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A discursive approach to narrative accounts of hearing voices and recovery.

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Substantive Objective: To research the range of discursive constructions 'recovered' voice hearers employ to describe hearing voices and the implications for positioning and subjectivity (what can be thought and felt) using each construction.

Methodological Objective and Method: To explore a 'sympathetic' application of Foucauldian discourse analysis, adapting Willig's (2008) method, analysing two published accounts.

Results and Conclusions: Heterogeneous discursive constructions for talking about hearing voices were identified, including: 'many-'selves'', 'taking-the-lead-in-your-own-recovery', 'voices-as-an-'imagined-world'' and 'voices-as-a-coping-strategy-for-dealing-with-trauma'. The discourse of the biomedical model was not prominent, suggesting alternate discursive constructions may create subjects with a greater capacity for 'living with voices' and create a subjectivity from which vantage point the experience holds meaning and value and can be integrated into life experiences. This research may have useful clinical applications for mental health services aiming to collaboratively explore service users' ways of understanding hearing voices.

Keywords: discourse analysis, service user perspectives, recovery.

Introduction

A focus on recovery is currently popular, but it's definition is contested (Pilgrim, 2009). Traditional approaches define recovery as an absence of symptoms, but a perspective developed primarily in service user movements presents recovery through notions of empowerment, coping skills, optimism and self-esteem, regardless of symptoms

(Romme & Escher, 1993). Research into a 'sealing over' or 'integrating' style of recovery (McGlashan *et al*., 1975), indicate 'sealing over' (in which the experience is afforded little personal relevance), is associated with a greater tendency to become depressed (Drayton *et al*., 1998), opposed to the 'integrating' style (affording the experience personal significance). 'Integrating' significantly increases the odds of remission at 1-year follow-up compared to 'sealing over', independent of symptom levels, insight, or therapeutic alliance (Staring *et al.,* 2011). Attitudes towards the experience can influence distress levels (Romme & Escher, 1993), and coping strategies enacted (Carr, 1998). Stainsby, Sapochnik, Bledin & Mason found higher quality of life in service users with a greater ability to make sense of symptoms and fewer expectations of negative life consequences from psychosis, and suggest "helping clients to build a more coherent sense of their difficulties may be at least as important as.. aim(ing) to reduce symptom levels" (2010).

Clinicians who support clients to author the experience may encourage an integrating style. However, clinicians may fear 'exacerbating the psychosis', or experience difficulties working with ideas which seem juxtaposed to professional perspectives, whilst resisting 'telling' clients how to interpret the experience. Geekie (2004), using grounded theory, analysed client's understandings of psychotic experiences, demonstrating that first-episode clients actively author their experience, and appreciate working collaboratively to develop shared meaning.

This work analyses published accounts of 'recovered' individuals, according to a definition of hearing voices no longer causing psychological distress (Romme *et al*., 2009), with the aim of exploring the utility of different ways of constructing the experience. The range of ways of talking about hearing voices, and their implications for positioning and subjectivity (what can be thought and felt) is under-researched, and

may present a valuable clinical resource, supporting clinicians' confidence to explore with service users the implications of different understandings of voice hearing, contribute to psychoeducation, and inform research looking at 'recovery' and heterogeneity in recovery.

Method

This paper presents two narrative accounts analysed as part of a year-long project into recovery in psychosis.

Sampling Procedure and Subjects

Theoretical sampling (Harper, 2006), selecting authors drawing on different discursive resources was used, with a particular focus on 'thick description' (rich details), (Geertz, 1973). 2009 brought a plethora of narrative accounts in Romme *et al.*'s '50 stories of Recovery'. Journals were searched to provide contrasting sources published in the same year, accounts from '*Psychosis*' and '*Schizophrenia Bulletin*' were originally analysed. Due to length restrictions, only two analyses of three analysed are presented. In discourse analysis (DA), small samples are common as analysis involves exhaustive coding of small amounts of text. The accounts were selected for offering strong, and differing 'thick descriptions' of the lived experience of hearing voices.

