

WHAT ARE THE EXPERIENCES OF THOSE ATTENDING A SELF-HELP HEARING VOICES
GROUP: AN INTERPRETATIVE PHENOMENOLOGICAL APPROACH

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

Introduction: Self-help Hearing Voices Groups (HVG) have grown in popularity here in the UK, and internationally, since the 1980s. Despite research into the potential benefits of attending self-help groups for other mental health problems, little is known about their potential benefit for voice hearers. The present study was designed to explore the experiences of those attending one self-help Hearing Voices Group in the UK.

Methods: A homogenous convenience sample of seven adults aged between 28 and 48 years old was recruited and participants were interviewed using a semi-structured interview schedule. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis. Analysis was conducted for individual participants in the first instance. Following this, a group analysis was conducted across participants to identify master and super-ordinate themes.

Results: Six master themes and eight super-ordinate themes emerged following the group analysis. Participants experienced the group as *A Secure Base* which offered the opportunity for *Coming Together to Help Ourselves*. As well as benefits of attending the group, participants also discussed challenging aspects to their experience; *Threats to Engagement* and *Vicarious Experience*. Participants experienced the group as *A Catalyst for Change* in terms of social and psychological recovery. Finally, participants talked about the sense of *Belonging to a Special Tribe* which offered mutual acceptance and social inclusion.

Discussion: The main findings of the research project are discussed in relation to existing psychological theories of groups and research into the effectiveness of self-help groups in other clinical contexts. The research adds to the existing knowledge base in terms of exploring how participants developed attachments to the group and its members.

Implications for the potential benefits of attending self-help Hearing Voices Groups are discussed. Finally, the clinical implications for Clinical Psychologists working with voices and with self-help Hearing Voices Groups are discussed. The research concludes with recommendations for areas of further research.

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ABBREVIATIONS

CBT: Cognitive Behaviour Therapy

CBTp: Cognitive Behaviour Therapy for Psychosis

HVG: Hearing Voices Group

HVN: Hearing Voices Network

IPA: Interpretative Phenomenological Analysis

NHS: National Health Service

NICE: National Institute of Clinical Excellence

BPS: British Psychological Society

TAU: Treatment as Usual

RCT: Randomised Controlled Trial

CHAPTER ONE

"It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself..."

Ralph Waldo Emerson.

This chapter will begin with defining voice hearing¹ in relation to schizophrenia and psychosis-related diagnoses. I will also situate the present research study in the wider theoretical and research context of understanding voice hearing. I will then outline evidence based psychological approaches to voice hearing and review the self-help movement, which offers as an alternative framework for understanding recovery and voice hearing. I will then present psychological theories of groups and summarise their application to self-help groups. The chapter will conclude with a review of the current literature relating to self-help groups in mental health contexts generally, and voice hearing specifically.

Schizophrenia, Psychosis and Voice Hearing

Definition

The experience of voice hearing is generally regarded, in Western cultures, as a diagnostic factor in mental illness, in particular that of schizophrenia and other psychosis related mental health problems (American Psychiatric Association, 1994). Voice hearing is often referred to as a 'positive symptom' of psychosis and psychosis-related diagnoses. Schizophrenia was first identified by Kraepelin in 1896 and was termed '*dementia praecox*' (1896 as cited in Bentall, 2003, p. 15). Kraepelin suggested that dementia praecox was primarily a disease of the brain, which appeared in early life and led to mental deterioration. Following on from the work of Kraepelin, the term 'schizophrenia' was first coined by the psychiatrist Eugene Bleuler. Bleuler used the term to describe the separation of personality, thinking, memory and perception (Bentall, 2003, p. 23). Bleuler believed that the illness was biological in origin and was chronic and longstanding in its nature.

¹ The term 'voice hearing' is used throughout the present research study rather than the more medicalised term 'auditory hallucinations'. This decision was based upon the language used by the group members themselves to describe their experiences.

Since its early inception in the 19th Century, the biological account of schizophrenia has been a dominant discourse and prevails in the current psychiatric system. However, neither Kraepelin's '*Dementia Praecox*' nor Bleuler's '*Schizophrenia*' identified voice hearing as a core feature. It was Schneider (1959 as cited in Bentall, 2003), who identified a link between voice hearing and schizophrenia; his ideas underpin the diagnosis of schizophrenia in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR; APA, 2000). An extract from the DSM IV-TR diagnostic criteria for schizophrenia is outlined in figure 1 below:

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- Delusions
- Hallucinations
- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behaviour
- Negative symptoms i.e., affective flattening, alogia or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

Figure 1. An extract from the diagnostic criteria for schizophrenia from the DSM-IV-TR.

Of primary interest in the extract above is the note that a diagnosis of schizophrenia can be assigned only if voice hearing is of a particular nature (e.g., 'keeping a running commentary'). Further, the DSM-IV-TR states that "*the essential features of schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1 month period*" (APA, 2000, p. 298).

More recently, the concept of schizophrenia has been critiqued for its lack of scientific reliability and validity which has implications for researchers (Bentall, 2003; Boyle, 1990) and for the stigma associated with receiving such a disempowering diagnosis (Bentall, 2003). There are implications for recovery too, in that schizophrenia is commonly perceived as a chronic and enduring illness from which one cannot recover. This deterministic view of recovery and prognosis is representative of the legacy of Kraepelin's work in the 19th Century.

There is no universally accepted definition of the term 'psychotic' in relation to symptoms of mental illness. The DSM-IV-TR defines 'psychosis' as the presence of certain symptoms, usually delusions or hallucinations. Psychotic symptoms are present in a range of diagnoses including; schizophreniform disorder, schizoaffective disorder, and brief psychotic disorder. What distinguishes these diagnoses is the duration of symptoms, for example less than one month for a diagnosis of 'brief psychotic disorder'. Common across diagnoses is the 'symptom' of voice hearing. It is this aspect of experience that present research study is concerned. The next section will focus on different accounts of the aetiology of voice hearing.

Hearing Voices

The characteristics of voice hearing vary between individuals, for example, many people may hear their name being called at only one time during their lifetime. For others, however, the experience is more frequent and intense. Many people experience voices commenting on their daily life, providing a monotonous narrative of activity. Others will experience the voices saying critical and derogatory comments about them which can cause a great deal of distress. 'Command hallucinations' describe voices which command the individual to act or behave in ways they do not wish ranging, for example, from making a gesture to harming themselves or others. This form of voice hearing is understandably cited as causing the most distress for voice hearers (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1995).

Alongside menacing voices, individuals with psychosis have talked about benevolent voice hearing experiences which offer comfort (Chadwick & Birchwood, 1994; Romme & Escher, 1993). What is clear from first person accounts of voice hearing is that the experience is varied and unique to the individual, and not all voice hearing experiences cause the individual psychological distress. I will return to this later after first considering the proposed aetiology of voice hearing.

Aetiology

The aetiology of voice hearing is very complex and there is little agreement in the research field. The following section will provide an overview of some of the explanations offered for the aetiology of voice hearing. It is beyond the scope of the present research project to

explore these accounts in great deal; the reader is signposted to suggested references throughout.

Historical perspective. Voice hearing has not always been regarded as a characteristic symptom of mental illness. Reports of the experience can be traced back to early religious figures such as Moses and Jesus. Furthermore, Socrates reported being guided by his 'daemon' described as "*a voice of wisdom which he did not experience as an aspect of his own thoughts*" (Romme & Escher, 1993, p. 39). In more recent historical accounts of voice hearing, Sigmund Freud was reported to have heard his name being called by "*an unmistakable and beloved voice*" whilst living in a foreign city alone (Freud, 1901/1966 as cited in Ritscher, Luckstead, Otilingam, & Grajales, 2004).

Julian Jaynes offered an alternative to the medical view of voice hearing. In his book, he described an ancient mental structure called the 'bicameral' mind. He claimed that, until a few thousand years ago, humans had not developed self-reflective consciousness; instead, humans were guided by the voices they heard. Voices were attributed to gods. He likened this mental structure to the voice hearing experiences of people diagnosed with schizophrenia (Jaynes, 1976).

Despite the presence of reported voice hearers throughout history, the experience of voice hearing is generally regarded as 'the first sign of madness' in Western cultures. Since the 1950s, the first line treatment for the positive symptoms of psychosis (voice hearing) has been neuroleptic (anti-psychotic) medication.

Biological account. Biological factors continue to be implicated in the aetiology of voice hearing and neuroleptic drugs are central to the treatment of schizophrenia (Picchioni & Murray, 2007). This is reflected in the National Institute for Clinical Excellence guidelines which state that, alongside psychological interventions such as Cognitive Behavioural Therapy (CBT), medication should also be offered as a treatment approach. (NICE, 2003; 2009). The dopamine hypothesis is the most common medical explanation for voice hearing, developed from the observations of the effects of antipsychotic medication. It posits that schizophrenia results from excess activity at certain dopamine synapses. It is believed, more recently, that the dysregulation of the dopaminergic pathways causes an over activity of the dopamine D2 receptor, particularly in the mesolimbic pathway (Roth, 2003). Typical anti-psychotic medication aims to block the D2 receptor, whilst atypical anti-psychotics were more recently developed to block the D2 receptor and the 5-HT_{2a} serotonin receptor. There is some evidence for the dopamine hypothesis in terms of the

proposed effectiveness of anti-psychotic medication in reducing ‘hallucinations’. Nevertheless, the ‘dopamine hypothesis’ remains controversial in the explanation of the positive symptoms of psychosis largely due to the fact that, despite improvements in symptoms, a significant number of people still experience voice hearing despite taking medication (Carter, Mackinnon, Copolov, 1996; Kane et al, 1996; Leudar & Thomas, 2000; Westacott, 1995). Furthermore, a considerable number of individuals do not respond to medication at all (Whitaker, 2004) and discontinue their use of medication due to negative side effects (Sederer & Centorrino, 1997). This has offered an opportunity to highlight psychological understandings of the aetiology of voice hearing, with the aim of developing more effective and acceptable treatments.

Psychological Understandings of Voice Hearing

There are a range of psychological understandings of and approaches to voice hearing. The field is extremely complex and developments in psychological understandings are on-going. Therefore, it is beyond the scope of the current research project to provide a comprehensive review. It is widely accepted, however, that voice hearing experiences have meaning for the voice hearer and psychological therapy ought to be a meaning making expedition (May, 2004). I shall provide a summary of the most pertinent psychological approaches to voice hearing in the context of the present research project.

Psychodynamic understandings. One of the earliest psychological explanations for voice hearing comes from the psychodynamic approach which asserted that voices are a manifestation of repressed desires or represents a poorly integrated sense of self. For example, Freud believed that voices had meaning and were the result of intra-psychic conflict, with malevolent voices often representing a critical super-ego (Freud, 1924). This understanding has links to more recent developments in the research of the role of inner speech and voice hearing.

Sub vocalisations and inner speech. It has been suggested that voice hearing may in fact reflect inner speech (Hoffman, 1986 as cited in Bentall, 2003). Bentall describes how we; *“covertly comment to ourselves about what we have done, formulate our plans for the day ahead, keep transient memories”* all in apparent silence (2003, p. 360). Research has found, however, that inner speech is actually accompanied by small activations of the speech muscles known as ‘sub vocalisations’. The theory that voice hearing might reflect

inner speech has been supported by the observation that voice hearers experience relief from their voices when they talk aloud or use the muscles that are involved in the production of speech (Green & Kinsbourne, 1990). Furthermore, it has been ascertained that the most common form of voice hearing is described as a voice(s) issuing instructions; this reflects the most common form of inner speech (Leudar, Thomas, McNally & Glinski, 1997). It is asserted by some, therefore, that voices represent inner speech which has been misattributed to another source (Morrison & Haddock, 1997).

The role of trauma. Traumatic experiences are also thought to be involved in the development of psychosis (Read, Van Os & Morrison, 2005). Research has found high prevalence rates of trauma in patients with psychiatric diagnoses such as psychosis and schizophrenia. Experience of sexual abuse is consistently highlighted in the research of those with psychosis (Ensink, 1994 as cited in Romme & Escher, 1993, p. 165–171). In an inpatient sample, 77% of those reporting childhood sexual or childhood physical abuse had one or more of the ‘characteristic symptoms’ of schizophrenia listed in the DSM-IV (APA, 2000; Read & Argyle, 1999). Furthermore, participants who experienced childhood abuse were almost twice as likely (35%) as non-abused patients (19%) to have two or more of the ‘characteristic symptoms’ of schizophrenia (Read, Agar, Argyle, & Aderhold, 2003). Experiencing trauma is, therefore, associated with the development of psychosis (Morrison, Frame & Larkin, 2003).

Traumatic experiences are also implicated in the voice hearing experiences of non-patients. For example, soldiers and victims of torture report voice hearing (Romme & Escher, 1993). This implies that traumatic experiences are involved in the development of voice hearing experiences in patient and non-patient groups. Vulnerability to develop psychosis is also related to how an individual copes with traumatic experiences. For example, in the comparison between voice hearers who became patients and those who did not, vulnerability to develop psychosis was related to the influence of the traumatic event on the individual’s ability to cope with stress (Romme, 1996). This is consistent with the *stress-vulnerability* model for psychosis (Zubin & Spring, 1977) which proposes that an individual is vulnerable to developing psychosis due to their unique combination of biological, psychological, and social factors. Alongside this, an individual’s perceived ability to cope with stress (and traumatic experience) is crucial for relapse prevention.

It is important to note that alongside early abusive experiences, the experience of voice hearing and hospital admissions are also conceptualised as traumatic events for many individuals with psychosis (Morrison et al, 2003).

In summary, then, traumatic experiences are implicated in the development of psychosis. Traumatic experiences can also occur in non-patient populations but these do not necessarily lead to the development of a diagnosable psychosis. What differentiates a patient from a non-patient, it seems, is the individual means of coping with traumatic and stressful events (including voice hearing). It is suggested, therefore, that voice-hearing and traumatic experiences exist along a continuum.

A common human experience. A more recent way of understanding voice hearing is to consider that it exists along a continuum of human experience (Bentall, 2003). This idea posits that voice hearing is not exclusive to people with a diagnosis of schizophrenia or other psychosis-related disorders. Instead, it is suggested that voice hearing is present among non-psychiatric patients in the general population. This is in contrast to the typical response to voice hearing which has been to label the experience as indicative of mental illness and to prescribe anti-psychotic medication (Leudar & Thomas 2000). In a survey of 15,000 members of the general population, a voice hearing prevalence rate of 2.3% was found. One third of the participants experiencing voice hearing reported distress or impairment of functioning at a significant enough level to meet the criteria for a psychiatric diagnosis, but were not in receipt of care (Tien, 1991).

A further review of the literature found that voice hearing was not found exclusively within the psychiatric population (Johns, 2005). A number of other studies have surveyed hallucinatory experience within the student population. Consistent within this research is the finding that a significant proportion of the people studied have experienced a hallucination at some time in their life. For example, in a sample of 375 college students 71% reported at least one experience of a hallucinated voice during wakefulness, and 39% reported hearing their thoughts spoken aloud (Posey & Losch, 1983).

Given the prevalence of voice hearing experiences in the general population, researchers in this area have concluded that voice hearing should be regarded as a part of human experience which exists along a continuum, rather than a symptom of mental illness. What seems to differentiate patient and non-patient voice hearers is the distress associated with the experience. I will return to this later. This shift in conceptualising and making sense of voice hearing as a phenomenon of common human experience has had an impact on the development of psychological treatments.

Attachment theory and relating to voices. There is limited research investigating the relevance of attachment theory for psychological approaches to psychosis (e.g., Berry,

Wearden, Barrowclough & Liveside, 2006; Berry, Barrowclough, & Wearden, 2007; Birchwood et al, 2004; Dozier, Stovall, & Albus, 1999). Attachment theory essentially aims to explain our patterns of emotion regulation and proximity seeking behaviour in the context of our relationships at times of threat (Bowlby, 1988 as cited in Holmes, 2001). Attachments are developed in early life between the child and primary caregiver and has been defined as *“a bond or tie between an individual and an attachment figure...based on the need for safety, security and protection”* (Prior & Glaser, 2006, p.15). The responsiveness of the caregiver will lead to the development of patterns of attachment; these, in turn, lead to internal working models which will guide the individual's style of relating (Bowlby, 1969 as cited in Prior & Glaser, 2006, p. 21). If, for example, the primary caregiver does not respond to the needs of the child, the child will develop an insecure attachment style and will expect other people in their lives to respond in the same way as their attachment figure. By contrast, if the child experiences the primary caregiver as consistent, nurturing, and providing safety then the child develops a secure attachment style.

The relationship with the primary caregiver will act as a ‘secure base’ from which the child can go and explore the world around them, safe in the knowledge that they can return to the secure base at times of distress or psychological need (Ainsworth, 1963 as cited in Prior & Glaser, 2006). Needless to say, without a secure attachment the child will struggle to develop a secure base with the primary caregiver. This will limit the individual’s ability to become autonomous in the world without the safety of a secure base to return to. Early attachments pave the way for how we continue to relate to others in adulthood, and are considered stable over our lifetime. More recent research, however, has provided evidence that attachment styles can be altered if adult experiences of attachment conflict with our early working models (Hamilton, 2000).

Attachment theory is relevant for understanding psychosis as a number of studies have found that adults with a diagnosis of psychosis have reported insecure attachment styles in relation to their parents (Dozier, Stevenson, Lee, & Velligan, 1991; Dozier & Lee, 1995). It has been hypothesised that individuals with psychosis and an insecure attachment style are less likely to seek help which is characterised as a feature of the ‘sealing over’ recovery style (Tait, Birchwood & Trower, 2004). Recovery styles describe an individual’s style of psychological adjustment to distress. The ‘sealing over’ recovery style has been described as one coping strategy by which individuals minimise the significance of symptoms and the impact of psychosis (McGlashen, 1987). Within psychosis, this recovery style predicts disengagement and poorer outcomes in the longer term and has been linked

to greater psychological vulnerability and lower resilience which contributes to an individual's vulnerability to further relapse (McGlashen, 1987; Tait et al, 2003). Insecure attachment styles, therefore, relate to a 'sealing over' recovery style which has the potential to lead to greater relapses. Attachment styles are also important in predicting future relating styles. This means that the attachment style with which an individual relates to their voice(s) can also be identified. The relational aspect of voice hearing in terms of the relationship between the voice and the voice hearer is, therefore, also important in the psychological approach to working with voice hearers.

An internalised other. Related to attachment theory is the conceptual development of voice hearing which suggests that the voice may represent an internalised 'other'. Benjamin (1989) was first to suggest this way of conceptualising voice hearing, stating that voice hearers had '*integrated, personally coherent relationships with their voice*' (p. 308). Furthermore, research has found voices often represent significant relationships of the voice hearer (Leudar et al, 1997). Alongside these findings, Chadwick, Birchwood and Trower (1996) state:

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).

As the quotation indicates, voice hearers can develop a relating style to their voice(s) which is indicative of their attachment style. These findings have clear psychological treatment implications for altering the relationship between voice hearer and voice(s) as demonstrated by Social Rank Theory (Gilbert et al, 1992).

Social rank theory and voice hearing. An individual's attachment style and how they relate to their voice would fit with Social Rank Theory (Gilbert et al, 1992) which postulates that as human beings we exist in social groupings according to ranks. Social ranks are determined by dominant and subordinate positions. It is postulated that Social Rank Theory may explain the relationship between the voice hearer and their voice in terms of dominant and subordinate positions (Byrne, Birchwood, Trower, & Meaden, 2006). As such, understanding an individual's pattern of relating has an impact on the therapeutic alliance, the relationship to the voice, and an individual's self-perception in relation to

others (Berry, et al, 2007). This is particularly important if the voice hearer perceives themselves to be in a disempowered position to their voice which can lead to psychological distress.

Power, omnipotence and beliefs about voices. The work of Chadwick and Birchwood (1994; 1995), suggest that the perceived power and omnipotence of the voice over the voice hearer leads to disempowerment and psychological distress. This explanation is in opposition to earlier theories which believed frequency of voices influenced distress levels. More than 85% of voice hearers perceive their voice to be powerful and omnipotent (Birchwood & Chadwick, 1997). Furthermore, the perceived omnipotence of the voice has also been associated with the likelihood of the voice hearer to act on the commands of the voice (Cheung, Schweitzer, Crowley, & Tuckwell, 1997). This has led to the development of CBT based treatments which aim to alter the relationship between the voice and the voice hearer for example, Cognitive Therapy for Command Hallucinations (CTCH; Birchwood, Meaden, Trower, Gilbert & Plaistow, 2000), Person-Based Cognitive Therapy (PBCT; Chadwick, 2006), and Relating Therapy (Hayward, Overton, Dorey, & Denney, 2009). All approaches are CBT based and aim to alter the relationship between the voice hearer and the voice(s).

Overview of the Evidence for Psychological Treatments

Historically, schizophrenia and associated positive psychotic symptoms were viewed as difficult to treat and there was little room for psychological approaches. With advances in antipsychotic medication development, medication became the mainline treatment for schizophrenia. Until the 1950s, treatment generally took place in large asylum hospitals. Following the closure of many of these asylums, treatment moved towards being community-based and anti-psychotic medication remained the first-line treatment. With the move to community-based treatments, psychological approaches to schizophrenia and psychosis have developed and voice hearing has been viewed as a meaningful experience to be understood and made sense of. Despite the psychological understanding of voices outlined, it is acknowledged in the field that psychological treatment is still considered complex and challenging.

The National Institute of Clinical Excellence (NICE) published guidance on the treatment of schizophrenia (NICE; 2003, 2009), and recommended that cognitive behavioural therapy (CBT) should be offered to everyone with a schizophrenia spectrum

diagnosis. In particular, CBT should be offered to those with persistent and distressing symptoms and with a history of relapse. New wave CBT approaches to voice hearing are currently developing as mentioned above; for example, Person-Based Cognitive Therapy (Chadwick, 2006), and Relating Therapy (Hayward & Fuller, 2010). These approaches have not yet received support in the NICE guidelines, and so are not reviewed here. Similarly, there is evidence for the effectiveness of Psychodynamic Psychotherapy (Gottdiener, 2004) and Systemic Family Therapy (Carr, 2009), for schizophrenia and psychosis. However, these interventions do not focus specifically on the experience of voice hearing and so will not be reviewed here. The following section will, therefore, explore the evidence for CBT as a psychological approach voice hearing.

Cognitive behavioural therapy. CBT, as an approach, rests on the assumption that there is a link between thoughts, feelings, and behaviours. Developed by Beck (e.g., 1963; 1970), CBT has been adapted to treat the positive symptoms of psychosis as well as the associated affective symptoms such as social anxiety and depression. For psychosis-related diagnoses, CBT tends to focus on reducing the frequency, intensity or severity of voices.

The gold-standard for evaluating the efficacy and effectiveness of research is the randomised controlled trial (RCT). This design controls well for confounding variables and ensures treatment fidelity. It is argued that RCTs have greater external validity and as such the results are considered to be robust. However, the clinical relevance of findings from RCTs can be criticised due to the stringent criteria adopted; this can have implications for the ecological validity of findings. Nevertheless, RCTs are widely accepted as the most robust means of evaluating the effectiveness of treatment approaches. However, the findings from RCTs of CBT for psychosis are mixed. First, several well designed studies have indicated the positive effects of CBT on clinical outcomes such as reducing symptoms and improving insight (Jones, Cormac, Silveira & Campbell, 2004).

Jones and colleagues (2004) conducted a Cochrane systematic review of the effectiveness of CBT for schizophrenia and found mixed results. The authors included nineteen RCTs in the review, eighteen of which reported results for the positive symptoms of psychosis. All the trials focussed on individuals with psychosis from different diagnostic groups such as schizophrenia, delusional disorder or schizoaffective disorder. Results of the review indicated that CBT plus standard care did not reduce relapse and readmission compared with standard care. In terms of CBT versus supportive psychotherapy, CBT had no effect on relapse. When comparing CBT plus standard care with standard care alone, statistically significant improvements in mental state were found at 18 months in those

participants receiving CBT (as measured by the Brief Psychiatric Rating Scale; BPRS; Overall & Gorham, 1962). Finally, in terms of positive symptoms, a significant effect of CBT plus standard care was found in the long term for hallucinations.

The authors concluded that CBT was effective in reducing positive symptoms. Due to variability across results, however, they could not "*assert any substantial benefit for cognitive behavioural therapy over standard care or supportive therapies*" (Jones et al., 2004, p. 14).

A more recent review pooled the data from published trials of CBT in schizophrenia, major depression and bipolar disorder (Lynch, Laws & McKenna, 2009). CBT was compared with treatment as usual (TAU). The results of this review indicated that CBT was not effective in reducing symptoms in schizophrenia or in preventing relapse but did have significant effects on improving depression. The authors concluded that CBT was not superior to TAU.

CBT groups for psychosis. There is limited evidence for the effectiveness of CBT groups for voice hearing. In an exploratory study of the effectiveness of CBT group treatment of voice hearing there was a significant decrease in the perceived power of the voices, a reduction in distress, and an increase in the number of coping strategies used (Wykes, Parr, & Landau, 1999). The study was well designed in terms of using measures with sound psychometric properties. However, the study used a waiting-list control design, which is not as robust as a randomised control trial design (RCT). A RCT design would have controlled for multiple threats to validity including sample characteristics. The present study did not have a control or comparison group and so non-specific group factors may have accounted for change; as could the effects of treatment expectancy which was not controlled for in the design.

Further research has found CBT to have a direct and encouraging effect on reducing beliefs in the power and omnipotence of voices (Chadwick, Sambrooke, Rasch & Davis, 2000). Yet, in a randomised controlled trial comparing CBT group to group psycho-education, both groups yielded positive outcomes but there was no advantage held by CBT (Bechdolf, et al, 2004). Similarly, Pinkham, Gloege, Flanagan and Penn (2004) used a CBT treatment for voice hearing in a group setting. They found improvements on an array of measures tapping beliefs about voices, severity of voice hearing, and positive and negative symptoms. However, findings should be interpreted with caution due to small sample sizes and lack of control/comparison groups.

