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“We’re not all dangerous and crazy”. Negotiating the voice hearing identity: A critical discursive approach.

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Abstract

A critical discursive approach examined how the voice hearing identity is negotiated. Conflicting constructions identified voice hearing as distressing but also as a normal experience. The discursive strategies reveal that when individuals who hear voices construct their identity, they must either disavow their own distress to avoid stigma, or accept the stigmatizing accounts of their identity imposed on them if they are to have their distress recognized. The study points to the value and importance of discursive approaches in uncovering unspoken distress in individuals and society, and towards the need to address identity issues in clinical and social interventions.

Keywords: Identity; voice hearing; discursive psychology; psychosis; discourse analysis.

Introduction

Despite the various ways in which the experience of hearing voices has been understood during different historical periods and times, normative descriptions are consistently pathological in nature. Hearing voices has been constructed by psychiatry to be an incurable illness, a disorder, a pathological symptom to be feared by others (Woods 2015).

Being different from the norm is an identity that is accountable implicating issues of power if some have the authority to make decisions over others. People who hear voices, in seeking help, become accountable to the health care system as to whether these experiences pose a threat to themselves or others. They are also made accountable if they are not able to achieve the normative ideals of Westernised culture for example if they are not able to work, be autonomous and independent. The identity constructed for people who hear voices in the media is problematic due to the frequent association of hearing voices with the psychiatric diagnosis of schizophrenia or psychosis and violence, distorting public images of this experience (Fazel et al., 2014). The construction of voice hearing as an illness conceptualises the phenomenon as a social problem in need of control, reinforcing current practices that permeate our institutions.

In recent years new understandings are emerging. Georgaca and Zissi (2019) describe how social factors and the environment impact on perceptions of mental illness, and suggest that empowering discourses that challenge stigma can have a positive influence on individuals' recovery and wellbeing. There are also researchers and clinicians that challenge the view that hearing voices is a sign of madness, suggesting that these experiences can also be understood as dissociative phenomena due to trauma (Longden et al., 2018a). Coupled to this, initiatives such as the hearing voices movement support non-pathological explanations and have inspired the running of local hearing voices groups, which have been found to have positive emotional, social and clinical outcomes (Longden, Read and Dillon, 2018b).

The purpose of this article is to present the findings of a qualitative study investigating how people who hear voices negotiate their identity within the current social setting. In recent years we have seen a rising interest in identity issues with ethnic minority and LGBTQ clients. 2016). Evidenced-based interventions for people who hear voices do not address identity issues and the research attempted to bridge this gap. Current cognitive behavioural interventions focus on altering the way that individuals appraise their voices as a way of managing distress (Morrison, 2017). Psychology's focus on cognitions and how they shape our perceptions and actions came to be challenged in the 80s by the discursive turn to language (Willig, 2013). Language began to be reconceptualised from a means to describe internal states and external reality to having a performative function and the power to construct subjects and objects (Foucault, 1978). Individuals were thought to have a stake in the way they constructed their accounts to accomplish something in interaction. Discourse analysts thus seek to understand what individuals are trying to accomplish with talk by examining the social context in which it is produced. There are power implications in the way that social categories are talked about, having an impact on identity and subjectivity (Benwell & Stokoe, 2006). These discursive assumptions make current interventions for people who hear voices problematic, if they address 'maladaptive cognitions' without taking into consideration the social context and how these experiences are talked about and formed through our interactions with others. It is argued that a discursive approach can offer something more than individualistic models of the self and enables a better understanding of how people who hear voices negotiate their identity.

There is limited research investigating the role of identity in mental health (Howe, Tickle & Brown, 2014; Mawson et al., 2011; Shea, 2010; Yanos, Roe & Lysaker, 2010). Yanos et al. (2010) developed a conceptual model explaining the impact of an 'illness' identity on recovery. They propose a narrative approach to reconceptualise one's life story with themes of personal agency, potential and change that may counteract the negative impact of disempowering narratives of illness. Connell, Schweitzer and King (2014) found that loss of self, resulting from a loss of social roles due to hospitalisation and sickness narratives, can be overcome by adopting a dialogical approach that may lead to an enrichment of the self. Resuming social roles leads to self-consolidation and building a stronger sense of self through others. A discursive approach may further explore this process of constructing an identity through others by adopting a social constructionist approach.