Ethical considerations

The public domain convention suggests this research is ethically unproblematic. However, the very personal nature of the accounts, potential vulnerability and disempowerment of the authors problematises this convention. The authors cannot be effectively anonymised as search-engines may identify the source of quotes, exposing authors (Eysenbach & Till, 2001). Romme & Escher (1993) suggest recovery involves

proudly adopting the identity of a voice hearer, and the authors, who have published in their own names, may concur. As such, disguising their identities is both impractical and inappropriate.

These considerations suggest conducting an analysis without consent is acceptable, but publishing an analysis without consent is unacceptable. Additionally, a preliminary analysis seems necessary to facilitate informed consent, and authors were asked to consider anonymity issues. This analysis was validated by both authors.

Methodology

The theoretical perspective of critical psychology (Hepburn, 2003), a social constructionist epistemology (Gergen, 1985), and a critical realist ontology (Parker, 1992) were adopted. Social constructionism is a broad framework characterised by: (i) considering knowledge to be socially, culturally and historically specific; (ii) conceptualising knowledge as sustained by social processes and a social action linked to power, and (iii) doubting the taken-for-granted world (Gergen, 1985). Social constructionism is often paired with relativism (doubting the existence any underlying, singular 'reality') or critical realism. Critical realism acknowledges language constructs versions of underlying material and social structures (institutions/conditions), which limit the possible range of meanings, 'grounding' the versions of reality that discourse constructs (Parker, 1992). Critical psychology (Hepburn, 2003) is critical of psychology itself, (questioning practices, assumptions and influences), and critical of society (institutions, organisations, or practices). As readers may be unfamiliar with the methodology, a brief description is given.

A discourse is "a system of statements which constructs an object" (Parker, 1992). When analysing a text, one should expect to find parts of discourses (not complete discourses). Heterogeneous DA methods exist. This research adapts Willig's

(2008) method, designed for written sources, to focus on the effect for the speaker, rather than the audience. To illustrate, discourse analysis often asks 'how does this discourse limit and control what others may do and say?', whereas this research asks 'how does this discourse affect what the speaker can think and feel?' Specialised terminology includes 'discursive construction' – how the object (in this case hearing voices) is 'brought into being' through language using implicit and explicit references, 'action orientation', referring to what is achieved by different constructions, 'position', the implications in terms of rights and duties, 'practice' – the way constructions and subject positions open/limit what can be done/expressed/inferred, and 'subjectivity', the implications for what can be thought/felt. To summarise, the analysis uses the broad principles of social constructionism and applies the relevant features of Willig's (2008) DA method.

Results and Analysis

A description of each author briefly introduces the accounts. Each construction is analysed separately; source references are abbreviated using the line number. Antaki *et al.'s* (2003) quality criteria for DA was used to critique the analysis, suggesting high quality. The full analysis is available on request. Concluding remarks summarise the research.

Olga:

Olga's account (Runciman, 2009), was published in Romme *et al*. (2009). Olga lives in Denmark, was training to become a psychologist when she first contacted mental health services (242), works with voice hearers (232-234), and is prominent in the Danish Hearing Voices Network (234-237). Two constructions of voice hearing were

prominent in Olga's account. These were: having-many-'selves', and taking-the lead-in-your-own-recovery.

Having-many-'selves'

Olga constructs herself as having many 'selves'. Her account is subtitled "The voices of me!" (1), implying ownership of the 'voices' or 'selves'. Olga describes the journey of recovery as uniting these 'selves':

> "With him (Olga's 'God' voice) I began the journey of union, uniting the fragments, joining each piece of me to me, to finally become whole, become me, become Olga." (112-113).