Penn and colleagues (2009) compared CBT group for voice hearing with supportive therapy. Participants were randomly assigned to group CBT or enhanced group supportive therapy (ST). Results indicated that participants in supportive therapy rated voices as less malevolent compared with CBT group participants. Significant differences were found between the groups on a measure of total symptom scores measured by the 'Positive and Negative Syndrome Scale for Schizophrenia' (PANNS: Kay, Fiszbein, & Opler, 1987), in that the CBT group showed lower total symptoms than the ST group ($F(1,57)=5.80$, $p=.019$, $d=-.64$) at 12-month follow-up.

Finally, Wykes and colleagues (2005), compared CBT group with TAU and found greater benefits to social functioning but no general effect of group CBT on the severity of hallucinations. Furthermore, the severity of hallucinations was reduced in some but not all of the therapy groups. This effect appeared to be associated with the level of experience of the therapist in terms of a greater improvement with more experienced therapists.

Summary. The literature reviewed has yielded mixed results regarding the effectiveness of CBT (individual and group) when compared with standard care or other treatments. There is some evidence for improving insight and reducing positive symptoms but this is far from conclusive. This suggests that there is still a long way to go in offering psychological treatments which successfully and effectively reduce psychological distress around voice hearing. Developments in cognitive behavioural therapy for psychosis (CBTp) have been aimed at reducing the psychological distress associated with voice hearing rather than aiming to reduce frequency or severity. With this change in direction, CBTp has yielded positive results in terms of improvements in depression and control over the voices (Wykes, Steel, Everitt & Tarrier, 2007). This is a very specific form of CBT for command hallucinations, however, and is not applicable to those with different forms of voices.

Underlying the effectiveness research is the notion of 'recovery' and what this means for researchers, clinicians, and service users alike. Implicit in the effectiveness research into voice hearing is the focus on clinical recovery as a primary outcome; that is, a reduction or absence of voice hearing experiences. This narrow definition has the potential to overlook improvements in the domains of social and psychological recovery. As such, the clinical definition of recovery within the hearing voices effectiveness and efficacy research is considered inappropriate when considered in isolation.

The Freedom to Hear Voices

Whilst psychiatry and Clinical Psychology were attempting to understand the aetiology and treatment of voice hearing, the mental health service user movement was emerging and offering an alternative understanding of voice hearing to those offered by mainstream traditional mental health services. These understandings and approaches are neglected in the formal NICE treatment guidance for schizophrenia and in the broader effectiveness and efficacy literature due to a lack of published evidence. NICE selects which research to include in its guidance according to a hierarchy of evidence. The hierarchy is designed according to criteria which assess the robustness and validity of the findings. The highest level of evidence for a treatment is the RCT; qualitative research and service user accounts are not considered as robust. Despite this, consumers have emphasised the importance of interventions which promote voice hearing as a meaningful experience. The following section will outline the development of the shift away from pathologising voice hearing as a symptom of mental illness, to its conceptualisation as a meaningful experience worthy of understanding in the context of the recovery and service user movements.

The Recovery Movement

The advances in understanding voice hearing as a meaningful experience as opposed to a symptom of severe and enduring mental illness has had impacted on understanding recovery in the voice hearing population and on psychological treatments. Historically, a pessimistic view of recovery for those with a diagnosis of schizophrenia or psychosis existed. For example, it states within the DSM-IV-TR that prognosis is variable, with some individuals *“displaying exacerbations and remissions, whereas others remain chronically ill...complete remission (i.e., a return to full pre-morbid functioning) is probably not common in this disorder”* (APA, 2000, p. 308-309). This description of recovery leaves little hope for those diagnosed with schizophrenia and often leads to stigmatisation (Pitt, Kilbride, Nothard, Welford & Morrison, 2007).

With the rise of the Hearing Voices Movement as part of the wider Recovery Movement in mental health in the UK (Allott, Loganathan & Fulford, 2002), a shift occurred in relation to the prospect of recovery for voice hearers. Personal stories of recovery began to emerge in the literature in the 1980s which emphasised that people with severe mental illness had the ability to move beyond the illness (Onken, Craig, Ridgway, Ralph & Cook, 2007). Furthermore, research indicated that approximately 50% of people with

schizophrenia significantly improved or recovered (Rogers, Norell, Roll & Dych, 2007). Instead of being viewed as unachievable, recovery has since been reconceptualised; an individual can recover, despite the continued presence of voice hearing experiences (Coleman, 1999; May, 2004).

The service-user movement and personal experiential accounts of voice hearing also contributed to the re-conceptualisation of recovery for voice hearers. For example, in his writings of personal experience of voice hearing and his process of recovery, Ron Coleman stated that *“one of my fundamental beliefs about recovery is the premise that recovery cannot and does not happen in isolation...recovery is by definition wholeness and no one can be whole if they are isolated from the society”* (Coleman, 1999, p.15). Key to this alternative definition is the distinction that recovery ought not to be defined as a clinical outcome, but rather as a process of healing. Furthermore, Coleman emphasises the role of social inclusion in the individualised recovery process.

Building on the recovery movement in voice hearing is the work of Patricia Deegan, an advocate of the mental health recovery movement. She stated that *“the goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human”* (Deegan, 1996, p. 92). In relation to voice hearing, this way of understanding recovery would accept voices as a part of the human condition, which is meaningful, rather than pathologising it as a symptom of mental ill health.

Furthermore, May (2004) advocates the use of a multi-dimensional definition of recovery which focuses on social and psychological functioning. Social recovery describes the development of meaningful social relationships and psychological recovery describes the process of making sense of one’s experience and regaining control. It has also been suggested in the recovery from trauma literature that there are three phases of healing in the recovery process; safety, making sense of experience, and social reconnection (Herman, 1992; May, 2004). Hearing Voices Groups (HVGs) have the potential to offer these three stages of recovery from trauma.

National guidance in the UK has also emphasised the importance of peer support in someone’s recovery journey. In a joint publication by the Care Services Improvement Partnership (CSIP), Royal College of Psychiatrists (RCPsych) and Social Care Institute for Excellence (SCIE) it is stated that access to peer support is an example of good practice (SCIE, 2007). Furthermore, peer support may be an important source of hope:

Hope is of central significance. If recovery is about one thing it is about the recovery of hope, without which it may not be possible to recover and that hope can arise from many sources, including being believed and believed in, and the example of peers (p.5).

Hope has consistently been highlighted as a central component to recovery (Bonney & Stickley, 2008; Kylmä, Juvakka, Nikkonen, Korhonen & Isohanni, 2006). The concept of hope in peer support groups is clear; meeting those who have recovered may engender hope in one's own recovery (Davidson, Chinman, Sells, & Rowe, 2006; Yalom & Leszcz, 2005).

Summary. Recovery as conceptualised in a medical framework relates to the absence of clinical symptoms. Applying this definition of recovery to the voice hearing population would mean the absence of voices. Whilst this may be possible for some individuals and, indeed, be the ideal outcome for many voice hearers, voice hearing may persist as an experience for some. Research has indicated that the psychological distress associated with voice hearing may be caused by the perceived power of the voice(s) over the voice hearer rather than the experience of hearing voices itself (Birchwood et al, 2000). Furthermore, there is a group of individuals who hear voices but are not distressed by them, I will return to this later (Romme & Escher, 1993). These findings indicate that, rather than aiming to eradicate voice hearing, interventions which promote a voice hearer's empowerment, agency and control may be a more helpful way of aiding psychological recovery.

Taken alongside clinical recovery (e.g., symptomatic alleviation) social and psychological recovery provides a more holistic approach to voice hearing. It naturally follows that the evaluation of the effectiveness of interventions within the hearing voices research field should also focus on the domains of social and psychological recovery. Furthermore, focussing on social recovery is crucial for understanding the role of self-help groups for voice hearing. The Hearing Voices Network was instrumental in pioneering such groups in the hearing voices field.

The Hearing Voices Network: Accepting Voices

Professor Marius Romme from Maastricht University introduced new ways of thinking about the phenomenon of voice hearing. Romme was working with a client, Patsy Hage,

who had heard up to twenty different voices since her childhood. During their consultations together, Hage gradually challenged her psychiatrist's framework for understanding her experience. These conversations led to an appearance on a Dutch television programme by Romme and Hage where they asked people who heard voices to telephone the show. This resulted in 450 telephone calls from fellow voice hearers. Those who telephoned in were then surveyed about their experience of voice hearing and their means of coping with the experience. Of the 200 questionnaires returned, 150 people said that they were able to cope with their voices without assistance from psychiatry. This finding led Romme and Escher to explore the differences between patient and non-patient voice hearers. It was found that perceived control and relationship to voices were crucial to the ability to cope. The authors concluded that approaches should focus on making sense of and accepting voices (Romme & Escher, 1993, 2000). These findings were the beginnings of an emancipatory approach to working with voice hearers.

Inspired by the findings of Romme & Escher (1993) a new approach to hearing voices was established in the UK in the form of the Hearing Voices Network (HVN) with *"its core position being that hearing voices is a normal human experience – not a symptom of illness, but often a reaction to a traumatic or intensely emotional event which has not been adequately resolved"* (Dillon & Longden, in press, p. 2). The HVN is an independent charity, separate and distinct from mainstream mental health services. Its core aims are to encourage self-help and 'experts-by-experience', in a challenge to the perceived dominance of psychiatry.

The Self Help Movement

Central to the ethos of the HVN is self-help, which has been defined as *"approaches to healing and recovery from emotional distress which focus on the endeavours of the individual to help themselves"* (May & Longden, 2010, p.257). Implicit in this definition is the notion that an individual can learn to manage, cope and recover from psychological distress. Furthermore, hope is engendered when an individual is empowered to help themselves. Self-help is an umbrella term which can comprise biblio-therapy, such as self-help books and leaflets, through more organised self-help groups. The term 'self-help' is often used synonymously in the literature with 'peer support'; the latter, however, can encompass programmes which are professionally facilitated.

The Alcoholics Anonymous (AA) programme is perhaps the most well-known self-help group. Founded in 1935 in the United States, the twelve step programme has become

a widespread source of support for those struggling with addictions. A quick web search of self-help groups in the United Kingdom reveals the overwhelming number of self-help groups available for a range of psychological and physical health needs; for example, depression, eating disorders, bereavement, diabetes, anxiety, and bipolar disorder, to name just a few. The rise in the availability of self-help groups for mental health problems has been attributed to various socio-political changes; such as the shift from institutional care to community care and the growing consumer movement (Hatzindimitriadou, 2002).

The characteristics of self-help groups are defined as:

[One special characteristic of self-help groups is] the drawing together of participants who have a specific common affliction or need. The common condition or affliction that draws members together does not encompass a single need but is rather a broad category of distress that may affect many aspects of an individual's life (Lieberman & Borman, 1979, p. 67).

The above quotations emphasises how the support offered by self-help groups extends beyond the target 'problem' or diagnosis to the plethora of associated difficulties. For example, a Hearing Voices Group may offer support in coping with voices as well as managing anxiety and depression, accessing benefits support, negotiating the psychiatric system, and accessing wider support agencies.

Self Help Hearing Voices Groups

Self-help is a key aspect to the emancipatory ethos of the Hearing Voices Network. They describe their Hearing Voices Groups (HVGs) as *"a number of people who share the experience of hearing voices, coming together to help and support each other"* (Hearing Voices Network, 2011). One of the main aims of the HVGs is to:

Offer a safe haven where people feel accepted and comfortable. They also have an aim of offering an opportunity to people to accept and 'live with their voices', in a way that gives some control and helps them to regain some power over their lives (Hearing Voices Network, 2011).

The UK's first HVG was established in Manchester in 1988. HVGs are heterogeneous in nature and respond to the needs of individual group members. Often

groups will include the relatives and carers of people who hear voices. There are currently over 180 groups within the UK branch of the HVN. In essence, the aim of HVGs is to empower individuals to run their own groups within the core values of self-help, sharing of experience, freedom of group attendance, and acceptance. This is in contrast to mainstream mental health services which, in the main, offer professionally-led interventions in the treatment of voice hearing.

Summary

With the rise of the Hearing Voices Network alongside the self-help Consumer movements, Hearing Voices Groups have grown in popularity and there are over 180 groups in the UK today. The HVN works within an empowering definition of recovery which aims to support voice hearers to accept and make sense of their voice hearing experience as part of the human condition. The self-help groups operate outside of mainstream services and are defined by being peer-led. Given the growing membership and prevalence of self-help Hearing Voices Groups in the UK, and internationally, it is important to present the psychological theories underpinning self-help groups.

Psychological Understandings of Groups

First, I will outline psychological theories which pertain to the therapeutic factors of groups more generally, before presenting psychological theories which relate to the helpfulness of self-help groups more specifically.

Psychological Theories of Groups

Yalom's therapeutic factors in groups. Central to exploring the helpful aspects of groups is the work of Yalom (Lieberman, Yalom & Miles, 1973; Yalom & Leszcz, 2005). Yalom synthesised existing research alongside his own clinical observations and developed eleven 'curative mechanisms' which are hypothesised to be the therapeutic ingredients of group psychotherapy. These are summarised in Table 1:

Table 1

Yalom's Therapeutic Factors in Groups.

| Therapeutic Factor | Description |
|---|---|
| Instillation of hope | Observing others with similar problems coping with their difficulties fosters a sense of hope with one's own ability to cope. |
| Universality | Valuing the opportunity to meet others with similar problems. |
| Imparting information | Advice and guidance given from either the therapist or the group members. |
| Altruism | The process of helping others which gives rise to benefits for the 'helper'. |
| Corrective recapitulation of the primary family group | The group enables the opportunity to re-enact critical family dynamics with group members in a corrective manner. |
| Development of socialising techniques | The group encourages the development of effective social skills. |
| Imitative behaviour | Members expand their personal knowledge and skills through the observation of the group members' self-exploration. |
| Interpersonal learning | Members gain personal insight about their interpersonal impact through feedback provided from other members. |
| Group cohesiveness | Belonging to a group with similar problems promotes group cohesion. Is an essential requirement to promote acceptance and encourage risk taking in sharing experiences. |
| Catharsis | The group space allows the opportunity to express difficult emotions without the fear of negative consequences. |
| Existential factors | Members accept responsibility for life decisions. |

More commonly known as 'therapeutic factors', each of the curative mechanisms is involved in self-help groups for voice hearers, for example, 'universality' in meeting others who share similar experiences. Further, there is the opportunity for 'catharsis' in terms of

an emotional release when disclosing experiences with other group members. Perhaps of most relevance for members of a Hearing Voices Group is the ‘development of socialising techniques’. Research has found that social isolation exacerbates voice hearing (Garety, Kuipers, Fowler, Freeman & Bebbington, 2001) and supportive social environments serve as a protective factor in moderating stressors which might induce a relapse (Romme & Escher, 1993). An individual who experiences distressing voices may also experience social isolation or social networks may have deteriorated during times of ill health. For example, it is estimated that 80% of people with schizophrenia experience enduring problems with social functioning (Thornicroft, et al, 2004). Meeting a group of peers with shared experiences may provide a buffer against social isolation.

‘Altruism’ as a therapeutic group factor may be relevant to self-help groups in terms of the benefits to the individual when trying to help others in the group. Finally, ‘imparting information’, such as offering feedback, advice and sharing coping strategies, may also be beneficial in self-help Hearing Voices Groups.

All of Yalom’s therapeutic factors are thought to be of value in self-help groups for voice hearers yet little is known about whether they are actually beneficial for those who attend the groups. This provides further rationale for the present study.

Lieberman (Lieberman & Borman, 1979) applied a similar framework to Yalom’s in exploring how self-help groups benefit members. Described as phenomenological, Lieberman explained how he “*viewed self-help groups through the eyes of the participants by asking them to recall experiences they believed were helpful*” (Lieberman & Borman, 1979, p. 196). Lieberman explored twenty self-help groups over the course of three years. The results of his comparative analyses across various self-help and professional groups found, across group types and clinical presentations, that the most beneficial helping process was gaining a new perspective through group processes. This corresponded to Yalom’s therapeutic factor ‘interpersonal learning’. Lieberman’s analysis found similarities across groups whether they were professionally led or not. This is an interesting finding when considering whether self-help groups can be professionally co-facilitated or purely peer-led.

Maslow’s hierarchy of needs. Alongside specific group processes, Maslow’s psychological theory of motivation is important when exploring self-help groups. Maslow theorised that, in order to reach self-actualisation, humans have a hierarchy of needs which need to be met (1943). This is outlined in figure 2 below:

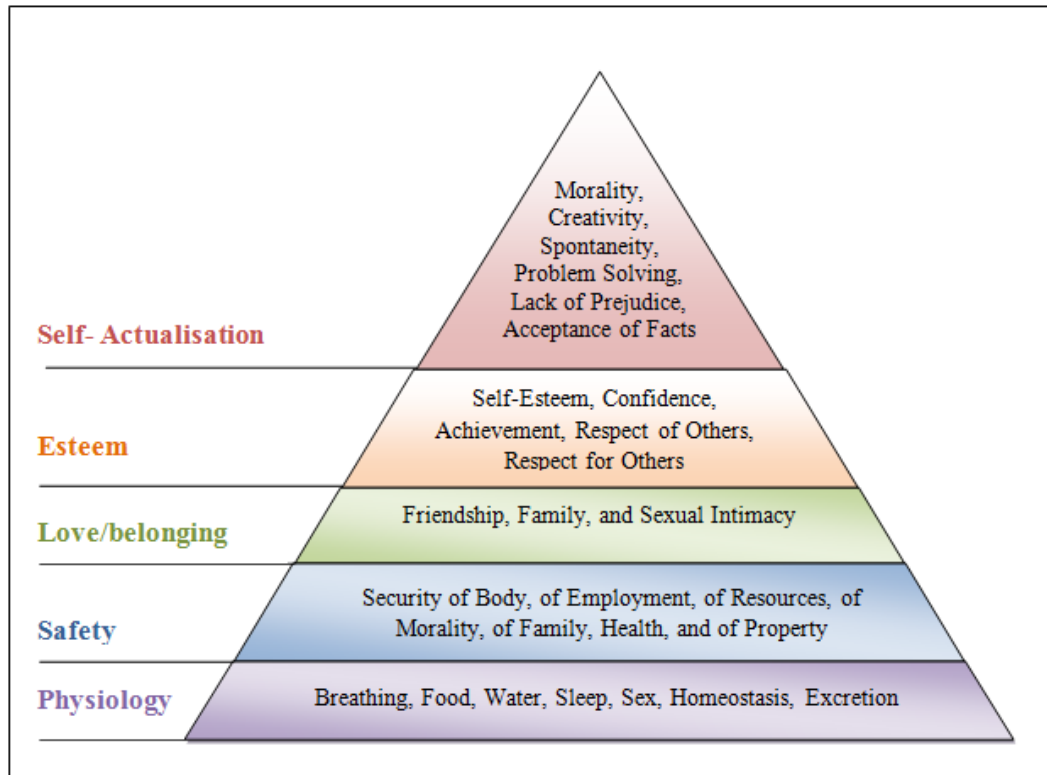


Figure 2. My interpretation of Maslow's hierarchy of needs.

As figure 2 outlines, human needs are hierarchical in nature. Basic needs, or 'deficiency needs', include physical needs and safety. Without these needs being met, higher order needs such as love/belonging cannot be met. At the peak of the pyramid is self-actualisation; reaching one's potential. According to Maslow, without friendship, self-esteem and a sense of belonging, this cannot be reached. The theory has met criticism for its ranking nature and for its individualistic focus. Self-help groups can be theorised as meeting a range of the presented human needs, namely; safety, friendship, self-esteem, respect for and of others, and a sense of belonging. By extension, having met these needs, an individual is empowered to reach self-actualisation in part because they are part of a group in which they have a sense of belonging.

Psychological Theories of Self-Help Groups

Several psychological theories explaining the perceived benefits of self-help groups have been described in the literature. Each will be described in turn.

Experiential knowledge. Borkman (1976, 1999) defined experiential knowledge as specialised knowledge obtained through living with the same experience, such as mental ill health. This particular knowledge is clearly different than the theoretical knowledge a professional holds about the service users they work with. This distinction is important when exploring the impact of self-help groups, particularly as the groups are traditionally peer-led and not professionally facilitated. Borkman also states that “*self-helpers describe knowing as involving bodily actions, not just intellectualised thought*” (1999, p. 36). This emphasises the distinction between ‘knowing’ on an intellectual and on a bodily level.

Experiential knowledge is often shared amongst members of self-help groups. Actively sharing experiences is thought to lead to validation, normalisation of experience, a reduction in social isolation, and a sense of belonging (Lieberman, 1993 as cited in Helgeson & Gottlieb, 2000).

There is the assumption that, within self-help groups, members often share and talk about the experiences they have in common. There is also the expectation that, in order for validation and normalisation to occur, members will attend to the emotional content of what is shared. Helgeson and Gottlieb (2000) raise the concern that there is the potential for invalidation if group members do not attend to each other’s experiences, particularly if they are negative. Similarly, there is the risk that group members may not understand the experiences of their peers. Helgeson and Gottlieb (2000) go on to say:

The sharing of experiences and expression of feelings are expected to lead to emotional support. Emotional support involves expressions of caring, encouragement, and reassurance. In a warm and accepting atmosphere, group members are expected to respond to one another’s disclosures in a positive way (p. 226).

Clearly, in order for disclosure and sharing to be meaningful for the members, a warm and encouraging group atmosphere is vital. Disclosure poses risks for group members if this sense of group cohesion is not present.

Social comparison theory. Festinger’s theory of the 1950s assumes that individuals who share something in common are drawn to each other in order to establish normalcy (Festinger, 1954). It is purported that, during stressful times, individuals are drawn to comparing themselves against others in order to appraise their own abilities and feelings. The theory describes two forms of social comparison; ‘upwards’ or ‘downwards’. First, in

terms of an 'upwards comparison', individuals can compare themselves with others who are perceived to be better than them. This can either give rise to a sense of optimism and hope. In terms of a 'downwards comparison', individuals can compare themselves to those who seem worse off which can also lead to the sense that one is 'better off' which can increase self-esteem (Salzer, 2002). Self-help groups clearly offer the opportunity for individuals to compare themselves with one another.

There are risks involved with social comparisons which may be unhelpful for group members. First, group members may compare their experiences to others and find no sense of connection or identification. This may cause individuals to feel more isolated and alone in their experiences. Helgeson and Gottlieb (2000) highlight the risks of 'upwards' social comparison in that an individual may feel frustrated that they are not coping as well as their peers. Furthermore, 'downwards' comparisons may cause anxiety for individuals who fear they may deteriorate.

Social support. Theoretically it has been hypothesised that self-help groups are beneficial because they incorporate the support of others with a shared experience, provide social networks, and create a sense of feeling more understood and less isolated (Helgeson & Gottlieb, 2000; Kyrouz, Humphreys & Loomis, 2002). Social support encompasses practical, instrumental, informational, and emotional support (Solomon, 2004). The elements of social support are evidently involved in self-help groups for voice hearers. Social support is widely recognised as having a beneficial effect on mental health in terms of improved quality of life and higher self-esteem (Goldberg, Rollins, & Lehman, 2003).

The benefit of social support is explained by the stress-buffering model, which suggests that social support acts as a buffer against stressors (Cohen & Wills, 1985). It is hypothesised that social support mediates the relationship between stress and health and enhances a sense of self-efficacy, a belief in one's ability to cope with life's stressful events. Self-help groups are hypothesised to offer a social network and support which can enhance the participant's ability to cope with the stressors associated with mental health problems. The individual's perception of the social support resources available to them is important. Clearly, if conflict and coercion exist within the group this dynamic can have a negative effect on wellbeing (Rook, 1990 as cited in Brown, Shepherd, Merkle, Wituk & Meissen, 2008).

Helper-therapy principle. The ‘Helper-therapy principle’ was proposed by Reissman in 1965 to describe the benefits of helping to the helper. He theorised that the act of helping others is an underlying mechanism of change within self-help group settings. He stated that *“while it may be uncertain that people receiving help are always benefited, it seems more likely that the people giving help are profiting from their role”* (p. 27). Further still, Reissman described how the principle could be generalised in group settings. He stated *“not only are individual group members aided through helping other members in the group, but the group as a whole may be strengthened in manifold ways as it continually offers assistance to individual group members”* (p. 32). The implications for the help-therapy principle in self-help hearing voices groups are clear; helpers may benefit from helping others and the group as a whole may also experience benefits.

Reissman makes the point that, at the time of his writing, much of the evidence for his theory was observational in nature. Further, the specific details of benefits to the helper are not detailed. There is the risk that the help provided by the helper may not be beneficial; for example, imparting incorrect advice and/or unhelpful coping strategies. Furthermore, the helper may feel a sense of burden in trying to offer help to others, particularly if trying to manage their own difficulties and distress.

Summary of Psychological Theories of Groups

Psychological theories underlying the perceived benefits of self-help groups have been presented. Social support, experiential learning, helping others, and belonging are all processes hypothesised as being helpful, as are Yalom’s therapeutic group factors. Potential negative elements of attending self-help groups have also been explored, such as the risks of social comparison. Having presented the psychological theories, I will now review the research literature which explores directly the perceived benefits of self-help groups.

The Benefits of Self Help Groups

There is a paucity of published research into the effectiveness of Hearing Voices Groups in particular and so research conducted into self-help groups for other mental health problems will also be summarised.

Process of Conducting the Literature Search

The terms 'self-help', 'mutual aid' and 'peer support' are used interchangeably in the research the literature. In order to conduct a comprehensive review of the existing literature, all of these terms were entered as search terms into the electronic database 'PubMed'.

In order to provide a summary of research from a range of sources; efficacy and/or effectiveness studies of self-help groups for mental health problems were included alongside qualitative research. For the present review, research which explored online self-help groups, groups for physical health conditions, professionally facilitated groups and groups for children or carers were excluded. Please refer to Appendix I for further details of the search process.

