A tripartite relationship theory of voice hearing:
A Grounded Theory study

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Abstract

Background: People hearing voices and in receipt of mental health treatment can experience distressing and disempowering relationships with their voices and other people. Practitioners lack knowledge and confidence to know how to help people when distressed by their voice hearing. Previous research has predominantly situated voice hearing within individual voice hearers but identified that mental health treatment contexts foster power imbalances that undermine practitioner-patient relationships, illustrated commonly through coercion, and experienced as traumatic. Less is known about voice hearing within these treatment contexts, both in terms of voice hearers' experiences of hearing voices and practitioners' experiences of providing treatment for voice hearing. This thesis aimed to advance current knowledge and understanding of the relational dynamic involving voice hearers, voices and practitioners, through investigating individual experiences of hearing and treating voices within clinical contexts, in order to develop theoretical explanation of voice hearing and provide an approach that supports people distressed by their voices and practitioners providing treatment.

Methods: This was a qualitative study that utilised a constructivist Grounded Theory methodology to explore the experiences of voice hearers (n=15), through semi-structured interviews, and practitioners (n=18) through focus group discussions (n=3). These findings were synthesised in order to construct the final theory.

Findings: A tripartite relationship theory situates experiences of voice hearing during mental health treatment within a clinical context, mediated through a voice hearer – voice – practitioner relationship. This consists of five theoretical constructs: Personal bully, Level of agency, Interpersonal dynamic, Who's making sense, and Medication: helping or hindering.

Conclusions: A novel theory, grounded in voice hearers' and practitioners' experiences, expands on current knowledge about voice hearing and contributes towards a philosophical shift of situating voice hearing within relationship and clinical contexts rather than the prevailing individual-centric approach. Recommendations are made at policy, service and individual levels.

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Author’s declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as References.

Chapter 3 consists of an adapted published article: (Allison and Flemming, 2019)

CHAPTER 1: Introduction

> “And I would say that my own kind of anxious avoidant pattern of relating is manifested in the way that I've learned to relate to the voices”. (Bella, research participant and voice hearer)

> “…if someone is very, very distressed by voices, it's kind of heart-breaking, isn't it? You want to intervene. It seems cruel not to do something…[but]… I suppose you're damned if you do it and damned if you don't do it. Sometimes it feels like you're stuck between a rock and a hard place”. (Carrie, research participant and practitioner)

In her above quote, Bella strikes at the heart of the debilitating experience of voice hearing for many people, especially for those entering mental health services for treatment. Voice hearing is about relationships. As Bella infers, people who hear voices can wrestle with an internal struggle with voices but also experience difficult relationships with other people. As such, voice hearing for many people can be all consuming, disempowering and impact on their social interactions with others. People can hear their voices in secret, concealing from others the shame and abusive and aggressive threats they endure from their voices. Voice hearing also affects those who try to offer help. In the second quote above, Carrie refers to the difficulty mental health practitioners can experience when trying to provide support for people distressed by voice hearing. In trying to help, practitioners can sometimes contribute to voice hearers’ internal struggle.

This thesis aims to advance current knowledge and understanding of this internal-external dynamic involving voice hearers and practitioners, through investigating individual experiences of voice hearing within clinical contexts, in order to provide an approach that supports both those distressed by their voices and practitioners offering their help.

1.1 Chapter overview

This thesis aims to contribute towards current knowledge about voice hearing by situating voice-related experiences in clinical settings within the context of a tripartite relationship between people hearing voices, mental health practitioners, and the voices themselves. In this chapter, I: (1) situate me as a practitioner-researcher and higher education teacher in the area of mental health nursing; (2) introduce voice hearing; (3)

situate voice hearing within a context of mental healthcare commonly associated with coercive practice; (4) set out the aims and objectives of this thesis; (5) provide a brief commentary about the use of terms throughout the thesis; and (6) outline the chapter structure of the thesis.

1.2 Rationale for inquiry: practice experiences related to voice hearing

My experiences as a mental health nurse working in clinical practice and higher education have inspired and motivated my interest to investigate voice hearing in this thesis. Following registration as a mental health nurse in 1997, I worked in hospital and community clinical settings. I learned to take a sceptical approach towards psychiatric diagnoses and medication treatment from an early stage in my nursing career and, instead, to understand each individual's personal context through their stories about their life experiences. During my first nursing post in a specialist mental health unit, there were many examples of patients who had received several different diagnoses. For many, despite several diagnostic changes, their circumstances largely remained unchanged and they continued to spend several years in receipt of mental health treatment. Furthermore, their primary treatment was medication, typically including antipsychotics, antidepressants and anxiolytics, and usually in large doses. Before leaving, after five years, I learned from talking to several patients that their diagnosis and medication had masked and, worse still exacerbated, their problems. For those particular patients, in response to their lack of improvement, the clinical team discontinued their medication and reassessed them again. At that time, I had been surprised to see the positive effect of this and how different the patients became. This experience led me to question the value of psychiatric diagnoses and medication treatment.

This left its impression on me and influenced my clinical work in terms of understanding and treating people distressed due to their mental health. This was especially influential in terms of my approach to helping people distressed by their voice hearing. Some twenty years ago, it was common for practitioners (including me) to be advised by senior colleagues in clinical practice to avoid talking to patients about their voices for fear of colluding and making the voices worse. Instead, practitioners predominantly aimed to diagnose and treat people with antipsychotic medication. Even at that time, I questioned the therapeutic value of this and I subsequently undertook a career-long journey to learn how to engage and improve ways of talking to people about their voices and distress. This has led me to place less value on diagnoses and medication and more on learning to talk with people in order to understand their experiences of voice hearing. Throughout my career, I have been fascinated listening to people's experiences of hearing voices and especially to learn that many voice hearers personify and describe social relationships with their voices (Woods et al., 2015). It influenced my motivation to contribute towards improving knowledge regarding how we understand experiences of voice hearing, relationships between voice hearers and their voices and, where this results in distress, how to help improve these experiences and treatment approaches.

I moved into higher education to take up an academic role in 2008. Since that time, and in addition to my involvement in nursing and healthcare education, I have maintained clinical contact time with people hearing voices and practitioners providing treatment for voice hearing. This has included co-working with a colleague, who is also a voice hearer, to deliver education and training on Voice Dialogue through workshops aimed at voice hearers and practitioners. Voice Dialogue (Stone and Stone, 1989) was originally developed as a method of communicating with subconscious parts of our personalities but has recently transferred across into voice hearing as a method of 'Talking with Voices', wherein a facilitator talks directly to a person's voice(s) (Corstens et al., 2012). It aims to reduce distress related to voices and develop more harmonious relationships between voice hearers and their voices. This approach has helped shape my understanding of voice hearing, especially relationships between people and their voices. It provided me with an opportunity to begin to appreciate some of complexities and interpersonal dynamics related to distress associated with voice hearing. It subsequently stimulated my interest in understanding the internal-external interpersonal dynamics experienced by people who hear voices.

From my clinical experience, I understand that voice hearing can be initially nonsensical and, for some, can be very distressing. However, through listening to voice hearers and their voices, voice hearing can become understandable and less distressing through making sense of what/who the voices are and how they relate to a person's life. Through reading the work of Romme and Escher (Romme and Escher, 2013, Romme et al., 2009, Romme et al., 2006, Romme and Escher, 1989a) (discussed further in Chapter 2), I learned that voices can carry important information (or messages) relating to the voice hearer's life history. When unpacked and understood, this can become part of an empowering experience for the voice hearer and contribute towards their development of a more harmonious relationship with their voices.

However, I also learned that some people experience their voice hearing as even more distressing when in receipt of mental health treatment. I became aware that patients, including those distressed by voice hearing, could be administered treatment against their wishes. For example, during my time in clinical practice, I observed practitioners physically restrain patients and forcibly administer an injection of medication or threaten patients with an injection should they refuse to accept oral medication. I also observed practitioners threaten patients with either increased medication, Electroconvulsive Treatment (ECT) and/or detainment under the Mental Health Act (2007) unless they complied with treatment. From these observations, which sometimes included my own involvement, I observed and understood these types of treatment approaches within the treatment setting as practitioners exercising a form of power over patients. I also became aware through further reading and discussion with many voice hearers, including some publicly known such as Ron Coleman, that their recovery did not begin during their time in treatment but after their discharge from mental health services (Coleman, 1999). This influenced my own thinking around the therapeutic value of the treatment approaches in mental health services and the potential impact of this on voice hearing.

Consequently, my concerns regarding treatment decisions, regarding practitioners' struggles in knowing how to help, and my awareness of challenges to the credibility of the therapeutic value of mental health treatment by those in receipt of it, raised questions about mental healthcare for people distressed by voice hearing. Practitioners broadly, and mental health nurses specifically, lack knowledge and confidence regarding treatment approaches for voice hearing (White et al., 2019, Bogen-Johnston et al., 2020, Kramarz et al., 2020). My fascination in trying to understand complexities associated with voice hearing and to improve treatment experiences, for both voice hearers and practitioners, has been my primary motivation for this thesis.

1.3 Voice hearing

At its most simplistic level, voice hearing refers simply to hearing a voice or several voices when there is no speaker present (Waters, 2010). Extending this definition, Woods (2013) attributes a symbolic identity to voice hearing, informed by interpersonal, political and cultural contexts. As such, voices are personal to a voice hearer in that only they can hear them, but voice hearing is also a meaningful experience that contributes to one's identity. The voices are also experienced as distinct from the voice hearer's own voice and thoughts and can be accompanied by other sensory experiences such as a smell or visual presence. Voices can be heard from different locations, for example inside the voice hearer’s head or from specific locations outside their head (Beavan, 2012). They can vary in age, gender and be identifiable by the voice hearer as specific people or commonly the Devil or God. Voice content can vary between different voice hearers but can enable the voice hearer to identify the voice (Birchwood and Chadwick, 1997). Typically, especially for people in receipt of treatment in relation to voice-related distress, voice content involves abusive and threatening language. Most voice hearers can identify at least some of their voices (Beavan, 2007) and tend to describe these in either positive or negative terms (Beavan, 2012).

Establishing an explanation and approach to treating voice hearing is vigorously debated in the literature by researchers, practitioners and people hearing voices. This debate is informed by biological, psychological and sociological ideologies (see chapter 2 for more detail). Most research, however, has focused predominantly on investigating a biological causality, for example hypothesizing voice hearing being caused by brain abnormality or genetic inheritance, or understanding voices in psychological terms, for example due to cognitive dysfunction (Waters et al., 2012, Kalhovde et al., 2013). In clinical practice, voice hearing is commonly termed an *auditory hallucination* and considered to be a symptom associated primarily with a diagnosis of schizophrenia (Larøi, 2012) or one of the symptoms of a broader concept of psychosis (Pierre, 2010). Psychosis consists of cluster of symptoms and several related conditions, including the most common schizophrenia, which represent a major psychiatric disorder concerning alterations to a person’s perceptions, thoughts, mood and behaviour (National Collaborating Centre for Mental Health, 2014).

Regarding psychosis, results from the most recent Adult Psychiatric Morbidity Survey (UK) in 2014 (McManus et al., 2016) suggest that the prevalence rate across the adult general population is less than one in a hundred people. There are no significant differences in rate between men and women (although there is a higher rate in black men at 3.2%), it is more common among economically inactive people and less for those employed, and more common for people who live alone. Almost all people diagnosed with psychosis are prescribed medication, with around half (54.4%) receiving counselling or other psychological therapy, and only 6% receiving a psychological therapy without also using medication (McManus et al., 2016). This reflects my experience of working in clinical practice, where I observed almost all patients treated with medication and fewer opportunities for alternative treatment options.

In terms of people within mental healthcare, people hearing voices admitted to mental health services are commonly diagnosed with schizophrenia. Most people diagnosed with schizophrenia hear voices, with an estimated lifetime prevalence of 64-80% (McCarthy-Jones et al., 2017), and 25-40% are troubled by voices despite medication treatment (Mueser and McGurk, 2004). A median prevalence rate of 53% of voice hearers experience voices that instruct them to do something, commonly referred to as command hallucinations (Shawyer et al., 2012). This increases the risk of violence to others and self (Haddock et al., 2013) and is generally associated with increased risk of harmful or dangerous actions. Furthermore, people diagnosed with schizophrenia are associated with an increased risk of suicide (Kjelby et al., 2015). Interestingly, patients' risk of suicide has been found to be influenced by their perceptions of the treatment environment. For example, findings from a recent prospective study associate patients' perceptions of being coerced during their treatment with an increased risk of suicide attempts post discharge (Jordan and McNiel, 2019). This raises the importance of understanding how voice hearing is experienced within a treatment context.

There is also evidence, however, that voice hearing is not restricted to specific diagnoses such as schizophrenia or even psychosis. In a systematic review, Waters and Fernyhough (2017) found voice hearing to be associated with a wide range of medical conditions, including: endocrine-related metabolic conditions such as thyroid function; chromosomal disorders, autoimmune disorders, acquired immunodeficiency disorders (HIV/AIDS), sleep disorders, neurological events, traumatic brain injuries, cardiovascular events, and neurodegenerative conditions. Voice hearing has also been found to be experienced in the wider population group (Johns et al., 2014). Prevalence rates of voice hearing in the general population vary, with findings estimated at 7.3% (Kråkvik et al., 2015), 6% (Linscott and Van Os, 2013) and 5-13% (Beavan et al., 2011). Some researchers hypothesise that voice hearing is a dimensional experience along a continuum from mental health to mental illness (Powers et al., 2017, Van Os et al., 2009). Furthermore, some voice hearers do not have a diagnosis of mental illness (Beavan et al., 2011) and many do not seek or need professional help (Sommer et al., 2010). Consequently, many voice hearers do not come to the attention of mental health services to receive treatment. Such a wide range of diagnoses challenges the diagnostic value of voice hearing, both in terms of establishing an underlying explanation for voices and a diagnostic-led treatment approach.

In contrast, people who do experience distress because of their voice hearing typically come to the attention of mental health services. People falling into this group are distinct from other voice hearers in terms of the extent to which their voices negatively affect their mental health and will likely experience difficult relationships with their voices.

1.4 Voice hearing, mental healthcare and coercion

As I explain above in section 1.2, I observed coercion throughout my clinical practice and became aware that, for some voice hearers, they experienced treatment as coercive and unhelpful. Coercion is commonly defined as *"the action or practice of persuading someone to do something by using force or threats"* (English Oxford Dictionaries) and is widespread in mental healthcare. In terms of specifically defining coercion in relation to mental health practice, however, there is lack of universal agreement (Molodynski, Khazaal & Callard, 2016). Instead, several terms are used in the literature to define a wide range of coercive actions (e.g. soft coercion or hard coercion), which I discuss in Chapter 3. I discuss a background context regarding mental health services in more detail in Chapter 2 and I investigate the coercion literature in Chapter 3.

It is important to establish and understand the role of coercion in clinical environments, practitioner-patient relationships and its potential impact on voice hearing. Influenced by my practice experience, I wanted to investigate the possibility of a link between coercive treatment approaches and voice hearing. In order to understand this in more detail, in Chapter 3 I discuss an evidence synthesis of coercion literature that I conducted early in my PhD, which helped to establish a background clinical context in which voice hearing is experienced. As I go on to discuss in Chapter 3, it became evident from the evidence synthesis that coercion is a much-debated phenomenon, broadly defined across mental healthcare, and negatively affecting patients' treatment experiences and subsequent distress. In my published article of this evidence synthesis, I found that practitioner-patient relationships within mental health treatment environments can be undermined by imbalances of power, typically illustrated through a range of coercion, and described by patients in traumatic terms (Allison and Flemming, 2019).

A gap in the literature emerged from the review in Chapter 3 regarding the impact of coercion on specific types of mental distress. There is increasing evidence associating previous trauma, such as difficulties resulting from relational violations of various sorts, as a key trigger to the onset of voice hearing (Cunningham et al., 2016, Gibson et al., 2016, van Dam et al., 2012, Arseneault et al., 2011, Arseneault et al., 2010, Read et al., 2005).

This is exacerbated when some patients also perceive their treatment as traumatic, including feeling bullied by practitioners (see Allison and Flemming, 2019). Although many participants included in the empirical coercion literature have a diagnosis of schizophrenia, and report negative experiences related to coercion, there has been little if any attention given to investigating if, and how, coercion specifically affects problems such as voice hearing. This emphasises the importance of investigating whether or not treatment contexts, in which coercion commonly occurs, underlie experiences of voice hearing. It also places emphasis on practitioners' understanding of how they relate with people who hear voices during treatment.

1.5 Investigating voice hearing in the context of this inquiry

Extending the above point, there is empirical evidence associating distressing voice hearing with previous trauma (e.g. Read et al., 2005), wherein distressing experiences have resulted from a violation of some sort in a previous relationship(s). Patients who perceive their relationships with practitioners as difficult and disempowering as a result of coercion can experience this as re-traumatising and this can negatively affect their treatment (Allison and Flemming, 2019, Paksarian et al., 2014a) and lead to avoiding future contact with mental health services (Swartz et al., 2003, Hotzy and Jaeger, 2016, Jaeger et al., 2013).

Whilst difficult life experiences are associated with voice hearing, there is a gap in the research literature detailing *how* life experiences are linked to voice hearing (Thomas et al., 2014). It is yet to be established sufficiently how voice hearing is experienced within practitioner-patient relationships and how interactions (both between voice hearers and their voices and with practitioners) within this treatment context subsequently affects treatment and recovery. This highlights the importance for further investigations into understanding voice hearing and potential influences related to practitioner-patient relationships. At a time when the efficacy of conventional biological approaches to understanding and treating voice hearing lacks sufficient evidence, there is a need to explore and understand contexts in which voice hearing may be triggered to enable support that is more effective for people hearing voices in clinical settings. Consequently, this thesis is concerned with voice hearers who have been in receipt of treatment, and practitioners providing treatment, within mental health services provided by the National Health Service (NHS) and private, voluntary and third sector organisations. In the next Chapter, I set out in more detail a broad context of mainstream mental health services and treatment for voice hearing.

1.6 Aims and Objectives

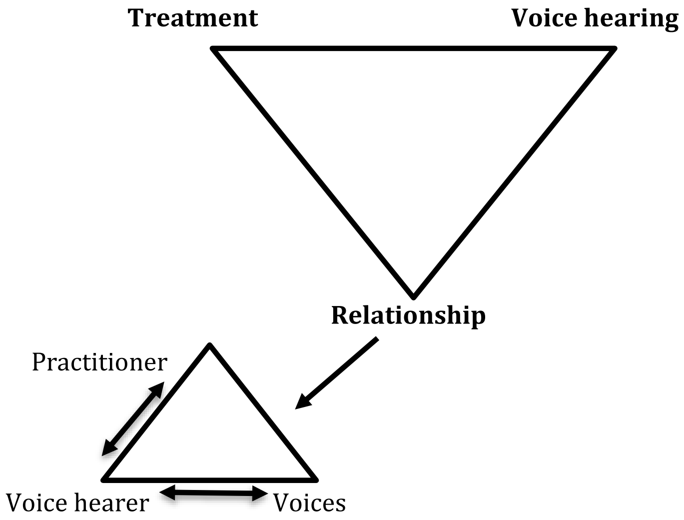
The aim of this thesis is to understand the experience of voice hearing within the context of a tripartite relationship of voice hearer-voice-practitioner.

The objectives of the thesis are:

1. To understand how voices can influence, and be influenced by, mental health treatment, from the perspectives of: (a) patients who hear voices and received treatment and (b) mental health practitioners who provide treatment for patients who hear voices.
2. To understand whether "coercion" exists within the tripartite relationship of voice hearer-voice-practitioner in the context of mental health treatment.
3. To use the above to develop theory that explains how patients' experiences of voice hearing might be mitigated (either attenuated or exacerbated) by the voice hearer-voice-practitioner relationship during mental health treatment.
4. To make recommendations about how mental health practitioners can change their relationship with patients who hear voices, and with the voices themselves, in the form of attitudes and behaviours during treatment, to attenuate or prevent exacerbating the voice hearing of patients.