This extract indicates the voices are parts of 'herself', and 'uniting' them equates to recovery. This construction resonates with Stone & Stone's (1989) discourse of personality which suggests we have many different selves: an 'aware ego' and multitude of 'sub-personalities' or 'selves', (e.g. critic, joker, carer), who experience life in different ways. An 'aware ego' may be able to balance these 'selves'. Stone & Stone suggest particularly demanding environments may encourage more powerful 'selves' (pusher, perfectionist, parent) to dominate the consciousness, and the 'aware ego' may cease to 'listen' to less powerful 'selves'. For example, 'selves' strongly associated with vulnerability (e.g. child) may be suppressed, as awareness of one's vulnerability can be anxiety-provoking. They propose emotional wellbeing is contingent on balancing these 'selves', and that voices may represent disowned 'selves'. Stone & Stone's construction portrays hearing voices as not especially different to the internal tensions of people who don't hear voices. Their approach is influenced by Jungian psychoanalytic principles

(ibid). This discourse is popular within the hearing voices movement, informing the voice dialogue therapy technique (Corstens, Escher & Romme, 2008). Olga draws on this discourse when she writes:

> "together, we created me, a fragmented child, who became a fragmented adult, who finally became whole, became me, became Olga." (4-6).

This extract describes separate selves as 'fragmented' (implying distress), and balance between the selves as 'becoming whole', resonating with Stone & Stone's discourse of personality. Stone & Stone's discourse of personality explicitly draws on a discourse of interpersonal relationships. A discourse of interpersonal relationships constructs others as potentially enriching or damaging to one's wellbeing, describing changeable relationships of power, status, control, and allegiance. This discourse can construct relationships as difficult yet potentially rewarding, and everyone as existing within social relationships (Hogg & Vaughan, 2002). The construction of having-many-'selves' is prominent during the first half of Olga's account. The action-orientation of this construction allows Olga to construct pain from her voice's words as 'real' anguish: "saying terrible things which hurt, cutting like a knife into the soft part of me" (56-57). Using this construction, Olga can explain their effect on her emotional wellbeing, and how this relationship caused her to self-harm: "they came in, sneaking in like thieves in the night, stealing my soul, filling my world with blackness and hatred... causing me to burn my tongue and cut my arms" (37-42). The relationships also threaten her survival: "How could I survive them" (3). From within Stone & Stone's discourse of personality, an imbalance of 'selves' can "easily destroy us" (1989). The implications for practice may be that Olga can describe her experiences (what she heard, how she felt) and

present managing the voices as difficult. The implications for subjectivity of this construction may be that Olga thinks and feels her experiences are relatively normal – as emphasised in the discourse of Stone & Stone (1989).

Taking-the-lead-in-your–own-recovery

Olga also constructs voice-hearing as something for which service users should 'take-the-lead-in-their-own-recovery'.

> "So how did I recover? By looking death in the eye... I could not leave this earthly world on a lie. I wrote: 'I have tried everything' - but I hadn't. I had not done it my way, so busy was I listening to others – the so-called 'experts' – experts who, in reality, are as much in the dark about suffering of the mind as the sufferers themselves." (176-182).

She continues to describe preparing a "plan" (182), organising therapy, despite advice to the contrary from the healthcare providers (185-193), coming off medication and feeling better for the change "I didn't feel worse, I felt alive" (207-208). This construction resonates with a discourse of 'do-it-yourself'. Do-it-yourself has been described as a philosophy which challenges cultural hegemonies, and questions passive 'consumer' roles, and 'needs' constructed by 'experts' (Triggs, 2006). Do-it-yourself healthcare (self-care) comprised part of the feminist movement, who highlighted the hazards of professional healthcare services (Boston's Women's Health Book Collective, 1971), and objected to the 'pathologising' of normal femininity (Levin, 1995). Levin remarks "the do it yourself vaginal examination using a speculum became the symbol of their (feminist's) struggle." (1995). In the late 1990s, the wider focus of the medical establishment shifted from compliance (obedience), to concordance (jointly agreeing treatment) (Mullen, 1997). However, in mental health, medication adherence is often the goal, treatment can be forced, and ethical implications are often ignored

(Vuckovich, 2010). This construction, ‘taking-the-lead-in-your-own-recovery’ also resonates with a postmodern and post-structural loss of faith in the scientific narrative (Rotblat, 1999). This discourse questions science’s ability to self-regulate, and it’s claims of ‘value-free’ (i.e. neutral ethical) research. This discourse questions the dominant role of scientific ideas in policy-making, highlighting examples of science having a detrimental effect for humanity.