Self Help Groups in Mental Health Contexts

A critical discussion of the current research into the use of self-help groups in mental health clinical contexts now follows. Eight papers of interest were found. Research will be presented according to the primary findings relating to psychological and social functioning. Table 2 below contains details of the studies included in the present review.

Table 2.

Self-help Groups in Mental Health Clinical Groups

| Authors (date) | Nature of Group | Study Design | Sample | Outcome Measures | Findings |
|---|---|--|---------------|--|--|
| Bright, Baker & Neimeyer (1999) | Weekly mutual support group for service users with depression | Randomised 2x2 design Mutual support vs. group CBT Peer vs. professional led | N=98 | BDI* Hamilton* Hopkins Symptom Checklist* | Improvement on all measures Equivalence of CBT to peer support Equivalence of peer to professionally led groups |
| Cheung & Sun (2001) | Chinese mental health service users | Quantitative ratings of perceived helpfulness of attending a self-help group. | N= 51 | Rated statements in three areas of a structured interview; perceived benefit obtained from the group, occurrence of the helping processes, and helpfulness of the processes. | Found significant differences among the helpfulness scores, $F(8, 43) = 8.38, p < 0.001$ Universality, self-disclosure and instillation of hope most helpful factors Altruism and feedback considered least helpful A stepwise regression analysis identified support and catharsis as the strongest predictors of perceived benefits of participation. |
| Magura, Laudet, Mahmood, Rosenblum & Knight (2002). | Chronic mental illness and substance misuse | Prospective Longitudinal | N= 240 | Adherence to medication | Attendance at group associated with better adherence to medication |

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|--|---|---|---|--|--|
| Roberts, Salem, Rappaport, Toro, Luke & Seidman. (1999) | Members of national mutual-help group GROW | Prospective Longitudinal | N=98 | SCL-90* SAS* | Improvements on measures of psychological symptoms and social adjustment. Giving help was associated with improved functioning. |
| Burti, Amaddeo, Ambrosi, Bonetto, Cristofalo, Ruggeri, & Tansella (2005) | Members and non-members of self help agencies | Longitudinal prospective outcomes study 1 year duration Comparison between self-help group consumer and non-consumers | N= 44 in each group | BPRS* GAF* CAN* | Global functioning improved across groups but no significant differences were found. No significant differences in clinical or social measures at follow up in either group. Reduced hospital admissions for members of self-help groups. |
| Finn, Bishop & Sparrow (2007) | Existing and new members of Australian peer support group GROW | Cross sectional survey. Longitudinal survey over six months measuring psychological wellbeing. Qualitative interviews | Cross sectional N=934 Longitudinal survey N=28 Qualitative interviews N=24 | Self report measures including a six factor psychological wellbeing scale Use of medication Hospitalisation rate | Length of membership correlated with reduced medication use and hospitalizations. Being a GROW member associated with improvements in autonomy, coping skills and self-worth. Themes from interviews: Life skills development/application and a change in self-perception. |
| Leung & Arthur (2004) | Members a Hong Kong based self-help groups for those recovering from mental illness | Qualitative interviews | N=12 | n/a | Three main categories emerged from interviews: meaning of self-help, experiences of self-help groups and changes in life. Positive experiences of being in the |

groups were reported including feeling cared for and supported within the group. Group members cited improved social networks, empowerment and emotional catharsis as the prominent changes experienced.

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|--------------------------|-------------------------------|--|--------|------------------------|---|
| Segal & Silverman (2002) | Members of self help agencies | Interviews at baseline and at 6 months Measures on a range of psychological outcomes. | N= 255 | PES* ISFS* ASFS* | Improvements in personal empowerment (p<0.001) No significant differences in domain of independent social functioning Significant decrease in assisted social functioning (p<0.001) |
|--------------------------|-------------------------------|--|--------|------------------------|---|

*Notes: *SCL-90= Symptom Checklist-90), *SAS= Social Adjustment Scale, *BDI=Beck Depression Inventory, Hamilton*, Hopkins Symptom Checklist*, BPRS= Brief Psychiatric Rating Scale, *GAF= Global Assessment of Functioning, *CAN= Camberwell Assessment of Need, *PES= Personal Empowerment Scale, *ISFS= Independent Social Functioning Scale, *ASFS= Assisted Social Functioning Scale.*

Comparisons with other treatment groups. Bright, Baker, and Neimeyer (1999) compared the efficacy of group cognitive behavioural therapy (CBT) and mutual support groups (MSG) for depression in their randomised controlled trial. Participants were randomly allocated to either group CBT or MSG which were either professionally or para-professionally facilitated. Professionals were defined by their completion of training in clinical psychology programmes and had experience of delivering individual therapy. One half of the professionals also had experience of conducting groups. Para-professionals were recruited from community self-help groups and therefore had experience of facilitating groups but held no formal training. As part of the research design, the therapists were given training on CBT techniques such as the cognitive model of depression and techniques for challenging cognitions. Therapists were also trained in methods used in MSG such as feedback, communication skills, and group problem solving. Therapists also received training on 'components of group therapy' and 'potential problems in conducting groups' (p. 493). Therapists were grouped in pairs and conducted both a CBT group and MSG group.

The authors conducted a range of pre-therapy tests to assess for group differences and therapist differences; no significant differences were found. It can, therefore, be assumed that any statistical differences observed were not due to group or therapist differences.

The authors found improvements on all measures of depression with the outcomes of the mutual help groups being equivalent to those of the CBT groups. Furthermore, the authors found that peer-led groups were as efficacious as professionally led groups. The number of participants who fell below case-ness at the end of treatment as measured by the Beck Depression inventory (BDI) was greater in the CBT group compared to members in the MSG. Furthermore, professionally facilitated CBT groups had a greater number of members below the clinical threshold compared to CBT groups facilitated by para-professionals. It could be argued that this is explained by the prior training professionals will have received in treating depression.

It is important to note that the MSGs were not pure self-help groups in terms of the training offered to the leaders by the research team. It was evident that the para-professionals had experience of facilitating groups but it was not clear whether the paraprofessionals had personal experience of depression. It is generally expected in self-help groups that facilitators share the same experiences as the members. Nevertheless, the finding that all participants demonstrated improvements is encouraging. The research design did not permit the analysis of processes of change and did not control for non-

specific group factors. Being a member of a group may have accounted for the variance in scores, as could the specific techniques employed by the therapists. Finally, generalisability of the findings to participants of hearing voices groups is limited due to the exclusion of participants with diagnoses of psychosis and bipolar disorder.

Improvements in psychological wellbeing. GROW is a grassroots self-help organisation that provides a peer support program for people with a mental illness. GROW, which is not a mnemonic, was established and developed by mental health survivors over fifty years ago. Its core aim is to support personal growth and development. Many research articles have been published about the effectiveness of the GROW programme. I shall summarise the findings of Finn, Bishop and Sparrow (2007) who sought to explore the impact of GROW on its members' psychological wellbeing and mental health.

First, in total 2,350 questionnaires were sent to GROW members across 267 Australian GROW branches to provide cross sectional data across GROW members. A total of 934 questionnaires were returned (response rate 40%) of which 907 were included in the final analyses. Second, a longitudinal survey was conducted. A total of 54 GROW members, with less than two month's membership, were surveyed at time point one (no specific details were provided) and at six months follow up. Complete data were collated for 28 members. Third, qualitative interviews were conducted with 24 GROW volunteers to describe their experiences before and after joining GROW. These data were content analysed.

In terms of the cross sectional survey, length of GROW membership was moderately correlated with a reduction in medication use and a reduction in hospitalizations. In terms of psychological wellbeing, an association between improvements in autonomy, coping skills, sense of self-worth/purpose and GROW activities was found. Moderate positive correlations between length of GROW membership were found with autonomy and environmental mastery. Longitudinal data were analysed using a multivariate analysis of variance. Pertinent results included statistically significant improvements on wellbeing factors of autonomy, environmental mastery, personal growth, and self-acceptance/purpose in life.

According to the authors, data from the focus groups and interviews generated two overarching themes; life skills development and application and a change in self-perception. The former included sub-themes of education, interpersonal development and helping. The second theme encompassed a sense of belonging, feeling useful and feeling valuable.

In summary, the authors concluded that the data from the quantitative and qualitative elements of the design demonstrated the beneficial aspects of GROW membership across several domains of mental health and psychological wellbeing. However, there are several methodological weaknesses which mean results should be treated with caution. First, the reliability and validity of the measure of psychological wellbeing were not described so its ability to adequately measure this concept is unclear. Second, sampling bias and self-selection bias pose threats to the validity of the findings yielded from both forms of data collection. As results were dependent on self-report, social desirability may have impacted on how participants completed the measures. Finally, all participants were self-selected and chose to remain in the research. This means that the views and outcomes of those who did not opt in or those who dropped out of the research are missing. As such, the views detailed in the research only represent a portion of those accessing the GROW self-help groups.

Despite the methodological flaws, this research provided a useful description of change at an individual level in the domains of psychological functioning, described important group processes, and developed themes of change related to being a GROW member from in-depth qualitative interviews. The nature of mutual support groups determines that results cannot be generalised, and one would not wish to do so considering the heterogeneous nature of groups. Nevertheless, important themes which relate to Yalom's (1975) group therapeutic factors were evident. The research raises important findings worthy of further exploration.

Social functioning and empowerment. Segal and Silverman (2002) sought to explore the relationship between self-help agency members and social functioning and empowerment. The self-help agencies included in the study were run by consumers of services. Two hundred and fifty-five randomly selected participants of self-help agencies completed an interview at baseline and at six months. Measurement involved the use of well validated tools with sound psychometric properties. Furthermore, the researchers statistically controlled for the potentially confounding effect of previous exposure to the self-help agency in their analyses. Changes in domains over the two time-points were conducted using paired samples t-tests.

Participants indicated a significant improvement in personal empowerment but no significant changes were observed in the domain of independent social functioning, although assisted social functioning demonstrated a significant decrease. The improvement in personal empowerment is encouraging but without the presence of a

control group, causality attributed to attendance at self-help agencies is limited. A complicated picture of change in social functioning was observed, in that assisted social functioning decreased but scores on independent social functioning demonstrated no change. The researchers account for this by explaining that participants had been involved with self-help agencies for some time and as a result had reached their potential on the domain of assisted social functioning prior to assessment. In conclusion, the authors suggest that a model of care which promotes empowerment to make decisions about care is the active ingredient necessary in self-help agencies to engender positive outcomes.

The helper-therapy principle. Roberts, Salem, Rappaport, Toro, Luke and Seidman (1999) aimed to explore the links between psychological adjustment and the help-giving interactions in the self-help group for people with serious mental illness known as GROW. According to the Helper-therapy principle (Reissman, 1965) the authors hypothesised that helping processes (help-giving and help-receiving support) interactions would predict psychological adjustment.

Over a period of twenty-seven months, 10 research assistants attended fifteen different self-help groups, which were part of the wider GROW organisation. During these meetings help-giving and help-receiving processes were observed and coded. Group members were then approached to complete longitudinal interviews at two time-points in order to assess psychological adjustment. Both self-report and interviewer-rated measures were utilised to assess psychological adjustment in order to control for self-report bias.

First, participants demonstrated significant improvements on measures of psychological and social adjustment. Second, in a series of multiple regression analyses, the authors found that those group members who offered help to others demonstrated improvements in psychological adjustment. Participants who provided helpful comments to other group members had higher self-reported social functioning and interviewer rated psychosocial functioning. The amount of help received was not significantly related to levels of psychological adjustment.

The findings of this research project indicate the importance of help-giving and help-receiving processes in self-help groups. It is important to note that helping processes were coded by observers and not explicitly identified as helpful by the group members themselves. Discrepancies may, therefore, exist between the researchers' and group members' definitions of 'helping process'. Other factors, aside from the helping processes, could account for the change in psychological adjustment such as non-specific group processes. Further, an interaction between helping processes and other factors may

account for the significant changes. It is also noted that extra-therapy life events were not measured. Elliott (2002) recommends a systematic approach to attributing causality to the intervention rather than plausible rival non-therapy hypotheses. According to the framework, which was developed for systematic case study research, extra-therapy life events may act outside of the intervention and contribute to positive change. This potential threat to causality was not measured and so the observable improvements cannot confidently be attributed to the group and helping processes.

Despite the concerns regarding the attribution of causality, this piece of research provides encouraging results about the role of helping processes in self-help groups. More importantly, the research observed a relationship between helping and psychological wellbeing. This finding is strengthened by the fact that both interviewer and self-report measures of psychological adjustment were utilised. The research did not, however, control for self-selection bias which is an inherent challenge when attempting to explore self-help groups.

Helpful aspects of self-help groups. Cheung and Sun (2000) explored a mutual aid group for people presenting with anxiety and/or depression. They aimed to explore group members' perceived helpfulness of the self-help group through structured clinical interview focussing on three areas; benefits, helping processes, and helpfulness of helping processes. The researchers analysed the data using within-subjects analysis of variance and found significant differences among the helpfulness scores. Post hoc t-tests were performed to examine the differences among the perceived helpfulness of the processes and results showed that 'universality', 'self-disclosure', and 'instillation of hope' were considered significantly more helpful than most of the processes. These results again reflect Yalom's (2005) therapeutic framework for groups. Interestingly, 'altruism' and 'feedback' were considered least helpful. The researchers performed a stepwise regression analysis to identify the processes that most strongly predicted perceived benefits of participation; 'support' and 'catharsis' were significant predictors.

The results must be interpreted with caution due to a small, specific sample of participants who presented with anxiety and depression. It is unclear how these results may be generalised to individuals with experiences of voice hearing self-help groups.

Meanings of self-help. Leung and Arthur (2004) explored the experiences of those participating in a self-help group for people recovering from mental illness. The researchers conducted twelve interviews with self-help group members; questions focussed on the

meaning of self-help and personal experiences of participating in self-help groups. Detail regarding the approach used to analyse the transcripts was not provided; although credibility checks were utilised in terms of an external researcher checking the interview data to confirm the development of themes.

Three major categories were derived from the interview data; 'meaning of self-help', 'experience of self-help group', and 'changes in life'. The first category was characterised by participants recognising that self-help was a process of helping oneself and recognising one's own power. The second theme was characterised by the reflections of participants' experiences within the self-help groups. For example, participants reported feeling cared for and supported in the group. Finally, the third theme consisted of seven subcategories which described how participants' defined their changes following the group. These included references to social circles, emotional catharsis, learning, empowerment and learning from others' experiences. The most frequently stated benefits in the transcripts of respondents were social networks (11 respondents), emotional release (10 respondents) and better functioning (9 respondents).

Overall, the researchers concluded that the experience of attending self-help groups was beneficial according to the 'helper therapy principle' (Reissman, 1965) and according to Yalom's (1975) therapeutic factor of 'group cohesiveness' which enabled a supportive environment for members to share their experiences and feel cared for. The main changes identified by participants related to increased social networks, empowerment and emotional catharsis. These domains would loosely fit onto improvements in quality of life and social functioning.

It was apparent that self-help group members responded entirely positively to the experience of attending the groups. It is important to note that participants were selected using purposive sampling which does not control for selection bias. Sampling past members of the self-help group would have offered an insight into why they no longer attended the group, potentially offering a negative counter-voice. Alongside this, there were no details regarding the process of analysis and construction of themes and sub-themes. This makes it extremely difficult to appraise the quality of analysis, and therefore the themes and explanations are interpreted with caution.

Longitudinal research findings. A range of longitudinal prospective outcome studies have explored the benefits of attending self-help groups. In their study, Burti and colleagues (2005) found a reduced rate of hospital admissions and a reduced cost of services at two year follow up for self-help group members. However, measures of clinical

and social outcomes indicated no statistically significant differences. Furthermore, Magura, Laudet, Mahmood, Rosenblum and Knight (2002) explored groups for people with mental health and substance misuse problems. They found that attendance at the self-help group was the best predictor of medication adherence.

Summary. The existing literature pertaining to self-help groups in other clinical contexts is limited and impaired by the methodological concerns outlined. The methodological weaknesses described perhaps reflect the challenge of researching self-help groups. Nevertheless, from the evidence, helpful aspects of self-help groups appear to include enhancing coping strategies, gaining control and encouraging social reconnection. This coupled with the group therapeutic process inherent in group interventions, provides a strong rationale for the exploration of self-help groups for voice hearers.

Self-Help Hearing Voices Groups

Building on the research into self-help groups for mental health problems is the research specifically focussed on self-help groups for voice hearers. There was a dearth of research and only two studies of interest were found; they are summarised in table 3:

Table 3.

Self-help Groups for Voice Hearers

| Authors (date) | Nature of Group | Study Design | Sample | Outcome Measures | Findings |
|--|---|--|---|---|---|
| Meddings, Walley, Collins, Tullett, McEwan & Owen (2004) | Hearing Voices Group for Adults | Clinical audit Pre-, post- therapy and follow up measures, calculated clinical significance and conducted qualitative interviews. | N=12 50% male Mean age 41 years old Mean time hearing voices 13.3 years Mean length of time involved in service 11.7 years. | BAVQ* RSES* Consumer Constructed Empowerment Scale | Sense of empowerment (p<0.001) and self- esteem increased post group (p<0.000). Reduced frequency of voices (p<0.05), voices perceived as less powerful (p<0.05), and felt much better able to cope (p<0.05). |
| Lee, Hanna, Van Der Bosch, Williams & Mouratoglou (2002) | Hearing Voices Group for Older Adults | Clinical Audit Piloted 12 week group Pre- and post-therapy outcomes | N= 5 Mean age 72.2 years old | BAVQ-R* RSES PSYRATS* Semi- structured interviews (n=3) | No significant pre-post differences Most helpful aspects were listening to others, learning new coping strategies, friendliness of group members and opportunity to give advice. |

Notes: BAVQ= Beliefs about Voices Questionnaire, RSES= Rosenberg Self-Esteem Scale, BAVQ-R= Beliefs about Voices Questionnaire-Revised, PSYRATS= Psychotic Symptom Rating Scale.

Hearing voices group for adults. Meddings and colleagues explored the effectiveness of an NHS run HVG (2004). The weekly group was open and on-going in nature, adhering to the model recommended by the HVN. The group was facilitated by two Psychologists and a Project Worker with experience of hearing voices. Main topics of conversation in the groups related to coping strategies, famous people who heard voices, medication and recovery.

The authors attempted to evaluate the group by collecting pre- and post-group measures, assessing clinical significance and conducting qualitative interviews. The clinical domains assessed were the omnipotence of voices using items from the Beliefs about Voices Questionnaire (BAVQ; Chadwick & Birchwood, 1995), self-esteem as measured by the Rosenberg Self Esteem Scale (RSES; Rosenberg, 1965), and empowerment as measured by the Consumer Constructed Empowerment Scale (Sciarappa, Rogers and Chamberlain, 1994 as cited in Meddings et al, 2004). Measurement was taken prior to joining the group, after six month's attendance, and after 18 month's attendance.

The study found that the participants' sense of empowerment had increased post-group by 1.34 standard deviations (sds) and self-esteem had increased by 1.5 sds. Out of twelve participants, seven participants demonstrated a clinical improvement in terms of self-esteem and eight participants in sense of empowerment. Furthermore, participants heard voices less frequently, voices were perceived as less powerful, and participants felt more able to cope with the voices. However, there were no significant findings in terms of how much participants perceived their voices to control them.

In addition to using standardised measures the authors used personal construct scales to measure what people hoped to gain from the group. This served as a more individualised approach to measuring change. The more common constructs cited were to 'hear voices less often', 'to feel normal/less insane', 'to cope better with voices' and 'to feel less anxious/frightened or panicked'. The authors concluded that there was a large improvement on members' individual constructs although the authors omitted detail of how this was assessed.

In terms of qualitative feedback, the authors stated that participants' feedback was entirely positive. Members found the group enjoyable, helpful, useful and supportive. The authors conclude that the feedback related to Yalom's concept of 'universality' in group work (Yalom & Leszcz, 2005).

Despite the promising findings, there were methodological flaws in this study which failed to address threats to validity and consequently limits the ability to attribute causation to the group intervention. For example, there was little description of how participants

were recruited which fails to take into consideration self-selection bias and the implications this holds for interpreting qualitative feedback. Furthermore, detail regarding the statistical analysis was lacking. Multiple t-tests were conducted but the authors did not statistically correct for multiple comparisons using Bonferroni's correction. This increased the likelihood of detecting a significant change when there was not one.

Whilst the qualitative element was useful in gauging emerging themes, the authors did not detail how the interviews were conducted and whether the interview schedule was piloted. The interview questions were not available and so the interview schedule could not be critiqued in terms of whether its questions were leading or biased in any way. The main finding of interest was that participants reported being able to cope with the voices more. Yet detail of how this was assessed was missing. As a result, the findings must be accepted with caution due to multiple threats to their validity. Nevertheless, the research described a pattern of emerging themes of change which should be explored further.

Hearing voices group for older adults. Lee, Hannan, Van den Bosch, Williams and Mouratoglou (2002) applied the principles of hearing voices groups to an older adult population. They piloted a 12 week hearing voices group and collected pre- and post-therapy data using well validated tools. Their sample consisted of five older adults with a mean age of 72.2 years. No significant differences were found in terms of the quantitative measures, likely due to the small sample size.

The authors also conducted semi-structured interviews which were content analysed. Three group members stated that they had changed due to the group, in terms of increased confidence and feeling less isolated. The most helpful aspects of the group were described as being; listening to others, learning new coping strategies, friendliness and the opportunity to give advice to others. These tap into the helpful aspects of group therapy as outlined by Yalom and Leszcz (2005). Overall the preliminary results suggested that the group was useful to its members and the authors suggested that this provided a basis for further exploration.

Summary of Current Literature

The literature review has highlighted the paucity of research into the experiences of those who attend Hearing Voices Groups. There are several reasons for this. First, due to the open nature of self-help groups, the opportunity to evaluate in a more structured and standardised way has been limited. Second, the usefulness of standardised outcome

measures which focus on clinical markers of recovery in this context is questionable, which limits the ability to conduct well designed quantitative effectiveness and efficacy research studies. The review has detailed some therapeutic aspects of self-help groups in other clinical areas; however, it is not clear to what extent research from other clinical areas can be generalised to HVGs.

Despite the challenges of conducting research in this area, the research presented so far has attempted to explore the benefits of attending self-help groups. Some authors have captured the experience of their group members and yielded encouraging results; however, methodological weakness makes it difficult to draw confident conclusions from their findings. Given the lack of research into the potential benefits of self-help groups for voice hearers, there is a strong rationale to explore members' experiences of attending these groups.

Research Questions

Due to the growing prevalence of HVGs it seems essential to explore how these groups are experienced in order to have a greater understanding of their role for voice hearers.

Therefore the aim of this research is to explore the following questions:

1. What are the experiences of those attending a self-help Hearing Voices Group?
 - a. Why do participants attend the Hearing Voices Group?
 - b. What do participants enjoy about attending the Hearing Voices Group?
 - c. What do participants find unhelpful about their experiences in the Hearing Voices Group?

CHAPTER TWO

Method

This chapter will outline the design for the present research project. A description of the self-help Hearing Voices Group and the participants will be provided, as well as details of the recruitment and sampling procedures. I will then outline the process of data collection and data analysis, paying attention to ethical considerations. Finally, I will provide a reflexive statement in an attempt to situate myself as the researcher in the research process.

Design

The research was designed to explore the experience of those who attended a self-help Hearing Voices Group in the North-West of England. A qualitative design was chosen. A homogenous convenience sample of seven adults aged between 28 and 48 years old were recruited and interviewed using a semi-structured interview schedule. Interviews were transcribed, verbatim, and analysed using Interpretative Phenomenological Analysis (IPA) to generate experiential themes. Analysis was conducted for individual participants in the first instance. Following this, a group analysis was conducted across participants to identify master themes and super-ordinate themes.

Participants

Defining the sample of interest. I aimed to recruit a sample of individuals who attended a self-help group for voice hearing, in order to explore their experiences. I assumed that these groups would only be attended by voice hearers; however, it soon became apparent that individuals who did not identify themselves as voice hearers also attended the group regularly. This discovery had implications for the homogeneity of my sample.

First, this realisation led me to reassess my original inclusion criterion regarding self-identification as a 'voice hearer'. I began to question how to define a 'voice hearer' and realised that this was far more complex than I first thought. First, one view regards voice hearing as being a common human experience which exists along a continuum (Bentall, 2003); this could mean that anyone could be defined as being a 'voice hearer'. If I

was to take this stance in the recruitment it would mean that I could include all individuals who opted in. However, I was concerned that viewing voice-hearing according to the continuum theory might represent a bias in my own understanding of the phenomenon. Furthermore, whilst the continuum theory is one idea of understanding voice hearing, it has not been widely accepted across all areas of mental health care (David, 2010).

Second, the label of 'voice hearer' seemed to exclude some group members with voice hearing experiences. This led to my second consideration; that self-identification as a 'voice hearer' was challenging because the label of 'voice hearer' had a variety of different meanings and connotations for each individual group member. Some group members openly described themselves as a voice hearer whereas others were rejecting of the label as it did not fit with their own explanation of their experiences.

Third, the group was attended by participants who had a range of voice hearing experiences ranging from a single episode to daily experiences of voice hearing. As such, the homogeneity of my sample could be compromised because of the variety in individual experiences even if only self-identified 'voice hearers' were included.

Fourth, I was interested in why individuals attended the group if they did not self-identify as a voice hearer. I wondered whether there were shared experiences which kept these individuals attending the group routinely.

Given these considerations I decided not to exclude any group members from participating in the research on the grounds of self-identifying as a voice hearer. Instead, the homogeneity of my sample rested on the shared experience of attending the same self-help group, having contact with secondary care mental health services, and the experience of being prescribed, and taking, medication for psychological distress.