I illustrate the aim of the thesis in a 'treatment – voice hearing – relationship' framework below in Figure 1.1. This represents the objective of understanding how voice hearing experiences are influenced by treatment in a context of a voice hearer-voice-practitioner relationship.

Figure 1. 1: 'Treatment – voice hearing – relationship' framework



1.7 Terms used in this thesis

It is difficult to adopt a neutral position in terms of the language used to describe people in receipt of mental health treatment. There are several terms commonly used in mental health practice and literature, including but not limited to: patients, clients, service users, voice hearers, people with lived experience, mental illness, severe mental illness, mental disorder, mental health problems/conditions, schizophrenia, psychosis, voice hearing, auditory hallucinations, symptoms, and emotional distress. Additionally, the terms 'survivors' and 'consumers' arose from civil rights activism of the 1960s and 1970s and reflected a shift from being passive patients to survivors of psychiatry and consumers of services (Chamberlain, 1977). The terms I use throughout the thesis to describe people hearing voices are 'voice hearer', the associated verb 'voice hearing' and the term 'patient'. This reflects the language used by many voice-hearing writers in the literature and my clinical practice experience of discussions with people who hear voices. Furthermore, I use the term 'mental healthcare' rather than 'psychiatry' where I can to reflect the broader approach of contemporary services as opposed to the inferred biomedical approach commonly associated with psychiatry (I discuss this further in Chapter 2).

1.8 Thesis overview

Following the thesis aim and objectives set out in this Chapter, I flesh out the 'treatment - voice hearing - relationship' thesis framework in Chapter 2. This involves setting out an English mental health treatment context and the conventional medical and psychological treatment approaches within it for voice hearing. I also discuss relationships as being central to experiences and treatment of voice hearing and discuss the Hearing Voices Movement as an alternative to conventional approaches for conceptualising (and treating) voice hearing. In my discussion of the mental health treatment context, I refer to a gap in the literature specifically relating to the effects of coercion on patient–practitioner relationships and, specifically, voice hearing.

I actually began my PhD study by first investigating literature related to coercive practice, which I discuss in Chapter 3. As I discuss above in section 1.2, my motivation for investigating voice hearing is rooted in my previous clinical experiences as a mental health nurse working across different clinical treatment areas. I am aware from my clinical and academic work with other practitioners and voice hearers that treatment could involve coercive practice and be experienced as negative for some people. I wanted to situate and understand voice hearing in a treatment context in order to contribute towards improving treatment experiences. However, although I had previously observed or participated in coercive treatment, I had little understanding of it. This influenced me to begin writing this thesis by first investigating literature relevant to coercion in mental healthcare in order to establish a more detailed understanding and its potential impact on experiences of mental health treatment. Chapter 3 is an adaptation of my published evidence synthesis of qualitative literature about coercion in mental health treatment (Allison and Flemming, 2019). Due to a lack of evidence specifically related to voice hearing, it concerns the impact of coercive treatment on patient-practitioner relationships. I establish from the review that patients can experience a range of coercion, which is largely influenced by how patients experience their interactions with practitioners. These findings helped shape the research aim and objectives to focus my investigation into voice hearing and to situate this specifically within a treatment context.

In Chapter 4, I discuss a qualitative Grounded Theory methodology, which informs the research methods I utilized throughout my research study to collect and analyse data from voice hearers and practitioners. I attempt to coherently align the methodology and research methods throughout the research process. Chapter 5 details the research methods used to investigate the experiences of voice hearers. This involved semi-structured interviews of people who hear voices and have also received mental health treatment. I discuss the findings from these interviews in Chapter 6.

I sought to further develop the tentative theoretical coding from the voice hearers' interviews by investigating the perceptions and experiences of mental health practitioners. In Chapter 7, I describe the research methods regarding three focus groups of mental health practitioners and discuss the findings of practitioners' reported experiences.

A synthesis of the findings from the voice hearer interviews and the practitioner focus groups is presented in Chapter 8. Voice hearers' and practitioners' complimentary experiences and perceptions contribute towards advancing the theoretical coding. This encapsulates a broader tripartite relationship of voice hearer-voice-practitioner. This led to completing the theoretical coding wherein a tripartite relationship theory conceptualizes voice hearing within a clinical and interpersonal context.

In Chapter 9, the study findings represented through the tripartite relationship theory are discussed and in relation to relevant voice hearing literature. I argue that my study findings extend current knowledge by conceptualising voice hearing within a tripartite relationship by explicitly including both voice hearers' experiences of intra-personal relations (with their voices) and inter-personal relations (with practitioners). Chapter 10 concludes the thesis, in which I make recommendations based on the study findings. These are considerate of broader policy and service level changes and recommended changes for both practitioners and voice hearers.

1.9 Chapter Summary

The aim of this thesis is to understand voice hearing within a context of mental health treatment by considering the tripartite relationship between people hearing voices, their voices, and mental health practitioners. By using a constructivist grounded theory approach, data emerging from interviews with voice hearers and focus groups with practitioners will be analysed to develop a model that explains how patients' experiences of voice hearing might be mitigated (either attenuated or exacerbated) by the voice hearer – voice – practitioner relationship during mental health treatment.

CHAPTER 2: Contextualising voice hearing in this thesis

2.1 Chapter overview

Having introduced voice hearing as the focus of this thesis, in this Chapter I further detail the treatment and relationship elements of the thesis framework in order to set out a treatment context in which I investigate voice hearing by briefly introducing the concept of social power relevant to the investigation. I then discuss the UK mental health treatment context (specifically England due to the location of the study), including key health policies that have shaped services and treatment for voice hearing in England, and the pressure under which services operate. Following this, I discuss mainstream treatment provided in English mental health services including antipsychotic medication and Cognitive Behavioural Therapy for psychosis (CBTp). Finally, I discuss alternatives to these mainstream treatments, informed by increasing evidence associating traumatic life events with onset of voice hearing. These alternatives include the Hearing Voices Network (HVN), which has challenged conventional mental healthcare approaches, and an increasing focus on relationships in voice hearing (which aligns with the HVN approach).

2.1.1 Power in relation to this thesis

In the previous Chapter, I referred to my interest in the interpersonal dynamics between voice hearers, their voices and practitioners and my observations from clinical practice of power within these interactions. Before I begin to discuss a mental health treatment context, it is important first to introduce the concept of power. There is insufficient space to provide a comprehensive analysis of power but it is important to introduce it here, particularly in terms of how it plays out in relationships and applies to my investigation of voice hearing.

Hearn (2012, p16) defines power as “the capacity of some persons to achieve intended and foreseen events on others” and stresses the importance of understanding the nature and scope of it in order to understand society and influence social change. In order to help utilise the concept for this thesis, I found Hearn’s conceptual ‘reference grid’ (p4) a useful way of broadly understanding the complexity of power. This consists of five sets of pairs of terms, all of which are contrasted for the purpose of the grid but, in actuality, the pairs are inextricably linked and reflect the complexity of defining power.

First, physical versus social power. Hearn contrasts power in a physical sense, in which it can be physically applied as a force, with a social sense of power in which it is ‘held’ by people and described in terms of social encounters involving power through the "application of some invisible force" (p5). For example, in a mental health clinical setting, we can observe physical power when practitioners physically restrain patients; in terms of social power, patients may perceive practitioners to have the ability to make them accept medication or a treatment decision through their practitioner role and in influencing patients to comply with treatment by the potential use of the MHA.

Second, power 'to' versus power 'over'. This concerns power as the capacity to realise ends, which contrasts with power as the control of one agent over others. For example, power 'to' could involve a voice hearer having power to make informed treatment decisions whereas power 'over' could involve practitioners dominating the voice hearer through making treatment decisions without any collaboration.

Third, asymmetrical versus balanced power. Hearn argues that power is not dispersed uniformly across society (and even if it was it would not make it disappear) but concentrated in particular areas (e.g. individuals or organisations) and exist in a "web of relations" (p9) and hierarchies.

Fourth, power as structures versus agents. To help set out a workable understanding applicable to this thesis, power in structure refers to stable patterns such as gender or division of labour, power in agency refers to the intentions and actions of individuals and groups. For example, the structure of a mental health service is constitutive of the power of one social group (e.g. practitioners) over another (patients) in which the former hold power over the latter and can utilise legal measures (MHA) in order to administer treatment involuntarily. However, "social structures shape and are shaped by our power relations" (p12), wherein a "complex interaction of agencies…. [work through but also create]….layers of structure" (p13). As such, Hearn refers to agencies *in* structures.

Fifth, actual versus potential power. This concerns a more philosophical question in terms of determining how we know power is there if it cannot be seen or enacted and the complexity of power in terms of relations between social entities, which "should not be construed either solely as observable events, or as some substance or quality found in the powerful" (p16).

2.2 Policy shaping mental health services for voice hearing

I found it useful to consider Hearn's conceptual grid in relation to mental health services and the policies that have shaped it. For example, as I discuss below, in terms of asymmetrical power, recent policy increasingly recognises the importance of parity of esteem in order to address historical lower status and funding of mental health services and treatment compared to physical health. Polices have also contributed to structural organisation of mental healthcare and influenced the role of practitioners. In this section, I discuss a selection of health policies relevant to the mental health treatment context for voice hearing.

UK mental healthcare consists of inter-related inpatient and community services, the latter of which include primary care General Practitioner (GP) services and a range of community teams specialising in mental health. These services are complex and organised differently across regions by multiple providers, the largest of which is the National Health Service (NHS), and have undergone significant change over the past 20 years. Acute inpatient services provide intensive, short-term treatment for patients experiencing acute distress and for whom sufficient support cannot be provided in the community (Simpson et al., 2017). Although there are fewer alternative forms of mental health services (see Johnson et al., 2009), they generally provide support for people exhibiting less disturbed behaviour and so distress related to voice hearing is more likely to be treated in standard NHS services.

Health and social care policy shape service provision in terms of service aims and the investment in resources in order to deliver mental health care and the specific treatment interventions. This aligns with Hearn's asymmetrical/balanced power and power 'to'/'over' in terms of whether health policy can potentially provide guidance and resources for practitioners to deliver evidence-based treatment for patients or perhaps steers services to privilege some forms of treatment provision over other forms and thus influence the extent to which patients have treatment choice. The location of treatment has increasingly shifted towards the community. In the UK, the number of inpatient beds reduced significantly between 1955-2012 from 150,000 to 22,300 (The Commission on Acute Adult Psychiatric Care, 2015). From the late 1990s, the English mental health services underwent a significant period of transformation that shaped mental health services to its current provision.

In the 1990s, the increasing emphasis on community services led to challenges associated with the management of distressed and disturbed behaviour that had previously been contained within the hospitals. Increasing concerns regarding insufficient community mental health care, influenced by media coverage of adverse events in the community, contributed towards public and political pressure to reform services, leading to the publication in the late 1990s of the National Service Framework for Mental Health (NSF-MH, Department of Health, 1999). This was an ambitious and long-term strategy aiming to invest in the workforce and drive up the quality of mental health care (Thornicroft, 2000). It set out several milestones to improve care, integrate health and social services and reduce variations in quality in the NHS. Of the seven national standards set out in NSF-MH, two specifically addressed severe mental illness (such as schizophrenia), including emphasis on managing risks with patients, 24-hour access to services (standard four) and patients receiving a detailed aftercare plan and named care co-coordinator (standard five). In terms of increasing the quality of treatment, it also set out a target to review the workforce in mental health services and commission a workforce to deliver psychological therapies.

Further details regarding the NSF-MH targets were set out in The NHS Plan (Department of Health, 2000), with a focus on investing in primary and community care. These included setting out significant investment in healthcare provision, for example increasing hospital beds (7000), new hospitals (100) and one-stop primary centres (500), modernising GP premises (3,000), new 'modern matrons', more medical consultants (7,000), GPs (2,000), nurses (20,000) and therapists (6,500). The NHS Plan also integrated health and social care through the establishment of Care Trusts, which commissioned and had responsibility for health and social care services. Specifically relevant to the treatment of voice hearers, an additional target was set for three new specialist community services: 200 Assertive Outreach Teams, 335 Crisis Resolution Teams, and 50 Early Intervention Teams.

The specifications for each of these three new specialist services were provided in a further publication, the Mental Health Policy Implementation Guide (Department of Health, 2001). Each of the services are still relevant for voice hearers in current mental healthcare in terms of providing treatment for people diagnosed with a severe mental illness and with a history of poor engagement with treatment (Assertive Outreach), in an acute crisis (Crisis Resolution Teams), and experiencing or exhibiting early signs of a psychotic episode for the first time (Early Interventions Teams). Shortly after this focus on new specialist community care services, and in recognition of a lack of safe and therapeutic acute inpatient services, the Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision (Department of Health, 2002) was published. Amongst key targets included the need to invest in the inpatient staff (in terms of enhancing the nursing role and skill and career development), to maximise the quality and amount of practitioners' therapeutic time with patients, and to develop effective decision-making that placed patients in the process.

These policies were ambitious and aimed to drive up the quality of mental health care through investment in the workforce and specialist service provision. During this period of time, a new executive non-departmental public body of the Department of Health in England, the National Institute for Clinical Excellence (NICE), was established in 1999 with a remit to produce treatment guidance for practitioners based on best available evidence. It later evolved to become the National Institute for Health and Clinical Excellence in 2005 and then to become the National Institute for Health and Care Excellence in 2013 following the publication of the Health and Social Care Act (2012). The first clinical guideline CG 1 (https://www.nice.org.uk/guidance/cg1), published in 2002, focused on schizophrenia, which was replaced in 2009 by CG82 (https://www.nice.org.uk/guidance/cg82) with a broader focus on psychosis and schizophrenia, and further updated again in 2014 for the current version CG178 (https://www.nice.org.uk/guidance/cg178) (NICE, 2014). The evolution of these guidelines has increasingly recognised the importance of psychological therapy, specifically Cognitive Behavioural Therapy (CBT), as an adjunct to antipsychotic medication. There is also increasing recognition of the long-term harm and increased mortality associated with long-term use of antipsychotic medication. (See section 2.3 for further discussion regarding NICE guidelines).

Through No Health without Mental Health (DoH, 2011), the Department of Health set out further reform aiming to improve mental health services. Six key objectives were identified: (1) more people will have good mental health; (2) more people with mental health problems will recover; (3) more people with mental health problems will have good physical health; (4) more people will have a positive experience of care and support; (5) fewer people will suffer avoidable harm; and (6) fewer people will experience stigma and discrimination. In terms of improving mental health services, it identified that all patients should receive high quality care in the least restrictive environment and designed around the needs of individuals, but additionally to reduce costs.

The Health and Social Care Act (Act, 2012) brought further reform to the NHS in England. Primary Care Trusts were abolished and the commissioning process for health care was transferred to Clinical Commissioning Groups (CCGs), comprised of groups of GPs. It aimed to empower practitioners (GPs) to commission services and patients to gain greater control of their own care. However, there were concerns among practitioners and user groups that the overarching aim was to make financial savings and concerns regarding how the commissioning process could facilitate competition whilst also increasing patient choice (e.g. GPs consider medication as a front-line treatment for mental health rather than the limited availability of psychological therapies and therefore compromise patient choice) (Glover-Thomas, 2013).

Shortly after, and in the context of a global recession and austerity (see below for further discussion regarding austerity), the NHS Five Year Forward View (NHS, 2014) set out a vision for NHS services involving new models of care. This included recognition of the importance of sustainability and the economy: “the economic prosperity of Britain…depend on a radical upgrade in prevention and public health” (p.3). As such, it acknowledged a “funding and efficiency gap” (p.7) as a risk to quality care and staffing resources and gave emphasis to public health and to empower individuals to be supported to manage their own health. An independent Commission on acute mental health services, however, highlighted national wide variation in quality of mental health acute units, with particular concerns raised about quality of treatment and also the leadership and culture amongst the staff group (Crisp et al., 2016). This included staff shortages, with a subsequent increase in the use of agency nurses to fill gaps, difficulties in recruitment, a high turnover of staff, concerns regarding staff satisfaction, morale and burnout, and a recommended need to review the skill mix and training/development of staff.

In a context of historic lack of equal status given to physical health, including a lack of staffing resources, chronic underfunding, worsening patients’ outcomes and increasing demand on services, a ten year journey was detailed in the Five Year Forward View for Mental Health (NHS, 2016), with a particular focus on reducing inequalities to mental health care. It acknowledged the insufficient provision of NICE recommended treatment for patients, specifically very long waits for people with severe mental health problems for psychological therapies (or not even having access at all). Recommendations included the need for the funding of an additional £1billion in 2020/21, the need to make available

24/7 services to bring in line access to mental health care with physical health care and the need to expand community services to enable this, including increased access to psychological therapies. A workforce strategy launched in 2017 to implement the Five Year Forward View for Mental Health set out plans for an increase of 21,000 new posts across England (https://www.gov.uk/government/news/thousands-of-new-roles-to-be-created-in-mental-health-workforce-plan).

The NHS Long Term Plan (Department of Health, 2019) renewed a commitment to grow investment in mental health services faster than the NHS budget overall until 2023/24. This included a commitment of at least an additional £2.3bn on mental health care, increased provision of psychological therapies for depression and anxiety (an additional 380,000 people per year by 2023/24) and community-based physical and mental health care for 370,000 people with severe mental illness by 2023/24. Prior to this NHS England were reportedly meeting a target of spending at least 10% of the health services budget on mental health, set out by The Lancet Commission on Global Mental Health (Patel et al., 2018).

In terms of severe mental illness, the Long Term Plan provides commitment to the development and redesign/reorganisation of existing teams to move towards new integrated models of primary and community mental health care, and to include access to psychological therapies, trauma-informed care, improved physical care, employment support, medicines management and support for self-harm and coexisting substance abuse. In terms of inpatient acute care, it acknowledges the importance of providing a therapeutic environment to help support patient recovery and commits to reducing long inpatient stays to the national average of 32 days and to end out of area placements by 2021. It also commits to provide 24/7 community-based mental health crisis response across England by 2020/21, aiming to offer intensive home treatment as an alternative to acute inpatient admission, and working towards a 10-year goal of providing a single point of access for mental health crisis for everyone.

2.2.1 COVID-19 and mental health services

These more recent policy aspirations discussed above, however, have been severely hampered following the emergence of a new coronavirus. At the time of writing, we have just passed the one-year anniversary of the current coronavirus pandemic. SARS-Cov-2, known commonly as COVID-19, is an infectious coronavirus disease traced to have emerged in Wuhan (China) in December 2019 and declared a pandemic by the World

Health Organisation on 11th March 2020 (Ferguson et al., 2020). Globally, healthcare and economies have suffered as a result. It spreads primarily through respiratory droplets and, in terms of mental health services, poses a risk to both practitioners and patients. The long-term effects of medication and comorbid physical health problems make people in receipt of mental health treatment particularly vulnerable to the effects of COVID-19 (Smith et al., 2020). Practitioners have experienced increased levels of stress, depression, suicide, burnout and mental exhaustion (Fiorillo and Gorwood, 2020) and express concerns related to scare resources and a lack of cure or effective treatment options (Heale and Wray, 2020). They also may need to make difficult decisions, such as balance their own healthcare needs with those of patients and provide equitable care with constrained/inadequate resources (Greenberg et al., 2020).

In response to the potential impact on staffing resources, changes were made to the Mental Health Act (2007) by introducing the temporary Coronavirus Act 2020 (www.legislation.gov.uk). This enables a relatively easier process of compulsory detention and treatment of patients (by permitting one doctor rather than the usual two to recommend detainment under apply Sections 2 or 3) and, the extension of detention under some Sections (for example, extending detention in places of safety from 24 to 36 hours under Sections 135 and 136).