The action orientation of this construction changes the focus to recovery, and enables Olga to emphasise the importance of making her own decisions. This construction positions Olga as the most suitable person to manage her own mental health, yet also positions Olga as able to benefit from support from others:

> “My therapist could see a difference in me – that I was serious (about recovering and therapy) and it filled her with hope, my hope, hope that began to move back into me giving me strength and light...” (190-192).

This extract demonstrates how the construction of ‘taking-the-lead-in-your-own-recovery’ is not incompatible with receiving support, portraying helpful encounters with healthcare professionals. The implications for practice may be justifying ‘cherry-picking’ advice from professionals. From within the discourses of postmodern and post-structural loss of faith in the scientific narrative and do-it-yourself healthcare, this may be constructed as a reasonable action. The subjective implications may be that Olga can think and feel she has managed her own recovery, and feel proud of this. Additionally, it may enable Olga to think service users are the best placed to determine their care, and that collaborative support from healthcare professionals may be helpful.

Debra:

Debra's account (Lampshire, 2009) was published in the present journal. Debra lives in New Zealand, works in mental health, and has academic publications. Debra primarily uses the constructions of 'hearing-voices-as-an-'imagined-world'' and 'a-coping-strategy-for-dealing-with-trauma'.

Voices-as-an-'imagined-world' (132)

Debra describes her experience of hearing voices as an 'imagined world' (132):

> "...the visitation to the world of fantasy (named psychosis by mental health services) was to remain, and I became rather than a weaver of stories, an embroiderer. I had the ability to fill in all the gaps, not to leave out details... This is how you become convinced of the magic, by filling in the gaps with the minute details which give it life." (133-139).

This extract describes hearing voices as 'filling in gaps', influenced by Debra's imagination. This 'imagined world' is constructed as "stemming from pure, unadulterated fear" (144-145), and is analogous to a physical place: "This realm was to be my future where I would live for eighteen years" (153-154). Debra describes how inhabiting the 'world' inflicted emotional pain: "I was governed by voices who told me lies and truths, and both were delivered with brutality and inflicted wounds that scarred me forever" (154-155). This 'world' was so overwhelming Debra felt the only escape was suicide:

> "I came to the conclusion that I couldn't do this anymore. I had had enough. I was going to take my own life to bring it all to an end" (175-176).

The extract above demonstrates the power and intensity of her 'imagined world'. In addition to these negative aspects, Debra also highlights the value of the 'imagined

world' as a 'survival skill', connected to 'creativity' and 'productivity':

> "There are so many things which do not require explanation as a child, and the accumulation of explanations contributes in no small way to the loss of innocence and the idea of magic, which makes all things possible... I wish to be free to allow my mind to be creative and productive" (261-263).

This extract, and this construction, draw on a discourse of creative thinking and the power of imagination (Galindo, 2010). This discourse constructs imagination as able to transform our world and our lives, as innate, but often discarded in adulthood (Galindo, 2010). Leudar & Thomas's (2000) historical review analyses the changing social constructions of voice hearing, and argues it is "no more insane than other psychological faculties such as thinking, imagining or seeing and no more indicative of psychopathology than these psychological faculties", making explicit the similarity of creative faculties and hearing voices, clearly resonating with Debra's construction of hearing voices as an 'imagined world'. There has long been a discourse linking some aspects of 'madness' (hallucinations, mania) to 'genius' and creativity (Burton, 2009).