Social constructionists view identity construction as fluid, as residing in the social and continuously negotiated through others and the process of social interaction (Benwell & Stokoe, 2006; Burr, 2003). Voice hearing is a highly-politicised subject and a critical social constructionist approach to identity construction, which takes into consideration the social world and the power of language to form individuals and objects, is considered to answer the following research questions: how do people who hear voices talk about this experience? What resources do they draw upon in the social domain and with what consequences for identity construction?

Method

Participants were recruited from the Hearing Voices Network (HVN) because this setting allows for varied understandings of the experience of hearing voices. The recruitment strategy responded to limitations of prior studies that derived findings based solely on clinical samples with a diagnosis of schizophrenia or psychosis. Eight participants were recruited - 7 female and 1 male participant from a mixture of ethnic, occupational, educational, class and socioeconomic backgrounds ranging between the age of 18-70. The researcher (RA) attended hearing voices groups in London, Hertfordshire and Bedfordshire with the purpose of introducing the research and recruiting participants. Ethical approval for the study was granted by the psychology department ethics committee of City, University of London. Inclusion criteria consisted of persons over the age of 18 with a lived experience of hearing voices. The criteria excluded persons who experienced distress from hearing voices and who may have found attending an interview or talking about their experience of hearing voices distressing. Participants were given the opportunity to withdraw at any time during the process without consequence. Post-interview, a debrief session was carried out to ensure participants did not experience any distress and sources of support were provided.

The duration of the semi-structured interviews using narrative interviewing techniques ranged between 45-60 minutes. Participants were asked to talk about their experience of hearing voices, specifically in relation to the current socio-cultural and political climate. The interview guide consisted of three parts used loosely to give structure and keep focus on the research topic. The first part asked participants about their experience of hearing voices. The

second part examined how participants talk about this experience to others and the third part focused on the meaning that participants ascribe to this experience. Sample questions included: Tell me about your experience of hearing voices. How do you share this experience with others? How do you prefer to describe your experiences? What does this experience mean to you? Data was audio-recorded, anonymised and transcribed by the first author, taking care to remove any potentially identifying information. All data was stored and backed up in a secure location.

Analytic Procedure

A critical discursive psychological approach was adopted within a social constructionist framework and a dual analytic focus combining conversation analysis and poststructuralism (Wetherell, 1998; Edley, 2001). The analysis began by selecting text from the data corpus based on the research questions where participants implicitly or explicitly constructed the discursive object of voice hearing (Willig, 2013). The methodology employed converged on two levels. A micro level analysis of the action orientation of participants' talk looked at what participants tried to accomplish in interaction. This stage of the analysis examined the rhetorical devices that participants drew upon to support the discursive strategies used to negotiate identity. Rhetorical devices are techniques that speakers use to convey meaning with the purpose of persuading the listener. According to discourse analysts, words do not

simply reflect reality and individuals use a number of rhetorical devices for example generalisation to construct their version of events in a particular way (Potter, 1996).

Discursive strategy refers to how someone positions themselves in discourse and with what effect. Who one can be, is dependent on available positions in talk (Davies & Harré, 1990). This is a two-way process because discourses have an impact on individuals and practices, however the way that participants position themselves also serves to reinforce or undermine discourses (Sims-Schouten, Wiley & Willig, 2007). Discursive approaches have been criticised for their inability to account for issues of agency, subjectivity and why individuals chose certain discourses over others, sometimes to their own detriment. Critical discursive psychology is both agentic and deterministic. Despite individuals being determined by discourse, they are creative actors in the way they deploy language and construct accounts to accomplish a purpose (Edley, 2001). One way of defining oneself is through defining what one is not, in contrast to another (Burr, 2003). The process of identity construction involves highlighting and delineating in-group and out-group differences (Wetherell & Edley, 2009). It is this positioning within available discourses where identity work occurs (Davies & Harré, 1990).

What participants were trying to accomplish in talk was determined by looking at discourses (interpretative repertoires) and how individuals positioned themselves in these (Edley, 2001; Billig et al., 1988). This included looking at ideological dilemmas which are inconsistencies and deliberations in talk, for example when participants constructed themselves in contradictory ways within the same interview. The purpose of contrasting

constructions accomplishes a different outcome for participants in each discursive context. It highlights the dilemmatic nature of language, observed in the multiple and varied ways that speech can be composed, depending on the occasion (Edley, 2001; Billig et al., 1988).