Informed by UK government guidelines, practitioners within NHS Trust localities have reduced face-to-face contact where possible and are increasingly utilizing alternative methods such as telemedicine. Before the emergence of COVID-19, globally healthcare had been increasingly adopting an innovative use of digital technology. The impact of COVID-19 on mental health services has provided additional impetus for the National Health Service to implement Information Technology systems such as telemedicine as a new way of engaging and assessing patients (Smith et al., 2020). In the UK, recommendations relating to digital technology were made in the Topol Review (https://topol.hee.nhs.uk/) and in the NHS Long Term Plan (DoH, 2019). Practitioners are increasingly expected to have the technical awareness to use digital technology and to effectively communicate online with patients: provide telemedicine, the use of smartphones, digital therapies, and use of social media (Foley and Woollard, 2019). However, the evidence base for the effectiveness of digital treatment options for mental health is still in its infancy (Chang et al., 2020). At the time of writing, evidence is yet to emerge regarding the impact of the pandemic specifically for voice hearers and practitioners' treatment approaches for voice hearing.

2.2.2 Mental health services under pressure

As I describe above, during the twenty-year period from the NSF-MH (1999), mental health services have changed considerably, especially community care for people with severe mental health problems (including voice hearers). Laudable aims have included increasing the range of mental health service provision (especially in the community), increasing patient access to these services and their choice of treatments within these services, increasing the quality and quantity of the workforce, and 'parity of esteem' whereby mental health is given equal status to physical health.

However, despite the ambition of these policies, there is a gap between the investment and targets set out and the real-world clinical experiences in mental health care. Mental health practitioners are at breaking point due to continuous understaffing and increasing demand, with the British Medical Association calling for UK Government to ensure mental health care receives equitable resources as physical health care (Mahase, 2020). I also observed this during my time in clinical practice when engaging with practitioners and voice hearers.

It is important to situate these policies and their impact on mental health services within a broader economic and political context, particularly the global banking crisis in 2008. The banking crises required the UK Labour Government to bail out financial institutions with huge sums of public money. Two years later, the Coalition Government formed in 2010 commenced a period of austerity to reduce the budget deficit in response to the banking crisis. Key policy documents above emphasized cost efficiency following this period. Huge cuts to public and welfare spending followed this, which impacted on health and wellbeing and disproportionately affected vulnerable groups and mental health services (British Medical Association, 2016). A systematic narrative review of the health effects of the economic crisis in high income (OECD) countries found that mental health has been the most adversely effected by it (Karanikolos et al., 2016).

Consequently, despite the intentions and recommendations set out in policy regarding investment in mental health services, chronic underfunding and austerity has negatively impacted on mental health services, which have struggled under sustained pressure. This has contributed to pressure on inpatient services, insufficient provision for individuals in crisis, increased use of the Mental Health Act, and pressures on practitioners from being expected to do more but with less resource (Cummins, 2018). Chronic underinvestment in mental health services has led to concerning levels of inequality of service provision and services under increasing financial pressures (British Medical Association, 2014, Foley, 2013, British Medical Association, 2016, Gilburt, 2015).

It has become clear that a gap exists between policy and practice. Increasing financial pressure has constrained the provision of recommended, evidence-based mental health treatment. Reduced funding to mental health services has led to insufficient community services, a reduction of inpatient beds and inpatient services treating patients with increased levels of distress (Gilburt, 2015). Patients are becoming more acutely unwell at the point of hospital admission, more likely to be diagnosed with psychosis (thus troubled by voice hearing) and of higher risk (Gilburt, 2015, McCrone et al., 2008). Additionally, an increasingly generic, non-registered, non-specialist and junior workforce are challenged with delivering evidence-based treatment (Gilburt, 2015). Consequently, mental health practitioners increasingly struggle to sufficiently support and treat people, including voice hearers, with acute mental health problems.

2.3 Mainstream treatment for voice hearing: medication and CBT

Within the above service context, mainstream mental health treatment for voice hearing includes antipsychotic medication (aiming to reduce or stop voices) and Cognitive Behavioural Therapy for psychosis (CBTp) (aiming to improve 'living with' voices and often used as a secondary treatment to medication). NICE (2014) recommend that treatment for voice hearing should include antipsychotic medication (and a specific type, Clozaril, in situations where other antipsychotics have had no effect) and at least 16 planned sessions of CBTp. Additionally, family members are offered Family Interventions (FIs), ideally at least 10 planned sessions between 3-12 months. However, unlike CBTp, FIs do not specifically target voice hearing and so I have excluded it from further discussion. It is also recommended that people diagnosed with a first episode of psychosis are referred to a specialist Early Interventions in Psychosis service (within two weeks). For subsequent acute episodes, recommendation includes referral to a Crisis Resolution and Home Treatment team, which acts as a single point of entry to all other acute services in the community or hospital.

Before discussing treatment in more detail, it is important to situate the above policy and mainstream treatments against a backdrop of a prevailing biomedical approach that informs conventional understanding and treatment of mental health. Historically, there has been long-standing debate between biomedical (conceptualizes voice hearing as a symptom of a dysfunctional brain) and psychosocial accounts (conceptualizing it as a consequence of psychosocial factors related to individual life experiences) regarding mental health broadly and voice hearing specifically (Cooke et al., 2019, Shorter, 1998). According to Johnstone and Boyle (2018), a dominant biological narrative has informed the construction of an empirical evidence base from which understanding of voice hearing is located at an individual level and without sufficiently incorporating broader social, cultural and political contexts within which voices are experienced. For example, a diagnosis such as schizophrenia is a powerful biomedical narrative about the nature and cause of voice hearing that typically marginalizes more personally meaningful narratives. This narrative also aligns with the increasing influence of neoliberal values in Western politics. UK Government health policy aligns with neoliberal beliefs, with increasing emphasis on individualism and free market competition shaping decisions about healthcare (Bruce et al., 2014). The classification of mental illness is shaped by political and/or profit-driven objectives associated with commodifying medicalization of life experiences and a proliferation of individualised medication treatments with a rationale to treat biomedical illnesses (and benefitting pharmaceutical companies) (Esposito and Perez, 2014).

In terms of the influence of a dominant biomedical narrative on treatment for voice hearing, this privileges a biomedical explanation of voice hearing and marginalises more personally meaningful and individual accounts. Indeed, Woods et al. (2014) stress the importance of including the cultural context in which voice hearing happens in order to enrich the more privileged medical/psychiatric and psychological narratives. Larøi et al. (2014) observe that perceptions of voice hearing are culturally informed and vary across different societies but, subsequently, inform how voice hearing is accepted, researched and reported. It also places emphasis on individual causal factors and individual responsibility in terms of recovery. As such, there is insufficient acknowledgement of the influence of clinical contexts in which voices are experienced and the potential role of others, such as practitioners, in terms of how voice hearing is experienced.

2.3.1 Medication treatment for voice hearing

Dominated by the biomedical model, health-related problems are typically conceptualised as deviations from normal functioning. Nettleton (2021) summarises six assumptions upon which the model is based: (1) the mind and body can be treated separately; (2) dysfunctional body parts (symptoms of illness) can be mended; (3) medicine adopts a “technological imperative”; (4) reductive, biological explanations of disease marginalize other factors (i.e. psychological, sociological, cultural, etc.); (5) diseases are caused by a specific, identifiable 'disease entity'; and (6) the biomedical model is objective and universalized. Consequently, the biomedical model informs practitioners to investigate for biological causes of symptoms and signs of health-related problems and to prescribe treatment that targets these causes.

The biomedical model pathologises emotional distress (including voice hearing) as a distinct mental illness (Johnstone and Boyle, 2018). According to this approach, voice hearing is considered a symptom of conditions such as schizophrenia, which is assumed to be caused by biochemical, neuroendocrine, structural and genetic abnormalities in the brain (Andreasen, 1985). Neurons (cells in the brain) release signals to the receptors of other neurons, which become either excited (and pass more signals) or inhibited (and pass fewer signals or even stop altogether). These signals are released via neurotransmitters (chemicals), which enable pathways of neurons to link together different areas of the brain. A much-debated neurotransmitter in relation to voice hearing is dopamine. The action of antipsychotic medications targets parts of the brain responsible for voice hearing, acting as dopamine receptor antagonists (reducing dopamine) and contributing to the hypothesis that too much dopamine plays a role in the causation of schizophrenia (Berger and Rintelen, 2018).

However, to date, there has been no biological marker for schizophrenia (or voice hearing) identified. The evidence supporting the argument for genetic abnormalities is beset with methodological flaws based on poor reporting methods, poor and inconsistent diagnostic criteria and over-inclusion of a wide spectrum of diagnostic disorders, lack of blinding (researchers) and comparison group, and artificial inflation of the genetic contribution (Fleming and Martin, 2011). A biomedical perspective of voice hearing assumes that explanatory causes are predominantly internal and genetically predetermined, i.e. voices are due to a person's dysfunctional brain. Potential underlying problems (external to voice hearers) are considered less relevant and disregarded. As such, personal narratives that potentially link emotional distress with adverse life experiences within wider social, cultural, political and economic contexts are marginalised. This can lead to a belief that people who hear voices are passive victims of a mental disease and impact on individual agency, identity and the meaning ascribed to personal and distressing experiences (Johnstone and Boyle, 2018).

Despite this, a biomedical perspective hypothesizes that voice hearing is a consequence of genetic abnormalities and medication aims to target these. Antipsychotic medication is a primary first line treatment for voice hearing and is prescribed for most people hearing voices in receipt of mental healthcare (e.g. McManus et al., 2016). Critics argue that the evidence for antipsychotic medication is undermined by unreliable or missing data reported by pharmaceutical companies, statistical and methodological flaws and poor study design, and publication bias overestimating efficacy (Goldacre, 2014, Goldacre, 2010, Moncrieff, 2008, Bentall, 2009, Driessen et al., 2015, Sharma et al., 2016). However, evidence from several systematic reviews accounting for these conclude that antipsychotic medication is more effective than placebo in the treatment of schizophrenia. Findings from a systematic review of 167 placebo-controlled antipsychotic trials, including all antipsychotic trials since the introduction of chlorpromazine (the first antipsychotic in 1953) found an overall medium mean effect size and more effective than placebo, although only 23% of patients had a 'good' response compared to 14% in the placebo group (Leucht et al., 2017). Zhu et al. (2017) found that 81% of patients experiencing a first episode of psychosis had at least a minimal response to antipsychotics (defined as at least 20% reduction of measurement of psychotic symptoms) and 52% had a good response (50% reduction in symptoms). The most recent systematic review (at the time of writing) of the effects of antipsychotic medication for schizophrenia also found that, even accounting for poor reporting of randomisation, allocation and blinding, antipsychotics are more effective than placebo in preventing relapse and reducing hospitalisation in the short term (less than 12 months) (Ceraso et al., 2020).

However, critics (researchers, practitioners and voice hearers) argue that antipsychotic medication only suppresses voices, leaving people continuing to struggle with them and lack understanding of them (McCarthy-Jones and Longden, 2013, Kalhovde et al., 2013). At least one-third of patients continue to exhibit persistent symptoms when taking antipsychotic medication (Hasan et al., 2012) and a large proportion of patients do not comply with prescribed medication (Haddad et al., 2014, Kane et al., 2013, Chapman and Horne, 2013). Rather than target specific areas, antipsychotics act broadly on the brain and reduce dopamine across different pathways, resulting in a large number of unwanted adverse side effects. Newer 'second generation' antipsychotic medications are hypothesized to occupy dopamine receptors only temporarily and, consequently, lead to fewer dopamine-induced adverse effects. Evidence from a meta-analysis found that newer 'second generation' antipsychotic medications for treatment of schizophrenia are associated with comparatively more weight gain (2kg) and older ‘first generation’ medications associated with more extrapyramidal side effects (e.g. tremor, slurred speech, akathesia, dystonia, tardive dyskinesia), with no significant difference in terms of efficacy (Crossley et al., 2010). A more recent systematic review comparing a common older antipsychotic (chlorpromazine) with newer antipsychotics for treatment of schizophrenia similarly found no difference in efficacy but more extrapyramidal side effects associated with chlorpromazine (Saha et al., 2016). This is consistent with my clinical experience, although many patients gained considerably more than 2kg in weight, for some in excess of 30kgs.

A further criticism of the evidence supporting antipsychotic medication is the short duration of the investigations. Most antipsychotic medication trials last only a short time, often under 12 weeks. For example, most studies included in the above Saha et al. (2016) review were no longer than 8 weeks in duration; most trials included in the above Ceraso et al. (2020) review were for less than 12 weeks (47 out of 62 studies), with only seven studies longer than 26 weeks in duration. Although evidence supports the efficacy of antipsychotic medication over the short term, longer-term use is contested. Harrow and Jobe (2018) report that at least eight studies by eight different groups of researchers (Wunderink et al., 2013, Harrow et al., 2017, Kotov et al., 2017, Wils et al., 2017, Morgan et al., 2017, Moilanen et al., 2013, Bland and Parker, 1978, Harrison et al., 2001) have found no benefits associated with longer-term use of antipsychotics (between seven to twenty years). This is consistent with my experience in clinical practice wherein antipsychotic medication is prescribed as the primary treatment and continues for several years, often indefinitely, with unwanted side effects and often no obvious positive impact on voices. NICE (2014) acknowledge health risks associated with long-term use of antipsychotic medication and caution against using it as the ‘mainstay of treatment’.

2.3.2 CBT treatment approaches for voice hearing

In addition to medication treatment, people distressed by their voice hearing may also receive psychological treatments. The most commonly available psychological treatment, CBT, is widely researched in relation to several types of mental health problems and has been adapted for psychosis and voice hearing (referred to as CBTp). It was first adapted as an approach for voice hearing by Chadwick and Birchood (1994), who hypothesized that voice hearers’ beliefs about their voices (in terms of power, purpose and identity) influence their responses to their voices rather than what the voices actually say (content). Consistent findings from CBTp research concern voice hearers’ beliefs about malevolent voices, leading them to resist their voices, or about benevolent voices leading them to engage with their voices (Beck-Sander et al., 1997; Birchwood et al., 2004; Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1995; Chadwick et al., 2000; Van der Gaag et al., 2003). As such, according to a CBTp approach, voice hearers' actions towards their voices are largely determined by how comparatively powerful they believe their voices are in relation to oneself. According to this model, it is voice hearers' beliefs about their voices that causes them distress rather than the voice(s) *per se*.

Most CBTp research has focused on a broad range of symptoms rather than specifically voice hearing and reveals mixed results. Only a small effect has been found on overall symptoms (Jauhar et al., 2014, Garety et al., 2008) and only preliminary evidence specifically for command hallucinations (Pontillo et al., 2016). CBTp is criticised for focusing primarily on beliefs about voices rather than core reasons why voices are present (McCarthy-Jones and Longden, 2013). Furthermore, although CBTp is the most widely available psychological therapy for voice hearing (Thomas et al., 2014), the extent to which it is available consistently across services or at what point it becomes available in the voice hearer's admission to services is not clear. It is also costly to provide large-scale training of CBTp practitioners, resulting in only a small segment of the mental health workforce able to deliver CBTp (Thomas et al., 2014), despite health policy aims to increase the provision of CBT (as I discussed above in section 2.2.2). Accepting that voices *per se* are not problematic potentially conflicts with the use of antipsychotic medication as a treatment for voice hearing (given that they aim to stop the voices and can cause unwanted and harmful side effects).

To conclude this section, both antipsychotic medication and CBTp are treatments that target voice hearers at an individual level: antipsychotics target chemical imbalances within the brain; CBTp targets and challenges the beliefs individuals hold about their voices. As such, any effect of treatment is at an individual level. In terms of broader contributory factors, both approaches marginalise potential approaches to address the impact of other people on voices. Antipsychotic medication is the primary treatment for voice hearing and informed by contested research that has predominantly searched for a biological cause for voice hearing and an assumption that voice hearing is largely, if not exclusively, caused by biological brain abnormality. The evidence suggests that antipsychotic medication can be more effective than placebo but only in the short-term, it only supresses voice hearing and is associated with unwanted side effects and long-term harm to health. The evidence for CBTp suggests that it also has limited benefit for voice hearing and is not widely available.

2.4 Alternatives to mainstream medication and CBTp

Bentall and Varese (2013) argue that voice hearing is not caused by schizophrenia but, instead, is associated with it because of how schizophrenia is defined within conventional diagnostic criteria such as DSM 5 (APA, 2013) as a collection of 'symptoms'. In terms of a psychosocial approach, it is hypothesized that voice hearing results from a failure of source monitoring, wherein voice hearers fail to discriminate internal mental events from external stimuli and, instead, misattribute their own inner speech to an external source, i.e. voices (Bentall and Varese, 2013). Overall, evidence generally supports the hypothesis that people who hear voices have impaired source monitoring, possibly impacted on by stress, beliefs and cultural expectations (Bentall and Varese, 2013), although neurocognitive models (inner speech, memory-based, and predictive processing models) do not fully account for the social and agent-like characteristics associated with voices for some voice hearers (Alderson-Day and Fernyhough, 2016).

There is increasing evidence associating voice hearing with difficult life experiences. For example, empirical evidence associates voice hearing with stress (Slade and Bentall, 1988, Bentall and Varese, 2013), including anxiety before and during voice hearing (Delespaul et al., 2002) and even bereavement (Kamp et al., 2019). There has been increased interest in recent years investigating links between psychosis (and specifically voice hearing) and trauma (Lardinois et al., 2011, Read and Bentall, 2012, Larkin and Read, 2008, Varese et al., 2012). Several studies have found that many people who hear voices report that traumatic experiences of some sort have led to the onset of their voice hearing (discussed below). This line of inquiry can provide important personal historical contexts related to hearing voices that might help explain underlying emotions associated with voices (e.g. (Johnstone, 2009, Dillon, 2012).

In terms of trauma-related literature, evidence from observational studies associate experiences of trauma and psychosis (Arseneault et al., 2011, Mackie et al., 2011). Traumatic life events such as experiences of abuse are associated with an onset of psychotic symptoms later in life (Kelleher et al., 2013). Read et al. (2005) reviewed the literature pre 2004 and found evidence of a dose-response relationship between childhood trauma (childhood sexual abuse and/or childhood physical abuse) and psychosis, including voice hearing, and the more severe a person experiences abuse, the more likely they will experience voice hearing. Shevlin et al. (2008) analysed community samples from the UK (via the British Psychiatric Morbidity Survey involving 8,850 adults) and the USA (via the National Comorbidity Survey involving 5,782 adults) and found evidence of a significant association between multiple traumatic experiences (physical assault, sexual molestation or abuse, rape, physical abuse, childhood neglect, and bullying,) and the likelihood of psychosis. In their review of trauma and psychosis, Gibson et al. (2016) also found a medium to large effect size of a dose-response relationship between traumatic life events and psychosis. More recently, an analysis of World Mental Health Surveys involving the general population (n= 24,464) across 16 countries (excluding the UK) concluded that exposure to traumatic events is associated with increased risk of later onset psychosis of a dose-effect response: people experiencing 1 traumatic event are 2.3 times more likely to report psychotic experiences; those with 5 or more traumatic events are 7.6 times more likely to experiencing psychotic experiences (McGrath et al., 2017).

There is also evidence associating bullying and psychosis (Cunningham et al., 2016), although it is important to note that these associations are less specific to voice hearing and more generally to psychosis and paranoid thinking. Falukozi and Addington (2012) found trauma increased the likelihood of developing psychosis and psychological bullying to be the most commonly reported trauma. Although trauma such as subtle bullying can be difficult to recognise and measure, Gibson et al. (2016) reviewed the trauma and psychosis literature and found consistent associations between bullying and psychosis. In a cohort study of 14-16 year old school children (n=373) Campbell and Morrison (2007) found bullying significantly associated with psychotic symptoms, particularly paranoid thinking. In a review of empirical evidence, Arseneault et al. (2010) found concurrent bullying or bullying within a short time-span contributes to children’s mental health problems. In a meta-analysis of childhood bullying and psychosis, van Dam et al. (2012) found mixed results for clinical studies (n=4) but more consistent evidence of an association between childhood bullying and the development of non-clinical psychotic symptoms for population studies (i.e. non-clinical; n=10). Furthermore, stronger associations were found for psychosis with increased frequency of bullying, severity of bullying and the duration of being bullied. Cunningham et al. (2016) also concluded in their systematic review a dose-response relationship between childhood bullying and later psychosis to the extent that being bullied is more than twice as likely to lead to later development of psychotic symptoms.