The action-orientation of this construction may be to suggest hearing voices is 'natural'. Debra writes: "The ability to visit a private realm in your head is an essential, even natural part of thinking" (266-267), again echoing Leudar & Thomas (2000). This discursive construction appears to position Debra as 'not mad' and as a 'creative person'. The implications for practice of this construction may be that techniques which reduce stress (226) and anxiety (186-199, 210-213) are useful for reducing the need to 'retreat' to an 'imagined world' (274-275). Further implications for practice may be that all of us could hear voices, and hearing voices is not necessarily part of a biological psychopathology. The implications for subjectivity may be that Debra thinks and feels that hearing voices is not a biomedical condition, and that, although she was distressed, she was not ill.

Voices-as-a-coping-strategy-for-dealing-with-trauma

Debra also constructs hearing voices as a coping-strategy-for-dealing-with-trauma. She describes "Seeing the madness as a 'coping strategy', rather than a 'biomedical response'" (7-8). This construction is prominent in the first half of her account. Debra reports many traumatic experiences, including sexual abuse (47-49), emotional abuse [she was "isolated and marginalized by her peers", (73)], and rejection (28-45). Debra highlights five 'lessons' to do with lies (45, 60, 88, 317). For example:

> "It is alright to become a lie as long as the truth is kept secret" (78).

The above extract illustrates Debra's difficulties living in a traumatic environment, drawing on a wide discourse of childhood abuse and family dynamics causing trauma (Read, Goodman, Morrison, Ross & Aderhold, 2004, Shelvin *et al*., 2007). Specifically, Debra draws on a Laingian (Laing & Esterton, 1964) discourse of psychosis as a valid response to ontological insecurity (a state of questioning the aliveness, autonomy, realness and identity of the self and others). Laing and Esterton (1964) suggest ontological insecurity arises from a childhood spent in a family which utilises lies to manage family politics. In such a family, it can be impossible to determine the truth, or the truth of one's situation. Laing and Esterton (1964) suggest psychosis is a logical response to this environment.

The action-orientation of Debra's construction of 'voices-a-coping-strategy-for-dealing-with-trauma' may be to propose an external environmental aetiology, suggesting this could happen to anyone exposed to similar traumas. Using this construction, she cannot be culpable (biologically or through a degenerate lifestyle) for her mental health problems. Debra's positioning, using this construction, is as a victim, in a passive role:

> "...my fate would always be controlled by others and their opinions and judgements of me would determine my life." (38-40).

The implications for practice of this construction may be that other ways of coping with abuse are needed and to suggest the possibility that psychological distress following difficult environments should be expected, directly resonating with the discourse of Laing & Esterton (1964). The subjective implications of this construction may be that Debra thinks and feels she is not to blame for her distress, and thinks and feels like a 'survivor' of many different kinds of trauma.

Discussion and Conclusions

The two accounts may occasionally appear to undermine each other: Debra's statement 'my fate would always be controlled by others' may seem to undermine Olga's words 'together we created me'. Similarly, one construction may seem to contradict itself. For example Debra's construction 'hearing-voices-as-an-imagined-world' sometimes seems rather 'pleasant' and 'free', yet at other points very unpleasant. However, these accounts convey *journeys* of recovery, and constructions which can explain why it was distressing and why/how the situation improved may be useful, to retrospectively describe different stages of the journey. For example, within Stone & Stone's discourse, a malleable relationship with voices is expected, which may be negative or positive at different times. Debra's construction '*Voices-as-an-imagined-world*', for instance, re-designates 'symptoms' as 'not mad', drawing on the discourses of imagination and Leudar and Thomas (2000). Similarly, Olga's construction *'Having-many-'selves',* draws on Stone & Stone's discourse to construct her experiences as analogous to everyone's internal tensions. Complimentary constructions can strengthen each other –

Debra's '*voices-as-an-'imagined-world*'' and '*voices-as-a-coping-strategy-for-dealing-with-trauma*' seem to work well together – the trauma suggesting the need to retreat into the 'imagined world'. Similarly, Olga's '*taking-the-lead-in-your-own-recovery*' compliments the idea of integrating the '*many-selves*'.

I felt reluctant to do more to compare the accounts, as it seems ethically problematic to privilege one account, and privileging one account does not necessarily make sense - DA does not offer a singular 'best way' to talk about hearing voices and 'finding' and suggesting the 'imposition of' a 'correct' way contradicts the aim of putting service user's voices centre stage.