Positioning theory was used to identify how participants positioned themselves within available discourses and with what consequences for identity construction (Davies & Harré, 1990). Positioning theory proposes that during the process of social interaction, various subject positions become available for subjects to occupy. This process involves some negotiation, as individuals actively position themselves in discourse and as they do so intentionally or unintentionally position others. Conversational activity and what subjects are trying to accomplish in the interaction drives this positioning having an impact on subjectivity, including identities (Wetherell, 1998). Individuals thus take a more active role in choosing discourse and are not seen to be entirely determined by it.

The aim of the analysis does not take at face value what participants say, as a phenomenological approach might, but attempted to describe what participants are trying to accomplish with their accounts. Inconsistencies in the interpretation of the discursive strategies were attended to by subjecting the text to repeated readings, which were subsequently cross checked with the second author. The selection of these strategies for presentation was based on the frequency with which participants adopted these.

Findings

Participants used two main interpretative repertoires to construct the experience of hearing voices.

- Voice hearing was constructed as a difficult and distressing experience.
- Voice hearing was constructed as a normal, ordinary experience.

Six discursive strategies were identified in negotiating the voice hearing identity described in table 1.

Table 1

Discursive Strategies	
Negative Identity Practices	Positive Identity Practices
Disclaiming Blaming Justifying	Reframing Normalising Trivialising

Of interest is the polarity of these constructions, which was observed sometimes within the same interview. By drawing on the interpretative repertoire of voice hearing as a distressing experience, participants created a division between themselves and non-voice hearing populations by maximising difference in terms of their distressing experience. With the second repertoire of voice hearing as a 'normal' experience, participants used rhetorical devices to normalise the experience of hearing voices and in doing so attempted to achieve a greater level of proximity with the rest of the population. By drawing on this interpretative repertoire, participants minimised difference by constructing their experience as ordinary.

The way that participants negotiated the voice hearing identity was examined by looking at positive and negative identity practices (Bucholtz, 2009). It is how speakers use language to protect their identities (Bucholtz, 2009). Negative identity practices are employed when individuals want to distance themselves from a rejected identity thus emphasize identity as an intergroup phenomenon, whereas positive identity practices actively construct a chosen identity thus emphasize the intragroup aspects of social identity (Bucholtz, 2009).

When constructing their experience as distressing, participants drew on three discursive strategies to disclaim, blame and justify against pathological constructions of voice hearing. These strategies are differentiated from positive identity practices due to the way participants positioned themselves in discourse. To clarify, discourses offer positions that subjects can choose to speak from. For example, Hollway (1984) describes how women are constructed to be the object of the male sex-drive discourse, whereas men position themselves as the subjects of this discourse, which is the dominant position. There are power implications in this positioning as 'Other' oriented constructions serve to intensify in-group/out-group differences and are an important aspect of doing identity work (Wetherell & Edley, 2009). In the current research participants rejected being positioned by others as the object of pathological discourses. These strategies thus exemplify negative identity practices, because they seek to define what voice hearers are not by rejecting pathological notions of voice hearing and distancing themselves from negative constructions in the social domain. These practices are a struggle over identity because participants are rejecting the identity on

offer. The problem with these strategies is that they are overt, easily challenged, and less credible as the participants' stake is evident in the accounts produced. Others could argue that voice hearers have a vested interest in constructing themselves in this way. The discursive strategies of disclaiming, blaming and justifying will be discussed next.

Negative Identity Practices

Disclaiming

Participants adopted this strategy to disclaim pathological constructions of voice hearing in the social domain when they perceived their identity to be under threat for example when voice hearing was associated with pathological labels and notions of dangerousness. This strategy is other-oriented because current discourses construct voice hearers as the 'Other' in comparison to the norm. Such constructions do not allow participants to construct their identity in a preferred way; on the contrary they construct the experience in a negative light. By using this strategy participants are outright rejecting the identity on offer.

R: How would you tell someone about your experiences? **Neve:** "...I will just sometimes lash out if somebody says something derogatory or inappropriate about people with psychosis or schizophrenia or, you know, but I will just say 'I, you know, I've got schizophrenia, or I've got schizoaffective disorder or I hear voices' or something, you know, if it just comes up just to make everyone go 'Oh' and then I get a bit of air time to say 'We're not all dangerous and crazy and this article that you're reading is completely written wrong'. Look at this".