In terms of my clinical experience, many voice hearers have reported to me their previous physical and sexual abuse, experienced in both childhood and adulthood. These experiences were represented in their voices, typically in terms of physical appearance, character or sound (or a combination of all). It is also important to note that even though in my clinical experience not all voice hearers reported previous trauma, this does not infer an absence of trauma. Luhrmann et al. (2019) offer a cautionary note that, even though there is sufficient evidence to associate trauma as a significant risk factor for psychosis and voice hearing, the number of people who develop psychosis or voice hearing is significantly less than the number of people who experience trauma. Importantly the authors assert that association does not equate to causation and, for some people, trauma plays no role in their voice hearing. Upon reviewing qualitative studies, they conclude that trauma is associated with ('more harsh') voices for some people, but there is also evidence that voice hearers do not experience (or at least report to experience) trauma prior to voices. As such, inference of causality cannot be determined, i.e. some voice hearers have never been exposed to trauma and so exclusive focus on trauma as a sole cause of voice hearing is too simplistic (Henriksen and Parnas, 2015).

There are concerns regarding the reliability of findings from trauma studies, including variations in the measurement tools used, the duration of follow up and evidence lacking in power to draw definitive conclusion (van Dam et al., 2012). Trauma studies involve collecting data from self-report measures and retrospective reports but evidence suggests that psychotic patients' self-disclosure is just as reliable as non-psychotic patients and, in fact, psychotic patients tend to under-report abuse to practitioners (Read et al., 2005, Fisher et al., 2009); particularly men under-report (Fergusson et al., 2000). Whilst caution is noted, increasingly evidence associates trauma with psychosis and voice hearing.

Findings associating voice hearing with earlier trauma have been hugely significant in terms of helping to shift the dominant disease narrative of biomedicine towards exploring potential contributions arising from an individual's personal history relating to their voice hearing. As such, the trauma-related literature offers opportunities for people to consider how their life experiences may have impacted on their current voice hearing. In terms of practitioner-patient relationships in mental health treatment, it is important to establish whether increased distressing voice hearing occurs within a context of practitioner-patient relationships. It can also help practitioners to avoid potentially and inadvertently contributing to a context that exacerbates voice-related distress. Given that there may be an association between traumatic life experience and voice hearing, it is important to explore experiences of voice hearing during times of receiving treatment in mental health services.

2.4.1 Hearing Voices Movement

The Hearing Voices Movement (HVM) is rooted in the seminal work of Romme and Escher, which was the foundation for what became a global movement of voice hearers challenging conventional ideology in psychiatry (based upon biomedicine) for the right for people to define their own experiences. Romme and Escher (2000, 1993, 1989a) stress the importance of *accepting* voices as real rather than construing them as a meaningless symptom of an illness. They place emphasis on understanding an individual's own frame of reference to interpret voices rather than impose professional frameworks (i.e. biomedical, psychological or other practitioner/researcher driven frameworks) and also for voice hearers to change their relationships with their voices (see section below) and to use the support of other voice hearers. This contributed towards beginning to address a gap in knowledge regarding how people understand and experience voices, providing potential opportunity for alternative treatment approaches to biomedicine (antipsychotic medication) and/or psychology (CBTp).

Romme and Escher (1989a) described the background context of organizing what became the first Hearing Voices Congress (origin of the Hearing Voices Movement). Voice hearers shared their experiences, which led to the development of their model of three phases of voice hearing: the startled phase (the shock and distress of first hearing voices), the organization phase (coping with the voices), and the stabilization phase (learning to live with voices). In response to this and in challenging the biomedical approach in psychiatry to voice hearing, Romme and Escher and colleagues (Romme et al., 2009) made several recommendations for practitioners to help reduce stigma and isolation related to voice hearing. These included: (1) accepting voices as real; (2) understanding the language used by voice hearers and their voices as being important, i.e. voices might refer to light and dark to represent love and hate; (3) helping voice hearers communicate with their voices; and (4) encouraging voice hearers to meet with other people who hear voices. Their work stimulated further approaches to voice hearing that emphasized the potential associations between life experiences and voice hearing and the impact of relationships (between voice hearers and other people and between voice hearers and their voices) on voice hearing.

The HVM holds six core values: (1) normalizing voice hearing as a common human experience; (2) framing voices as understandable responses to life events; (3) valuing diverse explanations for voices (including biomedical); (4) owning and defining one's own voice hearing experiences; (5) valuing peer support from other voice hearers to help make sense of and cope with voices; and, finally, (6) accepting and valuing voices as real (Corstens et al., 2014). It is an example of an alternative approach to mainstream mental health treatment in which voice hearing is considered as personal, related to problems in living, and interpretable in relation to the voice hearer's life history that can include sustained, overwhelming and disempowering life events (McCarthy-Jones and Longden, 2013). However, despite the HVM advocating an alternative approach to conventional treatment whereby voice hearers and practitioners engage with and talk to the voices in order to develop and change these relationships (McCarthy-Jones and Longden, 2013, Corstens et al., 2012, Rácz et al., 2017), there are no rigorous trials yet to determine its effectiveness (McCarthy-Jones and Longden, 2013).

Some voice hearers (Waddingham, 2017, Dillon, 2010, Longden, 2010) are critical of mainstream treatment and do not subscribe to illness-based models (such as the above biomedical or CBTp approaches) that conceptualize voice hearing as a sign and symptom of an underlying mental disorder (i.e. schizophrenia) or gives insufficient emphasis to the broader context within which voices are triggered. Romme (2009) argues that, rather than a symptom of an illness, voice hearing is an experience best understood as a reaction to problems in life and between people. Waddingham (2017), Dillon (2012), Longden et al. (2012) stress the importance in their recoveries of finding their own personal explanations for their voice hearing and defining their own experiences and moving away from the above mainstream approaches to ones that are more collaborative, exploratory and meaning-making. Waddingham (2017, p188) reflects on her own voice hearing: *"*[Voices bring]*…rich…layers of meaning …*[and] *reveal different kinds of truth"*… [but voice hearers do] *"not need someone else to crack the code…*[and]*…trap and steal my right to defy definition"*.

2.4.2 Relationships and voice hearing

In challenging conventional mental healthcare, the alternative approach outlined above emphasises the importance of relationships associated with voice hearing experiences. This places greater emphasis on the value of developing relationships, both between voice hearers and practitioners and between voice hearers and their voices. As the third element of the thesis framework, I discuss relationships in the following section by, first, considering patient-practitioner relationships followed by consideration of relationships between voice hearers and their voices.

2.4.3 Patient-practitioner relationships

Positive interpersonal relationships between practitioners and patients are recognised in the empirical and professional-body literature as a cornerstone of helping patients to successfully engage in healthcare treatment (Peplau, 1991, Peplau, 1992, Wood and Alsawy, 2016). Professional standards for practitioners include developing trusting and respectful relationships with patients and promoting autonomy, empowerment and shared decision-making during treatment (Nursing & Midwifery Council, 2015, Royal College of Psychiatrist, 2014, National Collaborating Centre for Mental Health, 2012).

Such so-called therapeutic relationships require practitioners to suspend their own beliefs about mental health and facilitate patients' own understanding of their experiences. It also requires practitioners to engage in a genuinely shared decision-making process with patients, increasingly recognised in policy (Department of Health, 2019). Interestingly, however, there is evidence that practitioners can hold negative attitudes, lack hope about patients' treatment and believe that mental illnesses (such as schizophrenia) are predominantly informed by biological causes. For example, findings from a Swiss survey of the attitudes of mental health practitioners (n=1073) and general public (n=1737) towards mental illness suggest that psychiatrists had more a negative attitude towards mental illness, particularly schizophrenia, than the general public (Nordt et al., 2006). Ross and Goldner (2009) found from their literature review that even though mental health nurses, compared to general nurses and the general public, held more positive attitudes towards mental illness, they held more pessimistic attitudes towards recovery. Larkings and Brown (2017) conducted a systematic review examining whether or not biogenetic causal beliefs (i.e. belief in a biomedical perspective of mental illness) reduces stigma in people with mental illness and in mental health professionals. They concluded that all but one of the reviewed papers (10/11) found that biogenetic beliefs are associated with increased pessimism and stigma towards mental illness, although there is lack of detail regarding measurements used and information provided to participants regarding a biogenetic explanation.

According to Brewis and Wutich (2019, p.150), evidence consistently illustrates that the "worst stigma" towards people with mental health diagnoses such as schizophrenia comes from mental health practitioners. Perceiving patients' 'problems' (such as voice hearing) to be intractable symptoms of an illness, changeable only through medication (if at all), can lead to practitioners developing therapeutic nihilism, i.e. a loss of belief in the potential for patients to recover (Fleming and Martin, 2011). Not only does this foster low expectations for recovery but it also diminishes the role of relationships in the treatment process. Given that antipsychotic medication is the primary treatment for voice hearing, and for some the only form of treatment, many practitioners emphasize to patients the importance of adhering to prescribed antipsychotic medication. I observed in my clinical practice that, when practitioners attach less importance to developing relationships with patients, they place less value on facilitating patients to conceptualise their own experiences, which can challenge the notion of autonomy, empowerment and shared decision-making increasingly espoused in health policy.

My evidence synthesis of the coercion literature (Chapter 3) found the quality of therapeutic relationships in mental healthcare was lacking for many patients (Allison and Flemming, 2019). Furthermore, evidence suggests that negative practitioner-patient relationships and negative treatment experiences occur when patients have a lack of choice, control and involvement in their own treatment (Wood and Alsawy, 2016). Voice hearers declining medical explanations for their voice hearing may also be perceived as lacking insight into a mental illness (Beavan, 2012). Consequently, declining medication can subsequently increase the potential for voice hearers to feel pressured by practitioners into accepting it. As such, it challenges the notion of providing treatment underpinned by positive therapeutic relationships and, arguably, negatively impacts on practitioner-patient relationships. Indeed, some patients reportedly experience their mental health treatment as traumatic (Paksarian et al., 2014a).

2.4.4 Voice hearer – voice relationships

Some writers have argued that power relations between voice hearers and their voices and the control voice hearers perceive they have over their voices are central to voice hearing (e.g. (Birchwood and Chadwick, 1997, Mawson et al., 2011, Rácz et al., 2017). Over the past thirty years, psychosocial approaches have evolved in terms of shifting the focus from voice hearers' *beliefs* about their voices to how they *relate* with their voices. Whereas earlier psychosocial approaches relied heavily on CBT models that conceptualised voices as a sensory or thought-like stimulus about which voice hearers held beliefs, they have since evolved to conceptualise voices as social, person-like stimulus with which the voice hearer has a relationship (Hayward et al., 2014, Hayward, 2003).

Several commentators contend that developing a relationship between voice hearers and their voices is an important step towards their regaining control of their lives and over their voices (Romme and Escher, 1989b, Romme and Escher, 1993, Romme, 2009, Waddingham, 2017, Mawson et al., 2011, Rácz et al., 2017). Romme and Escher (1993), Romme and Escher (1989a) and Romme et al. (2009) emphasise the significance of the voice hearer – voice(s) relationship, suggesting that it influences whether or not voice hearers become distressed from their voice hearing. There is now a closer alignment of psychosocial approaches to understanding voice hearing within a relational framework, which brings into context the relationship between the voice hearer and their voices. Psychosocial interventions for voice hearing increasingly emphasise the importance of relationships between voice hearers and their voices.

Alternative to the biomedical approach, recovery according to this approach is not an attempt to get rid of voices, but to reduce distress from their voices by changing their relationship and taking back power from their voices (Romme and Escher, 1993, Romme et al., 2009, Romme and Escher, 1989a). In terms of Hearn's contrasting pair of power 'to' versus power 'over' (as I discuss in section 2.1.1), I have observed in my clinical practice that this concerns voice hearers decreasing the power their voices hold over them and increasing their own power to influence how they respond to voices. Those with positive relationships are less likely to be distressed by their voices; those with negative relationships can become distressed and consequently more likely to be admitted to mental health services. Since Romme and Escher's early work, there has been increased emphasis given to the importance of accepting voices as real (by both the voice hearer and others) in order for the voice hearer to engage and develop a relationship with their voices (Rácz et al., 2017, Payne et al., 2017, McCarthy-Jones, 2017, Romme and Escher, 2013, Romme et al., 2009). Indeed, several studies report that an important step towards this acceptance is for voice hearers to personify their voices (Beavan et al., 2011, Mawson et al., 2011, Rácz et al., 2017).

A psychosocial approach highlights the importance of identifying power within voice hearer – voice relationships, identifying any potential social factors that might influence this relationship, and infers that voices can change. From my own observations in clinical practice, voices can change and so can the relationship between voice hearers and voices. This suggests that there may be potential opportunities for practitioners to positively influence voice hearing experiences.

2.5 Lack of treatment choice: control and containment

Policy and mental health law legitimizes practitioners' physical control and restriction of patients' movement, including enforced treatment, resonating with Hearn's conceptual grid in terms of structural power and power 'over' (section 2.1.1) in relation to voice hearers. The World Health Organisation (WHO) raise concerns that people diagnosed with schizophrenia are prone to human rights violations in mental health services (https://www.who.int/news-room/fact-sheets/detail/schizophrenia). As such, WHO emphasise the need for mental health treatment to be compliant with Human Rights and the need for treatment informed by evidence and best practice. The Mental Health Act (1983): Code of Practice (DoH, 1983) provides statutory guidance for practitioners' restrictive interventions of people in receipt of treatment for their mental health, regardless of whether or not they are legally detained under the MHA. The MHA (2007), amending the 1983 Act, was in response to meet the challenges of the increasing locus on mental health treatment in the community and introduced greater powers for the detainment and treatment of people with mental health illness (Glover-Thomas, 2013). Supervised Community Treatment, commonly known as Community Treatment Orders (CTOs) came into effect with the 2007 Act and enabled a wider group of mental health professionals able to apply for a new role (Approved Mental Health Professional: AMHP) that could exercise legal detainment.

The National Institute of Health and Care Excellence (NICE, 2015) recommend restrictive interventions should only be used if other de-escalation and preventative approaches have failed and non-action presents as a risk to the patient and/or other people. In response to concerns about rising detention rates under the MHA disproportionately affecting people from black and minority ethnic (BAME) groups, the Five Year Forward View for Mental Health recommended an independent review of the Act. A final report of this was published in Modernising the Mental Health Act (DoH, 2018), in which the rising level of coercion in mental health services is acknowledged. It examined the increasing use of the MHA to detain patients, racial disparities in the application of the MHA, and concerns that the MHA is out of step with mental health services, and recommended reform of the MHA under four key principles: choice and autonomy; least restriction; therapeutic benefit; and the person as an individual. Government is yet to implement the findings from the review.

A further concern regarding treatment for voice hearing is a lack of genuine choice offered to people in receipt of care. Although recommended treatment for voice hearing includes a choice of pharmacological (medication) and psychological interventions (Care, 2015, NICE, 2014), in real world practice this choice is largely restricted to only pharmacological interventions (The Commision on Acute Adult Psychiatric Care, 2015, Care Quality Commission, 2017, Care Quality Commission, 2010/11). Insufficient access to evidence-based treatment such as CBTp (Gilburt, 2015) and a postcode lottery to treatment (Care Quality Commission, 2017) result in patients' needs, including voice hearers, being insufficiently met (Royal College of Psychiatrists, 2014).

There are also reported concerns regarding the quality of care in mental health services. The Care Quality Commission reports a culture in mental health services in which inpatient care is falling way short of expected standards. Blanket ward rules (i.e. limiting patients' access to outside, the internet, and restricted visiting times (Care Quality Commission, 2014) and 86% of ward doors locked (Care Quality Commission, 2016) results in even voluntary patients being detained in all but name and denied their basic rights and autonomy (Care Quality Commission, 2013). The culture within inpatient healthcare has been reported as one of 'control and containment' rather than personalised care and support and with too much reliance on medication (Care Quality Commission, 2013) and similarly extended to mental health community care with an increase in the use of Community Treatment Orders between 2008 and 2014 by 32% (Care Quality Commission, 2015).

Of further concern, many patients experience their treatment within mental health services as traumatic. Patients expect inpatient services to be a place of safety but acts of violence evoke feelings of fear, i.e. patients fearful of patients and practitioners and also practitioners fearful of patients (Gilburt et al., 2008, Sweeney A, 2014). Some patients also report punitive and disrespectful relationships with practitioners (Hughes et al., 2009). As such, a mental health treatment context may create a potential for associations of previous trauma to be played out in the treatment environment, particularly bullying. Being witness or victim to being forcibly medicated and other acts of violence and aggression is distressing, but not uncommon, for many patients during inpatient treatment (Gilburt et al., 2008, Sweeney A, 2014). Given that the evidence of the impact of trauma on voice hearing includes bullying, this is particularly concerning when considered in a mental health treatment context.

2.6 Chapter summary

In this chapter, I have discussed the 'treatment – voice hearing – relationship' thesis framework. In terms of the treatment context, I have outlined some of the challenges for practitioners and voice hearers in mental health services. Policy aims of increasing service quality and provision have not been fully realised in real-world clinical practice and reflect an increasing emphasis on individualism (i.e. focusing on voice hearers as discrete individual agents and targeting a hypothesised chemical imbalance (medication) or hypothesised unhelpful beliefs about voices (CBTp)). I suggest treatment is more complex than this and there has been insufficient consideration of the clinical context in which voices are experienced and which some patients may experience as traumatic and coercive. Understanding voice hearing within a mental health treatment context, which may involve coercion, is important in order to mitigate against the potential risk that practitioners might inadvertently contribute to a treatment approach in which distressing voice hearing is exacerbated. However, there is a dearth of empirical literature that situates the experiences of voice hearing within mental health services and, more specifically, within practitioner-patient relationships. Developing helping relationships and increasing knowledge about the relationships between voice hearers, voices and practitioners offers potential for voice hearers and practitioners to improve experiences of voice hearing and reduce voice-related distress. Future research to improve understanding of this relationship is needed and is examined in this thesis.

CHAPTER 3: Mental health patients' experience of softer coercion and its effects on their interactions with practitioners: A qualitative evidence synthesis

3.1 Chapter overview

This chapter presents a published article (Allison and Flemming, 2019) in which I investigated the impact of coercive treatment on patients' interactions with practitioners, with additional reflection provided in the chapter summary. I introduced coercion in the first chapter as being widespread in mental healthcare. In terms of the 'treatment – voice hearing – relationship' thesis framework, mental health treatment may be traumatic for patients through a range of coercive treatment approaches. As such, I wanted to understand the nature and extent of coercion within mental health treatment. Through investigating the coercion literature, I address the second objective of the thesis:

To understand whether "coercion" exists within the tripartite relationship of patient-voice-practitioner in the context of mental health treatment.

As I discuss in section 3.2, coercion ranges from harder forms, such as enforced medication, physical restraint or the application of the Mental Health Act, to softer forms such as verbal persuasion or verbal threats. By presenting this article, in this chapter I aim to synthesise qualitative evidence of mental health patients' treatment-related experiences of softer forms of coercion and its effects on their interactions with practitioners. I wanted to investigate specifically this form of coercion for two main reasons. First, much of the evidence base and current literature concerns harder forms of coercion. Consequently, there is a gap in current knowledge regarding the nature of coercion and less known about how softer forms inform conceptual clarity and understanding of the effect of coercion on treatment-related experiences. Second, by its nature, softer coercion is inextricably linked with verbal practitioner-patient interactions in clinical practice but difficult to recognise. For example, practitioners discussing medication compliance with patients might be perceived as offering choice or, alternatively, as being coercive. Furthermore, arguably, voice hearers may similarly perceive coercion in their interactions with their voices. That is, although voices are unable to apply harder coercion, it is conceivable they communicate in ways that align with softer coercion. Increasing understanding of softer coercion may also help increase understanding of how voice hearers experience their voices and treatment.