Whilst this may create a 'polite diversity' of different monologues, it also creates space for service users to share and explore alternative monologues, which may be conducive to good mental health, as "develop(ing) a personal narrative grounded in life history and linked to the psychological factors underlying the psychotic symptom" has been described as the aim of psychoanalytic psychotherapy (Garrett and Turkington, 2011). On a theoretical note, discursive constructions (as opposed to ideologies) may contain 'gaps' and inconsistencies (Parker, 1992).

Accounts were selected with a good 'thick description' of the literal experience of hearing voices as this may be a particularly difficult aspect to convey, and may not necessarily, for all voice hearers, map in a convincingly direct way to real-life experiences of trauma, or be similar to hearing someone call your name (discourses commonly expressed in academic and CBT literature, so possibly more available to voice hearers in therapy). It is not claimed that these accounts are representative. These authors may be particularly well educated in psychiatric theories. Psychoeducation typically focuses on compliance. Instead, psychoeducation highlighting a range of theories about psychosis and different ways of integrating the experience may be

beneficial. The biomedical model may make it difficult to afford the experience personal meaning and significance, and for service users who find the biomedical model useful, as the dominant discourse, it is readily available.

This research has highlighted and explored how two voice hearers who have 'recovered' construct their experiences and draw on discourses to understand and explain their experiences. These constructions, and the discursive resources they draw on, may support a unity between internal thoughts, feelings, and experiences, and how this may be conveyed to others, supporting 'integration'.

Methodologically, DA is commonly used as a technique of critique, to challenge dominant structures and institutions (e.g. Parker, 1992), or to examine how an individual (perhaps without conscious awareness) controls and censures others through language and conversational moves (Potter & Wetherell, 1987). Thus DA often presents a critical view of its subjects (implying they are strategically manipulative or deceptive), and employs caveats to suggest the manipulation may not be consciously motivated (Madill & Doherty, 1994). This 'sympathetic analysis' is compatible with assuming discursive constructions are consciously used[1]. This seems likely as they are considered accounts, and is supported by participant validation.

Sympathetic analyses of how individuals employ discourses to negotiate and understand their 'reality' have been absent in the literature. Yet this research demonstrates that DA can be sympathetically applied to personal accounts, offering a slightly different 'flavour' to the analysis. Sympathetic analyses are commonly created using interpersonal phenomenological analysis (IPA) (for examples specifically addressing psychosis, see Beavan, 2011, and Smith, Flowers & Larkin, 2009). IPA and

[1] By 'consciously used', in the framework of DA, I mean within the 'discreet self' constructed by discourse (Rose, 1996).

many approaches in psychology assume an ‘authentic experience’ exists, and would treat such accounts as conveying a ‘true’, singular meaning. A discursive approach, which resists meaning and the subject (resisting existentialist humanism), facilitates an analysis which examines the utility, not the authenticity, of different discourses – the focus is placed upon how useful is this way of speaking and thinking, and what does it achieve?

A discursive approach determines that “the key to discerning, critically, the modern experience of madness lies within the language used in the process of constituting that experience” (Switzer, 2010). Similarly, Rose (1996) considers that discourses construct the modern conception of humans as discreet ‘selves’, and that discourses construct ‘normality’ and ‘pathology’. This research suggests that actively constructing the experience of hearing voices affects the very nature of the experience. The dominant discourse explaining hearing voices is the biomedical model, and service users who challenge this discursively risk being categorised as ‘mad’, and unable to grasp ‘reality’. Yet psychosis is a condition which challenges perceptions and conceptions of reality, questioning whether a singular reality exists. For psychosis, one ‘authentic’ ‘reality’ may be the ‘reality’ of the psychotic experiences. Acknowledging the multitude of discursive constructions used to talk about ‘reality’ and examining the utility of ones employed by published, experienced service users, may illuminate ways of talking about and understanding psychosis that are useful for integration and recovery.

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