Recruitment criteria. The initial inclusion criteria consisted of the following:

- Individuals were regular attendees of the Hearing Voices Group
- Individuals had attended the Hearing Voices Group on at least two occasions in the six months prior to the interview being conducted
- Individuals had the capacity to understand what would be expected of them if they participated in the research
- Individuals were able to consent to participating in the research

Participants were excluded from the study if they were new members to the group, as their experiences were considered likely to be different than those who had attended the group on a regular basis in the six months preceding the interviews. Individuals were also excluded if they were in crisis or intoxicated at the time of recruitment and/or interview; it was decided in these instances that participants were unable to consent to participating. Finally, no participants were excluded according to diagnosis.

Recruitment procedure. The recruitment procedure had a number of stages. Firstly, I consulted the Hearing Voices Network website: <http://www.hearing-voices.org/groups.html> and referred to their 'groups' pages. I contacted three groups across the North of England. One group had to be excluded from the present research study as it transpired that it was professionally facilitated and operated within the NHS. The second group was voluntarily run and facilitated by those who had voice hearing experiences. I attended this group on three occasions in June 2010 and presented the research idea to the group members. Unfortunately, there was little interest from the group members. This may have been due, in part, to the group members having just completed participation in a different research project. I wondered whether this had left the group feeling 'over-researched' and so I decided to concentrate my recruitment efforts with the third group. The third group had expressed an interest following an initial email I had sent them. The group facilitator had offered to meet with me and discuss the research proposal in detail.

Following this discussion, I was invited to meet the group members and present the research idea. I explained what would be expected of the group members if they chose to participate and answered any questions and queries. Through this discussion it became apparent that the group wanted me to be an active member of their group and attend group sessions over the course of the research rather than relating to the group solely as an external researcher. This was an important consideration for group members as they wanted the opportunity to become more familiar with me and I had to gain their trust. Being an active member meant attending group sessions and responding to what group members said in the group. There was also the assumption that I would share what I felt comfortable to share in the group as well. I agreed that I would attend the group during the period leading up to interviews.

I attended the group on eight occasions between July and October 2010. During the course of attending the group, I aimed to be an active participant rather than a passive observer. I shared how I had been feeling during the week, particularly if that included

periods of stress or anxiety. I also responded to what group members were sharing, for example, asking them to tell me more about what they were describing, and sharing my thoughts. Whilst this was an important role to take, I was mindful of my professional boundaries and my role as a researcher and not a voice-hearer.

Through the course of attending the group, I was able to approach group members to ask whether they were interested in participating in my research project. I took copies of the participant recruitment letter and information sheet with me to help potential participants make an informed decision about participation (Appendix II). I left the information sheets, opt-in slips, and my contact details with the group members after I had attended the group weekly for one month. Potential participants had two ways of opting in to the research study:

- Participants could complete the opt-in slip and hand it to the group facilitator or, if they wished to remain anonymous, they could post it directly back to me in a freepost envelope provided.
- Participants could opt-in following verbal conversations I had with participants in group meetings.

One participant opted-in using the freepost envelope option; the remaining participants opted-in following verbal conversation with me. Following either route, appointments to conduct the interviews were made one or two weeks in advance with potential participants.

Sample information. The Hearing Voices Group had a large membership but at the time of the present research study, seventeen individuals were in attendance over the course of the six months of the research being conducted. Figure 3 below represents the recruitment flowchart of participants:

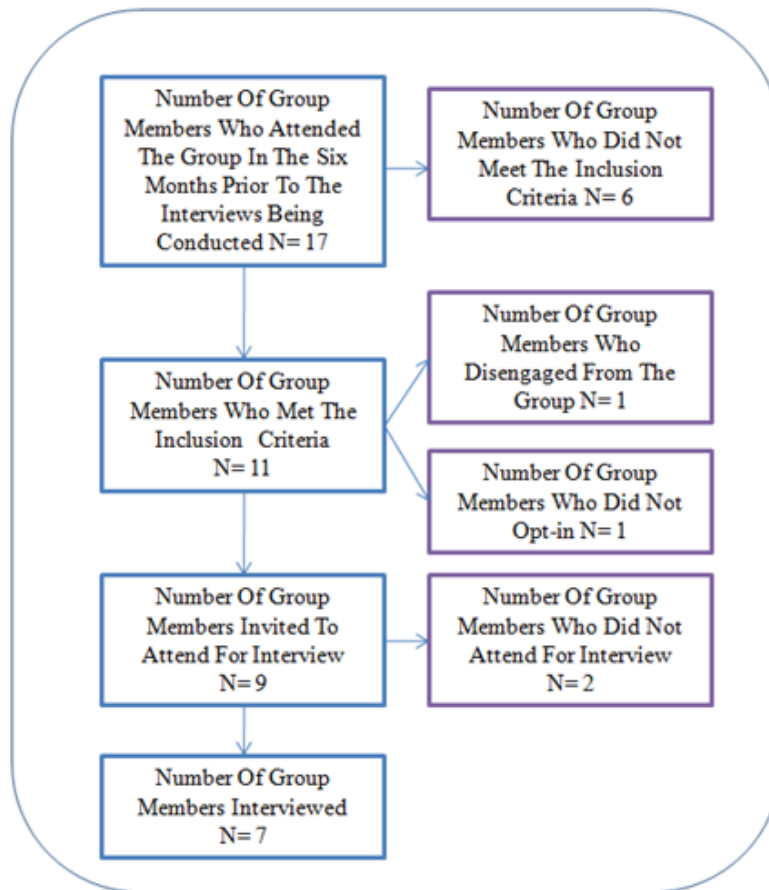


Figure 3. Participant recruitment flowchart

A number of participants did not meet the inclusion criteria; two individuals were in crisis at the time of recruitment, two new group members had not attended the group on more than two occasions and so would not have an equivalent group experience to the others, and the final two group members had re-engaged with the group after a break but had not attended the group during the six months prior to the interviews.

In total, of the eleven group members approached to participate, nine opted-in and seven kept their interview times. Of the seven who attended the interviews, five identified themselves as voice hearers and two participants did not identify with this description of their experiences. Table 4 summarises demographic information about the participants including age, ethnicity, and whether they identified themselves as voice hearers. In order to preserve anonymity, participants were assigned a pseudonym.

Table 4.

Summary of Participant Information

| Participant Pseudonym | Gender | Age | Ethnicity | Time with the Hearing Voices Group | Medication | Current Contact with Healthcare professionals | Employment | Voice Hearing Experiences | Length of Time Hearing Voices |
|------------------------------|---------------|------------|--------------------------|---|--|--|-------------------|----------------------------------|--------------------------------------|
| Jay | M | 46 | Afro-Caribbean and Irish | 3 years | Anti-psychotic | Psychiatrist | None | ✓ | >20 years |
| Amy | F | 48 | White British | 1 year | Anti-psychotic | Psychiatrist | None | ✓ | >10 years |
| Tom | M | 41 | White British | 1 year | Anti-depressants | Psychiatrist | None | x | n/a |
| Sean | M | 42 | Other | 2-3 years | Not currently taking medication but past experience of taking anti-psychotic | Psychiatrist | None | ✓ | >3 years |
| Catherine | F | 28 | White British | 1 year | Anti-psychotic | Psychiatrist | Studying | ✓ | >20 years |
| Eleanor | F | 37 | Black British | 3 years | Anti-psychotic | GP | Part-time work | ✓ | >12 years |
| Adam | M | 32 | White British | 2 years | Mood stabilisers | Psychiatrist | Volunteering | x | n/a |

Participants were adults of working age and had attended the HVG on at least six occasions in the six months prior to the interviews being conducted. Participants had experience of secondary care mental health services which included attending psychiatric outpatient appointments to manage medication. Participants ranged in ages between 28 and 48 years and had attended the Hearing Voices Group for between one and three years. For those participants who identified themselves as voice hearers, their experience of voice hearing ranged in experience from three years to over 20 years duration.

Hearing Voices Group

The Hearing Voices Network has operated in the UK since the 1980s and established the first Hearing Voices Group in Manchester in 1988. Historically, the group ran across three different locations in its founding city and changed facilitators a number of times. The group, in its current guise, had been operating with the current facilitator for three years prior to the interviews being conducted. Several of the group members had been involved with the group when it operated at different locations across the city.

The group ran weekly every Friday between 1-3pm and was characterised as an 'open' group in that members could attend as frequently as they liked. The group was facilitated by a non-voice hearing volunteer alongside several voice-hearing group members. The first half of group sessions begun by each member identifying their position on a 'jelly-baby tree' painting, this depicted different emotional states as illustrated in figure 4.



Figure 4. A photograph of the Hearing Voices Group 'jelly-baby tree'

Figure 4 illustrates the 'Jelly baby tree' utilised by the group as a focus for the first half of the group meetings. The group facilitator used it to 'check-in' with each group member and explore how the week has been for that individual. The group then took a tea break after the completion of this exercise. Following the break, the time was free from structure and group members discussed a range of health related topics including; voice hearing, unusual experiences, medication, mental health services, and past experiences. The group also discussed a whole range of non-health related experiences including music, hobbies and interests.

Ethical Considerations

Participant and interviewer wellbeing. Due to the sensitive nature of the topic, there was the potential for participants to be affected by the interview. Safeguards were

therefore put in place, for instance, participant wellbeing was checked verbally at the end of every interview. A list of helpful agencies' contact telephone numbers was collated to give to participants at the end of the interview. I conducted all of the interviews at the centre where the group ran, which was staffed during the course of the interviews. The voluntary staff members at the centre were aware that I was conducting interviews and were happy to be approached at the end of interviews if any participants became distressed. No participants became distressed during or after the interviews.

Consent. Informed consent was sought by providing participants with a detailed information sheet and asking them to sign a consent form (Appendix III). The information sheet was designed to clearly outline what participation would entail, my reason for approaching them, time commitment, likely topics to be covered in the interview, the potential for sensitive information to be discussed and levels of confidentiality and anonymity.

Before beginning the interview, I asked participants if they had any outstanding questions from the information sheet and whether they wanted me to clarify anything. Participants were then asked to read and sign the consent form. The consent form asked:

- whether participants had been informed of their right to withdraw consent up to one week after the completion of the interview;
- if they had been offered the opportunity to ask questions;
- if they consented to audio recording;
- that they consented to participate in the research.

Both the information sheet and consent form were developed in consultation with a service user consultant to ensure that they were clear, accessible and made sense to the reader. No participants withdrew their consent to participate in the research.

Confidentiality. As I had attended the group prior to the interviews being conducted, I was mindful of the impact this might have on participants feeling comfortable disclosing experiential information through the course of the interview. In an attempt to manage this, I emphasised that I was not allied to the centre where the group ran. Second, at the outset of the interview I clearly re-stated my position as a researcher and emphasised that everything discussed in the interview was kept confidential. There were

two caveats to confidentiality; first that I would be using anonymised extracts from the interviews in the final write up of the research, and second, that if participants disclosed information pertaining to risk to self or others, I would need to breach confidentiality and disclose this information to the staff at the centre where the group ran.

Finally, I made the decision that during the process of conducting interviews I would withdraw from attending the group sessions. This was a deliberate strategy to try to protect the participants' space in the group setting. I was concerned that, having talked to me about their experiences of the group, participants might feel they had to censor what they continued to say in the group if I were to continue attending.

Payment. Participants were paid £15 for their time. This was not made explicit during recruitment stages as I was concerned about coercion, so the offer of payment was made at the end of the interviews. It was made clear that the payment was a gesture of good will, thanking them for their time. I also emphasised that the payment did not have an impact on whether they could withdraw their consent; participants would be able to keep the payment irrespective of whether consent was withdrawn. All participants were offered payment and everyone accepted.

Ethical Application. As the research recruited participants from a self-help Hearing Voices Group which was affiliated to the voluntary organisation the Hearing Voices Network, NHS approval was not required. Therefore, the proposal was submitted to and approved by the University's Institute of Health Sciences' ethics committee (Appendix IV).

Qualitative Methodological Approach

The following section will provide a description of Interpretative Phenomenological Analysis (IPA) as a qualitative approach to the analysis of individual experience. This approach was deemed most appropriate for addressing the research questions of the present study.

Interpretative phenomenological analysis. IPA is associated with a branch of philosophical thinking known as 'phenomenology' which is concerned with how humans gain understanding about the world around them. IPA focuses upon "*people's experiences and/or understandings of a particular phenomenon*" (Smith, Flowers & Larkin, 2009, p. 46). It enables the researcher to engage with individual experience at an idiographic level and is inductive in its approach, that is, the researcher works 'bottom up' from the data. IPA does

not test prior hypotheses but rather aims to capture and explore the meanings participants attribute to their experiences.

Interpretation is a key part of the interpretative analytic process and has two elements. First, the individual's interpretation of their experiences and second the researcher's interpretation of the participants' interpretations (known as the double hermeneutic). Given this, the researcher's views of the world are implicated and the researcher must reflect on this throughout the research process. IPA accepts that data generation is, in part, constructed by the researcher in an interaction with the data. The role of the researcher is central in the research process in terms of the questions asked, the way the method is being used and the researcher's own assumptions, biases, experiences and knowledge.

Alternative approaches. Discourse Analysis was considered as an approach because of its roots in Social Constructionist epistemology. Discourse Analysis is concerned with how a phenomenon is constructed through language. If I had been primarily concerned with how voice hearing or self-help was constructed by the group members, this approach would have been more appropriate. As the research questions are more experiential in nature, Discourse Analysis was discounted.

Grounded Theory (Glaser & Strauss, 1967) was also considered as an alternative approach. Grounded Theory aims to make sense of phenomena and attempts to generate theories arising from the data being explored. Since its original inception as a qualitative methodology and approach, it has gone through several revisions. Common across the approaches, however, is the use of 'categories of meaning' from which theories emerge. Categories are constructed from the data corpus, and the researcher makes links between these, and assesses how one might establish relationships between these categories. Ultimately, a theoretical framework is devised which attempts to understand the phenomenon under investigation. The present research study was not concerned with developing a psychological theory relating to the benefits of self-help groups; this has already been documented. Instead, the present research study aimed to explore the *experiences* of those attending the group therefore, Grounded Theory was discounted.

Finally, Thematic Analysis (Braun & Clarke, 2006) was considered as an approach to data analysis because of its flexibility in approach, which arises from not being tied to a particular theoretical model. Thematic analysis has, however, been criticised as a poorly demarcated approach which underpins all other qualitative methods. Braun and Clarke (2006) maintain, however, that it is an independent method of analysis in its own right and

aims to; identify, analyse and report patterns and themes within data. Thematic Analysis was discounted, however, due to its lack of focus on the phenomenology of experience; something with IPA holds as central in its approach.

Justification of approach. Whilst the approaches referred to all aim to explore and make sense of a particular phenomenon, there are theoretical and methodological differences between the approaches which provide a rationale for choosing IPA for the present study. The role of induction in Grounded Theory is important in comparison to IPA. Grounded Theory aims to minimise the biases of the researcher by providing a step-by-step guides to analysis (Strauss & Corbin, 1990), and in some instances a coding paradigm can be provided. A coding framework can encourage the researcher to code data in a predetermined way. This deductive approach to research is in contrast to the inductive approach of IPA in terms of data being derived in a ‘bottom-up’ manner.

Finally, Grounded Theory is influenced by positivist epistemology within which the researcher believes that analysis will reveal pre-existing phenomena. This approach assumes, therefore, that the researcher does not impose any preconceptions or biases on the research process. This is in contrast to the role of the researcher in IPA research. Given these differences, IPA was favoured as more appropriate methodological approach.

Sampling and homogeneity. IPA is concerned with the detailed examination of people’s lived experiences and a small sample size is recommended for this endeavour. There is a concern with large samples that important detail in participants’ experiences may be lost. Whilst there are no formal guidelines regarding sample size for IPA projects; between four and ten interviews is advised for professional doctorate research projects (Smith, Flowers & Larkin, 2009).

Data collection. A range of qualitative approaches to the study design were considered. First, a focus group design was considered as an alternative qualitative approach. The strength of this approach rests in its potential to gather rich data collected in a dynamic group atmosphere. The researcher acts as a moderator and gently ‘steers’ the discussion in the group context. There is the potential for group members to generate discussions through their mutual questioning and the researcher can “*mobilize participants to respond to, and comment on, one another’s contributions*” (Willig, 2001, p. 29). With this approach, there is also the potential for the researcher to check-out and follow up ambiguous data in the group setting itself. However, focus groups have methodological

limitations in their own right. First, there is the potential for alternative views to be unheard in a group context; a phenomenon known as group think whereby group members conform to the majority view (Crawford & Acorn, 1997). Secondly, due to the group setting and the presence of other participants, disclosure of personal experiences may not be facilitated. A concern for the present study was how to encourage individual reflection on participants' experiences of the group. There was the potential for aspects of experience to be negative or unhelpful; I was concerned that these views may not be expressed in a focus group design. Furthermore, group processes which occur in focus groups need to be managed by the facilitator with care; something I did not feel confident to do due to my lack of prior experience conducting focus groups.

Semi-structured interviews, by contrast, appeared to hold a number of advantages. First, there is the flexibility to ask a range of open and closed questions in semi-structured interviews, thus addressing a variety of research questions. Second, the researcher has the space to develop a relationship with the interviewee throughout the interview process. This is important in order for participants to feel at ease when discussing experiences which may be sensitive in nature. Third, semi-structured interviews enable participants to talk in-depth about the topic under exploration, generating rich data. In terms of limitations, it is acknowledged that the researcher is, to an extent, guiding the interview and therefore there is the potential for the research to be biased from the researcher's position. Second, it is acknowledged that rapport can be difficult to build in an interview setting, posing a challenge for the researcher. Finally, the researcher requires sufficient skill to ensure that questions are not asked in a leading manner and needs to encourage participants to explore and reflect on their experiences.

Semi-structured interviews were selected as the most appropriate approach for the data collection in the present study for several reasons. First, I had prior experience of conducting semi-structured interviews and felt confident in the approach. Second, semi-structured interviews were easily organised within the time constraints of the research project. Third, there was the potential to elicit rich data in the context of using my clinical skills to develop good rapport. Finally, semi-structured interviews were selected as the most appropriate means of gathering the rich detailed account of lived experience required as they *"allow rapport to be developed; allow participants to think, speak and be heard"* (Reid, Flowers, & Larkin, 2005, p.22).

Interview Schedule

To help achieve a rich and detailed account, a semi-structured interview schedule was developed. The schedule was used as a 'virtual map' (Smith et al., 2009, p. 59) to guide me as the interviewer; it was not used to restrict the flow of the interview. The schedule was devised in collaboration with a service user consultant who advised on the topics and language. The schedule was organised in a way that was most engaging for the participant; for example broader questions at the outset and moving gradually towards more specific questions. These questions were only used as a guide so that the interview was shaped by the stories the participants wanted to tell (Appendix V).

Interview Setting

Interviews were conducted in a small group room at the centre where the Hearing Voices Group ran. It was hoped that a familiar surrounding would help to put participants at ease and was the least demanding venue for participants in terms of travel.

Transcription

Interviews were transcribed, including the semantic content of the interview, significant pauses, and hesitations. IPA does not require transcription to include detailed records of the lengths of pauses or all non-verbal utterances (Smith et al., 2009, p. 74).

I transcribed two of the seven interviews in order to immerse myself in the data. Due to time constraints, the remaining interviews were transcribed by the University of Leeds Doctorate in Clinical Psychology office administration staff. Independent transcribers were asked to read and sign a confidentiality agreement (Appendix VI). I listened to the audio-recordings of the interviews alongside the transcripts in order to ensure accuracy and encourage my engagement with the data.

Data Analysis

The data were analysed, by hand, and according to the several stages recommend by Smith et al., (2009) outlined below:

Table 5.

Stages of Analysis

| Stage | Title | Description |
|-------|--|---|
| 1 | Reading and Re-reading | Immersing self in the original data by reading the interview transcripts several times. The audio-recording of the interview listened to again. Record reflections and responses to the interview. |
| 2 | Initial Noting | Initial level of analysis describing the content, commenting on the language used such as key words, phrases or explanations, and conceptual coding. Aim to produce a comprehensive and detailed set of notes about the interview transcript. Record comments directly onto the hard copy of the transcript in one of the margins. |
| 3 | Developing Emergent Themes | Aim at this stage is to organise and interpret the data. Analysing discrete chunks of transcripts at a time. Analysing the explanatory notes; mapping the interrelationships, connections, and patterns. Aim to produce a concise statement about what was important in that particular chunk of the transcript. Noted in the other column. |
| 4 | Searching for Connections Across Emergent Themes | The process of mapping how the themes relate to each other. For example, developing a super-ordinate theme by putting similar themes together. Some emergent themes might be discarded at this stage, but should be kept in mind when approaching the other transcripts. Write all themes out on cards and physically organise and reorganise to produce a mapping. Develop a graphic representation of the structure of emergent themes e.g. a table or figure. Each theme should be annotated with page, line number, and a few key words to illustrate. |
| 5 | Moving to the Next Case | Repeat the process detailed above with the remaining transcripts. |
| 6 | Looking for Patterns Across Cases | This stage involves laying out the table of themes for each transcript and looking for patterns and connections. Ideal to represent patterns and connections in a table of themes for the group with each theme illustrated by each participant. |

Data analysis is an iterative procedure requiring close engagement with the data in order for the researcher to gain an *'insider's perspective'* on the topic being explored (Reid, Flowers, & Larkin, 2005, p. 22). First, each individual participant was treated as a single case and analysed individually following stages 1-4 outlined in table 5. The analysis was a cyclical process in which I regularly moved in between stages rather than following in a linear manner. The main stages of analysis involved:

- Several close readings of the data accompanied with making detailed reflective comments. I also used reflections that I noted at the time of conducting the interviews.
- Codes were generated and assigned to data units. The language of the codes was kept close to the original data in order to keep close to the individual's experience.
- In order not to lose the detail and idiosyncrasies of the individual's experience, interesting quotations were highlighted throughout the transcript.
- Emergent themes were then assigned to capture my interpretation of the codes.
- Emergent themes were then written on to post-it notes along with the page number and line number of each quotation.
- I then clustered the emergent themes in a variety of compilations until a final grouping was achieved which accurately reflected the participant's experience. Super-ordinate themes were generated at this stage of analysis.
- I then constructed a table which captured the super-ordinate, subthemes and their associated quotations. At this stage, further re-clustering and renaming could be achieved.
- Finally, a graphical representation of the participant's experience was designed using a thematic map with a freeware computer software programme (Xmind, 2011).

For an illustration of the coding process, please see the extract from one interview in Appendix VII. Following the analysis of each case individually, a group analysis was conducted whereby patterns across participants were elicited. This stage of analysis consisted of the following steps:

- I wrote the subthemes for each participant onto post-it notes with an accompanying quotation.
- The subthemes were then clustered and re-clustered until a pattern was reached which adequately reflected group experiences. Master theme names were assigned at this stage which reflected the interpretative and conceptual level of analysis.
- The master themes and their super-ordinate themes were then transferred into a table with accompanying quotations from all participants.

- A final set of master themes was then represented graphically using the same freeware computer software.

My Relationship to the Group

In order to gain the trust of the group, I was an active member of the group over the six months prior to conducting the interviews. By 'active' I mean responding to the contributions of group members as an individual rather than as a psychologist in clinical training, or a researcher. This was a difficult role to maintain at times, especially when I was called on by the group facilitator as an 'expert'. I often had to deflect this claim and respond as an individual. In terms of my membership, I would join in on the 'jelly baby tree' in order to be an active group member rather than a passive 'expert' observer.

There are implications of my being an active group member. First, the group may have changed simply as a result of my presence. Second, I am privy to additional knowledge about the group and participants' experiences which needed to be 'bracketed off' along with my biases and assumptions through the process of data analysis. Third, I developed good relationships with group members and was able to gain their trust; I believe this was extremely helpful in recruiting individuals, and in terms of establishing a rapport before the interviews were conducted. There was the potential, however, for participants to assume I had greater knowledge of the group because of my attendance. I was aware of this beforehand and ensured that I encouraged participants to give detailed accounts, regardless of my knowledge of the group. Finally, there might have been the potential for participants to censor what they disclosed in the interviews because I was also a temporary group member. Again, I made it explicit at the beginning of the interview that, whilst I had attended the group on a number of occasions, I was interested in all aspects of *their* experience and held no alliance to the voluntary centre which ran the group.

Quality Checks

One of the biggest challenges for qualitative researchers is how to ensure and demonstrate the quality and trustworthiness of their research. In response to this, Elliott, Fischer and Rennie, (1999) developed guidelines for evaluating the quality of qualitative research and recommendations for how qualitative researchers can enhance their practice. For example, they list credibility checks, transparency of the results, and reflexivity as key elements in

conducting good qualitative research. I took a number of steps to ensure the quality of the present research:

- I enlisted the help of my academic supervisors to provide credibility checks of a sample of transcripts. I sent extracts of interviews with accompanying codes and themes to my supervisors for their verification of my coding framework.
- Second, I talked at length with my supervisors about the emergent themes of each participant's individual analysis and the over-arching group analysis to ensure that I had kept close to the transcripts and the participants' words.
- I provided detailed data extracts to accompany master themes and super-ordinate themes in the forthcoming results section in order to be transparent about the findings.
- I constructed an audit trail when constructing the master themes. This can be used by the reader to assess the quality of my analysis (please refer to the accompanying CD-ROM).
- Finally, I have provided a statement of reflexivity to detail my own position in relation to the research topic.

In qualitative research, the researcher is integral to the process of data collection and analysis. Whilst this has its advantages in terms of engaging with the data and process of interpretation, it inherently produces a source of bias. I came to the research process with my own personal and professional experiences and assumptions. Rather than adopting an objective position, qualitative research requires the researcher to reflect on their position in the research process. This is defined as '*reflexivity*' (Henwood & Pidgeon, 1992). In order to encourage this process, I kept a reflective diary throughout the research process and I will now provide a reflexive statement to outline my position.

Reflexivity

As outlined, the experiences and background of the researcher is integral to the research process in IPA. It is the responsibility of the researcher to reflect on how their own experiences, biases and assumptions may impact on the research. Reflexivity is important throughout all of the stages of the research process.