Given the lack of empirical literature investigating coercion specifically in terms of voice hearing, particularly softer forms of coercion, this evidence synthesis broadly explores mental health patients' experiences. The key findings from this review inform the methodology and research study discussed in the subsequent chapters.

3.2 Background context

Coercion is controversial in mental healthcare, with long-standing debate regarding its acceptability and justifiability of infringing upon a person's rights. The World Psychiatric Association acknowledge coercion as an increasing international concern and evidence from international studies reveal international variation in the administration of coercion (Kallert, Monahan & Mezzich, 2007). Although commonly defined as *"the action or practice of persuading someone to do something by using force or threats"* (English Oxford Dictionaries), there is no single, uniformly agreed definition in relation to clinical practice (Molodynski, Khazaal & Callard, 2016). Lidz et al. (1998) and Szmukler and Appelbaum (2008) conceptualise coercion as ranging from harder types, such as legal measures, physical restraint and enforced medication, to softer types (see Table 3.1 for more detailed overview).

Soft coercion is defined in mental health literature as a *perceived* threat of punishment or force (Gilburt et al., 2010; Lloyd-Evans et al., 2010). Similarly, subtle coercion is an interpersonal interaction wherein one person exerts his/ her will upon another and *infers* the potential to action a threat (Lützén, 1998). The term 'softer' coercion is used to capture the meaning of both soft and subtle coercion. A qualitative evidence synthesis was conducted to obtain an overview of existing evidence regarding experiences related to softer coercion.

Practitioners (termed here as including mental health nurses and other clinicians in the mental health field) and patients report contrasting perspectives regarding coercion (Hem et al., 2016, Hotzy and Jaeger, 2016, Molodynski et al., 2010, Olofsson and Norberg, 2001). Some practitioners believe coercion can help patients avoid further deterioration and involuntary treatment (Hotzy and Jaeger, 2016) but can also feel pressured into coercively activating patients towards discharge (Femdal and Knutsen, 2017). But, whilst it is important for practitioners to feel able to justify their coercion (Vuckovich and Artinian, 2005), they can underestimate how coercive they can become (Hotzy and Jaeger, 2016).

Although patients report mixed experiences of coercion, these are often negative (The Commision on Acute Adult Psychiatric Care, 2015, Care Quality Commission, 2015) and disproportionally affect larger numbers of people from Black and Minority Ethnic (BME) groups (Care Quality Commission, 2014, Bhui et al., 2003). Some patients perceive coercion as being detrimental to their mental health and subsequently disengage or become increasingly non-compliant with treatment (Hotzy and Jaeger, 2016, Jaeger et al., 2013, Swartz et al., 2003). Patients can also perceive coercion as being traumatic (Paksarian et al., 2014b) or a form of punishment or to make things easier for staff (Olofsson and Norberg, 2001).

Table 3. 1: Range of different types of coercion found in literature (based on Lidz et al, 1998 & Szmukler and Appelbaum, 2008)

Terms in literature		Definition of coercion terms
TYPES OF SOFTER COERCION	**Soft or subtle coercion**	**Soft coercion refers to a perceived *threat* of punishment or use of force (see Lloyd-Evans et al., 2010, Gilburt et al., 2010). Focuses on whether or not a person believes they are being coerced. This is closely aligned with subtle coercion, which involves persuasion and encouragement, making decisions for service users, manipulation, and trading-off (Lützén, 1998). Subtle coercion is an interpersonal and dynamic interaction wherein a practitioners exerts his/her will upon a patient, becoming a *"type of weak paternalism"* (Lützén, 1998, p106).**
	Persuasion	**Practitioners attempt to influence a patient's decision by reasoning. Practitioners may outline benefits of treatment but the patient can accept or reject practitioner's suggestions.**
	Request for dispositional preference	**This concerns whether or not a practitioner asked what the patient wanted to do about hospital admission.**
	Interpersonal leverage	**When persuasion fails the practitioner may use their personal relationship with the patient as a way of influencing the patient's decision. Practitioner may influence patient through favouring one course of action over another. Patient may also be emotionally dependent on practitioner and subsequently want to please him/her.**
	Inducement	**Occurs when leverage is failing. Practitioners offer additional support but only if the patient agrees to accept the suggested treatment.**
	Giving orders	**Practitioner states to the patient that they must do something. This is distinct from a threat by lack of a condition.**
	Deception	**Practitioner lies or deliberately deceives the patient.**
	Threats	**Practitioner gives a conditional statement to the patient, e.g. support will be withdrawn unless they accept treatment or practitioner threatens the patient with the use of the Mental Health Act (MHA) if they continue to refuse treatment.**
TYPES OF HARD COERCION	**Seclusion**	**Patient is removed from communal areas of a clinical in-patient setting and isolated in a locked seclusion room.**
	Show of force	**Practitioner acts in a way that demonstrates to the patient that power or force is available if needed in order to administer treatment.**
	Physical or mechanical restraint	**Restraint of a patient through physical force by practitioners or the use of equipment such as net beds (not used in the UK) to restrain patients.**
	Enforced/ forcible medication	**Enforcement of medication via an intramuscular injection administered by practitioners. Involves physically restraining the patient in order to administer medication.**
	Compulsory / involuntary/ formal coercion (or treatment or admission)	**Use of legal authority to facilitate treatment and/or hospital admission. Patient is legally required (under the MHA) to accept treatment even against their wishes.** **In contrast, informal or voluntary coercion (or treatment or admission) refers to treatment without the use of legal measures.**
	Hard coercion	**Refers to the way coercion is applied by practitioners, e.g. physical restraint and/or forced administration of medication (Meehan et al., 2000, Hoekstra et al., 2004, Kontio et al., 2012, Wynn, 2004).**

However, patients also report contrasting perceptions about coercion, for example voluntary patients can feel coerced and involuntary patients may not feel coerced (Kallert et al, , 2011). Practitioners influence the experience of being coerced. For example, positive perceptions of coercion are associated with patients believing practitioners act in good faith, are beneficent, open and honest (Bennett et al., 1993) when coercion is administered transparently and fairly (Hotzy and Jaeger, 2016), in their best interests (Lorem et al., 2014) and through collaborative and trusting relationships with practitioners (Thogersen et al., 2010).

International and cultural differences in the use of coercive measures influence the numerous terms found in the literature to define the type and frequency of coercion. This varies internationally, with the UK being more or less exclusive in the use of physical restraint, whereas other nations make more use of seclusion (Netherlands and Switzerland), mechanical restraint (Germany, Italy and Norway) and net beds (parts of Austria, Czech Republic and Slovakia) (Steinert and Lepping, 2011). The significance of cultural context is emphasised when conceptualising coercion within a broad range of harder to softer types of pressure. Through conceptualising coercion in this way, softer coercion occurs in a context of harder coercion, i.e. verbal statements are more threatening when accompanied by physical force.

Despite service users reporting harrowing experiences related to coercion (e.g. Hughes et al., 2009, Paksarian et al., 2014b), less attention is given in the literature to softer coercion. But, due to differences described above, *"the 'heterogeneity of coercion' remains poorly understood"* (Molodynski, Khazaal & Callard, 2016, p.1) and Szmukler (2015) calls for a more precise understanding in order to advance thinking and research into coercive practice. This review, therefore, is context-specific to the UK and Ireland due to their similar legal and clinical practice frameworks regarding mental health and the subsequent influence on the range of coercion permitted on a similar population group.

Most mental healthcare in the UK has shifted to the community (The Commision on Acute Adult Psychiatric Care, 2015) but is insufficiently resourced, contributing to patients' increased disturbed behaviour during inpatient admissions (Gilburt, 2015). Standard and alternative services predominantly provide medication as treatment (Johnson et al., 2009, Johnson et al., 2010a, Gilburt et al., 2010, Osborn et al., 2010, Slade et al., 2010, Byford et al., 2010). A different patient group tend to use alternative services: mostly female, from a BME group, less likely to be legally detained, more likely depressive rather than psychotic and exhibiting less disturbed behaviour (Johnson et al., 2010b).

Conventional quantitative research methods insufficiently capture and under-represent lived experiences and meanings associated with being coerced (Russo and Wallcraft, 2011) and mental health treatment (Landeweer et al., 2011, Jarrett et al., 2008, Hannigan and Cutcliffe, 2002, Olofsson and Norberg, 2001, Lützén, 1998). However, although interest in qualitative investigations of in-depth perspectives of receiving coercive treatment has recently increased, most knowledge derives from quantitative methods focusing on harder types of coercion.

This review brings together and examines qualitative research exploring mental health patients' treatment-related experiences of softer coercion and its effect on their interactions with practitioners using thematic synthesis (Thomas and Harden, 2008). It details a transparent and rigorous approach to methods of searching, inclusion and quality criteria and synthesis with the aim of informing future mental health policy and practice. Reporting of the findings is informed by ENTREQ guidelines (Tong et al., 2012).

3.3 The Review

3.3.1 Aims

The aim of this review was to explore mental health patients' treatment-related experiences of softer coercion and its effect on their interactions with practitioners through a synthesis of qualitative research. There are 2 main objectives:

1. Identify patients' experiences of soft/ subtle coercion during admission to, or in, treatment in mental health services.
2. Explore the perceived effect of this coercion on patient-practitioner interactions.

3.3.2 Design

The review was undertaken using a thematic synthesis, a design well suited to questions about perspectives and experiences of health-related issues (Thomas and Harden, 2008) such as coercion. The method involves analysing and drawing conclusions from primary research and 'going beyond' the original findings to formulate a new interpretation (Thomas and Harden, 2008).

3.3.3 Search methods

A searchable question was formulated using SPIDER search tool (Cooke et al., 2012) (see Figure 3.1). The initial search included combinations of the terms 'coercion', 'coercive measures', 'psychiatry', 'mental health', 'patient', 'client', 'service user', 'experience', 'lived experience', and 'relationship'. Subject headings were used where possible. Following an iterative approach, 'Treatment pressures' (Duncan, 2013) was also later included. Given the heterogeneity of coercion internationally, the subsequent influence of this on softer coercion and the need to identify studies situated within similar legal and clinical practice frameworks, searches were restricted to UK and Irish studies.

Figure 3. 1: SPIDER search tool (Cooke et al., 2012).

SPIDER	SEARCH
(S) Sample	People receiving mental health treatment
(PI) Phenomenon of interest	Subtle/soft coercive clinical practice & treatment
(D) Design	Variety of methods, e.g. interviews, focus groups, observations
(E) Evaluation	Perspectives, experiences and understanding of people subjected to coercive treatment
(R) Research type	Qualitative research (including mixed methods)

Inclusion criteria

Studies were included if they:

1. Reported treatment-related soft or subtle coercion experiences of patients in mental health services.
2. Reported the effect of treatment-related soft or subtle coercion on interactions between patients and practitioners.
3. Used qualitative research to obtain and analyse data.
4. Used mixed methods studies and reported separate qualitative findings.
5. Included participants aged over 18 years.
6. Were conducted in the UK or Republic of Ireland.

Exclusion criteria

1. Studies referring to predominantly harder types of coercion, e.g. physical restraint.

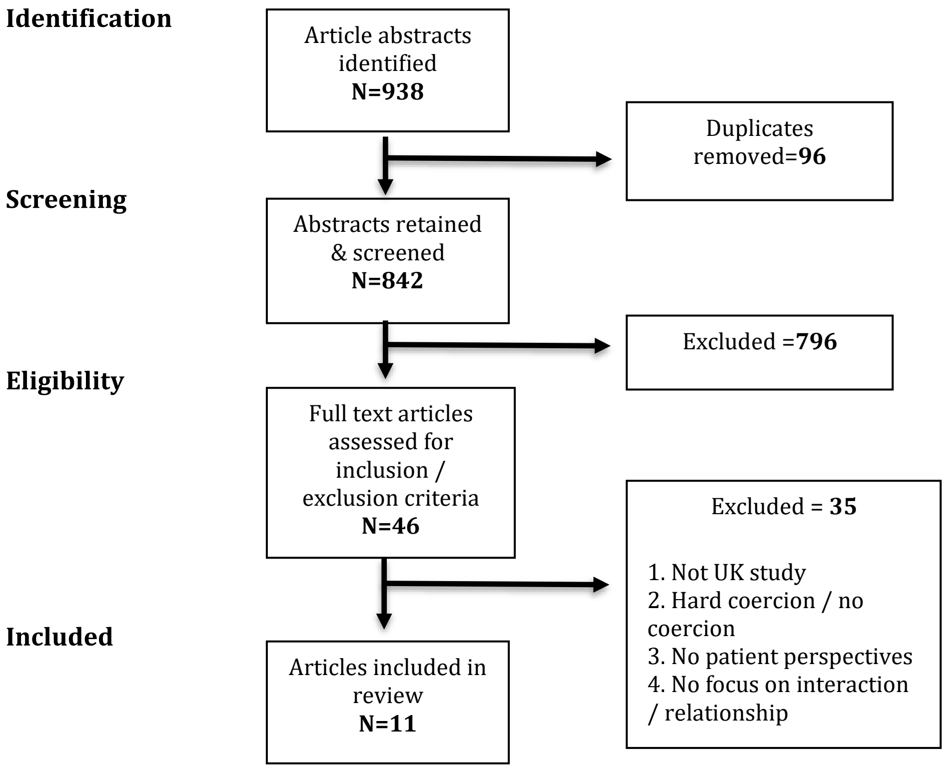
Searches were conducted in the following databases: CINAHL, Embase, Medline, PsycINFO, and the Web of Science. Grey literature was also searched: Health Management Information Consortium, UKCRN study Portfolio, Social Care Online, British Library Thesis Database (EThOS), Networked digital library of theses and dissertations, Proquest

Dissertations and Theses (UK & Ireland), NHS Evidence, the Department of Health website, OpenGrey, and PubReMiner. No date restrictions were applied to the databases and the search was completed in September 2015. No further articles met the inclusion criteria during an updated search in January 2018 of the following databases: CINAHL, Embase, Medline, and PsycINFO.

3.3.4 Search outcome

Figure 3.2 illustrates 938 articles were initially identified. Duplications (n=96) were removed and titles and abstracts were screened for eligibility. Most (n=796) were not relevant and excluded. After reading the remaining full texts (n=46), 35 articles were excluded, resulting in a final 11 articles eligible for inclusion.

Figure 3. 2: PRISMA 4-phase flow diagram (Moher et al, 2009).



Four of the studies employed interviews (Sweeney et al., 2014, Duncan, 2013, Lloyd-Evans et al., 2010, Hughes et al., 2009); two employed interviews and focus groups (Laugharne et al., 2012, Gilburt et al., 2008). Six studies employing interviews used applied Grounded Theory techniques (Gault et al., 2013, Katsakou et al., 2012, Laugharne et al., 2012, Katsakou et al., 2011, Gault, 2009, Gilburt et al., 2008). Of these, Sweeney et al. (2014) and Katsakou et al. (2011) involved a qualitative arm of mixed methods studies.

One study employed Interpretive Phenomenological Analysis (McGuinness et al., 2013). Finally, two of the articles (Lloyd-Evans et al., 2010, Gilburt et al., 2008) were part of The Alternatives Study (TAS) and one article (Sweeney et al., 2014) followed TAS investigation with the same authors.

3.3.5 Quality appraisal

Recent guidance by the Cochrane Qualitative and Implementation Methods Group recommends researchers assess methodological strengths and weaknesses (Noyes et al., 2018). Each article was assessed independently by the first author (RA) for methodological quality in accordance with the Critical Appraisal Skills Programme (CASP) checklist for qualitative research.

Although all articles documented ethical approval, seven lacked a detailed reflexive account of the researcher-participant relationship (Gault et al., 2013, McGuinness et al., 2013, Katsakou et al., 2012, Katsakou et al., 2011, Lloyd-Evans et al., 2010, Gault, 2009, Hughes et al., 2009). However, four articles acknowledged power differentials in this relationship (Sweeney et al., 2014, Duncan, 2013, Laugharne et al., 2012, Gilburt et al., 2008). Due to the overall methodological quality of articles, none were weighted or excluded based on the quality assessment

3.3.6 Data abstraction and synthesis

To aid organisation, data were extracted electronically from the results/appendices and entered into ATLAS.ti by the first author (RA). Data abstraction and thematic synthesis (RA, consensus with KF) was in accordance with the methodology described by Thomas and Harden (2008), involving 3 stages:

1. Free line-by-line coding of primary studies.

Line-by-line coding of data was conducted in chronological order of articles. This captured meaning and content to develop initial 'free' codes (Thomas and Harden, 2008). Through constant comparison, codes were inductively constructed from the first 4 articles, after which coding became increasingly deductive and data began to fit into existing codes.

2. Organising free codes to develop descriptive themes.

Codes were reviewed and organised into related areas of 48 descriptive codes within 8 descriptive themes, representing the primary data.

3. Development of analytical themes.

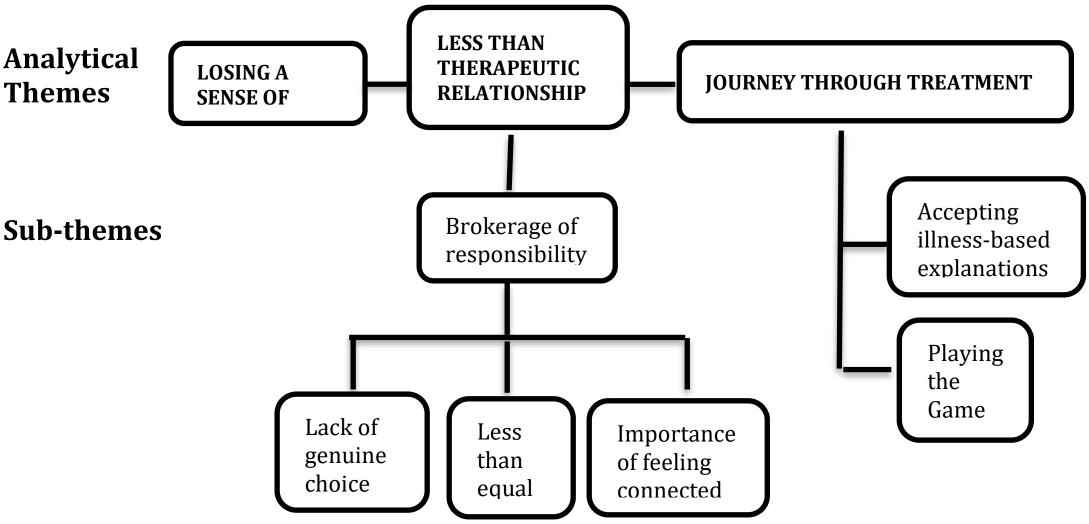
‘Going beyond’ this descriptive stage and developing analytical themes that address the review aim was achieved through a cyclical process of reviewing and re-reading the descriptive themes and codes in relation to the research question (Thomas and Harden, 2008). Thus further distinctions were made between each theme to develop sufficiently broader abstract analytic themes that answered the research question (see appendix xxx).

3.4 Results

The 11 reviewed articles include 268 patients receiving involuntary (n=106) and voluntary (n=36) treatment or a combination of both (n=126). Demographic details are unclear for some articles but, generally, there were equal numbers of males and females, aged over 18 years, and most previously admitted to mental health services. Over half of participants were white British, mostly diagnosed with schizophrenia/psychosis or affective disorder/depression. Ten studies were in England, one in Ireland (McGuinness et al., 2013).