Neve draws on a personal footing and uses direct speech ("I will just say...I've got schizophrenia") to add credibility to the account. Rhetorical strategies (Potter, 1996) such as generalisation/extreme case formulation 'all dangerous and crazy' make her account more

persuasive and rouse emotion in the audience. Neve is also drawing on a psychiatric diagnostic discourse, but she uses it here for her own aims by implicating this in the 'dangerous and crazy' construction.

Blaming

Participants used this strategy to blame others thus becoming less accountable. They inadvertently constructed themselves as moral agents in comparison to others who are viewed in a negative light. The strategy apportions blame to others for negative constructions of voice hearing in the social domain (the media, institutions, health professionals, pharmaceutical companies). It is not simply an attempt to reject pathological notions of voice hearing as the previous strategy attempts to do. The action orientation of talk specifically puts the blame on others making them accountable. Again, this strategy is other-oriented because participants constructed themselves in relation to what they are not and in direct comparison to others, who for example are constructed as not understanding and not knowing.

R: So, what was the message you wanted to get across to people?

Anna: "...They were talking about Stephen Fry there one day; this was a while ago, when it first came out. And they said 'Wouldn't want to marry him. He's got bipolar'. And I thought 'You're all so ignorant'. And then somebody else said ah 'Of course she suffers from depression, oh well she wants to pull herself together'. Things like that, you don't get the understanding. So, I'm not likely to go around telling everybody".

Anna uses direct speech as a rhetorical device to make her account more vivid and believable.

She adds detail and validity to the account using speech quotes that makes what she says hard to dispute. She also uses an x leads to y argument to present her account as self-evident.

Justifying

This strategy makes participants less accountable by justifying themselves, when confronted with constructions that may challenge or place their identity under threat. This strategy is adopted particularly in situations where their actions seem to reinforce pathological constructions of voice hearing thus making participants accountable. It is a way of distancing themselves from negative constructions of voice hearing by justifying why they do not conform to available constructions.

R: What did it mean to you to be part of that? **Anna:** "...I have been abusive myself and people have kept out of the way from me. But the thing is I'm more frightened of them, than they are of me really. That's what we want to get the voice across, because all you hear about in the papers is 'Paranoid schizophrenic, stabbed somebody', and so on and so forth and been arrested and they're usually down on the ground or something being manhandled by the police. And it's probably the voices telling them to do it. And they're more frightened of the police than anybody needs to be frightened of them. Cause I've been known to carry a knife but I didn't know that I was doing it. Do you know what I mean? Afterwards someone's told me and I couldn't believe it was me. It's like you're a different person, but you're very frightened. Cause hearing voices is frightening".

Anna states ("do you know what I mean?") to check understanding and present the account as self-evident. She uses the rhetorical device of disclaiming (Potter, 1996) to disavow what she subsequently advocates 'I have been abusive..., but...' She is thus acknowledging and addressing a potential counter-claim. She also constructs others as more frightening in comparison to her, constructing herself as a moral agent who is frightened of others and the voices, therefore is not accountable for her actions.

The following section discusses the discursive strategies of reframing, normalising and trivialising.

Positive identity practices

The discursive strategies employed to construct voice hearing as a normal and ordinary experience, resulted in normalised accounts that minimised and reframed pathological notions of this experience. Participants used these strategies to define what voice hearers are like. In doing so they attempted to bring themselves into closer proximity with the rest of the population. These strategies are self-oriented, because participants positioned themselves as the subject of these constructions. They are thus positive identity practices because they struggle over shared values and seek to delineate what voice hearers are like. These strategies are more effective than negative identity practices, because they are covert, participants' stake in these constructions are not as evident and are thus harder to challenge.

Reframing

Wherever possible participants attempted to reframe their experiences in ways that allowed for a less problematic identity for example they constructed themselves as atypical members of pathological categories relating to the experience of hearing voices. The discursive strategy of reframing allowed them to distance themselves from a position that is potentially problematic and particularly one that does not enable possibilities for action. Watzlawick et al. (1974) describes this strategy as a new interpretation given to a problematic situation (cited in Rhodes, 2014). Reframing involves restating a situation so that it may be perceived in a new

light. In the following extract Lauren constructed herself as an atypical member of the mental health diagnosis of schizophrenia or psychosis.