Reflexive Statement

I think it is important to clarify that I have not had any personal experience of psychosis or schizophrenia, nor do I have any friends or close relatives who have been given these diagnoses. I do not consider myself a voice hearer, although I have had two experiences where I have heard a voice when nobody was present. These experiences consisted of hearing someone call my name and hearing a whisper in my ear. Neither of these occasions caused me a great deal of undue or long-lasting stress or anxiety.

My interest in psychosis and schizophrenia started when I was employed as a community support worker for an NHS mental health service. This involved supporting individuals in the community who were labelled as having 'severe and enduring' mental health problems. The majority of individuals on my caseload had a diagnosis of 'schizophrenia' or had psychosis experiences. My main role was to support individuals in their daily lives. This included taking individuals to medical review appointments and meetings, and supporting individuals to access services. I found, however, that this group of individuals was somewhat neglected by mainstream mental health services. I felt that rather than enabling people I was maintaining a status quo in a service which felt stagnant. I felt hopeless in the situation and within a service which, to my mind, seemed to be maintaining rather than enabling. Due to the unusual experiences many of the individuals on my caseload had experienced, they were often marginalised by other groups in society. I wondered whether this process was being mirrored by mainstream mental health services. I felt strongly that change needed to occur at a wider systemic level in order to challenge the stigma these individuals faced.

From this early experience I have been interested in working with marginalised groups in society. I have also been inclined towards using social constructionist and community psychology approaches to understanding psychological distress. This is something which has continued throughout my clinical training, culminating in my final year elective placement in an early intervention in psychosis service. I have been interested in recovery approaches which are enabling rather than maintaining approaches which have the potential to pathologise experiences. I was attracted to the Hearing Voices Network's ethos of aiming to explore, understand, and empower individuals who have been marginalised and stigmatised due to their experiences.

I acknowledged that, as a white British female, I have pre-existing ideas about the importance of self-help and the potential restorative nature of groups. Recognising that this is my position, steps were taken throughout the research process to bracket off these

sources of potential bias. Providing this statement can be used by readers to evaluate the quality of my research design and findings. Alongside this statement it is also important to reflect on my participation in the self-help group. Throughout the research process I have attempted to stay close to the words of the participants rather than impose my additional knowledge of the group and/or participants. Where this additional knowledge and experience has been used, I have made this explicit, for example, in constructing the pen portraits of the seven participants and the Hearing Voices Group sampled.

Reflexive Interview

In order to provide a final area of transparency in the research, I engaged in a reflective interview designed to explore my experiences of attending the group, conducting the interviews, and engaging in the analysis. The aim of the reflexive interview was to highlight particular experiences of my role in the research process and, in doing so, to increase transparency. This served two functions: first, it helped to bracket-off my assumptions during the data analysis phase, and second; it provided greater transparency for the quality of the research findings to be judged by. The interview was conducted by one of my academic research supervisors who designed exploratory questions beforehand (Appendix VIII) and was conducted during the data analysis phase of the research process. The interview was audio recorded and transcribed. A summary of the interview will be presented in the results section. Please see Appendix IX for pertinent extracts from the interview.

CHAPTER THREE

Results

This chapter will present the results of the Interpretative Phenomenological Analysis which aimed to answer the following research questions:

1. What are the experiences of those attending a self-help Hearing Voices Group?
 - a. Why do participants attend the Hearing Voices Group?
 - b. What do participants enjoy about attending the Hearing Voices Group?
 - c. What do participants find unhelpful about their experiences in the Hearing Voices Group?

First, I will present a pen portrait of each participant in order to set the results of the group analysis in context. I will then present the results of the group analysis using a thematic map and I will explore each master theme with accompanying quotations. This chapter will conclude with a reflective statement which will expand on the reflections I made in my reflective interview.

Pen Portraits

The information for the following pen portraits has come from a range of sources. First, participants spoke about their experiences of voice hearing and other mental health experiences (such as depression) throughout the course of the interviews. Second, my reflections following the interviews were drawn upon. Finally, I used the reflections I made following my experience within the Hearing Voices Group. I have made the source of information explicit within each pen portrait.

Jay. Jay was a 46 year old Afro-Caribbean and Irish male who identified himself as a voice hearer and had been hearing voices for over twenty years. Jay had spent a large proportion of his life in prison which is where his first experience of voice hearing occurred. Jay first came into contact with the Hearing Voices Network whilst in prison and attended an in-reach HVG. Jay attended the HVG under exploration in the present study when he had been released from prison. He came into contact with the group through a friend who previously co-facilitated it. Jay had been attending the present HVG for over three years

and was an active group member, attending regularly. Jay told me in the interview that he was prescribed anti-psychotic medication which made him drowsy. This meant that Jay had difficulty getting to the group on time and tended to arrive after it had started.

During the course of my attending the group, I experienced Jay as warm and welcoming. He was often interested in finding out how other group members were feeling. Jay shared stories of his time in prison with the group. I also observed that Jay consistently arrived late for the start of the group. After the interview with Jay, I noticed that my experience of Jay in the interview mirrored my experience of him in the group. For example, prison was a dominant narrative in his interview and in his contributions to the group; this was unsurprising considering the dominance of prison in his life story.

Jay shared what might be termed 'unusual beliefs' with me in the interview and I remember being struck by how I could intellectually understand what he was saying but I was struggling to *really* know what he meant. I was also struck by Jay's entirely positive experience of the group. I was left wondering whether he was able to think of negative experiences of a group which had given him so much; if he had had any such experiences.

Finally, I was intrigued by the internal representation Jay held of a fellow group member who manifested themselves as an internal voice during the interview process. This was very interesting and I wondered what impact this had on his experience of the group. The interview with Jay lasted for forty four minutes. Jay's transcript was analysed and a thematic map was generated to represent his experience of attending the HVG (please refer to the included CD-ROM).

Amy. Amy was a 48 year old female who identified herself as a voice hearer. Amy spoke of three episodes of voice hearing over the past ten years and described how stressful life events preceded these episodes. Amy did not hear voices constantly. During the six months prior to the interview Amy had been hearing voices, but at the time of the interview she was not. Amy attended the group for less than one year at the time of the interview.

Amy had experience of attending two Hearing Voices Groups simultaneously; both ran at the centre. The first was the group which the present study is concerned with and ran on a Friday afternoon. The second group ran on a Tuesday and was much smaller with less than six members. The facilitator described the group members in the Tuesday group as being more distressed by their experiences. Considering these experiences, Amy often spoke in the interview about her experiences in both groups and how they were similar or different.

I struggled to encourage Amy to reflect and expand on some of her answers. This meant that I found the interview somewhat challenging. This paralleled, however, my experience of Amy in the group as I often observed Amy as being quite reserved and quiet.

In my experience of attending the group, I noticed that, on several occasions, Amy left the group at break-time. I wondered why this was a pattern for Amy and was intrigued to find out how she experienced the group. The interview with Amy lasted for thirty two minutes. Amy's transcript was analysed and a thematic map was generated to represent her experiences of attending the HVG (please refer to the included CD-ROM).

Tom. Tom was a 41 year old White British male and identified himself with the label of borderline personality disorder. Tom described a range of current psychological difficulties including low mood, identity and social isolation. Tom did not identify himself as a voice hearer. Despite this, he had not been excluded from the Hearing Voices Group by the facilitator or the existing group members. During the interview, Tom told me that he shared many other experiences with the group members. For example, low mood, contact with secondary mental health services and contact with a psychiatrist.

Tom told me during the interview that initially he sought the contact of the group to address his social isolation; he also thought it would be interesting to attend. I was intrigued to explore with Tom why he continued attending a group for voice hearers despite not identifying himself with that label.

During the interview, it became apparent that, despite not sharing the experience of voice hearing, Tom gained much from attending the group. For example, he told me that he felt accepted and that attending reduced his sense of isolation. It was clear from the interview that Tom felt he had close connections to his fellow group members and he described a sense of separation at the end of the group sessions.

I found the interview with Tom very interesting because he did not identify himself as a voice hearer and yet it appeared that he gained much from attending the group. This led me to wonder what affect it might have had if I had excluded Tom from the present research because he did not identify himself as a voice hearer. I reflected on whether a parallel process was at work in terms of me not excluding him from the research just as the group had not excluded him from attending.

The interview with Tom lasted for one hour and two minutes. Tom's transcript was analysed and a thematic map was generated to represent his experience of attending the HVG (please refer to the included CD-ROM).

Sean. Sean was a 42 year old male who identified himself as a voice hearer. Sean had attended the group for three years and told me that he had a diagnosis of schizophrenia. During the interview, Sean told me that he had spent some time in hospital which he felt had led to him experiencing symptoms akin to Post-Traumatic Stress Disorder (PTSD). This left Sean managing with some very distressing emotions during the time he attended the Hearing Voices Group prior to the interviews being conducted. Sean also had experience of attending the group which ran on a Tuesday at the centre.

During the interview, Sean's voices were active and this, at times, distracted him from the interview. I wondered whether this was a similar dynamic for Sean to manage within the group. Interestingly, whilst reflecting on what Sean gained from attending the group, he told me that an image of a fellow group member popped into his head with their voice encouraging him. I found this interesting and wondered, after the interview, about internalised attachments to fellow group members.

Sean also spoke of his intense sense of empathy for others and how this impacted on his experiences in the group. For example, Sean described being lifted and encouraged by positive feelings in the group. Conversely, Sean talked about having to manage when he took on other people's negative emotions from the group. This made me wonder about the negative side of attending a group when group members may be distressed.

Finally, Sean told me that he had found the interview very interesting in that it allowed him the space to reflect on his experiences in the group. Subsequently, Sean said that participating in the interview might in turn impact on his experience of the group. This made me wonder about the potential impact of being involved in the research on individual and group dynamics.

The interview with Sean lasted for one hour and twenty-three minutes. Sean's transcript was analysed and a thematic map was generated to represent his experiences of attending the HVG (please refer to the included CD-ROM).

Catherine. Catherine had been attending the group for approximately two years. Catherine did not identify herself as a voice hearer as she felt that the description was incongruent with her own explanations for her experiences. Catherine described hearing the thoughts of other people rather than voices per se. This distinction was important for Catherine in her sense making of her own experiences. Catherine told me that she had had these experiences for as long as she could remember.

Catherine told me that her role in the group was a complex one in that she initially began her experience with the group as a volunteer. Catherine had come to the centre for

a placement which related to her academic studies; this led Catherine to identify herself as a professional in relation to the group. It was later, following stressful events, that Catherine started using the group in more of a personal way. Catherine told me in the interview that this was not an easy transition for her to make. Catherine described a role conflict in terms of when to be a professional in the group and when to disclose her own experiences.

Catherine told me in the interview that she had only recently begun to talk about her own unique experiences with her group members. This meant that her experience of talking and sharing experiences in the group was at an earlier stage in the process compared with other participants in the sample.

The interview with Catherine lasted for one hour and two minutes. A thematic map illustrating the results of Catherine's individual analysis can be found on the included CD-ROM.

Eleanor. Eleanor told me that she identified herself as a voice hearer and had heard voices for over twelve years. She said that she viewed her experience of voice hearing in a spiritual way and often used her connections with her church as a way to seek support. Eleanor described experiencing one dominant voice at difficult times throughout her life. For example, Eleanor told me that she was following a medication withdrawal programme under the supervision of her general practitioner but this caused the dominant voice to come 'thudding' back into her life.

Eleanor had attended the Friday Hearing Voices Group for three years and had previous experience of attending other Hearing Voices Groups in the past. Eleanor was the only member of the sample who was in paid employment at the time of the interviews.

During the interview Eleanor told me that she saw herself as a strong person and had been told by the facilitator that she was an inspiration to other group members. I experienced Eleanor in the group as very reserved and someone who did not share her experiences freely. In the interview, Eleanor told me that she liked to listen in the group and wanted to keep some of her own experiences to herself. Eleanor also spoke about the non-voice hearers who attended the group, and she questioned whether they could really understand the experiences she had to go through as a voice hearer.

The interview with Eleanor lasted for forty six minutes. The results of Eleanor's individual analysis can be found in a thematic map included on the CD-ROM.

Adam. Adam was aged 32 years old and identified himself with the diagnosis of bipolar disorder. Adam told me that he had experiences of clinical depression since his early twenties. Adam described one experience of voice hearing during a period of mental ill health, but did not identify himself as a voice hearer.

Adam had been attending the group for two years, initially as a volunteer. Adam told me that he had seen the centre where the group ran advertised and wanted to help out. He told me that volunteering was a way for him to beat his depression. Adam valued helping people and began attending the Hearing Voices Group, initially as a volunteer. During the interview it became apparent that Adam began to attend the group, not only as a volunteer, but as a member also.

Adam told me that despite not being a voice hearer, he felt he shared many similar experiences with his fellow group members; for example, medication usage, attending psychiatric appointments, and spending time in a psychiatric hospital.

I was struck throughout and following the interview by Adam's positive regard for the group and the unconditional acceptance he experienced from the group. Adam attributed much of his positive individual change to the group and the centre more generally. Following the interview, I wondered whether you do indeed need to have experience of being a voice hearer to experience many of the positive elements of being in a group, such as acceptance and support.

The interview with Adam lasted for one hour and twenty-five minutes. The results of Adam's individual analysis can be found in the illustrated thematic map included on the CD-ROM.

Results of the Group Analysis

A group analysis was conducted to explore experiences of the Hearing Voices Group across participants. Please refer to the included CD-ROM for an audit trail which details the process of clustering individual participant themes to form group master themes and super-ordinate themes. The result of the group analysis is depicted in the thematic map below:

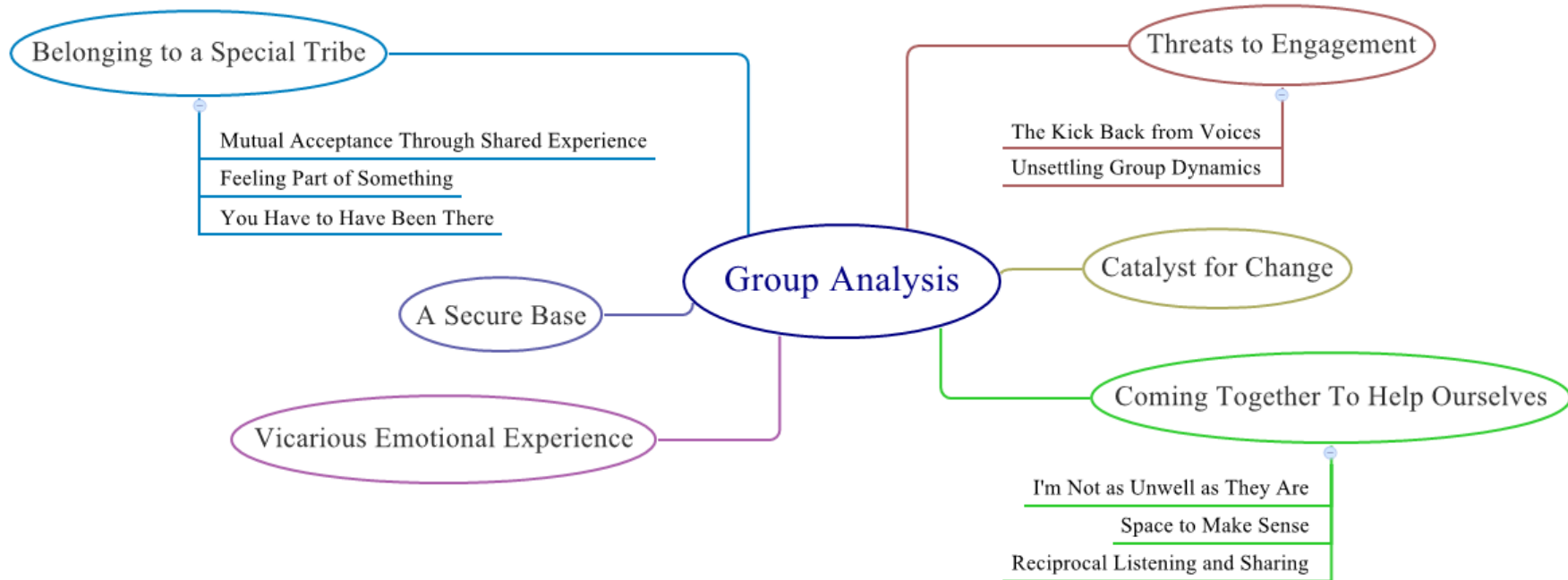


Figure 5. Thematic map representing the master themes and super-ordinate themes following the group analysis

Figure 5 details the six master themes and eight super-ordinate themes generated following the group analysis. Table 6 details the frequency of these themes across the seven participants:

Table 6.

Frequency of Master Themes and Super-ordinate Themes across Participants.

| | | Participant | | | | | | |
|--|---|-------------|-----|-----|------|-----------|---------|------|
| Master Theme | Super-ordinate Theme | Jay | Amy | Tom | Sean | Catherine | Eleanor | Adam |
| Threats to Engagement | Unsettling Group Dynamics | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | The Kick Back From Voices | ✓ | ✓ | x | ✓ | ✓ | ✓ | x |
| A Catalyst for Change | | ✓ | ✓ | ✓ | x | x | x | ✓ |
| Coming Together to Help Ourselves | I'm Not as Unwell as They Are | ✓ | x | ✓ | x | x | ✓ | x |
| | The Space to Make Sense | x | ✓ | x | ✓ | ✓ | x | ✓ |
| | Reciprocal Listening and Sharing | ✓ | ✓ | x | ✓ | x | ✓ | ✓ |
| Vicarious Emotional Experience | | x | x | ✓ | ✓ | x | ✓ | x |
| A Secure Base | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Belonging to a Special Tribe | Mutual Acceptance Through Shared Experience | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Feeling A Part of Something | ✓ | ✓ | ✓ | ✓ | x | x | x |
| | You Have to Have Been There | x | ✓ | ✓ | ✓ | ✓ | ✓ | x |

Table 6 describes the frequency of the master themes and super-ordinate themes across participants. As can be seen, elements of participants' experiences are represented in all of the master themes apart from *Vicarious Emotional Experience* which was present for three participants and *A Catalyst for Change* which was present for four of the seven

participants. I will now explore each master theme in more detail along with additional quotations. Please refer to table 7 in Appendix X for additional illustrative quotations.

Threats to Engagement

The *Threats to Engagement* master theme related to aspects of the group experience which participants found challenging and threatened their sense of safety in the group. The master theme was split into two super-ordinate themes; *Unsettling Group Dynamics* and *The Kick Back from the Voices*. Both of these related to separate aspects of experience which impacted on participants' ability to engage in the group.

Unsettling group dynamics. The super-ordinate theme captured aspects of the group interactions which challenged participants and threatened their ability to attend or engage in the group. Participants talked about group members who dominated the group discussion, attended when they were unwell or disrupted the flow of conversation by arriving late. For example, Eleanor stated *"it's just that [short pause] sometimes when people walk in very, very late...sometimes it's a big distraction. So, I think it would be nice if people stopped at the time"* (p. 61).

As well as challenging group members, participants talked about the limitations of the facilitator in terms of some experiences being misinterpreted or feelings being unattended to; for example, Tom stated:

It's when he said that I looked really depressed and um... [pause] and then he might have said something to cheer me up...And uh... and then I started to uh... smile....then um... he said that I didn't seem that depressed anymore, you know, I started smiling. And uh... sometimes I sort of get really down and that (p. 32).

Unsettling Group Dynamics had the potential for participants to feel uncontained which meant that they felt silenced or unheard in the group as illustrated by Amy who stated that, *"the Friday group is bigger and the people in it are slightly louder. So it's kind of more vocal. Um... It's not such a quiet group"*. This was in contrast to Amy's experience of the Tuesday group which was described as being smaller and more intense.

The kick back from voices. This super-ordinate theme described the negative repercussions of voice hearing following engagement and talking in the group. This super-ordinate theme was clearly only relevant to the self-identified voice hearer participants in the sample. Participants talked about the intensity of voice hearing following the group, *“I was gonna do certain things with the group or whatever, and I felt that there would be kick back from my voices as a result of doing things. So, th... that they would start hammering me even more”* (Amy, p. 56). This quotation also illustrated the silencing effect the voices had on Amy’s ability to talk in the group. This potential to be silenced was shared by others; for example, Catherine talked of an *internal backlash* which occurred following the group if she had talked about her ‘thoughts’, *“well, apart from anything else, they don’t like me talking about them at all. And they tend to get quite [pause] angry and stuff...they don’t like it. And they for years said, “Don’t do it. Don’t say anything””* (p. 34). The negative repercussions following the group was not the only threat to engagement; participants also talked about having to manage their experiences with voices in the group session, *“because sometimes it can be difficult to sit and listen to somebody when you’ve got the voices in your mind”* (Sean, p. 69).

A Catalyst for Change

The master theme *A Catalyst for Change* described the enabling effect of the group on participants’ personal recovery journeys. It was clear from the interviews that participants were all at different points in their recovery journeys. Nevertheless, the master theme was relevant for Jay, Amy, Tom and Adam who each described different aspects of psychological recovery. For example, they described improved self-esteem; for example, *“that boosted my confidence a little bit and made me feel a bit better about myself”* (Amy, p. 51) and *“well, then you see it’s uh... it’s almost like I’ve achieved something...”* (Tom, p. 44). Furthermore, Jay talked about an enhanced understanding: *“well erm, has anything changed? Understanding, more understanding...other people, and myself”* (p. 25).

Participants attributed the personal improvements to their group membership, as illustrated by the following quotation from Adam who stated, *“this maybe year and a half, two years has really brought me out of my shell, I’ve been able to build my self-esteem back”* (p. 58). The instrumental role the group had for participants’ personal journeys of recovery is perhaps best illustrated by the following quotation from Adam:

The group did not know, this is probably the best thing about it, did not know what it wanted to help me, where it wanted me to go, I didn't know where it wanted me to go but we kind of met somewhere in the middle where every option's open and that's where I'm at (p. 60).

The quotation highlights that, despite not having an objective or goal in mind, the group and Adam worked in symbiosis to reach a critical point in his recovery process.

Coming Together to Help Ourselves

The master theme *Coming Together to Help Ourselves* related to the ability of group members to help themselves outside of professional intervention. The master theme captured the sense that participants were being helped by attending the group and was composed of three separate elements which formed super-ordinate themes; *I'm Not as Unwell as They Are*, *The Space to Make Sense*, and *Reciprocal Listening and Sharing*.

I'm not as unwell as they are. First, for three participants the super-ordinate theme reflected the positive effect of comparing themselves favourably to other group members. For example, *"although I had issues myself, I didn't feel tha... as though my issues were as bad as theirs"* (Tom, p. 10). The effect of this comparison was a feeling of being in a better position, for example, *"people with illnesses same as you and worse than yours and seeing them in their illness and just think 'wow' I don't believe in God but 'thank God I'm ok'"* (Jay, p. 20). In essence, the group members compared themselves with others who were worse off than themselves as a way of making them feel better about themselves.

The space to make sense. The second super-ordinate theme reflected the ways that group members used the group to make sense of a range of experiences, not solely voice hearing. This super-ordinate theme emerged from four group members who used the space in a variety of ways. For example, the space was used to make sense of voice hearing, *"learning to manage the... the voices, learning to... learning of ways of distracting yourself from them, learning of ways of coping with them from other people"* (Amy, p. 56) and other associated issues with voice hearing:

It starts with voices to get you in the door and then deal with loads of other issues that come along as a result of having difficulty dealing with the voices, dealing with a life in times with the mental health system where you hear voices (Sean, p. 4).

In the above quotation Sean described the plethora of other concerns the group members have to manage alongside voice hearing and how the group is a helpful forum for discussing them. Sense was also made of other experiences and mental health issues in the group:

Although it's not about the voices, it's about other things that the people in the group have experienced... so... about handling anxiety, handling nervousness um... how to handle psychiatrist's appointments um... talking about medication and whether to tail it off or not to tail it off (Amy, p. 47).

Furthermore, the super-ordinate theme captured how participants make sense of their experiences inside the group, and as a result of being in the group:

It's not necessarily the case of what is said in the group, it's what's not said cos I might sit there and think of all of these things I should be saying in the group but somebody else is talking and I never get the chance. But they're all playing around in my head (Sean, p. 54).

Finally, the super-ordinate theme captured the emotional fallout and consequences of making sense of experiences in the group:

I've had the door flung open and other people are sat there going, "Well, they're lying to you. They're not this. They're not that. They're not..." It kind of... I don't know who to believe at the moment (Catherine, p. 59).

In the above quotation, Catherine was describing the impact of hearing other group members' explanations for their voice hearing and comparing this with her own understanding. This led her to question the power of her 'thoughts' and their control over her. Furthermore, other people's perspectives and understandings of voice hearing contradicted her own understanding for example, *"jars with my own beliefs [pause] so, it*

makes it kind of... My immediate reaction is, "No. You don't" (Catherine, p. 42). These quotations highlight the impact of making sense of experiences for a participant who was early on in her sense making in the group. Despite the negative consequences, Catherine also reflected on how the group altered the control her 'thoughts' had over her at times; *"the group almost disempowers them in a way at times. So, it's not that they don't have any control, but it's not a 100% total"* (p. 70). This quotation highlights the potential for the group to empower the voice hearer.

For Adam, the group was also the first place he was able to talk about and make sense of his experiences of mental health problems, *"I've used it as like a sounding board to figure out what I should be thinking or you know ideas for stuff like, deep stuff as well"* (Adam, p. 36). This quotation illustrates, along with the others, that the group offered a space for its members to make sense of a range of experiences with varied consequences.

Reciprocal listening and sharing. This super-ordinate theme reflected the mutual benefits of listening and sharing in the group. Five participants reflected on how they used the group to share their own experiences in order to help others, *"listen to theirs and see if you can help them with what you've used against yours"* (Jay, p. 7). Alongside sharing to help others, participants described finding it helpful to listen to others' experiences also, *"would much rather hear what everybody else has got to say and chip in with what coping strategies and things that I have to say"* (Eleanor, p. 26). The personal impact of listening and sharing was twofold; first, participants reflected on the emotional expression this afforded them, *"I find it helpful just to be able to... to express what I've been going through, just to be able to talk openly"* (Amy, p. 20) and second, helping others helped participants themselves, *"but you know by investing a little bit of yourself in another, it's one of those things castle spread upon the waters and return ten-fold or whatever"* (Sean, p. 97).