Three analytic themes were produced (see Figure 3.3), broadly capturing patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners. These demonstrate that patients attribute negative experiences during treatment not just to coercion but also to mental distress. But during treatment, relationships with practitioners significantly influence their perceptions of coercion. Additionally, how patients attribute mental health distress and how they engage in treatment influence their transition through treatment. That is, some patients perceived treatment as coercive but others did not, despite similar treatment contexts, subsequently influencing their response to coercion.

Figure 3.3: Overview of analytical themes and sub-themes



Patients' experiences are situated within the broader treatment environment across mental health services, which are predominantly aligned with a conventional biological model of healthcare and reliance on medication. Patients mostly reported this as negatively coercive, especially traditional inpatient wards: "the whole environment was very very threatening" (Lloyd-Evans et al., 2010) or felt "like a prison" (Gilburt et al., 2008). Consequently, many patients reportedly experienced inpatient wards as "like being inside a pressure cooker" (Sweeney et al., 2014), where practitioners are seen as "prison guards" (Sweeney et al., 2014) and where patients "feel like you know, a sort of criminal who's sort of violated their rules…" (Duncan, 2013).

The analytic themes are discussed below. Unless stated otherwise, quotations refer to traditional inpatient settings.

(1) Losing a sense of self

This first theme broadly concerns whether patients attribute treatment-related experiences to either their mental health or to coercive treatment.

Some people lose opportunities in life due to their mental health problems, which can change their sense of identity: "I was at work I had a life before this. I was all right, I was going to university" (Gault, 2009); "I used to be someone, went to college, had a job, now I'm just a patient" (Gault et al., 2013). But, once admitted to mental health services, patients report contrasting perceptions about treatment. For example, some recognise their own vulnerability due to mental health problems: “I was a danger to myself…I was telling people to pick up their litter and you can’t do that here, I was…taking risks” (Katsakou et al., 2012); some perceived their mental health rather than coercive treatment to be problematic: “My illness has affected me, but I wouldn’t say being sectioned has affected me” (Hughes et al., 2009), to the extent that some believe that patients can be “too ill to engage [with practitioners]” (Lloyd-Evans et al., 2010). These examples illustrate that, for some patients, personal circumstances rather coercion is reportedly problematic.

However, most patients attribute negative experiences to coercion, e.g. feeling like “an underclass because you don’t have the rights that anyone else in the society has” (Duncan, 2013) or being reminded of previous trauma as a result of being physically restrained: “That took me back to my childhood…my childhood abuse” (Hughes et al., 2009).

(2) Less than therapeutic relationship

Once admitted to mental health services, patients’ treatment-related experiences are significantly influenced by their relationships with practitioners. This is the largest analytic theme and includes four sub-themes (Brokerage of responsibility, Lack of genuine choice, Less than equal, and Importance of feeling connected). It encapsulates the notion of a ‘Brokerage of responsibility’ as of central importance in terms of coercive treatment experiences, which consists of a dynamic shift of responsibility between practitioners and patients. This is influenced by the extent of patients’ genuine choice of treatment, perceived equality between patients and practitioners, and the quality of engagement between patients and practitioners as an underpinning foundation for success.

(2a) Brokerage of responsibility

The notion of responsibility between practitioners and patients can be complex and constantly shift but it centres on ensuring patients comply with treatment. Patients report both positive and negative experiences in relation to either self-determination or having their responsibility taken from them by practitioners.

Some patients acknowledge practitioners’ professional responsibilities: “I think a lot of the fear [for] consultants is that if somebody does kill themselves they are accountable, they haven’t done their job” (Gilburt et al., 2008). Some also retrospectively acknowledge benefits from coercive treatment: “I certainly would have been a serious problem at work….so I’m glad [involuntary admission] happened” (Katsakou et al., 2012).

Patients’ ownership of responsibilities is typically demonstrated by their adherence to prescribed treatment: “I have the ultimate responsibility for my actions. Who has responsibility over my medication and whether I take it or not? I do” (Laugharne et al., 2012). But, the impact of mental health (as identified in ‘Losing a sense of self’) can also affect patients’ level of responsibility: “I think when you’re very ill [practitioners] have to take decisions” (Laugharne et al., 2012); “Sometimes when I feel very lost I want to be told what to do…at some level I want to be told no, you can’t go out…because I can’t make that decision myself…” (Sweeney et al., 2014). Failure to take such ‘responsible’ action can lead to practitioners taking responsibility to ensure treatment compliance: “I thought…what can I do to protest?…I stripped off naked and I started parading…around the ward naked. And of course they didn’t like it…they restrained me…took me to my bedroom and they injected me” (Duncan, 2013).

(2b) Lack of genuine choice

Patients reported their treatment as one revolving around medication, administered through a combination of softer coercion such as threats and harder forms such as physical restraint. Sometimes patients perceived they had no real genuine treatment choice: “They say if I don’t take the tablet they were going to inject me” (Lloyd-Evans et al., 2010); “I refused to take an injection…I became involuntary’ (McGuinness et al., 2013).

Given such limited choice, for some patients treatment aimed to “drug you up” (Gault, 2009) or “control or manage [patients]” (Gault, 2009). In a context in which harder coercion can be administered, threats can be sufficient to coerce patients into accepting treatment: “in my experience a lot of coercion actually goes on without the mental health act…just through the fact that the mental health act could be brought in…I’ve been… told that if I didn’t comply…I would be sectioned on numerous occasions” (Gilburt et al., 2008). Consequently, many patients believe they are left without any real choice: “I did feel coerced…it certainly didn't feel like I had a choice” (Katsakou et al., 2011).

(2c) Less than equal

Whereas the sub-theme ‘Brokerage of responsibility’ captures some positive experiences related to relationships and coercion, by contrast ‘Less than equal’ represents more negative experiences. For example, some patients find relating with practitioners difficult: “you come to see the staff as being sort of the prison guards…you can’t really have a relationship with people you see as holding you captive” (Sweeney et al., 2014).

Examples across all clinical settings illustrate patients perceiving treatment as dehumanizing: “[practitioners see] only the illness, not the person” (Gault et al., 2013) or “[I’m] just another black woman with schizophrenia” (Gault, 2009) or “part of a slave underclass” (Duncan, 2013). Some perceived practitioners as being aggressive and abusive and reciprocated: “treat me like an animal, then I’ll act like an animal” (Hughes et al., 2009). The following example illustrates how harder coercion contributes to perceived power of softer coercion and the subsequent power imbalance in practitioner-patient relationships: “They took me back to the room, they put me face down on the bed, actually holding my face into the cushions, so that I couldn’t breathe. I was fighting and fighting. And they were saying, um, go on, pull her trousers down and stick it in her arse. I thought they were raping me” (Hughes et al., 2009).

(2d) Importance of feeling connected

Patients described the importance of personal qualities in practitioners, e.g. practitioners should be “caring and understanding” (Sweeney et al., 2014) and “understand…accept and…treat [patients] with dignity…as if I was my normal” (Katsakou et al., 2011). It is also important for patients “to feel connected as a person, rather than simply a patient” (Duncan, 2013).

However, some patients perceived they lacked a connection practitioners, e.g. “they have their own agenda about what I ought to do rather than let me talk about my problems…I can’t get them to listen to me” (Gilburt et al., 2008), “when I got here nobody actually listened to me” (McGuinness et al., 2013) or “there’s a whole team there and they don’t listen to you, they TELL you…it just made me feel like I wasn’t human…” (Katsakou et al., 2011).

It was evident across the reviewed papers that developing a trusting relationship is an important element of feeling connected with practitioners: “my consultant was brilliant...because he really got that I couldn’t trust him and he really…worked to rebuild that” (Duncan, 2013).But trust must be earned: “If someone does what they say they’re going to do then you are more likely to trust them… I have to earn people’s trust, so they have to earn mine” (Laugharne et al., 2012). Unfortunately, though, trust was lacking in some patient-practitioner relationships, e.g. “I resent them for not trusting in me after they know me” (Sweeney et al., 2014).

(3) Journey through the system

The final analytic theme captures patients’ perceptions about their transition through treatment. It represents two sub-themes of contrasting experiences: ‘Accepting illness-based explanations’ and ‘Playing the game’.

(3a) Accepting illness-based explanations

This sub-theme concerns patients’ acceptance of conventional treatment, informed predominantly by a biological understanding of mental health. Although ‘Lack of genuine choice’ captures negative experiences, some patients believe treatment can lead to a positive outcome: “I suppose in the end what made me well was the tablet form, the medication” (Gilburt et al., 2008); “without the medication I wouldn’t have become well again” (Hughes et al., 2009).

For any personal conflict regarding limited conventional treatment, some patients were able to reconcile this: “I don’t like this curfew of not being able to control my meds…. But when I weigh it up it’s worth it….” (Duncan, 2013). Even where coercion is recognised, it could be accepted: “even though it’s coercion when it actually happens….if you….anticipate it….it just feels, even if not at the time, afterwards certainly, because a lot of it’s…dealing with the aftermath…and it’s a much better process dealing with [it] when you actually…condoned the whole thing yourself” (Duncan, 2013).

Such acceptance enabled patients to put their faith in practitioners: “[practitioners] have got most power over my life. I don’t make many decisions because I’m frightened of making the wrong one” (Laugharne et al., 2012); “I’m not worried about choice on medication. I know what the doctor prescribes is going to be the right thing” (Laugharne et al., 2012). However, patients were aware that resisting would lead to practitioners threatening or persuading them: “if I stopped my medication, I’d be sectioned within 24 hours, I guarantee” (Gault, 2009); “I refused to take [tablets] at first…and then they came round with their heavies to try and inject me and then I stuck out my hand and took [the tablets]” (McGuinness et al., 2013). This again suggests that softer coercion is understood within a range of softer to harder coercion.

(3b) Playing the game

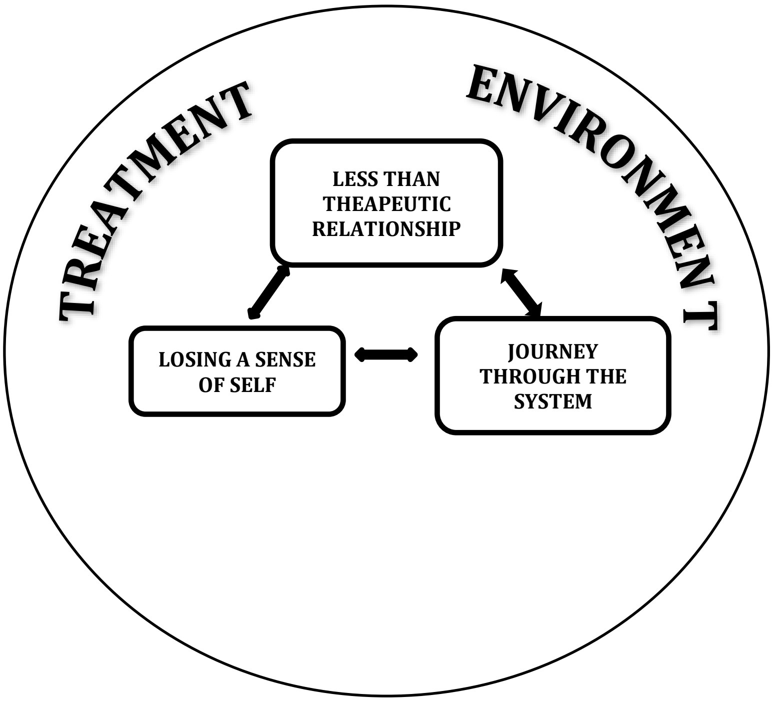
In contrast to accepting conventional treatment, ‘playing the game’ represents patients’ deceiving practitioners regarding treatment compliance, e.g. “I’d just pretend I took it [medication]” (Gault, 2009). Patients described using different approaches simply to exit mental health treatment: “being a good patient leads to getting my freedom back” (Gault, 2009); “I manipulated my way out of the section. I didn’t talk about the things that were hounding me, I sort of avoided subjects that were extreme” (Gault et al., 2013).

Some patients pretended to comply in order to deceive practitioners: “It makes you feel like you have to convey a certain impression to [practitioners] in order to win your freedom…To get out you have to play the game” (Sweeney et al., 2014). Similarly, others become “an exemplary patient” (Hughes et al., 2009) or approached treatment “like playing chess” (Sweeney et al., 2014) or simply complied: “the only way to get out is to cooperate…in order to get out…” (Duncan, 2013).

3.5 Discussion

This review synthesised qualitative evidence of mental health patients’ treatment-related experiences of softer coercion and its effect on their interactions with practitioners. These experiences occur within a healthcare environment, situated in a UK or Irish context, in which patients reportedly receive treatment against a backdrop of coercion, represented by three analytic themes (illustrated in Figure 3.4).

Figure 3. 1: Inter-relationship between analytical themes in context of treatment environment



It is evident here that coercion is a complex phenomenon about which patients report contrasting experiences. This complexity is recognised in philosophical and sociological theories of coercion. Broadly, coercion is conceptualised to fall within structural and agency perspectives. From a structural perspective, coercion is theorised to occur within social, political, economic and cultural contexts of society (Ball, 1978), i.e. a UK/Irish treatment environment. This supports findings in this review and the literature. Not only is coercion a global problem in mental healthcare (Kallert, Monahan & Mezzich, 2007), it is so widespread that mental health services have become "the theory and practice of coercion" (Szasz, 2007, p.xi) casting a "coercive shadow" (Szmukler, 2015, p.259) wherein patients fear treatment refusal leads to involuntarily administration. In the UK, inpatient wards are regularly found to include a coercive culture (Care Quality Commission, 2017, Care Quality Commission, 2016, Care Quality Commission, 2015, Care Quality Commission, 2014, Care Quality Commission, 2013).

By contrast, an agency perspective focuses on coercive interactions within relationships (Ball, 1978), i.e. between patients and practitioners. Most empirical literature regarding coercion concerns an agency perspective. Findings from this review suggest that relationships with practitioners play a key role in patients' experiences of coercion. The importance of therapeutic relationships is at the heart of professional codes of conduct (e.g. Nursing & Midwifery Council, 2015, Royal College of Psychiatrist, 2014) and UK national policy (e.g. Seale, 2016, NHS England, 2014), particularly in terms of practitioners' sensitivity to inherent power dynamics and fostering supported and shared decision-making. The 'Less than therapeutic relationship' theme supports wider literature in which patients' perceptions of coercion are seemingly influenced more by practitioner-patient interactions than by coercion *per se* (Sibitz et al., 2011, Hem et al., 2014).

But these findings also suggest that patients' self-determination, or lack of autonomy through practitioners' actions, do not necessarily determine perceived coercion. Patients also report a lack of equality in these relationships and a lack of genuine treatment choice. Further, patients report many examples in which important qualities they expect of practitioners are lacking. Collectively, this challenges the notion of positive therapeutic relationships and highlights the importance for practitioners' reflexivity when working alongside patients.

It is also evident that softer coercion takes meaning within a range of coercion in which practitioners ensure treatment compliance (Szmukler & Appelbaum, 2008; Lidz et al., 1998). In order to determine how coercion plays out within these relationships, commentators have focused broadly on either an 'enforcement approach' in which the *coercer issues* threats and/or direct force; or a 'pressure approach' in which coercion is determined by whether or not the *coercee subjectively perceives* they are threatened (Anderson, 2010). Harder coercion, such as legal detainment or enforced medication, is relatively easy to determine. But softer coercion, such as determining whether or not a verbal interaction is threatening, is less clear. According to a 'pressure approach', softer coercion is determined by patients' *believing* power behind the threat, i.e. that practitioners will enforce harder coercion if necessary. Patients' beliefs about the credibility of potential threats might explain some contrasting reports of perceived coercion. Further, the eventual outcome (i.e. recovery or deterioration) may subsequently influence whether or not treatment-related experiences are retrospectively perceived as beneficial (and not coercive) or threatening (and therefore coercive).

These findings are bound to the context of the review aims and UK/Irish-centric perspective, which focuses on a limited population reporting context-specific experiences. A further limitation is only one author (RA) completed extraction of references, coding and analysis. Therefore, relevant literature may have been inadvertently excluded and other reviewers may conclude a different interpretation of the findings. Caution must also be noted regarding the construction of the analytic themes. In their critique of theoretical coding in Grounded Theory, Wasserman et al. (2009) argue that the clear technique of data-specific levels of coding (i.e. line-by-line) becomes ambiguous when coding at conceptual and theoretical levels. Similarly in this review, although synthesising the data was in accordance with methods described by Thomas and Harden (2008), there is a lack of explicit guidance when moving from data-specific descriptive level to abstract analytic themes.

3.6 Concluding comments

This review contributes to the current evidence base regarding the mixed but predominantly negative impact of coercion on patients receiving mental healthcare. They also indicate that power associated with softer coercion is influenced by patients' beliefs that practitioners will administer harder coercion if necessary. As such, patients' experiences of softer coercion manifests within relationships with practitioners. It is therefore important for practitioners' education to include an understanding of how the broader healthcare environment, in which treatment occurs, might impact upon their role of providing treatment and the impact of this on potential for coercion in caring relationships.

This review identified a gap in knowledge regarding the impact of coercion on specific types of mental health problems, e.g. voice hearing, depression or anxiety. Future research is needed to investigate why coercion affects people differently, the processes involved, the role of diagnosis, and how coercion is defined in mental healthcare and by whom. It is also important to replicate a context-specific evidence synthesis from different populations within other health systems to compare findings and build upon the evidence base regarding softer coercion.

3.7 Chapter summary

Findings from a systematic literature review suggest that coercion exists within mental health services, experienced by patients through disempowerment in their relationships with practitioners and the treatment they receive. It is unclear whether coercion impacts on patient – voice – practitioner relationships, and if so how. My research study addresses this gap in knowledge.

CHAPTER 4: Methodology

4.1 Chapter overview

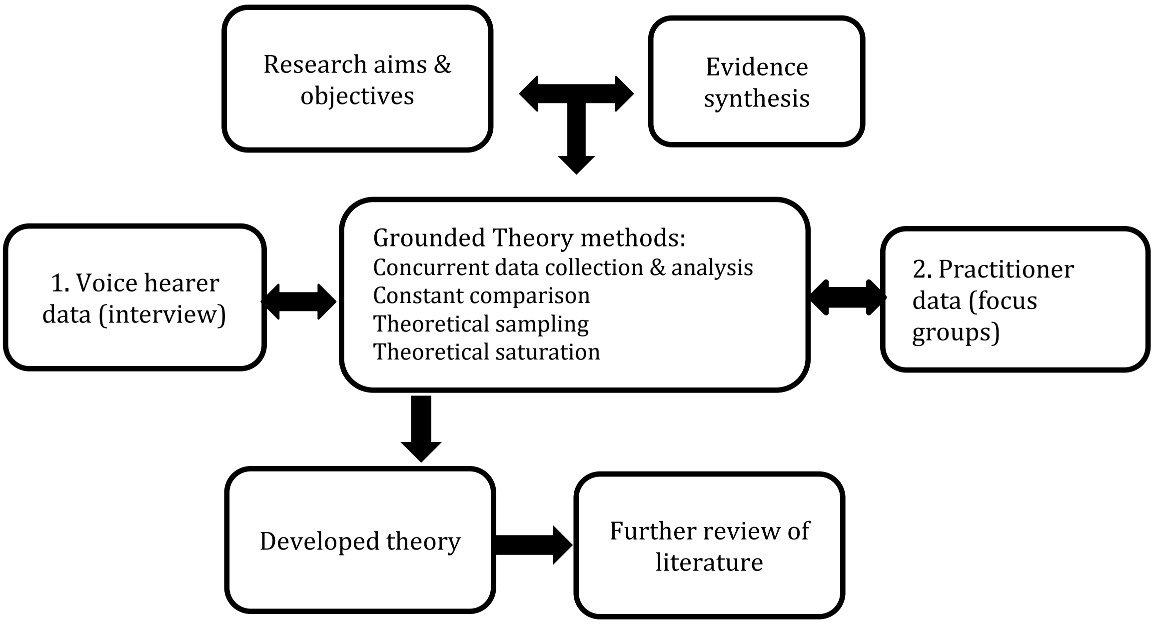
In this Chapter, I describe how I address the thesis aim and objectives by utilizing a qualitative constructivist Grounded Theory (Charmaz, 2014) approach. I provide a rationale for choosing a qualitative study design and discuss Grounded Theory methodology and theory construction for the purpose of this study.

