Dimensions and the psychosis phenotype. *International Journal of Methods in Psychiatric Research*, 16 (1), 34-40.
- Angst, J. (1998). 'The emerging epidemiology of hypomania and bipolar II disorder'. *Journal of Affective Disorders*, 50, 143-151.
- Bentall, R.P. (2003). *Madness explained: Psychosis and human nature*. London: Penguin Books.
- Boyle, M. (2002). It's all done with smoke and mirrors. Or, how to create the illusion of a schizophrenic brain disease. *Clinical Psychology*, 4, 9-16.
- Chapman, L.J., Chapman, J.P., Kwapis, T.R., Eckblad, M., & Zinser, M.C. (1994). Putatively psychosis-prone subjects 10 years later. *Journal of Abnormal Psychology*, 103, 171-183.
- Claridge, G.S. (1972). The schizophrenias as nervous types. *British Journal of Psychiatry*, 112, 1-17.
- Claridge, G.S. (1997). *Schizotypy: Implications for illness and health*. Oxford University Press: Oxford.
- Craddock, N., & Owen, M. (2010). The Kraepelinian dichotomy – going, going... but still not gone. *British Journal of Psychiatry*, 196, 92-95.
- Crow, T. (1990). The continuum of psychosis and its genetic origins. *British Journal of Psychiatry*, 156, 788-797.

- David, A.S. (2010). Why we need more debate on whether psychotic symptoms lie on a continuum with normality. *Psychological Medicine*, 40, 1935-1942.
- Dean, K., & Murray, R.M. (2003). Should schizophrenia survive? In J. Van Os, & P. McKenna, *Does Schizophrenia Exist? Maudsley Discussion Paper No 12*. (pp1-6). London: Institute of Psychiatry, Kings College.
- Eaton, W.W., Romanoski, A., Anthony, J.C., & Nestadt, G. (1991). Screening for psychosis in the general population with a self-report interview. *Journal of Nervous and Mental Disease*, 179, 689–693.
- Ellason, J.W., & Ross, C.A. (1995) Positive and negative symptoms in dissociative identity disorder and schizophrenia: A comparative analysis. *The Journal of Nervous and Mental Disease*, 183 (4), 236-241.
- Garety, P.A., Bebbington, P., Fowler, D., Freeman, D., & Kuipers, E. (2007). Implications for neurobiological research of cognitive models of psychosis: A theoretical paper. *Psychological Medicine*, 37, 1377-1391.
- Goel, D.S. (2007). Does schizophrenia exist? *Medical Journal Armed Forces India*, 63 (2), 104-106.
- Johns, L.C., & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review*, 21 (8), 1125-1141.
- Johns, L.C., Nazroo, J.Y., Bebbington, P., Kuipers, E. (2002). Occurrence of hallucinatory experiences in a community sample and ethnic variations. *British Journal of Psychiatry*, 180, 174-178.
- Johns, C.L., Cannon, M., Singleton, N., Murray, R.M., Farrell, M., Brugha, T., Bebbington, P., Jenkins, R., & Meltzer, H. (2004). Prevalence and correlates of self-reported psychotic symptoms in the British population. *British Journal of Psychiatry*, 185, 298-305.
- Kay, S.R., Fiszbein, A., & Opler, L.A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13 (2) 261-276.

- Kay, S.R., Opler, L.A., Lindenmayer, J-P. (1989). The positive and negative syndrome scale (PANSS): Rationale and standardisation. In J.W. Ellason, & C.A. Ross (1995). Positive and negative symptoms in dissociative identity disorder and schizophrenia: A comparative analysis. *The Journal of Nervous and Mental Disease*, 183 (4), 236-241.
- Kessler, R.C., Birnbaum, H., Demler, O., Falloon, I.R., Gagnon, E., Guyer, M., Howes, M.J., Kendler, K.S., Shi, L., Walters, E., & Wu, E.Q. (2005). The prevalence and correlates of nonaffective psychosis in the National Comorbidity Survey Replication (NCS-R). *Biological Psychiatry*, 58, 668-676.
- Ketter, T.A., Wang, P.W., Becker, O.G., Nowakowska, C., & Yang, Y. (2004). Psychotic bipolar disorders: Dimensionally similar to or categorically different from schizophrenia? *Journal of Psychiatric Research*, 38, 47-61.
- Kraepelin, E., ([1913]2004). Dementia praecox. In J. Read, L.R. Mosher & R.P. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia*. (pp21-34). London: Routledge.
- Lake, C.R., & Hurwitz, N.H. (2006). Two names, one disease. *Current Psychiatry*, 5, 43-60.
- Lake, C.R., & Hurwitz, N.H. (2007). The schizophrenias, the neuroses and the covered wagon; a critical review. *Neuropsychiatric Disease and Treatment*, 3 (1), 133-143.
- Lawrie, S.M., Hall, J., McIntosh, A.M., Owens, D.G.C., & Johnstone, E.C. (2010). The 'continuum of psychosis': scientifically unproven and clinically impractical. *British Journal of Psychiatry*, 197, 423-425.
- Lichtenstein, P., Yip, B.H., Björk, C., Pawitan, Y., Cannon, T.D., Sullivan, P.F., Hultman, C.M. (2009). Common genetic determinants of schizophrenia and bipolar disorder in Swedish families: A population-based study. *The Lancet*, 373, 234-239.
- Meehl, P.E. (1962). Schizotaxia, schizotypy, schizophrenia. *American Psychologist*, 17, 827-838.