R: What did you mean pseudo psychosis?

Lauren: "Well a psychiatrist explained to me years ago, that because I could recognise my hallucinations as hallucinations, they weren't true psychosis. Now I get delusions, which I believe are true. I don't see them as delusions, so if somebody, psychiatrists, wants to argue they are delusions I would debate that with him or her. So, they could say I'm psychotic on that. But the hallucinations, I can see as hallucinations so they're called a pseudo psychosis, not a total psychosis".

Lauren uses category entitlement (the psychiatrist) to make her account more credible by drawing on a psychiatric diagnosis as evidence for her claims that she is not psychotic, thus making it difficult for others to dispute her account. At other parts of her interview she constructs psychosis as a potentially dangerous illness drawing again on a psychiatric discourse.

Normalising

Participants used this discursive strategy to construct the experience of hearing voices as a normal, ordinary experience to reduce perception of difference and otherness, by establishing a level of proximity with the rest of the population (Wetherell & Edley, 2009). This strategy is self-oriented because participants provide alternative constructions to voice hearing from pathological ones by attempting to define what voice hearers are like. The strategy aims to bring voice hearers into closer proximity with the rest of the population by establishing shared values.

Neve: “Well it is normal but it’s not seen that way I don’t think by other people”. R: How do you think it is seen by others? **Neve:** “...Either it’s scary cause you might be dangerous or it’s scary cause it’s completely weird and people just can’t understand what I’d be like so they just kinda like ‘I can’t relate the inside of my head to the inside of your head’, which is really bizarre, cause the inside of my head works in a similar way to well everyone, the inside of everyone’s head is pretty weird. And whenever you find out something about somebody’s ways of thinking or beliefs and things, you’re like ‘What? It doesn’t make any sense!’ So, everyone’s different and weird and I don’t think, you know, I relate it quite often to my voices, are quite often troublesome to me in the night? That, you know, If I’m stressed, they’ll wake me up at like 3 in the morning, and kind of make lots of noise, but I know from other people that don’t hear voices, that when they’re stressed, they wake up at 3 o’clock in the morning with their thoughts racing round in their heads. And that’s completely normal. And I’m like ‘Well it’s not so different from that!’ It’s just like, my body and my brain reacting to the fact that I’m stressed and disrupting my sleep. And for you it’s your thoughts, for me it’s the voices”.

Neve uses extreme case formulation (“completely weird”, “completely normal”), direct speech quotes, and generalisation (“everyone’s different and weird”) to strengthen the assertions made. She adopts a personal footing to talk about her own experience adding credibility to the account (“I relate it quite often to my voices”).

Trivialising

Participants used this discursive strategy to minimise the distress they experience. What these constructions accomplish for participants is to allow them to remain in control, save face and reassure others. One of the strategies adopted is to use humour to cope with difficulty (Gelkopf, 2011). The alternative would mean participants having to face their reality and acknowledge the sometimes very distressing and severe consequences that the experience entails for themselves and others. Thus, distress in this strategy is omitted and not

spoken about. Trivialising is a common strategy adopted to manage guilt (Gelkopf, 2011; Scott, 2007).

R: Can you tell me a little bit more about that? How it helps you? **Lauren:** “It helps me by not taking things too seriously at least in the moment of time that I’m using humour. It also helps me help others. By letting them know that I’m ok. Just that I know that one friend in particular worries a lot about me, cause I’m most honest with her, so if I take the piss out of myself it means she doesn’t have to worry as much. Yea I mean, I wanna take the piss out of myself because it’s sad. It just it makes it easier. It’s so hard and dark so much of the time”.

Lauren uses extreme case formulation and generalisation to make her account more persuasive and effective (“a lot”, “most honest”, “It’s so hard and dark most of the time”).

Throughout the analysis attention was placed on the rhetorical devices that participant used, the action orientation of talk – what participants tried to accomplish with their talk, and the wider resources in the social domain that they drew upon to construct their accounts.