4.2 Qualitative study design

Qualitative research is a broad term encapsulating a range of different (and even opposing) philosophical approaches with a common aim of establishing in-depth meaning and understanding of phenomena situated within its natural setting (Silverman, 2011). It is broadly rooted in interpretivism, which assumes that social and cultural interpretations inform individuals' understanding of social life (Crotty, 1998). In other words, it is concerned with how social reality is experienced, understood and interpreted. This makes it a relevant approach to generate knowledge *inductively* from the experiences of voice hearers and practitioners captured in interviews and focus group discussions respectively.

The study design (Figure 4.1) involved two stages. At the outset, I had initially planned to address the research objectives by conducting semi-structured interviews with participants about their experiences of voice hearing within a treatment setting. Prompted by questions about treatment experiences during interview, in addition to their experiences of voice hearing, participants' spoke about their experiences and relationships with practitioners. Listening to their experiences, I became increasingly interested in gaining a better understanding of the role of voice hearers' relationships with practitioners in terms of voice hearing experiences. I became aware of the importance of exploring both sides of the voice hearer – practitioner relationship. Consequently, the first stage involved collecting and analysing data from voice hearers via semi-structured interviews (discussed in Chapters 5 and 6) before a I conducted a second stage of collecting and analysing data from practitioners via focus group discussions (discussed in Chapter 7). Practitioners' data were then synthesized with the voice hearers' data to complete the development of theory (discussed in Chapter 8).

Figure 4.1: Study design.



4.3 Grounded Theory methodology

As I explain in Chapter 1, I approached this investigation from a practitioner perspective having spent several years caring for and working alongside people who hear voices and with a desire to help improve treatment approaches to help voice-related distress. After searching the literature, I became aware of a lack of well-established theoretical literature grounded in the experiences and perspectives of voice hearers, and specifically situated in clinical settings. I wanted to contribute towards the evidence-base for voice hearing by developing theory applicable to clinical practice. As a novice researcher, Grounded Theory appealed to me. It is suitable for investigating underlying social processes and actions to develop theoretical explanation (Charmaz, 2014, Corbin and Strauss, 2015, Birks and Mills, 2015) and I was drawn to its structured approach, which provides a guide to data collection and data analysis in order to develop middle-range theory (Mills et al., 2006).

Since the original version was developed in the 1960s (Glaser and Strauss, 1967), there are now several versions of Grounded Theory. Several common features include: (1) the aim of theory development grounded in the data; (2) an emphasis on patterns in the research data rather than individual stories; (3) concurrent data collection and analysis; (4) theoretical sampling during the analysis, which informs subsequent data to collect; (5) a constant comparative method of coding data; (6) a focus on actions and processes when analysing data; and (7) memo writing during data collection and analysis (Charmaz, 2017).

The main difference between these versions lay in the philosophical assumptions of the researcher (Mills et al., 2006). I was drawn to the constructivist version developed by Charmaz (2014), who "acknowledge[s] subjectivity and the researcher's involvement in the construction and interpretation of data" (p14) and aligns constructivist Grounded Theory with interpretivism to provide "an *interpretive* portrayal of the studied world, not an exact picture of it" (p17). This aligns with my 'worldview' in terms of acknowledging multiple interpretations of voice hearing. As I explained in Chapter 1, I became aware from my clinical practice that, for many voice hearers, their understanding of their own voice hearing had been informed by practitioners. In my experience, this usually involved practitioners providing a biomedical explanation of voices and justifying the administration of antipsychotic medication, leading to voice hearers perceiving their voices as a symptom of a life-long mental illness. However, some voice hearers developed alternative understandings, often through exploring their experiences with their peers (i.e. in Hearing Voices Groups), leading to alternative conclusions about possible roots of their voices, such as associations with previous difficult life experiences. From observing this in practice, I learned of the importance of remaining open to different interpretations and associated meanings regarding voice hearing, which may or may not align with dominant narratives or practitioners' explanations. As such, my own 'worldview' aligns with Charmaz's constructivist philosophy as an appropriate approach to investigate possible multiple explanations for voice hearing situated within and shaped by a mental health treatment context.

At its simplest level, theory is defined as "a set of concepts used to define and/or explain some phenomenon" (Silverman, 2011, p52). There is a lack of consensus between different versions of Grounded Theory regarding how theory is defined and developed (Apramian et al., 2017), however the constructivist version with which I align "relies on empirical observations and depends on the researcher's constructions of them" (Charmaz, 2014, p231). According to Charmaz (2014, p13), "the constructivist approach shreds notions of a neutral observer and value-free expert". Assuming that 'reality' may exist outside of the researcher's mind, Burr (2003, p158) argues that research does not produce a "final description of the world" but instead "reality may be inaccessible or inseparable from our discourse about it". I aimed to develop an interpretive representation of the experiences of voice hearers and practitioners and situated specifically within an English mental health treatment context. My understanding of participants' 'real' experiences (i.e. what they said during the interview) was made through my own interpretation rather than assume the 'real' is what they said. That is, the meaning associated with this was constructed and dependent upon the interactions between the participants and me as a researcher.

Middle range level theory is situated between the philosophical / grand theories and empirical generalisations framed as hypotheses, offering potential for shaping knowledge and practice (Liehr and Smith, 2017). More specifically, middle range theory consists of a limited number of concepts addressing a relatively concrete and specific phenomenon, and are classified as descriptive, explanatory or predictive (Fawcett and Desanto-Madeya, 2013). Descriptive middle range theories are the most basic type, providing a descriptive account of a phenomenon typically about only one concept. Explanatory types explain why and the extent to which at least two concepts are related. Predictive types also include at least two concepts but additionally predict the effect of one concept (i.e. an intervention) on another (i.e. outcome). According to these distinctions, this investigation aligns with an explanatory type of middle range theory. 'Situation-producing theory' can be empirically tested to evaluate the impact on patient care and communicate empirical knowledge to others (McKenna, 1997). Consequently, through applying a constructivist Grounded Theory methodology, I wanted to develop a theoretical understanding of voice hearing applicable to practice, which would provide an opportunity for future testing, and with an overall aim of improving treatment experiences for both voice hearers and practitioners.

Both in their original (Glaser and Strauss, 1967) and subsequent work (Glaser, 1992, Strauss and Corbin, 1990), Glaser and Strauss advocate a delay in formally reviewing literature in order for researchers to preserve their neutrality and prevent their knowledge from impacting on the study (although both acknowledge that researchers will have engaged in the field to some extent). Although Charmaz (2014) agrees with this in principle, she is more pragmatic by encouraging reflexivity to enable the researcher to account for the influence of this knowledge. As a general rule, though, the convention is for researchers to avoid in-depth examination of the literature such as a systematic review (Birks and Mills, 2015). I avoided engaging in an in-depth examination of voice hearing literature until after completion of the study to remain closely aligned with conventions of Grounded Theory methodology. At the start of my PhD, however, I investigated the coercion literature (Chapter 3) so that I could provide sufficient background literature for ethics approval and which informed the research aim and objectives. Upon reflection, I found it difficult to find a balance given my previous knowledge and clinical experience of voice hearing.

4.4 Researcher positionality

Positionality describes the researcher's position in relation to the research study, including recognition of their inclusion in the social world about which they are researching and acknowledgment of their influence on the research process (Holmes, 2020). This concerns the extent to which my position as researcher has been integral to the analysis during the research process. Reflexivity, which concerns the researcher's acknowledgement of potential influences on the research process, is a prerequisite informing the development of positionality. This requires researchers to recognise and explicate how their own values, assumptions, and a priori ideologies might shape the research process (May and Perry, 2017, Engward and Davis, 2015). Positionality also concerns whether the researcher approaches the investigation from an 'inside' or 'outside' perspective. Pike (1954) coined the terms 'emic' (insider) and 'etic' (outsider) to account for a researcher's position in relation to the researched phenomena. In contrast to an emic position that establishes a viewpoint from participants' perspectives, I take an etic position that establishes a viewpoint from my perspective as researcher, which takes into account participants' responses and my observations, interpretations and reporting.

Extending the above discussion in section 4.3, my positionality is congruent with Charmaz's (2014) constructivist version of Grounded Theory. Critical of the notion of neutral observation or value-free expertise, Charmaz (2014) encourages the researcher to be cognisant of their subjective contributions throughout the research process. In this respect, it is important to acknowledge my previous and current experiences shape my observations and interpretations. As I discuss in section 1.2, I am a mental health nurse, a university lecturer, a doctorate researcher and I have personal friendships with people who hear voices and practitioners. My clinical and personal background stimulated my interest and initially provided some insight regarding voice hearing and mental healthcare. In particular, it also informed my underlying views concerning the nature of voice hearing and the culture of mental healthcare. Influenced by these experiences, especially Voice Dialogue approach (Stone and Stone, 1989), I believe voices are understandable through voice hearer's constructing personal meaning in relation to their own life history. Critically challenging these views through reflective writing (for example, memos) and supportive discussions in supervision meetings supported reflexivity during data collection and analysis.

4.5 Chapter summary

In this chapter, I have discussed a qualitative approach as appropriate for this study, wherein I specifically utilise a constructivist Grounded Theory methodology. Aligned with a constructivist version, I have also acknowledged my interpretivist approach as a researcher in the collection and analysis of the experiences of voice hearers and practitioners, which I begin to discuss in the next chapter.

CHAPTER 5: Voice hearers' experiences of voice hearing during treatment: Research methods

5.1 Chapter overview

The aim of this first of two stages of the study design was to investigate how people recall their experience of voice hearing during treatment interactions with practitioners. In this chapter, I describe how I utilize a qualitative constructivist Grounded Theory methodology to collect and analyse (via semi-structured interviews) data from 15 voice hearers, specifically relating to their experiences in a mental health treatment context. For the purpose of this study, I defined a treatment interaction with a practitioner as any interaction related to treatment, ranging from informal situations such as administering medication or talking between practitioners and patients to more formal situations such as treatment review meetings. In the following section, I describe the recruitment process of voice hearer participants, data collection, Patient and Public Involvement (PPI), ethical considerations and, finally, the coding process for data analysis. I explain the findings in Chapter 6.

5.2. Recruitment & participants

The treatment setting involved NHS mental health services providing treatment for people in relation to their voice hearing. This includes acute inpatient wards and community services such as Community Mental Health Teams, Assertive Outreach Teams, and Early Interventions in Psychosis teams. This range of clinical settings was to help capture broad treatment-related experiences and aid recruitment of a difficult-to-reach participant group. As Chief Investigator (CI), I recruited participants via a Principle Investigator (PI) within a local NHS Mental Health Trust to liaise with key contacts within the Trust, and within local Hearing voices Groups, to identify potential participants for the study (see Figure 5.2 below). Those meeting the following criteria were considered eligible for the study:

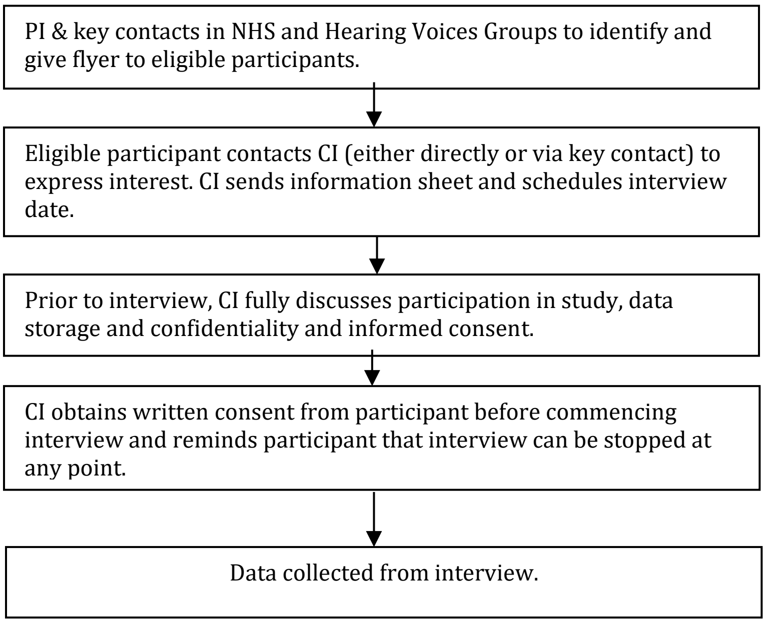
Inclusion criteria:

- Experienced voice hearing (either currently or previously), either self-defined or diagnosed by a responsible medical officer.
- Received mental health treatment (either currently or previously, including all health settings).
- Minimum age 18 years.
- English speaking
- Agrees consent to participation.

Exclusion criteria:

- Lacks mental capacity (determined by the Mental Capacity Act).

Figure 5.1: Process for participant recruitment and data collection



The PI distributed a Participant Information Sheet (see appendix 1) and Study Flyer (see appendix 2) to key gatekeepers across the Trust and local Hearing Voices Groups. Eligible participants expressing an interest to participate contacted me directly, although if requested by a participant (through a key contact), I contacted them. After making contact, I sent to the potential participants an information leaflet (if they had not already received one) and scheduled an interview date. As the study progressed, it became increasingly difficult to recruit participants. Having only one PI slowed down recruitment and there was no time to amend the study protocol for ethics approval to include a more assertive recruitment strategy to enable me to advertise the study more widely through, for example, social media. Because of the difficulty with recruitment, I engaged with another gatekeeper from a different region of the same NHS Trust, who played an important role in successfully recruiting several participants.

5.3 Data collection

I collected data between October 2018 and October 2019 via semi-structured in-depth interviews. This type of qualitative interview relies on participants' engagement in the interview process and recollection of their experiences. I selected this type of interview to align with a constructivist version of Grounded Theory (Birks and Mills, 2015). This was informed by Charmaz's (2014) conception of open ended, semi-structured qualitative interviewing, chosen as a method to engage in dialogue with participants in order to illicit their stories and perceptions regarding their experiences of voice hearing and treatment.

The aim of semi-structured interviewing was to focus on participants' interpretations and associated meanings (Gubrium and Holstein, 1997) regarding their experiences of voice hearing during treatment. Furthermore, it was a method to talk with participants in order to develop their *social construction* (Silverman, 2011, Charmaz, 2014) of their voice hearing in a treatment-related context. Throughout the interviews, I remained mindful regarding both my interactions with participants but also the voice hearer - voice relationship. From my clinical experience, I was aware of the potential intrusion of voices during interview and the potential sensitivity related to some of the questions and discussion. As such, I considered this a supportive method to help manage voice hearers' potential interpersonal stress and distraction.

All participants heard voices and had been in receipt of treatment from mental health services (either currently or previously) in relation to their voice hearing. Seven interviews were conducted at the University of York, three were conducted in a residential/supported community setting, three interviews were conducted in participants' homes, one was conducted in a hostel, and one was conducted in a mental health centre/outpatient setting. The interview data were audio recorded and transcribed and then transferred into a computer assisted qualitative data analysis software (CAQDAS), specifically NVivo (version 11).

I developed an interview guide (Table 5.1 below) and used it as an *aide-memoire* to help interview discussions to remain on track to meet the study aims. This was developed following advice from the Bradford Hearing Voices Group (HVG) (discussed in more detail in section 5.4) and shaped by a pilot interview (with a person who hears voices) prior to commencing the study. Rather than using the interview guide as a rigid list, the questions I asked were often bound to the immediate context of active voice hearing during the interview. The interview guide evolved over the course of interviewing in order to pursue the development of increasingly conceptual coding. Prior to the first interview, the interview guide focused on two themes: experiences of voice hearing and experiences of treatment interactions, with several prompts where needed. My experience of the 'Voice Dialogue / Talking with Voices method (Corstens et al., 2012) informed my sensitivity to voices during interview and the initial questions and prompts were influenced by both the pilot interview and from consultation with the Bradford HVG.

Table 5.1: Initial interview Guide

Experiences of voice hearing:

1. Tell me a little bit about the voices you hear? (Prompts: how many do you hear? Are they positive/negative/neutral/dominant? Do they have names? Do they represent anything for you?).

2. Can you tell me more about how your voices communicate to you? (Prompts: are they commanding/advisory/commentary? How do they affect you? Do they have a visual presence? Where are your voices in relation to you? Does this ever change?).

Experiences of treatment interactions:

3. I am interested in hearing about your experiences of treatment. (Prompts: can you tell me about a time when you interacted with a practitioner during treatment and what happened? What were your perceptions of the practitioner during the interaction(s)? How did you interact with one another? What sense did you make of the interaction? How typical for you was this example of a treatment interaction?).

4. How did you experience your voices at that time? (Prompts: what did your voices say? How did your voices respond? Did your voices have anything to say about the interaction? Or about the practitioner? Where were your voices in relation to you? Did this change? How did your voices at that time compare to before and after the interaction? How did it compare to other treatment interactions?).

5.4 Patient and Public Involvement (PPI)

Prior to commencing the study, I consulted the Bradford HVG for advice regarding the study documents and interview questions. As part of the international Hearing Voices Network, Bradford HVG is a self-help group for people who hear voices, providing a space for people to meet weekly to exchange experiences and ideas for coping and gaining control over voices. I contacted the group facilitator, discussed my initial thoughts regarding the study objectives and asked permission to attend a group meeting to discuss these further with the group members. A participant information leaflet (appendix 1), study flyer (appendix 2) and consent form (appendix 3) were sent to the group facilitator in advance of meeting with the group, which helped to serve as a focal point for discussion when I attended. Upon reflection, I should have scheduled additional follow-up meetings with the group to enable further discussion, particularly regarding recruitment difficulties described above, and to reflect on the evolution of the interview questions.

During my attendance, I asked the group for their comments regarding the study, questions to ask in the interview and about the study documents. Group members reported that they believed this was an important study to help validate people’s voice hearing and treatment experiences and contribute to improving future treatment experiences for other voice hearers. They advised on language used in the study documents, preferring the terms ‘voice hearer’ and ‘people who hear voices’ and rejected terms such as ‘schizophrenia’ or ‘schizophrenic’, ‘mental illness’ or ‘mental disorder’. This is consistent with lived experience accounts found in the literature and subsequently informed the study documents and language used in this thesis.

The group also raised two issues specifically relating to potential anxiety participants might experience when taking part in the study. The first related to the possibility that participants might feel apprehensive about what they anticipated I could ask during an interview. The second concerned the possibility that, should a participant become distressed during interview, I might contact their mental health keyworkers/services and, in so doing, breach their trust and disempower them in terms of negating their option of self-managing their own distress. Consequently, to address the first concern and reduce potential apprehension, participants received an information leaflet before interview, which included example questions asked in interview. To address the second concern, I agreed with the group that it would be better to avoid contacting a participant’s key worker (practitioner) in the event of a participant becoming distressed during interview. Instead, I suggested to participants that they could bring along with them a family member or friend to be available after the interview and/or they could request that I contacted an appropriate person should they become distressed.

5.5 Ethical considerations

Ethical approval was provided by the university’s Research Governance Committee and the NHS Research Ethics Committee prior to commencing the study. As part of the approval process, a study research protocol set out details relating to data collection and analysis, storage of data and ethical considerations (see appendix 4).

Prior to each interview, I informed participants about the aims and details of the study through a Participant Information Leaflet and offered further opportunities for further questions and discussion in relation to these details. I stressed the voluntary nature of participation in the study so that participants clearly understood that they could request further information or change their mind at any point and cancel either before or during the interview. Participants could also request their interview data to be retrieved or destroyed and I informed them about anonymity and the confidential treatment of data. All participants provided written informed consent.