Vicarious Emotional Experience

The master theme *Vicarious Emotional Experience* captured an interesting group dynamic whereby participants reported experiencing the emotions of others in the group. This master theme was pertinent for three participants; Tom, Sean and Eleanor, and is best reflected in the following quotation: *"I actually start feeling what other people are feeling and I have to go off and start putting it into context and work out if this my feeling, or somebody else's feeling"* (Sean, p. 50).

The master theme encompassed the consequences of *Vicarious Emotional Experience*. First, participants reported negative consequences, for example, *“Don’t know whether sometimes I might be losing my mind and um... [pause] Or my mental health condition’s getting worse by being here, you know”* (Tom, p.58). This was exacerbated by being around those who are considered more unwell than themselves, for example:

Well, psychologically I’m not really sure whether it’s doing me any good the fact that, you know, if I’m with a lot of people that have got a lot of problems, it might kind of um... magnify my own problems (Tom, p. 56).

This was echoed by Sean who stated *“I don’t know I end up feeling like sometimes I end up carrying other people’s problems”* (p. 43). Eleanor spoke about the consequences of bearing witness to distress. She stated that, despite being a positive person, *“sometimes it’s a little bit sad for me you know, to hear what some of the people in the group have actually had to go through”* (p. 73).

Participants also reported the potential benefits of *Vicarious Emotional Experience*; for example, Sean stated, *“but there is a positive side where it’s... it’s a little bit of an up and then you can always catch on to a little bit of it and pull yourself up”* (p. 24).

A Secure Base

The fifth master theme was named *A Secure Base* and reflected the strength of attachment and connections between group members and to the group itself. The master theme was relevant for all seven participants in the sample and is encapsulated by the following quotation, *“so it’s a family, you know like, I don’t know what your family situation is but mine’s a close family so it’s the only other place that I know where it feels like that”* (Adam, p. 19). Sean highlighted the emotional connection between group members when he stated, *“it is kind of palliative, kind of coming together to hug each other so you can go apart thinking “wow”, you know”* (p. 78).

Core elements of a secure base, such as containment and consistency, were also described by participants. For example, Eleanor described the group as containing which made her feel comfortable, *“I really enjoy coming, and I just think that, you know, when I come here, I feel as though I’m relaxed as well”* (p. 50). Alongside feeling comfortable, Amy described the security and safety the group gave her, *“[I] felt safe here”* (p. 9).

The security of the group was also emphasised by Eleanor when she described the pull to attend the group during a particularly stressful time for her, *“things got pretty bad a couple of months ago, well, last year, I needed to really be here and needed to really communicate with [facilitator]. You know, really needed to communicate what was actually going on for me...”* (p. 36). The importance of reconnecting with the group when she was feeling unwell reflected proximity-seeking behaviour.

The intimacy and consistency of relationships between group members was emphasised as being important. For example, Catherine stated that *“I feel like the people in the group are my friends. So, [short pause] it’s that sort of... just that feeling like you’re surrounded by people that give a damn”* (p. 28). This sentiment was extended by Eleanor who emphasised the consistency of relationships *“and you know that people are always going to be there. You can come in here at any time you want”* (p. 38).

Furthermore, Jay described the strength of attachments when he expressed concern for his friends in the group, *“all my mates here, they’re nice people and they need a lot of help”* (p. 46). A feature of a secure base is the ability to tolerate separation. This was described by Tom who reflected on a feeling of loss at the end of group sessions, *“I suppose you become attached to people and then all of a sudden it’s time to go and it’s like there’s a feeling separate... separateness there. Yeah. Separation”* (p. 47).

Finally, two participants in the sample spoke about an internal working representation of fellow group members, which reflected their attachment to the group and its members. For example, during the interview Sean told me:

you know I’m sat here talking about this and you know...got a little picture of [name] in your mind and it smiles and says, “Hi, [name]”...’cos she’s like the grandmother of the group. She kind of started it originally (p. 18).

Belonging to a Special Tribe

The final master theme was named *Belonging to a Special Tribe* and reflected the nature of the group identity participants described: *“and so to me other people who are mental, it’s like you’re, it’s like a special tribe you know”* (Adam, p. 26). The group identity was constructed around experiencing mental health problems rather than voice hearing exclusively. The master theme was relevant to all seven participants and was composed of three super-ordinate themes; *Mutual Acceptance Through Shared Experience*, *Feeling a Part of Something*, and *You Have to Have Been There*.

Mutual acceptance through shared experience. This super-ordinate theme related to participants' experience of being unconditionally accepted by others who shared their experiences. It is best summarised by the following quotation, "*yeah just acceptance, it's just acceptance. It's just plain faced acceptance, you know like your family accepts you*" (Adam, p.22). The unconditional nature of acceptance was expanded by Amy who stated that, "*I felt like I... I'd got somewhere to come, somewhere I could be that I could just be myself...with the voices included*" (p. 8). The idea that participants had somewhere to go where they were wholly accepted for themselves had repercussions for how they felt, "*I was just thinking well at least I'm not alone you know, and that's very important 'cos who wants to be alone*" (Adam, p. 13).

The importance of finding those who shared their experience was frequently described by participants, "*see that's the thing it's finding others who share the same experience as you*" (Sean, p. 29). Finding others who shared their experience and understood them had powerful consequences for participants. For example, it led to a sense of validation:

It give me erm rest, that the way I'm thinking is right ... just like, the seal of approval to me self, even though I knew that anyway you know but it comes from someone else, thank God for that (Jay, p. 36-37).

Experiences were also normalised, "*it is nice to be able to talk about it and not be the freak in the room...*" (Catherine, p. 19). This in turn helped participants to accept their experiences, "*and made me feel a bit more normal about what I was experiencing, made me accept it a bit more*" (Amy, p. 59).

Feeling a part of something. The second super-ordinate theme related to participants' sense of belonging and inclusion. This had a direct impact on the sense of social isolation participants experienced, for example:

Well, I've um... it helps me in the way that I've developed um... a social network through coming here. Yeah. Which um... otherwise might not have happened if I would've just been left to uh... sort myself out in mainstream society (Tom, p. 80).

Feeling a Part of Something also encompassed a sense of purpose and achievement, “*It’s given me like a sense of purpose that I’ve managed to get up and get out and, you know...*” (Tom, p. 44). Participants experienced belonging which contrasted to the social exclusion and sense of stigma they had experienced elsewhere, “*but then here you kinda come along and you’re not marginalised you’re not isolated*” (Sean, p. 31). The consequences were described by Tom who stated, “*and uh... makes me feel as though I can uh... be part of society. Yeah. I can contribute something*” (p. 98).

You have to have been there. This super-ordinate theme described participants’ experience of others without experience of mental health problems being unable to understand or identify with them. For example, Amy stated, “*I guess um... hearing voices is quite something that you can’t really discuss with everybody*” (p. 50) which highlighted the limitations of exploring experiences with non-voice hearers. The notion of relating and understanding was also highlighted by Tom. As a non-voice hearer in the group he still felt he could relate on some level to his fellow group members, “*I suppose I... in some ways I can relate and other... other ways I can...I can’t, you know. It’s uh... it’s mixed, really.*” (p. 93) but as the quotation suggests the element of relating was limited somewhat, “*you might understand somebody’s issues, but then theirs’ not really what you’re going through. And you can’t identify with them*” (p. 85).

Participants described the consequences of talking with those who did not share their experiences, which included professionals:

I think once you start getting people in who only know about stuff because they read it in a textbook... they perhaps feel like they’re listening...but they might be missing stuff because they don’t have that core understanding (Catherine, p. 77).

As the quotation suggests, participants felt a sense of belonging and identification with those who have experiential knowledge of their experiences. When experiences are not shared, the sense of belonging, understanding and acceptance is hindered. This sense of ‘us and them’ was highlighted by Eleanor when she talked about the presence of non-voice hearers in the group:

*But me personally, I don't mind but I have that fear at the back of my mind
"Do you really understand what's going on? Do you really understand the
stresses and traumas that we have to go through?"
(p. 67).*

For participants, then, the experience of being with others who shared their experiences led to a sense of acceptance and belonging. This in turn meant that participants could be themselves and talk openly about their experiences.

Reflexivity

Part way through the analysis stage of the research one of my academic supervisors interviewed me about my experiences of attending the group, conducting the interviews, and the research process as a whole. This was a useful opportunity to reflect on my experiences and identify assumptions I had made in the research process. It also afforded me the space to think about what it had been like for me to attend the group and interview its members. I felt that I had similar reflections to those participants made in their interviews. I would like to share some of those reflections in this section. Please refer to Appendix IX for extracts from the interview itself.

I was negotiating a complex role in terms of being a researcher, a psychologist in clinical training, and myself in the group. I had been told that the group had prior negative experiences of professionals sitting in on the group. It was essential, therefore, for me to gain the trust of the group and not to repeat past patterns where professionals had reportedly exploited the group. This was part of the reason for me attending the group sessions, and was essential to build the relationships that helped the recruitment and interview stages of the research process. Without having done so, I do not believe the interviews would have been as rich as they were.

Along with Tom and Adam, I was attending the group as a non-voice hearer. Nevertheless, I felt that I shared some experiences with the group members in terms of aspects of mental health, for example experiences of anxiety and stress. I think my view that mental health exists along a continuum meant that I could place myself in relation to members of the group. This was a view shared by Tom and Adam in relation to their group membership.

I reflected on what it was like to join and be part of a group. I think it is intrinsic to want to belong, and find a group of people who share our values, beliefs and with whom

we can identify. Identification was not my personal experience of the group, however, as I do not identify myself as a mental health service user or voice hearer. Nevertheless, I tried to relate the sense of acceptance and identification which the participants felt to my experience of being a member of other groups. This led me to think about the groups I belong to and why I value being part of them. Some of the reasons I felt accepted in these groups related to the security of being able to be myself. This sense of being accepted for who you are was certainly echoed in words of the participants.

Finally, I underestimated the impact the interviews might have on the group members and their experience of the group in turn. Several participants commented that the interview gave them space to reflect on their role in the group. This left me wondering what participants' experiences of the group might be following the interviews.

CHAPTER FOUR

Discussion

This study was designed to explore the experiences of those attending a self-help Hearing Voices Group. The primary research question consisted of three sub questions:

- a. Why do participants attend the Hearing Voices Group?
- b. What do participants enjoy about attending the Hearing Voices Group?
- c. What do participants find unhelpful about their experiences in the Hearing Voices Group?

Following seven detailed and rich individual semi-structured interviews with group members, six master themes and eight super-ordinate themes were elicited. This chapter will explore how these findings fit within the wider research literature presented in Chapter One, and links to psychological theories will be made. I will then explore the clinical implications of the main findings and recommend areas for further research. To offer a critical reflection of the research, I will explore its methodological strengths and limitations.

Main Research Findings

A Secure Base. Participants experienced the group as safe and containing as reflected in the master theme *A Secure Base*. The master theme encapsulated the characteristics of a secure attachment style as outlined in Chapter One. Participants found the experience helpful and, along with other aspects, the experiences encapsulated by the master theme offers insight into the research sub-question ‘why do participants attend the Hearing Voices Group?’

Participants experienced the group as containing, secure and responsive to their emotional needs. This related to Bowlby’s theory of attachment styles, in terms of emotion regulation and proximity seeking behaviour in relationships (Bowlby, 1988 as cited in Holmes, 2001). Providing a secure base offered participants the opportunity to develop a secure attachment to the group and its members. This finding relates to Bowlby’s (1982) ideas relating to the development of internal working models of the self in relation to others. Participants’ inner working models may have been altered through experiencing the group and its members within a secure attachment framework. This finding has further support as participants spoke of attending the group when unwell in order to seek support.

This experience relates to the proximity-seeking behaviours that occur when individuals feel under threat or are experiencing psychological distress, such as hearing difficult voices. Participants also experienced the group as consistent in terms of believing that the group would always be there for them. In essence, group members reported feeling able to return to the 'secure base' of the group when feeling distressed.

This master theme also reflected the strength of attachments between group members; for example, participants experienced the group as safe and containing. Nurturing this sense of security enabled participants in this sample to develop intimate and meaningful relationships with their fellow group members. This was demonstrated by the feelings of separation which followed the end of group sessions. Of particular interest were two participants' reflections on their internalised representations of group members in the interviews. These internal representations manifested themselves as both voices and images for the participants involved. I am not able to comment on whether all participants had this experience. The finding reflects, nevertheless, the powerful internalised attachments for group members, and relates to research which indicates that the nature of voice hearing includes relationships that are important for voice hearers (Leudar et al, 1997). Within object relations theory, external objects (people) exist as internal objects to which we relate (Gomez, 1997). It could be argued that group members have internalised representations of other group members which manifest themselves as voice hearing experiences. This is an interesting finding and is important in contextualising voice hearing experiences as relational in nature.

Belonging to a special tribe. Participants highlighted the value of belonging to the Hearing Voices Group as encapsulated by the master theme *Belonging to a Special Tribe*. There are several valued components to this complex master theme. First, participants valued feeling 'part of something'. Second, participants experienced being part of a group which reduced their sense of social isolation. Third, participants found a positive group identity which was defined by personal experience of mental health problems. I will explore each of these components in turn. Taken together, these elements form an answer to the research sub-question 'what do participants enjoy about attending the Hearing Voices Group?'

Maslow theorised about the importance of belonging for individuals in terms of an individual's ability to reach self-actualisation. Maslow also described the need for safety and belonging before reaching self-actualisation. Without *A Secure Base* from which participants felt safe and contained, the sense of '*Belonging to a Special Tribe*' may not

have occurred. Participants felt like they belonged and were valued which contrasted with their previous experiences of exclusion, social isolation, and stigma due to negative societal attitudes towards psychological distress. The importance of belonging was also identified by Foulkes, the founder of group analysis:

The first and foremost aspect with which group psychotherapists are usually concerned, and according to which they form their concepts, is that of belonging, of participation. Being a respected and effective member of the group, being accepted, being able to share, to participate (Foulkes & Anthony, 1957 as cited in Brownbridge, 2003, p. 33).

For group analysis, then, the concept of belonging is central to the therapeutic work and to our identity formation. Of central importance is the idea of respect and contribution in groups. Participants related to this concept because they felt a sense of purpose and achievement in attending the group. Alongside Foulkes, Nitsun highlighted the healing potential of belonging to a group:

It could be argued that group is the most socially relevant form of psychotherapy in a world in which local communities are breaking down. It could be seen as a continuing context for group affiliation, a place where the human narrative can continue to be told (Nitsun, 1996 as cited in Bledin, 2004, p. 483).

In the above quotation, Nitsun is arguing that groups have a restorative and healing effect which is in contrast to a broken society. For participants in the current sample, having experienced social exclusion, isolation, and stigma in relation to their voice hearing experiences, belonging to a group was incredibly powerful. Clearly these ideas of belonging and the restorative and healing nature of groups are not new, but perhaps their role in Hearing Voices Groups needs to be explored further.

It could be argued that *'Belonging to a Special Tribe'* served as an antidote to social marginalisation and reduced social isolation by providing participants with a supportive social network. Research into psychosis suggests that increased social support acts as a buffer against stress; stressors exacerbate symptoms associated with psychosis (Cohen & Wills, 1985). Furthermore, it has been suggested in the literature that social isolation can exacerbate voice hearing experiences (Garety et al, 2001) and individuals with psychosis

have often experienced a deterioration in their social networks (Thornicroft et al., 2004). Finding a group to belong to offered participants the opportunity to reconnect to their social worlds and reduced their sense of isolation. Social reconnection is an important factor when considering social and psychological recovery (May, 2004) and has been suggested as a phase in the process of healing from trauma (Herman, 1992). Other researchers have identified social support as a benefit of self-help groups (Helgeson & Gottlieb, 2000). It would be of further interest to explore whether reduced social isolation impacted on participants' experience of voice hearing and psychological distress. I will return to this idea later.

The master theme encapsulated the sense of belonging as well as the notion of 'a special tribe'. Participants valued belonging to a group which was defined by personal experience of mental health problems (including voice hearing). The sense of acceptance offered by the group was in contrast to the experience participants described when talking about non-voice hearers or those without personal experience of mental health problems. The latter experience led to a sense of 'us and them'. This is something I was acutely aware of as a mental health professional in the group without personal mental health service user experience.

The sense of 'us and them' relates to social identity theory, regarding in-group bias (Tajfel, 1982). Tajfel proposed that individuals tend to find a group to belong to in order to enhance self-esteem. Enhanced self-esteem can only be achieved if individuals are part of a group which is seen as superior to one or more other groups. It is argued that *Belonging to a Special Tribe* is indicative of an in-group bias, whereby group members aim to increase their self-esteem through positive group identification.

A challenge for the group members continues to be the social stigma surrounding mental health problems generally, and voice hearing specifically (Thornicroft, 2006). Whilst attitudes to mental illness are changing, individuals with a mental illness are still perceived as belonging to a socially inferior group in society (NHS information centre, 2011). So, an in-group bias may go some way to increasing the group member's self-esteem, but the positive effect is moderated by societal attitudes to mental health problems.

Finally, participants identified feeling supported as a helpful aspect of their experience as illustrated in the super-ordinate theme *Mutual Acceptance through Shared Experience*, which formed part of the master theme *Belonging to a Special Tribe*. These experiences reflect other research findings related to the benefits of self-help groups outlined in Chapter One. For example, in their study Cheung & Sun (2001) found that 'universality' was the most helpful aspect of self-help group membership for mental health

service users. Furthermore, 'support' and 'catharsis' were highlighted as the strongest predictors of perceived benefits of participation. Indeed, Yalom's therapeutic group factor of 'universality' was involved here in terms of participants describing the importance of findings others who shared their experience. This had two consequences, first it led to a sense of mutual acceptance (Yalom & Leszcz, 2005) and second, a sense of belonging as highlighted by the work of Maslow (1943) and in group analysis (Foulkes & Anthony, 1957 as cited by Brownbridge, 2003).

Coming Together to Help Ourselves. Participants described the benefit of mutual aid under the master theme *Coming Together to Help Ourselves*. The master theme consisted of three super ordinate themes and answers the research sub-questions; 'why do participants attend the Hearing Voices Group?' and 'what do participants enjoy about attending the Hearing Voices Group?'

First, participants experienced the group as a *Space to Make Sense* of past experiences, difficult emotions, and the distress experienced as a result of voice hearing. As mentioned, participants commented on feeling safe and contained within the group under the master theme *A Secure Base*. Safety and security were key elements for participants to begin making sense of their experiences. Participants valued the *Space to Make Sense* inside and outside of the group session. For example, Sean stated that he continued his sense making outside of the group following sessions. Furthermore, he commented on how he used the space in the group to make sense of experiences without necessarily talking out loud with other group members. For participants, sense making can therefore be characterised as an internal and/or interactive process within and outside of the group.

Sense making has also been identified as an important stage in the process of healing from past traumas (Herman, 1992) and it is argued that the group offered its members the space to heal. Within psychosis, trauma can refer to the traumatic experiences many people with a diagnosis of schizophrenia or psychosis have experienced, such as abuse, the trauma associated with the symptoms of psychosis itself (such as voice hearing), and the trauma following hospital admission (Morrison, et al, 2003). Participants referred to these types of traumatic experiences within the group sessions I observed. In this sense, the group offered the space to heal from past, present, and on-going traumas that members faced on a daily basis. Making sense of experiences of psychosis was a valued aspect to participants' experiences and has consistently been highlighted as an important process by

service users (Knudson & Coyle, 2002) and emphasised as an important aspect in the recovery process (May, 2004; Pitt, et al, 2007).

The super ordinate theme *I'm not as Unwell as They Are* related to the psychological consequences of social comparison and represented aspects of the group experience which participants found helpful. Social Comparison Theory (Festinger, 1954) proposes that individuals compare themselves to those who seem worse off and this 'downwards' comparison can lead to the sense that one is 'better off' which can in turn increase self-esteem. The sense of being better off may also relate to Yalom's therapeutic factor 'instillation of hope'; observing others with similar problems coping with their difficulties can engender a sense of hope about one's own ability to cope (Yalom & Leszcz, 2005). Clearly this group process was evident in participants' experiences of the Hearing Voices Group, and was found to be beneficial to the participants in this sample.

Participants also valued listening, sharing, and offering help to others, captured by the super-ordinate theme *Reciprocal Listening and Sharing*. These group processes are emphasised as beneficial in the group psychotherapy literature (Yalom & Leszcz, 2005) and relate to participants' psychological and social journeys of recovery. Indeed, one participant emphasised the value of investing in others, "*to an extent you do gain a lot by investing your, investing in others*" (Sean, p. 97). The potential benefits to the helper were conceptualised within the 'Helper Therapy Principle' (Reissman, 1965) and by Yalom's therapeutic group factor 'altruism' (1965). The former theory found some support from Roberts et al (1999) who explored help-giving interactions in a self-help group. They found that participants who provided helpful comments to other group members had higher self-reported social functioning and interviewer rated psychosocial functioning. The finding that participants experienced benefits from helping others in the group echoes the findings of Roberts et al., (1999) and is consistent with Reissman's theory of the benefits of helping (1965). The results of the present research also fits with findings from Lee and colleagues (2002) whereby participants cited giving advice to others as a beneficial aspect to their experience of attending a Hearing Voices Group.

A Catalyst for Change. There seemed to be a link between the experiences described under the master themes *Coming Together to Help Ourselves* and *A Catalyst for Change*. The former related to the helpful ways participants empowered themselves in the group. With this experience, participants were then able to experience the group as *A Catalyst for Change* in terms of the group being instrumental in their individual recovery journeys. As outlined in Chapter One, recovery was traditionally conceptualised as the

relief of clinical symptoms. With the rise of the consumer movement, recovery was reconceptualised as a process rather than an outcome. Furthermore, recovery was seen as not only possible, but achievable for those who had the experience of voice hearing (Rogers et al., 2007). This concept of recovery as a process is encapsulated in the following quotation:

Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being...and from crushed dreams. Recovery is often a complex, time-consuming process (Anthony, 1993, p.527).

The role of self-help Hearing Voices Groups in offering the elements of recovery as identified by Anthony is clear. Participants reflected on increased self-esteem, talked about plans for volunteer work and paid employment, and hopes for their future. The self-help Hearing Voices Groups offered participants the opportunity to empower themselves, make sense of experiences, help one another and embark on a journey of psychological and social recovery; in that sense it was a catalyst. Given that service users are calling for more recovery-orientated services, the findings of this research are encouraging of self-help Hearing Voices Groups supporting the consumer constructed view of recovery.

Vicarious Emotional Experience. Alongside positive aspects to their experience of the group, participants also reflected on challenging experiences as encapsulated by the master theme *Vicarious Emotional Experience*. The master theme provides a partial answer to the research sub-question ‘what do participants find unhelpful about their experiences in the Hearing Voices Group?’

The master theme described a continuum of *Vicarious Emotional Experience* which group members experienced, almost contagiously. At one end, participants felt uplifted by positive emotions in the group. Conversely, however, participants also described the negative aspect of taking on others’ negative emotions and/or experiences. This group process was cited by Yalom as a reason for drop-out of group therapy, “*several clients who dropped out of group therapy reported being adversely affected by hearing the problems of other group members*” (Yalom & Leszcz, 2005, p. 246).

The master theme also captured the sense that being around others who are perceived as being worse off than themselves had the potential to make that individual feel worse. It seems that participants were experiencing the risks associated with social

comparison. The negative consequences of social comparison were highlighted in the literature by Helgeson and Gottlieb (2000) who stated that a downward comparison may cause anxiety for individuals who fear that their own mental health may deteriorate. For participants, *Vicarious Emotional Experience* had positive and negative elements.

Threats to Engagement. The master theme *Threats to Engagement* captured aspects of the group dynamics which participants experienced as challenging. Participants described how these dynamics had the potential to adversely affect their experience and psychological wellbeing. Various experiences were captured by the super-ordinate themes *Unsettling Group Dynamics* and *The Kick Back from Voices*. These elements offer insight into the research sub-question ‘what do participants find unhelpful about their experiences in the Hearing Voices Group?’

Unsettling Group Dynamics relates well to Yalom’s conceptualisation of ‘the monopolist’ in group therapy settings (Yalom & Leszcz, 2005, p. 391). Yalom described group members who dominate the group space or who monopolize the group with crises. Participants reflected on their experience of other group members as distracting the flow of the group by telling apparently unrelated stories or arriving late to sessions. Of course, Yalom’s observations relate to group psychotherapy rather than the open nature of self-help groups. Nevertheless, it seems that there is the potential for dominant group members to adversely affect the group experience for other members in self-help groups too.

Alongside dominant members in the group, participants’ voice hearing experiences in the group could also be conceptualised as a challenging group member. For example, in experiencing *The Kick Back from Voices*, participants described trying to divide their attention between their own internal experiences, the content of the group discussion, and managing the impact of dominant group members. It is almost as if voices are personified and constitute group members in their own right, who are at times comforting and at other times distracting.

It was interesting that voice-hearer participants reported *The Kick Back from Voices* in response to attending the group, or talking about their voice hearing experiences in the group. It could be argued that the Hearing Voices Group offered the space for voice hearers to begin relating to their voices in a more helpful way. In fact, Amy stated she was trying to, “*identify what the voices were about and what they were trying to do and build some sort of relationship with them to try and understand them better*” (p. 22). There are, however, negative repercussions in that participants experienced negative responses from

the voices as a result of talking in the group. This dynamic has been explored within individual psychological therapy for psychosis (Chadwick et al, 1996). It could be hypothesised that through attending the group and making sense of the voice hearing experience, the power differential between voice hearer and voice is altered. This would fit with advances in the psychological treatment of voice hearing which is aimed at improving the relationship between the voice hearer and the voice (Birchwood et al, 2000; Hayward, Denney, Vaughan, & Fowler, 2008; Hayward et al, 2009; Hayward & Fuller, 2010). It could be argued, therefore, that talking about their voices in the group had the potential for voice hearers to feel more empowered and develop a greater sense of agency and control over their voices.