Discussion

All participants drew on both interpretative repertoires in constructing identity. On the one hand they constructed voice hearing as a distressing experience and on the other as a normal, ordinary experience. These repertoires are contradictory; the former is associated with denigration and the latter with idealisation. Reynolds & Wetherell (2003) speculated that marginalised social categories often involve managing both denigrating and idealised positions

simultaneously. There is an impact on the identity of voice hearers when there is an absence of collective methods of dealing with denigration, if positive constructions are overshadowed by dominant denigrating ones. Participants showed an investment in such practices and their actions were choices; some reproduced the social structure whilst others undermined it.

As we have seen, the identity of being a voice hearer is contested and negotiated, like all identities, and this was achieved through positive and negative identity practices. The consequence of having to negotiate these conflicting ways of constructing voice hearing involves delicate footwork in identity work and in specific negotiating category membership (Reynolds & Wetherell, 2003). Categorisation is crucial to identity work and involves attending to insider and/or outsider issues where individuals can only define themselves in comparison to others (Bucholtz, 2009). By using the discursive strategies of disclaiming, blaming and justifying, participants attempted to define what voice hearers are not. It is what we expect from participants from a stigmatised group in trying to negotiate a 'spoiled' identity (Goffman, 1976). These strategies are negative identity practices that distanced participants from the pathological labels of schizophrenia or psychosis. They demonstrate a struggle over identity itself, which in this case is rejected. For example, this was observed when participants attempted to create binaries between 'good' and 'bad' people, where violence was associated with 'bad' people as opposed to the experience of hearing voices. Hearing voices therefore becomes irrelevant to the use of violence and is dependent on whether one belongs in the

‘good’ or ‘bad’ category. This tendency to formulate the world through binaries is a discursive technique that intensifies notions of otherness (Wetherell, Taylor & Yates, 2001).

On the other hand, participants actively chose to identify themselves as voice hearers and through positive identity practices attempted to normalise these experiences, for example by constructing people who hear voices as ordinary people, who work and get on with their day to day lives just like everyone else, despite hearing voices. The construction of voice hearing as normal and ordinary is a positive identity practice where the shared values of the group are worked over. In order to achieve this however the distress that voice hearers experience is omitted from these accounts. It is not talked about and this is a cause for concern. The strategies identified highlight the intense discursive work required to negotiate the identity of being a voice hearer. It is a problematic identity. The question remains whether it is possible for participants to draw upon the more positive and idealised repertoires, without having to construct themselves as atypical category members or minimise the distress they experience at their own expense. The discourses of pathology and danger often associated with these experiences are hard to resist, particularly as they inform our institutions and practices. Talking about the distress associated with hearing voices and seeking support results in pathological labels being attached to these experiences and individuals being subjected to interventions (pharmacological or other) to treat the ‘disorder’.

The discursive strategies highlight the lack of positive resources in the social domain that may allow participants to construct their identity in preferred ways. It is argued that even

non-pathological discourses such as recovery-based-approaches (McCabe, Whittington, Cramond & Perkins, 2018) and constructing voice hearers as victims of trauma (Moskowitz, Mosquera & Longden, 2017) are not necessarily emancipatory in nature and serve to reinforce the status quo continuing to marginalise those in distress. It is difficult for some to attain recovery if they do not have access to resources that will enable them to do so, for example gaining access to job opportunities and maintaining friendships. These discourses divert attention away from social causes of distress by locating problems in the individual, while other more critical discourses, such as anti-psychiatry, are rejected (Cromby, 2016).

Participants want their experience of hearing voices to be viewed more positively. However, this becomes problematic if they cannot identify themselves as voice hearers due to the stigma associated with hearing voices, leading to the distress they experience remaining unspoken. There is a desire to attain 'normality', which is difficult to accomplish with current pathological discourses that serve to preserve the status quo and the existing social order. These barriers to constructing a preferred version of self, have a negative impact on identity and should be addressed in interventions for people who hear voices. Notably as an important theme found in a meta-synthesis of the subjective experience of people with 'psychosis' was loss of self and the need to re-establish a sense of self through others (McCarthy-Jones et al., 2013). Howe, Tickle and Brown (2014) also identified a dilemma between having to accept or reject the diagnostic label of schizophrenia as part of one's identity (Howe, Tickle & Brown, 2014). There are consequences if distress remains unspoken; individuals may not seek help,

they may disengage from sources of support, they may suffer in silence sometimes with severe consequences. The potentially negative effects can be seen to be particularly relevant in the context of certain promising new treatment initiatives that propose when voice hearers are encouraged to take a dialogical approach to talk about their voices, can lead to a meaningful reduction in distress. (Romme et al. 2009; Suri 2011; Place, Foxtrot & Shaw, 2011). It is important for voice hearers to be able to talk freely about their experiences without fear of negative consequences