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

NHS Choices, (2013a). Schizophrenia. Retrieved September 9, 2013 from  
<http://www.nhs.uk/conditions/Schizophrenia/Pages/Introduction.aspx>.

NHS Choices, (2013b). Psychosis. Retrieved September 9, 2013 from  
<http://www.nhs.uk/Conditions/Psychosis/Pages/Introduction.aspx>.

NICE Guidelines (2009). Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. Retrieved September 9, 2013 from <http://www.nice.org.uk/nicemedia/live/11786/43608/43608.pdf>.

Oxford Dictionary (2013). Definition of adjunct. Retrieved September 9, 2013 from  
<http://oxforddictionaries.com/definition/english/adjunct>.

Peters, E.R., Day, S., McKenna, J., & Orbach, G., (1999a). Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology*, 38, 83-96.

Peters, E.R., Joseph, S.A., & Garety, P.A., (1999b). Measurement of delusion ideation in the normal population: Introducing the PDI (Peters et al., Delusions Inventory). *Schizophrenia Bulletin*, 25 (3), 553-576.

Pope, H.G., & Lipinski, J.F. ([1978]2007). Diagnosis in schizophrenia and manic-depressive illness, a reassessment of the specificity of "schizophrenic" symptoms in the light of current research. In C.R. Lake, & N.H. Hurwitz, The schizophrenias, the neuroses and the covered wagon; a critical review. *Neuropsychiatric Disease and Treatment*, 3 (1), 133-143.

Posey, T. B., & Losch, M. E. (1983). Auditory hallucinations of hearing voices in 375 normal subjects. *Imagination, Cognition and Personality*, 3, 99– 113.

- Read, J., (2004a). The invention of 'schizophrenia'. In J. Read, L.R. Mosher & R.P. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia*. (pp21-34). London: Routledge.
- Read, J., (2004b). Does 'schizophrenia' exist?: Reliability and validity. In J. Read, L.R. Mosher & R.P. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia*. (pp43-65). London: Routledge.
- Romme, M.A., & Escher, A.D. (1989). Hearing voices. *Schizophrenia Bulletin*, 15 (2), 209-216.
- Sedgewick, H.A. ([1894] 2003). 'Report of the census on hallucinations'. In R.P. Bentall, *Madness explained: Psychosis and human nature*. London: Penguin Books.
- Singleton, N., & Lewis, G. (2003). *Better or worse: A longitudinal study of the mental health of adults living in private households in great Britain*. London: The Stationery Office.
- Sommer, I.E.C., Daalman, K., Rietkerk, T., Diederens, K.M., Bakker, S., Wijkstra, J., & Boks, M.P.M. (2008). Healthy individuals with auditory verbal hallucinations: who are they? Psychiatric assessments of a selected sample of 103 subjects. *Schizophrenia Bulletin*, 36 (3), 633-641.
- Szasz, T.S. (1993). 'Crazy talk: thought disorder or psychiatric arrogance?' *British Journal of Medical Psychology*, 66, 61-67.
- Tandon, R., Keshavan, M.S., & Nasrallah, H.A. (2008). Schizophrenia, 'just the facts': What we know in 2008. Part 1: Overview. *Schizophrenia Research*, 100, 4-19.
- Tarrier, N., Kinney, C., McCanhy, E., Humphreys, L., Winkowski, A., & Morris, J. (2000). Two-year follow-up of cognitive-behavioral therapy and supportive counselling in the treatment of persistent symptoms in chronic schizophrenia. *Journal of Consulting and Clinical Psychology*, 68, 917-922.
- Tien, A.Y. (1991). Distributions of hallucinations in the population. *Social Psychiatry and Psychiatric Epidemiology*, 26, 287-292.

- Van Os, J. (2009). 'Salience syndrome' replaces 'schizophrenia' in DSM-V and ICD-11: Psychiatry's evidence-based entry into the 21<sup>st</sup> century? *Acta Psychiatrica Scandinavica*, 120, 363-372.
- Van Os, J., Hanssen, M., Bijl, R-V., & Ravelli, A. (2000). Straus (1969) revisited: A psychosis continuum in the general population? *Schizophrenia Research*, 45, 11-20.
- Van Os, J., Linscott, R.J., Myin-Germeys, I., Delespaul, P., & Krabbendam, L. (2009). A systematic review and meta analysis of the psychosis continuum: Evidence for a psychosis proneness-persistence-impairment model of psychotic disorder. *Psychological Medicine*, 39, 179-195.
- Varghese, D., Scott, J., Welham, J., Bor, W., Najman, J., O'Callaghan, M., Williams, G., & McGrath, J. (2009). Psychotic-like experiences in major depression and anxiety disorders: A population-based survey in young adults. *Schizophrenia Bulletin*, 37 (2), 389-393.
- Wiles, N.J., Zammit, S., Bebbington, N.S., Meltzer, H., & Lewis, G., (2006). Self-reported psychotic symptoms in the general population: Results from the longitudinal study of the British National Psychiatric Morbidity Survey. *British Journal of Psychiatry*, 188, 519-526.
- Yung, A.R., Phillips, L.J., Yuen, H.P., Francey, S.M., McFarlane, C.A., Hallgren, M., & McGorry, P.D. (2003). Psychosis prediction: 12-month follow up of a high-risk ('prodromal') group. *Schizophrenia Research*, 60, 21-32.