Summary of findings. In summary, the main findings offer insight into the research question and sub-questions posed. First, participants felt accepted and a sense of belonging to a valued group. Experiential knowledge, universality and the space to make sense were all described as valued elements of participants' experience in the group. Furthermore, participants experienced the group as a secure base which offered containment and safety. Taken together these experiences enabled participants to engage with their own individual journeys of psychological recovery involving social reconnection. Alongside the valued elements of participants' experiences were more unsettling aspects. These aspects threatened engagement with the group and provided a challenge for group members. Elements of these challenges were unique to voice hearer participants such as *The Kick Back from Voices* whilst other challenging group dynamics were experienced across participants. I shall now explore the clinical implications of these main findings and consider areas of further research. I will conclude with a critique of the present study and closing reflective comments.

Clinical Implications and Areas of Further Research

Managing *The Kick Back from Voices*. First, in terms of clinical intervention, the results of the present research highlights the challenge of working with voices as conceptualised by the master theme *The Kick Back from Voices*. Specifically, participants talked about the negative reaction from their voices following disclosure in the group. This related to the power differentials being challenged. Little is known about how to manage this 'backlash' from voices and it can often contribute to the discontinuation from individual psychological therapy (Chadwick et al, 1996). Interestingly, despite experiencing

the 'backlash', participants continued attending the self-help group. In fact, one participant talked about how attending the group challenged their perception of the control the voice had over them. Perhaps there is something for Clinical Psychology to learn here, in terms of how the 'backlash' is managed and contained in a way that is meaningful rather than threatening. For example, when working individually, Clinical Psychologists could normalise the 'backlash' as a part of the process inherent when attempting to challenge the power of the voice. Furthermore, Clinical Psychologists might attempt to make sense of this 'backlash' with service users in a curious questioning style. For example, wondering with the service user why the voice has become more aggressive or punitive; what function does this serve for the voice? Researching and developing successful strategies to manage the 'backlash' is an area for further exploration which can begin by exploring how self-help group members cope with the 'backlash'.

Attachment style, recovery styles, and relating to voices. As mentioned in Chapter One, research has indicated that a large proportion of individuals with a diagnosis of psychosis demonstrate an insecure attachment style (Dozier et al., 1991; Dozier & Lee, 1995). An insecure attachment style predicts that individuals will not seek help during times of crisis which increases their risk of relapse (Berry et al, 2007). The potential to use the group as a secure base has an impact on the development of a secure attachment style. This in turn has implications for an individual's recovery style. For example, it follows that if an individual is able to experience the group as a secure base and begin to develop a secure attachment style in relation to the group, there is the potential for individuals to then demonstrate an 'integrated' recovery style. An 'integrated' style is related to a secure attachment and this in turn is related to reduced relapse rates (McGlashen, 1987). This hypothesis would, of course, require further exploration. For example, one could measure the attachment and recovery styles of those attending a self-help Hearing Voices Group compared with those who are not.

Alongside recovery styles, experiencing the group as *A Secure Base* may have clinical implications for the way we understand relating to voices. It has been hypothesised that the psychological distress associated with voice hearing is related to the perceived power the voice has over the voice hearer (Byrne, Birchwood, Trower, & Meaden, 2006). Recent findings in the CBT literature look promising in terms of altering the power differential between voice(s) and voice hearer which decreases psychological distress (Chadwick & Birchwood, 1994, 1995; Birchwood et al, 2000). Perhaps the findings from the

present research can add to our understanding of how attending a self-help Hearing Voices Group has impacted on the relationship between voice hearer and their voice(s).

Given the sense that participants experienced the group in a safe, containing, and secure way, it would be interesting to research more directly whether this had an impact on how participants related to their voice(s). For example, did participants in this sample feel more empowered in relation to their voice, and experience less distress as a consequence of experiencing the group as a secure base? There is a small selection of appropriate outcome measures to assess the relationship between voice hearer and voice. For example, subordination and power in relation to the voice could be measured using the 'Voice Power Differential' scale (VPD; Birchwood et al, 2000). A more recently developed outcome measure the 'Voice and You' (VAY; Hayward, et al, 2008) could be used to assess the relationship with the voice. Furthermore, an individual's sense of control and power over their voice could be measured using the 'Beliefs about Voices' questionnaire (BAVQ-R; Chadwick, Lees & Birchwood, 2000). These measures could be utilised alongside a measure of psychological wellbeing such as the 'General Health Questionnaire' (GHQ; Goldberg & Hillier, 1979) to explore three hypotheses. First, the relationship between voice and voice hearer improves during the time of attending the group. Second, psychological wellbeing improves as a result of attending the group. Finally, that there is a significant and positive relationship between improvements in the relationship between voice and voice hearer and improvements in psychological wellbeing. Ideally, a longitudinal research study design would explore whether these improvements were maintained in the longer-term.

The impact of self-help groups on psychological wellbeing. The present research was not concerned with exploring change in relation to group mechanisms. Nevertheless, participants reported many positive psychological and social improvements and participants made particular reference to the benefits of helping others. Attempts have been made to explore the role of helping processes in improving participants' psychological wellbeing. For example, in their study Roberts et al., (1999) observed and rated help-giving and help-receiving interactions in self-help group sessions. They found that participants experienced helping others as mutually beneficial. It would be important to explore whether helping processes are related to participants' psychological wellbeing when attending self-help Hearing Voices Groups.

A study could be designed to measure the impact of helping interactions on participants' psychological wellbeing. First, group sessions would need to be rated by an observer using a structured observation schedule to rate helping processes. This would

require the development of a sound observation schedule. Second, at baseline, new group members' psychological wellbeing could be assessed using a measure such as the general health questionnaire (GHQ; Goldberg & Hillier, 1979) and personal empowerment might also be measured (e.g., the Consumer Constructed Empowerment Scale; Rogers, Chamberlin, Ellison & Crean, 1997). Measurement could be repeated at several time points during group attendance and at follow-up (if participants discontinued attending the open-natured self-help Hearing Voices Group). The hypothesised changes on these outcome measures could be explored in relation to the observed helping interactions in the group sessions. Collecting quantitative data and obtaining consent to either observe or video record group sessions might prove challenging given the confidential nature of self-help groups.

Alongside benefits of attending, participants also reflected on experiences in the group which threatened their engagement. This was encapsulated by the master themes *Threats to Engagement* and *Vicarious Emotional Experience*. Specifically, participants referred to *The Kick Back from Voices* and *Unsettling Group Dynamics* as challenging aspects to their experience. It would be interesting to explore whether these experiences had a negative impact on psychological wellbeing. For example, were they reasons for group members disengaging from the group? There are several potential research designs which could be adopted to further explore unhelpful aspects of group sessions. First, a qualitative research project could be designed to explore this further by recruiting and interviewing members who discontinued attending the self-help Hearing Voices Group. Alternatively, unhelpful aspects of group sessions could be explored with active group members. For example, a measure of global distress such as the 'Clinical Outcomes in Routine Practice' outcome measure in its short form (CORE-OM; Evans et al, 2000) could be used on a weekly basis to capture sessional measures of distress. The data on psychological distress could be accompanied by the self-reported measurement of *The Kick Back from Voices* or self-reported unhelpful aspects of group sessions. The research would aim to explore patterns and relationships between psychological distress, unhelpful group aspects, and the 'backlash' from voices. The results of this research would go some way to further exploring the helpful and unhelpful mechanisms in group sessions in relation to psychological wellbeing.

The role of social inclusion in self-help groups. Alongside researching the impact on psychological wellbeing, further research into the restorative role of social inclusion would be of further interest given that research has found that social isolation exacerbates voice

hearing (Garety et al, 2001). Furthermore, supportive social environments serve as a protective factor in moderating stressors which might induce a relapse (Romme & Escher, 1993). Participants emphasised the importance of the group in providing a secure base and reducing social isolation by proving a social network. It would be interesting, therefore, to further explore whether participants have noticed changes in the frequency and intensity of their voice hearing experiences or whether they have noticed a change in how they manage stressful events, as a result of group attendance.

A study might be designed to explore this by asking new group members to measure their distress in relation to their voice(s) using the 'Beliefs about Voices Questionnaire' (BAVQ; Chadwick & Birchwood, 1995) at the beginning and after attending the group for six months, for example. Participants' sense of social support or social recovery would be assessed across these time points also. This would pose more of a challenge in terms of identifying measures with good construct validity as the concept of social support and/or networks is challenging to measure adequately. Initially, the 'social functioning' subscale of the CORE-OM could be utilised (Evans et al, 2000), or participants could be asked to rate on an individualised measure how supported they felt by friends, family, and other significant relationships, on a weekly basis. Potential correlations between the two concepts could then be explored quantitatively. If encouraging results were yielded, this would provide further evidence and justification of the psychological and social benefits of attending self-help Hearing Voices Groups.

Quantitative studies need to be designed adequately to control for variables which also might also account for change. For example, there may be the need to statistically control for the confounding effects of participants receiving individual therapy concomitantly. As self-help groups are open in nature, applying more controlled study designs is difficult to achieve, however, this does not mean it should not be attempted.

What are the active ingredients in the self-help group? Two participants were non-voice hearers and yet were accepted by and contributed to the self-help group. Furthermore, they shared many of the benefits of attending a self-help Hearing Voices Group as their voice-hearer group members. Given that non-voice hearers benefitted from attending the group, this poses the question of what was the most helpful aspect of attending the self-help group. Was acceptance, rather than coping with voices, the most powerful aspect of participants' experience? Research designed to measure the specific benefits of self-help Hearing Voices Groups compared to non-specific group factors could provide the answers to these questions. A suggested research project might comprise an

exploratory research design aimed to explore the difference between non-voice hearers' experience of the group with voice-hearers' experiences of the group. This might take the form of semi-structured interviews or focus group methodologies. Either way, the experiences of both groups of participants could be compared and contrasted in a larger sample than the present study.

This leads on to the question of what constitutes a therapeutic group. I would argue that all groups exist along a continuum of therapeutic benefit depending on the needs of the group members. Self-help Hearing Voices Groups, Analytic groups, CBT-based groups, and professionally assisted peer support groups all offer therapeutic benefit. It could be argued that a range of groups are beneficial according to an individual's stage in the recovery process. For example, attending a self-help Hearing Voices Group early on in the diagnosis stage (as part of early intervention in psychosis services) would offer social support, universality, and normalisation of experience. Individuals might also use the self-help groups or individual psychological therapy to make sense of their experiences of psychosis and/or learn strategies to cope with their voices in a more helpful way. Perhaps further research could go some way to exploring the active ingredients of self-help Hearing Voices Groups in order to offer the most helpful and meaningful groups to service users according to their needs in the recovery journey.

The importance of experiential knowledge. Participants in the sample were in contact with mainstream mental health services and all participants had previous experience of receiving treatment through mainstream mental health services (such as mental health hospitals and therapeutic communities). This element of common experience meant participants could compare their mainstream mental health service experience to that provided by the self-help groups. Reference was made in participants' interviews to the freedom of attending a self-help group that was outside of the policies and procedures of a mainstream service. Participants also reflected on the importance of empowering themselves, rather than sitting with professionals who may not have personal experience of mental health problems. This relates to the notion of experiential knowledge outlined in Chapter One (Borkman, 1976; 1999).

Experiential knowledge is defined as a specialised knowledge obtained through living with the same experience. Experiential knowledge was shared amongst the participants and was captured in the master themes *Belonging to a Special Tribe* and the *Coming Together to Help Ourselves*. Clearly, the ability to come together with others who shared their experience was something unique for the participants of the self-help group,

and something they had not experienced during their contact with mainstream mental health services. A natural progression from self-help groups for voice hearers might be the provision of consumer-run organisations (CROs) which have the benefit of providing services by and for service-users. This would ensure that service users have access to the types of services they value which might include self-help Hearing Voices Groups.

With current changes in the NHS relating to commissioning of services, it is possible that CROs could tender for business in offering self-help Hearing Voices Groups as a viable treatment approach for voice hearers alongside mainstream services. This would depend, of course, on further robust research findings which highlight the benefits of attending self-help groups for voice hearers in terms of an RCT. Ideally, service users would be offered the choice of attending self-help groups within and outside of mainstream mental health services and alongside traditional psychological and pharmacological approaches should they wish.

Collaboration between clinical psychology and self-help groups. Whilst Clinical Psychology, as a profession, is limited in offering experiential knowledge, mutual acceptance and a sense of belonging, it can offer the therapeutic space to apply specific interventions which aim to alter the power differential with the voice. There is the argument, then, for Clinical Psychologists to be involved in the facilitation of self-help Hearing Voices Groups alongside voice hearer co-facilitators in order to maximise their efficacy. Clinical Psychologists would be able to contribute specialist psychological interventions which aim to change the relationship with the voice(s), make sense of voices in the context of traumatic experiences, and manage the challenging group dynamics which participants in the present research cited as an unhelpful aspect to their experience.

There are certain dilemmas when considering the prospect of Clinical Psychologists co-facilitating self-help Hearing Voices Groups. First, Clinical Psychologists do not necessarily share the experience of voice hearing which may undermine the importance of experiential knowledge to group members. This may have a negative impact on group members' experience of the group. Second, Hearing Voices Groups which combine psychological interventions with the ethos of self-help and empowerment have representation in the NHS (Ruddle, Mason & Wykes, 2011). The research into the effectiveness of these groups, however, has yielded mixed results. For example, there is little evidence for their relative effectiveness and/or efficacy in comparison to individual psychological therapy and/or medication and little is known about their supposed superiority over self-help Hearing Voices Groups. Given the uncertainty about their

effectiveness, the addition of Clinical Psychologist's specialist interventions to self-help Hearing Voices Groups does not necessarily mean that participants in these groups demonstrate improvements on measures of psychological distress. This suggests that there is still much to learn in exploring the most efficacious combination of self-help and psychological techniques in self-help Hearing Voices Groups.

Finally, by involving Clinical Psychologists in the co-facilitation of groups, the power and value of being peer-led may be being negated which may account for the mixed research findings. Alternatively, Clinical Psychology could offer supervision to group facilitators. This would enhance the skills of facilitators in managing unhelpful group dynamics. Research could then be conducted to compare the experiences of those attending a self-help Hearing Voices Group (which was facilitated by a group facilitator receiving supervision) compared with a Hearing Voices Group where the group facilitator who was not receiving supervision from a Clinical Psychologist. This research would go some way to exploring the importance of group facilitation and specialist interventions in self-help Hearing Voices Groups. In offering supervision, however, there is the danger of de-skilling competent group facilitators and so supervision would need to be offered in a careful and considered way.

The opportunity for training and consultation. Further training and consultation could be offered to mental health professionals about the therapeutic benefits of self-help Hearing Voices Groups in terms of acceptance, belonging, universality, and experiential knowledge. Furthermore, the importance of making sense of voice hearing experiences could be further emphasised to mental health professionals. Members of self-help Hearing Voices Groups are well placed to offer this training and consultation to other mental health professionals. Care needs to be taken, however, that involving service users in training and planning of services is done in a meaningful and non-tokenistic way.

Critique of the Present Study

The present research constituted an original piece of exploratory research with individuals attending a self-help Hearing Voices Group. It has contributed to an important area where little was previously known about the value of self-help groups for voice hearers and the wider group membership.

The results were consistent with psychological theory and findings from the self-help group literature, which proposes the potential benefits of attending self-help groups.

Furthermore, the present research highlighted the potential limitations and negative experiences of attending a self-help Hearing Voices Group.

Several steps to ensure credibility of the research findings were taken including; reflexivity, credibility checks, use of data extracts and the production of an audit trail. These elements ensured that the research findings were grounded in the words of the participants and protected from the preconceptions of the researcher.

Despite the strengths of the present research there are some limitations which need to be acknowledged. First, the sample contained those who chose to participate in the research. This poses a threat to the validity of the findings in terms of the potential that the sample was biased towards those who enjoyed attending the Hearing Voices Group. This is a difficult dynamic to avoid in the research process and it is difficult to say whether this had an impact on findings. Having said that, negative aspects of attending the group were highlighted by participants and so it is concluded that the self-selection bias was minimised as much as is possible within the confines of qualitative research. As mentioned, a recommendation for future research would be to explore the experiences of those who discontinued attending the Hearing Voices Group. This would go some way to exploring alternative perspectives of the experience.

My complex role in the group as an 'active-observer' had the potential to impact on the findings in several ways. First, my participation in the group may have led to my imposing preconceptions about the group onto the research findings. This was protected against by engaging in the credibility checks as mentioned. Second, because participants had developed a relationship with me in the group there was the potential for them to censor what they told me in the interview process. I was aware of this at the outset of interviews and prompted participants to expand on their answers as much as possible throughout the research interview. Nevertheless, there was the potential for participants to censor their answers, given their prior relationship with me. Conversely, without having established a relationship with group members I think that my ability to recruit would have lessened and participants may not have felt at ease with me in the interview itself.

A further possibility is that, due to my activity in the group, participants assumed I understood more of their group experience implicitly or that I held similar assumptions about the group as they did. This had the potential for participants to limit what they said to me in the interviews. I tried to manage this by asking participants to expand on their answers as much as possible.

The Hearing Voices Group is only one of potentially over 180 operating in the UK today. Each of these groups will have their own sub-groups and sub-cultures which give

them their individual identities. As such, the results of the present study reflect a subsample of those attending one self-help Hearing Voices Group. Whilst it is not the aim of qualitative research to generalise its findings, it is important to bear this in mind when contextualising the research findings of the present study. The group consisted of voice hearer and non-voice hearer members and so the results of the group analysis cannot be said to represent the views of all members of self-help Hearing Voices Groups.

Following on from this, is the issue of compromised homogeneity in the sample. Homogeneity was characterised by participants' experience of regularly attending the self-help Hearing Voices Group. Alongside this, the sample consisted of self-identified voice hearers and non-voice hearers. This was a methodological concern from the outset but I was also mindful not to exclude non-voice hearers because they had not been excluded by the group and they were active group members. I believe that including the two non-voice hearers in the group analysis added value in terms of the development of the *Belonging to a Special Tribe* master theme. Whilst the experience was pertinent for other participants, the phrase was coined by a non-voice hearer participant and emphasised the importance of group identity, regardless of self-identification as a voice hearer.

The importance of experiential knowledge could also be contextualised by the experiences of the non-voice hearer participants (e.g., Tom feeling a lack of identification at times). This contrasting experience helped to develop the super-ordinate theme *You Have to Have Been There*. Further research might aim to explore the experiences of voice hearer and non-voice hearers in the group. I would hypothesise that the experiences would exist along a continuum; much like the findings of this study, in terms of varying levels of relatedness and identification amongst participants.

Furthermore, the Hearing Voices Group operated within a centre which offered many other resources to the group members. Many participants also attended other groups which ran at the centre for example, a men's group and a women's group. This meant that participants sometimes found it difficult to separate out the experiences which related to the Hearing Voices Group and those that related to the wider centre itself. I do not believe, however, that their experiences exist in a vacuum; the role of the centre and the other groups, may have had an impact on how participants engaged with and experienced the Hearing Voices Group.

In terms of the methodological approach, IPA rests on the assumption that individuals are able to access and interpret their own experiences. The researcher is then in the position to interpret participants' interpretations. In my experience of conducting the interviews, the ability to interpret and reflect varied among participants. This may have

impacted on the level of reflection generated in the data. Nevertheless, it is my belief that whatever participants had to say in the interview was of importance and significance.

Conclusion

The research explored the experiences of those attending a self-help Hearing Voices Group. Findings were consistent with research findings relating to the benefits of self-help groups in other clinical contexts. This was the first piece of research to explore the benefits of a self-help Hearing Voices Group for its members, which did not solely include voice hearers. Participants consistently talked about the power of belonging, and acceptance by the group. Participants also found that the group provided an opportunity for them to make sense of their voice hearing experiences, despite the degree of 'backlash' cause by the voices. Talking about the voices in the group appears to have an impact on the relationship with the voice. Further research needs to be conducted in order to advance our understanding of this. Finally, it is important to note that the group was more than just for voice hearers, as demonstrated by its membership. Arguably, the most beneficial experience for participants was the opportunity to forge a positive group identity, in contrast to prior experiences of marginalisation and social isolation, irrespective of whether or not the participant was a self-identified voice hearer. Participants of this self-help group were able to use the group to make sense of their experiences in a safe and contained environment; the group acted as a secure base for its members.

Closing Reflective Comments

At the outset of the research process, I assumed that the self-help group under exploration would mainly focus on the experience of voice hearing. Given the attendance of non-voice hearers at the group and from the stories of those I interviewed, it is clear to me that the self-help group was for much more than the voices. It provided a forum for its participants to explore a range of issues they were grappling with in a non-judgemental, safe, and caring atmosphere. It reminded me of Roger's core conditions for counselling and how the power of being heard should not be underestimated (Roger, 2004).

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APPENDIX

Appendix I Literature Search Terms

The literature search included a series of steps as outlined below:

1. The electronic database 'PubMed' was searched to yield articles pertinent to self-help groups and voice hearing. Due to the lack of published literature in this area, the Hearing Voices Network and the Intervoice websites were searched for relevant research relating to self-help groups for voices hearers:



Figure 6. Screen-shot from the publications page of the Intervoice website

Two potential articles of interest were found here. One was excluded from the literature review due to it being a personal commentary rather than an exploration of the experience of group members.

2. Due to the lack of published literature for self-help groups for voice hearing, the electronic database 'PubMed' was searched to yield articles pertinent to self-help groups for voice hearing and other mental health diagnoses. Figure 7 depicts the yielded 72 results:

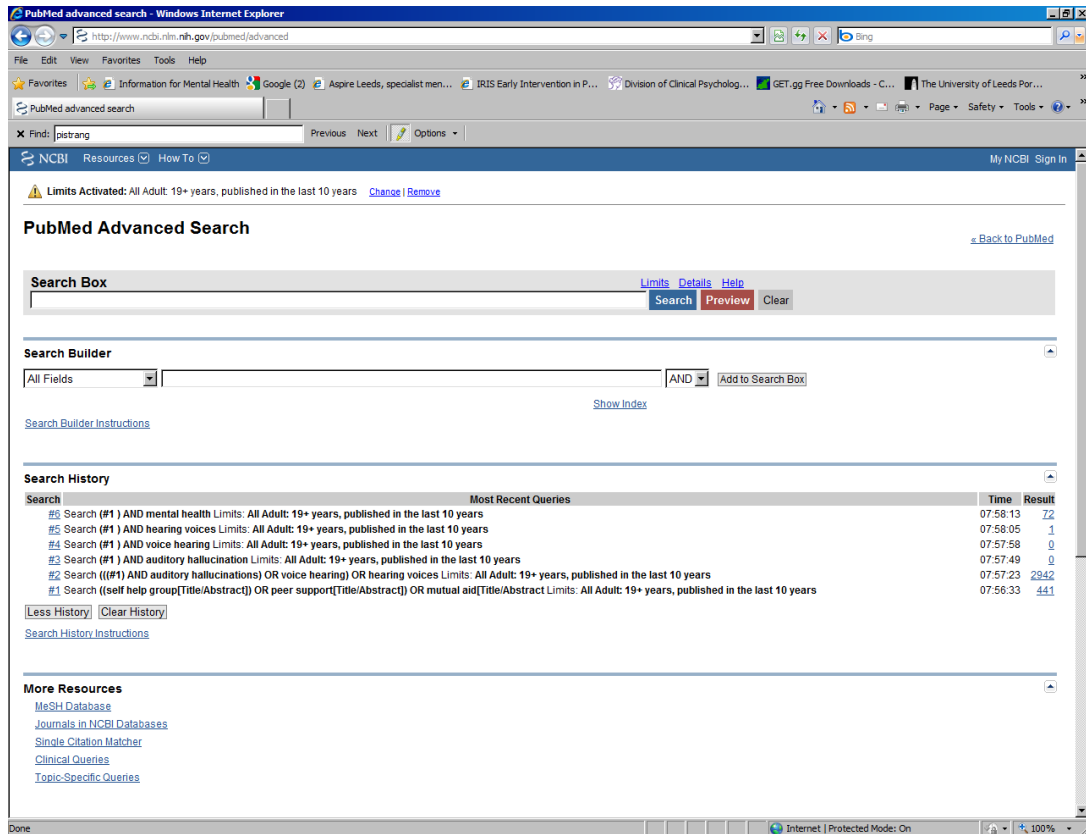


Figure 7. Search history from PubMed electronic database

The 'related articles' function in PubMed was also consulted to ensure that no relevant articles were missed. Following this, the titles and abstracts of the 72 articles were read in order to assess whether they met the inclusion and exclusion criteria. Of the 72 articles found, eight articles of interest were found. From these, three articles met the inclusion criteria. The remainder were excluded on the grounds of being related to physical health problems or were web-based or bibliotherapy support.

3. Second, the reference sections of the relevant articles were then reviewed for other articles of interest. Five articles of interest were found using this method and were included in the final literature review relating to self-help groups for other mental health problems.

Appendix II Recruitment Letter and Information Sheet

Programme in Clinical Psychology
Leeds Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Road
Woodhouse
Leeds
LS2 9LJ

Date:

Dear Hearing Voices Group member,

I am a Psychologist in Clinical Training at the University of Leeds and am completing a piece of research as part of the programme. You are being invited to take part in this research which asks voice hearers to explore their experience of attending Hearing Voices Groups. It is important that you understand what the research will involve and why it is being done before you decide if you want to participate. The details provided on the information sheet tell you why we are asking for help with this project, what you will be asked to do, how long it will take, and what will be done with the results. You might want to share this information with friends or family members before you make your decision.

If you do think that you might like to be involved in our project, please be assured that we will try not to inconvenience you in any way. The amount of time that we will be asking from you will be kept to a minimum and we will endeavour to be flexible in any arrangements that we make with you.