When asked about their experience of hearing voices, participants chose to position themselves in normative accounts of the experience and rejected pathological notions. A discursive approach allowed for a deeper understanding of the strategies used through language to do identity work. It provided an alternative perspective to thinking about the experience of hearing voices and current interventions on offer that consider this experience to be pathological. If changes can be made to the way that voice hearing is understood by the public and professionals, then people who hear voices may find it easier to be open about their experience. The critical discursive approach highlighted this unspoken distress bringing these issues to the forefront.

Application, limitations and future research

The discursive strategies identified reveal how participants negotiated the voice hearing identity. The way that these experiences are talked about has consequences. The disclaiming, blaming and justifying strategies reject pathological constructions of voice hearing.

They are not effective in constructing a preferred identity because they are explicit and highlight participants' stake in the accounts produced. They could easily be challenged by others. They also serve to create division between voice hearers and others. The normalising, justifying and reframing strategies on the other hand are implicit and not as easy to challenge. They allowed participants to come into closer proximity to the rest of the population resulting in a more positive identity. However, adopting strategies that construct a 'normalised' account of voice hearing reinforces the power of normalisation and what is perceived to be the norm, preserving the status quo (Foucault, 1978). The norm is not subjected to critical analysis and those who cannot attain this ideal continue to be excluded and marginalised from society. Furthermore, adopting this strategy diverts attention from the societal causes of distress; unemployment, isolation, crime, lack of opportunities and depleting resources. The discursive approach used in this study uncovered this unspoken distress. More organised efforts need to be made by the media and institutions to enable voice hearers to talk about their distress.

These findings shed light on the ideological patterns present around the experience of hearing voices that may allow the construction of alternative views. It has been suggested that working against a preferred sense of self can be damaging for identity (Brown & Augusta-Scott, 2007). Identities can be profoundly political and sometimes serve the interests of the dominant social order. We need to challenge these concepts, including the discourses that inform our own clinical practice if we are to enable people who hear voices to construct preferred identities that are not damaging. Working towards a preferred identity should also

be included as part of our interventions with people who hear voices. This is not currently being addressed in research or interventions for voice hearers and presents a gap. This may include taking an outside-in approach to therapy including a critical examination of the broader discourses of voice hearing in society and constructing a preferred, multifaceted identity that is not solely based on a model of illness and pathology.

We should neither enforce our theoretical models on people who hear voices, nor prescribe the right way to be or live. What we can do is initiate a dialogue between the self and others that may lead to an enriched sense of self, enabling people who hear voices to construct a preferred identity (Lysaker & Lysaker, 2010). Guildfoyle (2014) describes this process as offering escape routes to oppressive ways of being. Professionals may thus support people who hear voices in the lives they want to pursue. Such attempts are meaningless if we do not engage in political action to reduce the stigma associated with voice hearing and make more profound changes to the way that these experiences are understood, medicalised and treated in society. Examining the way in which individuals negotiate or resist identities will have limited effect if we do not take into consideration the cultural meanings and structures that impact on agency and limit potential for change.

Limitations

The discursive strategies were determined by taking into consideration the surrounding text, which was omitted here making it difficult to validate findings. However, the dual analytical approach combining methods from two theoretical traditions

(ethnomethodology and Foucauldian discourse analysis) provided a more comprehensive analysis adding validity. It is acknowledged that the data analysed by the researcher (RA) were not generated in a natural setting, thus participants may be orienting to the interview situation particularly as they viewed this as an opportunity to disclaim pathological notions of this experience. In addition, the researcher's prior experience or working with people who hear voices in the NHS will have an impact on the knowledge produced. No attempt is made to generalise findings, which have been co-constructed between the researcher and participants. Further research is suggested to explore the discursive strategies that people who hear voices adopt in different settings other than the HVN, to investigate whether they adopt similar or different strategies to those observed in the current research. It is possible that the normalising strategies that participants used were influenced by their association with the HVN which encourages different understandings of voice hearing, but other contexts may offer fewer possibilities to construct a preferred self.

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