Thank you for taking the time to consider our invitation.

Kind regards,

Gemma Hendry
Psychologist in Clinical Training.

Under the Supervision of:

Dr Garry Brownbridge,
Dr Sylvie Collins,
& Dr Rufus May.

Information Sheet

| | |
|------------------------------|--|
| Research Title: | What are the Experiences of Those Attending A Self-help Hearing Voices Group: An Interpretative Phenomenological Approach. |
| Principal Researcher: | Gemma Hendry Psychologist in Clinical Training |
| Contact Information: | Programme in Clinical Psychology Leeds Institute of Health Sciences Charles Thackrah Building 101 Clarendon Road Woodhouse Leeds LS2 9LJ |
| Telephone Number: | 0113 343 2732 |
| Email: | umgh@leeds.ac.uk |

What is the project's purpose?

There is a growing prevalence of Hearing Voices Groups in the UK and internationally. However, there is very little research into this area and it seems crucial to explore this area of self-help from the perspectives of those who attend them. Therefore, the primary aim of this research is to explore what the experiences of those attending the Hearing Voices Group are. Furthermore, we would like to explore what you believe the potential helpful and unhelpful aspects of attending the group are. The research will be conducted during late 2010 and completed by June 2011.

Why have I been chosen?

You have been chosen to participate in the research because you attend a Hearing Voices Group. It is expected that between 6 and 8 people in total will be asked to take part in the study.

Do I have to take part?

It is important to know that taking part in the research is *entirely voluntary*. If you do not agree to participate there will be no negative consequences in terms of your current or future access to mental health services. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

However you may withdraw from the research up to *two weeks* after completing the interview, without question or explanation.

What will happen to me if I take part?

You will be asked to attend for one interview where the Hearing Voices Group usually runs. I will aim to meet at a time most convenient with you. The interview will last for approximately 1 hour and I will ask to record our conversation with a digital audio recorder. I will ask a series of questions exploring your experience of attending the Hearing Voices Group.

After the interview, the recording be typed up and anonymised. This will enable me to analyse and generate themes. Once all the interviews have been analysed a report will be written which can be made available to you should you wish to receive it.

What are the possible benefits of taking part?

Whilst there are no immediate benefits to taking part in this research, some people find talking about their experiences helpful. Furthermore, as there is very little published research in the role of self-help groups for voice hearers, it is hoped that the research will enhance our understanding of the experience of attending Hearing Voices Groups and their role for voice hearers.

What are the possible disadvantages and risks of taking part?

It is not expected that any discomforts, disadvantages or risks should arise from participating in this research. However, some people can find recalling their experiences distressing. Should this happen during the interview we can take a break or decide to stop the interview.

If you experience distress after the interview is completed, I will be available to talk to should you wish. I will also provide you with a list of useful telephone numbers to use should you wish. Furthermore, you will be encouraged to think with fellow group members or with the group facilitator of strategies to help you manage your distress and to explore the meaning of the distress experienced. I will also provide you with the contact details of the members of the research team for you to use should you have any questions or concerns following the interview.

What happens if the research study stops earlier than expected?

It is not expected that the research will be stopped earlier than expected. However, if this is the case the reason(s) will be explained to you.

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. The written transcript of the interview and the audio recording will be stored in a locked filing cabinet at the University of Leeds. All electronic data will be stored on a password protected computer on the University of Leeds computer network.

In terms of anonymity, you will not be referred to by your real name in all written reports. Instead you will be given a codename. Identifiable information will be kept to a minimum in order to ensure that you cannot be identified in any reports or publications. It is important to note that we will be using direct quotations in the final research report.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

You will be asked to explore your experience of attending the hearing voices groups. As there is little research into this area we are keen to explore any areas you find important rather than us defining the areas of interest. As such this aim can only be achieved via semi-structured interviews rather than a questionnaire.

Will I be recorded, and how will the recorded media be used?

The interviews will be audio recorded to help with the analysis. Your consent to record the interview will be sought before the interview begins. The audio recording of the interview will be used only for analysis and for illustration in conference presentations and lectures. No other use will be made of them without your written permission.

Only my academic supervisors (Garry Brownbridge and Sylvie Collins) and I will have access to the original recordings. This means that your group facilitators will not have access to the audio-recording or written transcript of your interview. It is hoped that this will help you to feel comfortable to speak about all aspects of your experience in the group without worrying that your facilitators will know the detail of what you have spoken about.

What will happen to the results of the research project?

A brief report containing the results of the research will be sent to those who participate in the research if requested. Furthermore it is hoped that the research will be submitted for publication in 2011/2012. If accepted for publication it is important to note that you will not be identified in any report or publication. Finally, the data generated as part of this research will be securely stored at the University of Leeds for use in potential future research involving the Hearing Voices Groups.

Who is organising and funding the research?

The research is completed as part of the Doctorate in Clinical Psychology programme at the University of Leeds.

What next?

Should you wish to participate in the research please complete the opt-in slip and post back to me using the FREEPOST envelope provided. I will then contact you by your preferred means of communication to arrange a convenient time to meet with you to conduct the interview.

Contact for further information

If you have any further questions please do not hesitate to contact me on umgh@leeds.ac.uk or by using the address and telephone number at the top of the letter accompanying this information sheet.

Thank you for taking the time to read this information.

✂-----

I have read the information sheet and would like to take part in this study and I consent to being contacted in order to arrange a convenient time to complete the interview:

Name: _____

Which Hearing Voices Group do you attend:

How many times have you attended the group in the last 6 months:

Contact number: _____

Please post this slip back to me using the FREEPOST envelope provided within the next two weeks. Alternatively, you can return it to me when I come back to your Hearing Voices Group in the next month. If you have any questions at this point, please do not hesitate to contact me on 0113 343 2732.

Appendix III Consent Form

Consent Form

Title of Research Project: What are the Experiences of Those Attending Self-help Hearing Voices Groups: An Interpretative Phenomenological Approach.

Name of Researcher: Gemma Hendry

Please initial box

1. I confirm that I have read and understand the information sheet/letter dated [] explaining the above research project and I have had the opportunity to ask questions about the project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

4. I agree for the data collected from me to be used in future research.

5. I agree to the interview being audio recorded.

6. I agree to take part in the above research project.

Name of Participant

Date

Signature

Lead Researcher

Date

Signature

To be signed and dated in presence of the participant

Appendix IV Ethical Approval Letter

Faculty of Medicine and Health
Research Office

Room 10.110, Level 10
Worsley Building
Clarendon Way
Leeds LS2 9NL

T (General Enquiries) +44 (0) 113 343 4361
F +44 (0) 113 343 4373

**UNIVERSITY OF LEEDS**

Gemma Hendry
Dept of Clinical Psychology
Leeds Institute of Health Sciences
University of Leeds
Charles Thakrah Building
101 Clarendon Road
LEEDS LS2 9LJ

24 June 2010

Dear Gemma

Re ref no: HSLT/09/ 029

**Title: What are the Experiences of Those Attending Self-help Hearing Voices Groups:
An Interpretative Phenomenological Approach**

I am pleased to inform you that the above research application has been reviewed by the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics (LIHS/LIGHT) joint ethics committee and following receipt of the amendments requested, I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation at submitted at date of this letter.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information (r.e.desouza@leeds.ac.uk)

I wish you every success with the project.

Yours sincerely

A handwritten signature in cursive script that reads "Laura Stroud".

**Professor Alastair Hay/Mrs Laura Stroud
Chairs, LIHS/LIGHT REC**

Appendix V Interview Schedule

- How long have you heard voices for?
- When and how did you become aware of the hearing voices group?
- How long have you attended the hearing voices groups for?

Interview Guide:

1. Tell me about the first time you attended the hearing voices group.
 - a. How did you feel?
 - b. Were there any other feelings?
 - c. Tell me more about that.
2. Can you tell me about anything you find helpful about going to the group?
 - a. Clarify experiences.
 - b. Tell me more about that.
3. Tell me about how you decide to go to meetings.
 - a. What things do you consider before deciding whether to attend?
 - b. What other things effect that decision?
4. When you think about your experience of attending the group now compared to in the past has anything changed?
 - a. Can you tell me more about that?
 - b. Anything else?
5. Have there been times when attending the hearing voices group has been unhelpful?
 - a. Can you tell me more about that?
 - b. Is there anything else you find unhelpful about attending the group for example, in terms of practicalities, your feelings or specific aspects of the group?
6. Tell me about what you might change about the hearing voices group.
7. Has you attending the hearing voices group affected the way you think about yourself?
 - a. In what ways?
 - b. Has it changed how you feel about yourself?
8. Has your experience of attending the hearing voices group affected you hearing voices?
 - a. Do your voices respond to you going to the group?
 - i. Can you tell me more about that?
 - b. What, if anything, do you notice about your voices when you are in the group?
 - i. Can you tell me more about that?
9. Is there anything else you would like to tell me about your experience of attending the hearing voices groups that we haven't already covered?

Appendix VI Confidentiality Statement for Transcribers

Confidentiality Statement for Transcribers

Ethics Committee, School of Psychology, Leeds University

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Ethics Committee of the D.Clin.Psychol course requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

- 1) I understand that the material I am transcribing is confidential.
- 2) The material transcribed will be discussed with no-one.
- 3) The identity of research participants will not be divulged.

Transcription procedure

- 4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.
- 5) I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.
- 6) All materials relating to transcription will be returned to the researcher.

Signed.....**Date**.....

Print name.....

Researcher.....

Project title.....

Appendix VII Coded Interview Extract

| Themes | Codes |
|---|----------------------------|
| 577 Interviewer: yeah just very tuned in to what's going on | dynamic process |
| 578 Participant: yeah, bouncing off [name] and bouncing of me; it's no | descript suite combine the |
| 579 <u>what is issue</u> , <u>trying to find explanation</u> empathy, it's one of those...have you ever seen Star Trek? | need. |
| 580 Interviewer: no <u>focus on the feelings or others</u> | description t.v |
| 581 Identified as Empath Participant: oh they had an <u>Empath</u> on the Starship Enterprise and they'd | description t.v |
| 582 sit there and [inaudible] "I'm sensing confusion Captain" and there's a picture on the news screen, "I'm sensing confusion", really? And that's | description t.v |
| 583 Vicarious emotional <u>meaning experience</u> <u>? emotional contagion?</u> <u>because of / management</u> <u>counter-Marguerite</u> not what empathy is about, it's I actually <u>feel/feeling</u> what other people | Actively feeling |
| 584 neg group processes? are feeling and I have to go off and start putting it into context and work | Talking about projection? |
| 585 out if it's <u>this/ny feeling</u> <u>for somebody else's feeling</u> ? And it takes a while, <u>counter-transference?</u> | transference |
| 586 hence a lot of time spent sitting in quiet places trying to figure out what's | Transference |
| 587 past-group feelings | Transference |
| 588 going on | Transference |

Themes

Codes

| | | | |
|----|--|--|-----------------------------|
| | can be worse sent here | | |
| | Social reconnection | | |
| | we engage with life? | | |
| | reduces isolation | | |
| | ↓ social isolation? | | |
| | Pulls me out | | |
| | open up | | |
| | were thrown just words | | |
| | Sit & talk | | |
| | Other perspectives | | |
| | horizontal | | |
| 72 | you've got Schizophrenia, but if you could avoid talking about it." And | | Family reactions, court |
| 73 | then you're kinda like, well ok then, that's like 90% of me you've got to | | keep 90% you out |
| 74 | keep out of the room wh wh wh what point can I come back and join | | joining in life |
| | <u>can exclude?</u> | | social can join in |
| 75 | in with the same life um so here it's kinda social, you can get back in and | | |
| 76 | talk to people. If I didn't I'd be stuck in my flat going absolutely spare | | |
| | <u>emotional aspects of isolation</u> | | |
| 77 | Interviewer: Mmmhmm | | |
| 78 | Participant: So it's great to sort of pull me out once a week to a place | | direct: engageable |
| | <u>emotional aspects?</u> | | |
| 79 | where... <u>You just open up</u> And it's more than just about the voices. I | | just open up |
| | <u>comes that</u> | | |
| 80 | mean we get a lot of people like you here to sit in and that's good because | | describing how go |
| 81 | it brings other perspectives. It sort of brings more to the mix. Um... Yeah. | | aspects |
| | <u>to hear the other</u> | | B brings other perspectives |
| 82 | How long have I been coming? Think it's about two or three years | | |
| 83 | Interviewer: Okay. So, it's quite a lot of... | | |

Appendix VIII Reflective Interview Schedule

- 1) Why did you become interested in hearing voices groups?
 - Have you had any experiences of hearing voices yourself?
 - Have any of your close friends or family had experiences of hearing voices?
 - Prior to the research had you attended any self-help or therapy groups either as a member or as a facilitator?
- 2) How did you recruit HVG members to take part in the study?
 - Which group/groups
 - Ease/difficulty of recruitment
- 3) Tell me about your own participation in the group
 - Why?
 - How?
 - What was it like for you?
- 4) Tell me about your first interview with a HVG member
 - How were you feeling (before, during, after)?
 - What did you learn from this interviewee?
- 5) Which was your most memorable interview?
 - Tell me about it
 - Why was it memorable?
 - What did you learn from this interviewee?
- 6) Before you started the IPA analysis, did you feel you had gained any new understanding from the interviews?
- 7) So what has it been like to do the IPA on the interviews?
 - Do you feel it's a valid way of interpreting the interviews and peoples reported experiences?
- 8) Thinking about the research process as a whole – Has conducting the research enabled you to learn anything about yourself?
 - How have you been changed by this experience?

Appendix IX Reflexive Interview Excerpt

Negotiating My Role in the Group

Participant: And it... We... well, initially, I wasn't planning on sitting in and being part of the group because by being... sitting in the group, then I'm part of the group that I'm exploring but then simply my presence of researching and conducting the interviews is changing the group, anyways... It's all kind of linked.

Interviewer: Mmmh.

Participant: Um... So, yeah. 'Cause I got the impression that the group had been mistreated in the past.

Interviewer: Mmmh.

Participant: And I was also right with me being perceived as um... a professional psychologist and part of the NHS. And this is a non-NHS group. They're outside mainstream services, and a lot of the group members had bad experiences of being in um... mainstream services so, they're outside mental health services. And so I was wary that if I um... I didn't want to replicate some of those bad experiences by coming and taking from the group and not giving them...O... Abusing that position of power, really.

Sharing in the Group

Interviewer: Wh... wh... wh... what was it like after that? Som... Did you get into a phase where... Did you become a member of the group?

Participant: Yeah. To an extent. Like I um... the first couple of weeks, I pretty much um... I sat back and observed but I still... I said the odd thing because I, you know, I've been in other groups um... like personal development group on the course and I'm... I kind of know what it's like if you've got someone in the group who's quiet and silent the whole time. I don't like it. It's quite powerful. So, I went round. There's the routine at the beginning where you position yourself on the jelly bean tree.

Interviewer: Mmmhmm.

Participant: Um... And so I contributed um... went and did that, identified where I was, reflected on how my week had been. So...

Interviewer: Mmmh.

Participant: If I was particularly anxious or stressed, I'd say that I was. And um... and then tentatively kind of would say more. So, um... like a few weeks in, I had some um... stressful family moves that um... my brother um... my sister's boyfriend's going off to um... uh... Iraq for the war 'cause he was a soldier.

Interviewer: Mmmh.

Participant: And we'd just found out about it, and I couldn't get back down south to see my family. So...

Interviewer: Mmmh.

Participant: ...I kind of shared that 'cause I thought it was personal enough that kind of I can see how that goes and that it... I don't know. I... I thought I didn't want to share too much but that might be okay. Um... And people were just really lovely about it. Like they kind of didn't necessarily have their own experiences of people going off to war or whatever but um... they sort of... they heard that I was stressed about it or upset about it, and they actually kind of responded in a...

Finding Common Ground

Participant: I... it did with um... obviously when people were talking about more their experiences of psychiatrist appointments and medication and side effects. Um... And really extreme sort of all painful things to hear about um... kind of suicidal thoughts...

Interviewer: Yeah.

Participant: ...And past histories of abuse, those are things that I can't relate to in a personal way. Um... And... But I could relate to some of the things when they were talking about sort of anxiety and low mood or...

Interviewer: Mmmh.

Participant: ...Um... We'd talk about uh... s... different stress like social housing stress...

Interviewer: Mmmh.

Participant: ...And noisy neighbours. And it's kind of little things that I think it's on the continuum that you know, my experience could maybe meet somewhere with theirs...

Unattended Emotions in the Group

Participant: Um... And I often wondered... it was it... one particular lady on one week, was a very difficult week, there was a lot of stre... there was a lot of um... high emotions in... in the group, and I don't know what that was about. It never really got spoken about, and um... I didn't like that. And the lady was sat there with um... her hands clasped but they were really, really tight, and, you know, they were sort of shaking from her... ma... she was squeezing her hands. And I noticed it, and no one seemed to attend to it.

Interviewer: Mmmh.

Participant: And I wasn't sure I felt like I c... I don't know why, I don't... didn't feel like I could say, "Are you... you okay? Or..." I didn't know what I could say, and nobody else seemed to say anything. And the group ended with her sort of distressed it seemed, being not noticed and acknowledged. And when the group ended, she released her hands, and she had like finger marks...

Interviewer: Mmmh.

Participant: ...Like deep red...

Interviewer: Mmmh.

Participant: ...Kind of purple. And I just thought, "This is just really sad." And so I wondered what was her experience in that group that she sat there. She comes every time. She sits really quiet. She sometimes will engage in the jelly bean tree. But I just... Yeah. I saw... I don't know what. I mean she was completely censored I suppose because she couldn't say anything.

Interviewer: And I guess she wasn't one of your interviewees?

Participant: I approached her and she agreed. And then she didn't turn up to my s...

Preconceptions Being Challenged

Participant: ...I was a non-voice hearer in the group, the facilitator's a non-voice hearer, and I was thinking how important is this gonna be. Um... And so it was kind of har... maybe the... the third participant that I became aware that there were non-voice hearers in the group. Um... That I started asking those questions in the interviews, and people said they weren't really that bothered that there were non-voice hearers in the group and that really surprised me uh... 'cause I thought it

would be really important that everyone was a voice hearer at least that the facilitator was a voice hearer but it not... it wasn't the participants experiences.

Learning About Self

Interviewer: Thinking about the research process as a whole, has conducting the research enabled you to learn anything about yourself?

Participant: Well, yeah, actually, it's something that I've reflected in my diary before um... sort of going into the an... going into the group um... where I think it still holds true is that um... ultimately, I think as an individual you kind of... I do think you crave to be part of the group and to feel accepted and to feel like you fit in and um... that really that's what we all do and that that's no different to the group members that I've sat in on and that I was part of their group, and I was accepted. Um... And so although I kind of... I personally, I really valued being independent and could get on with things and not very good at accepting help, and I'm not very good being vulnerable, that actually I was probably all of those things in the group, and it wasn't as terrifying as I probably thought it might be. So, there's something about um... kind of at... yeah... how you are in a group.

Appendix X Additional Results Tables

Table 7

Group Analysis Additional Quotations

| Master Theme | Super ordinate Theme | Illustrative Quotation | Participant |
|-----------------------|---------------------------|--|-------------|
| Threats to Engagement | Unsettling Group Dynamics | "I sometimes feel it's [group] less relevant to me to... 'cause... 'cause some of the stories i've heard of time and again." | Amy |
| | | "But also because you talk to someone you don't have then control over whether they go and tell someone else. And I'm sure the people in the group don't go do it and that but it's still that sort of fear almost that they could if they wanted to." | Catherine |
| | | "Instead of walking in like an hour late because obviously it distracts everything. It takes you off track." | Eleanor |
| | | "We were talking about things in a circle and then stuff comes in and fractures it a little bit, you know? I don't know if that's good or bad but" | Sean |
| | | "Sometimes i'll wake up in the morning and get a vision of [name] hanging around drunk and I'm like "oh God, I'm not going"" | Sean |
| | The Kick Back From Voices | 'I hear voices as soon as I step out there or in here, usually in the street round the corner I hear someone say my name.' | Jay |
| | | They tend to try and undermine things. If I started talking about them, it'll be, "They're laughing at you. They think you're pathetic."" | Catherine |

| | | | |
|-----------------------------------|--|--|---|
| | | "I would speak to [name] or [name] and then I'd go home, and they would basically torture me about the conversation that I've had..." | Eleanor |
| Coming Together To Help Ourselves | I'm Not as Unwell as They Are | "It helped me in a way because um... I kind of realised that, you know, my problems weren't as bad as theirs" | Tom |
| | | "The only thing that I'd question is some of the people are in the group are quite hard hit than others." | Eleanor |
| | The Space to Make Sense | " other people responded by just telling me how they'd handled their voices, how they sort of come to manage them... that in itself is beneficial 'cause it was real practical..." | Amy |
| | | " You talk about the other stuff, the voices, the other symptoms" | Sean |
| | | "so all those little bits of problem that I haven't spoken about, I was just in the group thinking about cos it's the kind of place that I can, kinda goes away a little bit" | Sean |
| | | "when you come in here, this is the first place I sort of uncroaked my throat you understand and then it came out a little bit" | Adam |
| | | "Sometimes I like it when other people say, "Oh, I experienced that, too", although sometimes that kind of makes me go, "No. You don't."" | Catherine |
| | | Reciprocal Listening and Sharing | "and it's great to come here and share" |
| | "The groups like a mouthpiece I guess, where you can, you know you speak, everybody talks" | | Adam |
| | "It was huge... A huge relief. It was um... A bit of an outpouring." | | Amy |

| | | |
|------------------------------|---|---|
| | | <p>“you’re sitting there and you’re feeling bleurgh but then you can pull yourself together a little bit in order to offer somebody else a little bit of extra support”</p> <p>Sean</p> |
| | | <p>“And obviously it’s a case of sharing... Sharing thoughts and ideas with everybody.”</p> <p>Eleanor</p> |
| | | <p>“would much rather hear what everybody else has got to say and chip in with what coping strategies and things that I have to say.”</p> <p>Eleanor</p> |
| Belonging to a Special Tribe | Mutual Acceptance Through Shared Experience | <p>“We’re all similar aren’t we, you know what we’ve been through”</p> <p>Jay</p> |
| | | <p>“It was the first time I’d ever been anywhere where I could speak openly about the voices”</p> <p>Amy</p> |
| | | <p>“In the general public, people have got a bit of an aversion to hearing about it or alarm bells ring with people or whatever. People think you’re schizophrenic or whatever.”</p> <p>Amy</p> |
| | | <p>“I felt like somebody else was uh... Going through the same thing as me.”</p> <p>Tom</p> |
| | | <p>“You get into social settings with family and friends. And it’s all well and good. “Yes. We know you hear voices. Yes. We know you’ve got Schizophrenia, but if you could avoid talking about it.” And then you’re kinda like, well ok then, that’s like 90% of me you’ve got to keep out of the room wh wh wh wh what point can I come back and join in with the same life”</p> <p>Sean</p> |
| | | <p>“It’s hard to know exactly why or what I get from it...Other than the fact that I can just be myself.”</p> <p>Catherine</p> |
| | | <p>“You know, and i’ve also shared everything with the [centre]. They know who I am. They know what I am. So, when I leave out of here, I feel very, very confident.”</p> <p>Eleanor</p> |
| | | <p>“it's nice to at least find a small group of people that they don't define you, that's</p> <p>Adam</p> |

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| | not the first thing they define you by you know so, or it doesn't matter as much to them because they understand" | |
| Feel a Part of Something | "I wouldn't have found that first initial thing of it's alright mate, you know, there are other people like you" | Adam |
| | "Sometimes I don't want to go to group. I don't want to come, but I have to sort of force myself to come. I have to force myself out o' the house." | Amy |
| You Have to Have Been There | "I think that's the other big difference. When you talk to someone with experience, they don't sit there going, "Oh, there there"" | Catherine |
| | "I don't mind the non-voice hearers being in the group but sometimes it depends because it's like you're questioning, "Do they really understand what's actually happening for us?"" | Eleanor |
| Vicarious Emotional Experience | "Well, psychologically I'm not really sure whether it's doing me any good the fact that, you know, if I'm with a lot of people that have got a lot of problems, it might kind of um... Magnify my own problems." | Tom |
| | "I actually start feeling what other people are feeling and I have to go off and start putting it into context and work out if is this my feeling, or somebody else's feeling?" | Sean |
| | "Some people have actually had a really hard time like either been abused as a child and things like that. But sometimes it can be quite distressing..." | Eleanor |
| A Catalyst for Change | "I'm gonna be running a narcotics anonymous group ...X said in jail, I might be in there one day helping people rather than doing time. If I ever did that it'd be great yeah that'd be an accomplishment" | Jay |
| | " that boosted my confidence a little bit and made me feel a bit better about myself" | Amy |

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| | <p>"I feel a lot more contented now, really. A lot happier. Um... A lot more grounded... A lot more confident."</p> <p>"This place was a catalyst...a catalyst to everything in the rest of my life"</p> | <p>Tom</p> <p>Adam</p> |
| A Secure Base | <p>"Like X or something like that, they start talking like X...I can't really explain; 'are you going on holiday?' you know...I love her voice, she makes me laugh"</p> <p>"you've spoken...with the same people, and there's some continuity there."</p> <p>"I suppose you could say it's like a surrogate family"</p> <p>"Yeah. I feel a bit um... Well, I mean, isolated when I finish the group. Yeah"</p> <p>"because people know you, I think in a lot of ways they know how you are without you having to go into great essay-long explanations"</p> <p>"What I find helpful about coming to this group is bec... Is that you know that there... That there's people that care about you"</p> <p>"when you tie together, you tie together quite fast and strong because you just, you sort of understand."</p> <p>"if you walk into a place like this and you're very vulnerable...there's some people out there that still are quite vulnerable and they feel, they feel safe"</p> | <p>Jay</p> <p>Amy</p> <p>Tom</p> <p>Tom</p> <p>Catherine</p> <p>Eleanor</p> <p>Adam</p> <p>Adam</p> |