Some participants heard active and distressing voices during the interview. This presented an additional challenge related to the unpredictability of voice hearing experiences during interview. Given my previous experience of talking with people about their voices during clinical interactions, as I discuss in Chapter 1, I had anticipated that participants would hear their voices becoming increasingly active and distressing during interview. Consequently, there were times during interviews when I had to make a decision regarding whether or not to continue with the interview. From clinical experience, I was conscious of the likelihood that participants might struggle to engage in the interview due to the extent to which they could become distracted by their voices. This raised sensitive issues relating to power during the interviews in terms of a complex relationship involving the participants and their voices but also potentially me in terms of how both participants and their voices perceived my presence.

Although I have several years' experience of interviewing as a practitioner, Hunt et al. (2011) consider clinical and research interviews to be different in terms of orientation, purpose and techniques. Leaving aside the different types of both clinical and research interviews, generally clinical interviews focus on collecting a history of a presenting problem in order to explain a range of symptoms, conceptualize or diagnose the problem to inform a treatment plan and then to evaluate this treatment. By contrast, the purpose of a research interview is to explore the phenomenon under investigation, which may or may not inform a participant's treatment plan.

Hunt et al. (2011) suggest there are different power differentials between clinical and research interviews. Regarding research interviews, it was an ethical condition that participants voluntarily agreed to participate, provided informed consent and remained comfortable and willing to continue participating. As such, in terms of interviews, participants are experts from whom I as the researcher learn about their experiences. By contrast, a clinical interview typically involves a patient receiving treatment from practitioners wherein the practitioner is typically considered by many patients as the expert aiming to assist the patient. Whereas the research participant is voluntary, the clinical patient can be formally required under certain circumstances (e.g. use of MHA) to take part in the interview.

Consequently, I thought it was important to remind participants that their participation in the interview was voluntary and depended on their willingness to continue participating. When I observed a participant to appear distracted and/or distressed by their voices or if a participant verbalised their struggle, I asked them how they were feeling and suggested a short break from the interview to allow time to discuss their preferred course of action. When this happened, we took a short break and I reminded participants they could stop at any time and, informed by my clinical experience of the working with voices, I asked them to reassure their voices I intended no harm to them or their voices. Interviews only continued following verbal assurances from participants they were happy to continue. None of the participants expressed their wish to end interviewing prematurely.

I assigned each participant a unique identification code to ensure anonymity of data. Only the consent forms included identifiable information linked to the unique identification codes. These were stored in a locked filing cabinet within a locked office at the University of York. These were then scanned (and hard copies shredded) and securely stored electronically along with all other study data on a University of York password-protected secure server. I recorded interview data on a digital audio recorder and stored it as MP3 files, which I then uploaded to a secure online transcribing service.

5.6 Data analysis

I transferred interview data into NVivo (version 11) to support the data analysis through managing large volumes of interview transcriptions and enabling the coding process. During data analysis, I utilized key features of Grounded Theory, such as concurrent data collection and analysis, coding, constant comparison during coding, memoing, theoretical sensitivity and theoretical sampling (Charmaz, 2014, Corbin and Strauss, 2015). As a fundamental analytical tool for theory development, coding consists of words or short phrases that symbolically represented the data (Saldaña, 2013). The coding process iteratively linked the data collection, analysis and theory construction. It was a cyclical process encapsulating stages in which data from interview transcripts were initially coded before becoming increasingly conceptual into theory to account for the general (Saldaña, 2013). The stages of coding included an 'initial' stage of open coding, in which codes were developed from data and then developed into a more advanced 'focused' stage in which categories were developed, before moving to a final stage of 'theoretical' coding to develop relationships between categories and their properties (Charmaz, 2014, Mills et al., 2006). There were several cycles of going back and forth between each of the stages. To maintain quality during the research process, I provide a clear account of decisions made throughout the study, including a reflexive account of interviewing (section 5.6.2).

5.6.1 Initial coding

Prior to initial coding, upon reflection, the initial interview guide provided some initial structure for coding. This first stage of coding involved a line-by-line approach to enable the breakdown and analysis of the nuances of particular events (Charmaz, 2014). I read each line of the interview transcriptions and named relevant sections in terms that I considered best represented the meaning of what participants reported. During this initial coding stage, the aim was to remain open to identify concepts and all possible theoretical directions (Corbin and Strauss, 2015).

Glaser (1998), Charmaz (2014) and, to a relatively lesser extent, Strauss and Corbin (1990) recommend the use of gerunds when focusing on coding *action*. According to Charmaz (2014), this helps emphasise *actions* and *process* rather than individuals as discrete units of analysis. I tried to make use of gerunds where I was able to in order to emphasise actions and process and avoid personifying participants but I found this hard to do for all coding. Where I was able to apply this, I found it a helpful way of focusing on what participants said they did rather than make a judgement about who or what they are. As I discussed in Chapter 2, dominant narratives in mental healthcare inform an understanding of voice hearing as a symptom of mental illness such as schizophrenia and the identify of many voice hearers typically as 'schizophrenics' and so I found it helpful to focus on action rather than personifying codes and participants' identity.

I checked interview data against existing codes and, where no existing code sufficiently represented that section of data, I assigned a new code. Coding of the first interview led to 35 initial codes, which increased to 174 initial codes after the second interview. At that point, the number of codes started to become overwhelming. The constant comparative method was helpful in terms of reassuring me, as a novice researcher, that I was remaining consistent with coding and Grounded Theory methodology. During the analysis of the interview data, it became a fundamental method to help make analytical distinctions. This involved comparing data between codes before allocating new data to either a pre-existing code or constructing a new code where relevant. It also included comparing interview statements or codes across all interviews.

Consistent with the constant comparative method, coding throughout the third interview transcript with the data from the first and second interviews led to merging and/or re-naming some of the initial codes. For example, 'Abusing laxatives as a way of coping' and

‘Using alcohol to cope’ merged to become ‘Using substances to cope’; and ‘Creating boundaries’ and ‘Setting time limits with voices’ merged to form a new code ‘Setting limits’. By merging other similar codes, the number of initial codes reduced to 109 after analysis of the first four interviews (see Table 5.2).

Table 5.2: Initial coding following first four interviews

Acknowledging difficulty for practitioners
Avoiding talking about voices
Becoming aware of voices
Being able to trust is important
Being accepted
Being alone can be unhelpful
Being bullied
Being distracted is helpful
Being encouraged to engage with voices
Being ignored
Being involved in treatment decisions is important
Being listened to
Being neutral
Being pathologised
Being taken away from family
Believing voices
Benefitting from medication
Concealing voices
Disclosing voices reduces their power
Dismissing as just voices
Distancing self from others
Distancing self from voices
Distinguishing self from voices
Exchanging energy with voices
Expecting MH services to be helpful
Experiencing changeable voices
Experiencing MH services as unhelpful
Experiencing stressful relationships
Fearing consequences
Feeling afraid of voices
Feeling angry with voices
Feeling depressed from voices
Feeling judged worsens voices
Feeling overpowered by voices
Feeling rejected
Feeling shameful
Feeling worse from medication
Finding it difficult to relate with voices
Giving space
Grounding oneself
Having a supportive network
Having courage to engage with voices
Hearing negative voices
Hearing positive voices
Hearing voices as real
Hearing voices relentlessly
Hiding from voices
Identifying purpose of voice
Identifying voice as part of self
Identifying voices
Identifying with other voice hearers
Identifying qualities in practitioners
Ignoring voices
Lacking involvement in treatment decisions
Learning to live with voices
Linking relating with voices and people
Linking tiredness and voices
Linking voices with trauma
Locating or looking for voices
Losing control of life
Making sense of voices
Managing stress
Moving from place to place
Packing in work
Perceiving oneself as mad
Perceiving practitioners lack interest in voices
Practitioners accepting voices
Practitioners dismissing voices
Practitioners failing to engage
Practitioners lacking hope
Questioning practitioners approach
Recalling concern from others
Recalling parent aspirations
Recalling previous abuse
Recalling previous difficulties
Recognising importance of agency
Recognising physical and mental health are intertwined
Reducing impact of voices
Reflecting on sense of achievement
Reframing voice hearing
Representing a barometer of stress
Running away from authority
Setting limits
Sobering up
Some voices more powerful than others
Standing up to voices
Taking a non-intrusive interest
Taking control of medication - treatment
Taking responsibility
Talking about voices can be difficult
Talking is helpful
Thinking nothing can help
Trusting people is difficult
Using substances to cope
Valuing a broader perspective
Voices are more powerful when kept a secret
Voices communicating with each other
Voices feeling threatened
Voices knowing previous history
Voices listening for information
Voices reacting to practitioners
Voices responding during interactions
Voices responding to emotions
Voices responding to personal appearances
Voices wanting to be acknowledged
Wanting to get rid of voices
Wanting to keep voices
Wanting to show they were wrong
Wrestling power with voices

Memos and diagrams

I utilized memo writing and diagramming to help reflect on the data and develop the analysis further (Corbin and Strauss, 2015, Charmaz, 2014). This was invaluable in order to examine, make comparisons and explore relationships between different codes. For example, early codes such as 'Concealing voices' and 'Talking about voices can be difficult' captured participants' avoidance of talking about voices. Reflecting on these codes enabled further questioning to examine the concepts further, for example: 'what do participants experience or anticipate they will experience by talking about voices'? In another example, two codes were sufficiently distinct from one another, 'Feeling overpowered by voices' and 'Wrestling power with voices', but led to me questioning what enabled the difference between being able to wrestle with voices and feeling overpowered by them.

Memos from earlier parts of the analysis contained impressions primarily about the participants' experiences. For example, in an early memo following the first three interviews, I reflected on an interactional dynamic described by participants about their lack of trust of practitioners, leading to their voices becoming louder and more powerful and participant describing feeling more distressed. Memos later in the analysis became increasingly theoretical. Consequently, this enabled the formulation of questions about processes involved in specific codes and about assumptions related to codes. This also shaped the questions asked in subsequent interviews in order to develop increasingly theoretical coding (discussed further below).

5.6.2 Reflexive account: interviewing voice hearers and the interview guide

Interviewing people who actively heard voices during the interviews required sensitivity to their potential distress and to the level of voice activity. From clinical experience, I knew the importance of respecting and acknowledging voices during conversation and the importance of avoiding being perceived by voice hearers and/or voices as hostile or threatening towards the voices in response to hearing how unpleasant the voices might be to the voice hearer.

Sometimes, talking about voices made them become louder for participants, more intrusive, feel closer, more hostile and more aggressive. Most participants heard one or more of their voices during interview, particularly when discussing their own personal issues. For most participants, they reported that their voices often commented about our conversation, which affected how participants engaged for fear of their voices' response.

As such, it was important to be observant of participants' verbal and non-verbal communication during interviews and to respond accordingly. This required a flexible approach in terms of the type of questions I asked. In addition to using the interview guide as an *aide-memoir*, I gave particular attention to the presence of voices and participants' current emotional state. This was especially pertinent during times of increased voice activity. Some participants found this too distracting and took short breaks from the interview.

The voice activity during interviews relates to the notion of 'power' and can be framed in terms of Hearn's power 'over' (in terms of voices having power over participants, as described by participants) as I describe in Chapter 2. Aléx and Hammarström (2008) reflect on the role of power during interview situations (such as between a nurse and patient). They argue that power determines what is spoken and written during the interview and caution that interviews may be experienced as a form of abuse. In relation to voice hearing, this is a particularly sensitive issue given the potentially historic trauma relating to interpersonal disempowerment with others, including potentially coercive treatment with practitioners, and the subsequent disempowerment with voices. Consequently, in terms of the interview context, Aléx and Hammarström (2008, p170) advise that "reflexivity is important for awareness of the complexity of how knowledge is created…[and enhances]…the credibility of findings by taking into account the researcher's values, beliefs, knowledge and biases". Informed by my clinical experience of voice hearing and the findings from the evidence synthesis of coercion literature (Chapter 3), I anticipated the potential for participants to feel disempowered during the interviews and pressured to participate in the conversation, to which I was concerned to avoid potentially contributing and participants (and voices) feeling subjected to my questioning. For example, some participants reported that their voices were active and felt threatened by my presence and questioning during interview and some perceived that their voices moved aggressively closer to them in response to my perceived threat. This sometimes made it difficult for participants to continue with the interview and raised ethical concerns in relation to me, potentially and inadvertently, being perceived by participants as abusing power during interview. I consequently believed it was important to regularly check with participants whether they wanted to continue and/or take a break and reassure voices that I intended no harm.

Despite many years' clinical and academic experience, I was conscious of my relative lack of experience as a researcher in terms of interviewing people in a research context.

Reflecting on the first interview, I became aware that my initial confidence derived from my experience as a clinical nurse rather than researcher. As such, at that time, I attended more to my ‘clinical’ interests of listening to participants’ stories regarding their voices rather than my research aim. I was comfortable talking about voices and treatment but I became aware that I could potentially become engrossed in conversation about voices and lose sight of the overall research question. This served as a useful reminder for me to be conscious of the research aim and objectives during interview, not just participants’ stories *per se*. As Holton (2010, p22) states: “grounded theory is about concepts that emerge from the data, not data per se”.

The analysis of the interviews informed my construction of concepts and, subsequently, influenced the types of questions in subsequent interviews from which to obtain further information about the concepts under study (Corbin and Strauss, 2015). As I became more confident in analysing the interview data, the interview guide evolved as the study progressed (see Table 5.3).

Table 5. 3: Revised interview guide

Experiences of voice hearing:

1. Tell me a little bit about the voices you hear?

2. Can you tell me more about your relationship with your voices?

(Prompt: how do you relate with/to your voice(s)? How close or distant are you from them?)

3. Other participants have spoken about power between them and their voices – what is your experience of this?

(Prompt: what role does power have in your relationship with your voices? What do your voices do when you interact with practitioners/others? What happens afterwards?)

Experiences of treatment interactions:

I am interested in hearing about your experiences of treatment.

4. Can you tell me about a time when you interacted with a practitioner during treatment and what happened?

(Prompts: what were your perceptions of the practitioner during the interaction(s)? How did you interact with one another? How typical for you was this example of a treatment interaction?).

5. What did/does your treatment typically involve?

(Prompts: are you prescribed medication? Do you receive therapy?)

6. How involved are you regarding decisions made about your treatment?

(Prompts: what does this mean for you and your voices? What happens when there is a disagreement about treatment? How do your voices react?)

The revised interview guide above emphasises (i) relationships with voices and the notion of relating and distance (question 2), (ii) power between participants and their voices and the impact of practitioners on this (question 3), and (iii) the level of involvement in treatment decisions (question 6). This reflected a shift away from voice hearing experiences *per se* and, aligned with the 'treatment – voice hearing – relationship' framework of this thesis, situated voice hearing within a relational and treatment context.

This also coincided with my increase in confidence during interviewing. In addition to revising the interview guide, I became conscious of shifting my focus from the interview guide to the participant. Reflecting on this at the time, I had recognised that the first two interviews were formulaic in terms of trying to remain close to the interview guide rather than treat it as an *aide-memoire* as originally stipulated. However, given the nature of participants' experiences of voice hearing during interviews, as the interviews progressed I became less attached to asking specific pre-set questions from the interview guide and more attentive to participants' stories and the immediacy of their emotional state. This was particularly important during times of increased voice activity for participants. On occasions when participants became distracted and distressed from their increased voice activity, it was important to be attentive of the immediacy of the situation, rather than attempting to follow a script of questions, and to acknowledge the presence of voices and the emotional state experienced by the participant. As such, my interviewing style moved more towards a conversational style. This helped me to develop confidence using a conversational approach in which participants became a "conversational partner in an extended discussion" Rubin and Rubin (2005, p4). This seemed especially important given the sensitivities related to voice hearing as described above.

5.6.3 Focused coding

The initial stage of coding gradually merged into focused coding, which aimed to advance the theoretical direction of the analysis (Charmaz, 2014). This happened after the first four interviews, during which time codes were beginning to form into groups (or categories) of the most significant or prevalent codes from the initial coding. At this point, coding began to involve conceptualising larger sections of the primary data. Diagramming was a helpful method of visualizing relationships between data and, consequently, to conceptualize the data beyond a descriptive level (Corbin and Strauss, 2015).

Moving from the initial stage to focused coding was not without its challenges. I found it difficult to transition from remaining open to the possibility of further initial codes when moving to the focused stage of coding. Following coding of the sixth interview data I questioned whether or not I was guilty of "forcing the data" and "common sense theorizing" (Charmaz, 2014, p155). Upon reflection, my previous clinical experience had begun to inform the coding process and my own preconceived ideas had begun to influence my conceptualising of the data. As such, there was a risk of focusing too much on limited initial codes aligned with my own previous knowledge of voice hearing. Consequently, this brought into question my theoretical sensitivity in terms of my own contribution and level of insight into the analysis of data (Mills et al., 2006). I became more conscious of the importance of reflexivity regarding whether data was coded according to participants' actions and processes or whether I was importing my own personal agenda (Charmaz, 2014).

Recognising this, and consistent with the constant comparative method, a cyclical process followed for the remainder of the analysis wherein all initial codes were reviewed after each interview and, where necessary, further revised. This helped me guard against moving through the coding stages too quickly. Through revisiting the coding process in this way, involving a constant comparative method and continued questioning and reflection of the data, I developed 12 focused codes (Table 5.4).

Table 5. 4: Focused coding (12 focused codes)

	Focused code	**Sub-code**	**Sub-code**
1.	Being accepted & supported	Feeling valued by practitioners Importance of being believed Talking about voices & problems is difficult	
2.	Being persecuted by voices		
3.	Dominating influence of medication	Being persuaded to take medication Benefiting from medication Coming off medication without support	
		Medication not helping voices	Feeling worse from medication Medication suppressing emotions Wanting to reduce or stop medication
4.	Empowering self through action	Disclosing voices reduces their power Grounding oneself Setting limits Taking responsibility	
5.	Fearing enforced or involuntary treatment	Importance of being involved in treatment decisions Lacking involvement in treatment decisions	
6.	Making sense of voices	Feeling physical presence of voices Identifying voices as part of self Linking voices with trauma Living with voices	

7.	Practitioners failing to connect & understand	Experiencing MH services as uncaring Perceiving practitioners lack hope	
8.	Practitioners not talking about voices	Framing experiences according to professional interpretation	
9.	Relating with voices	Finding it difficult to relate with voices	Being active and distracted is helpful Being critical of voices Concealing voices Distancing self from voices Linking relating with voices & relating with people Voices interacting with emotions Wanting to get rid of voices
		Relating more positively with voices	Looking after voices Perceiving voices are a guide
10.	Trust	Being able to trust is important Trusting people is difficult	
11.	Voice hearing is about power & control	Acting on what voices say Feeling threatened by voices Having agency with voices Hurting self for relief from voices Lacking agency with voices Power relations between voices Voices wanting to be acknowledged	
12.	Voices don't like VH getting help	Voices being disruptive	

By following this cyclical process, I merged and conceptually linked the initial codes where relevant until the above 12 focused codes were developed. For example, 'Being able to trust people is important' and 'Trusting people is difficult' were developed to become the focused code 'Trust'. One of the initial codes, 'Being persecuted by voices' was significant in terms of the number of participants it related to and representing the issue of power so prominent in the data and subsequent analysis. Consequently, this code became a stand-alone focused code.

The 12 focused codes are all grounded in the primary data and had greater conceptual depth than the initial codes. They include a relational power dynamic regarding the interactions between participants and their voices and between participants and practitioners. However, it is important to note the issue of a core category. There are differing views within Grounded Theory literature regarding the importance of a core category and the inclusion of exceptions or variations. In earlier literature, the importance of identifying a core category is stressed and all other categories are integrated around it (Glaser and Strauss, 1967, Strauss and Corbin, 1990, Glaser, 1992). The emergence of a core category in traditional Grounded Theory functions to integrate the theory and become the focus for further selective data and coding (Holton, 2010). By contrast, this is less important for Charmaz (2014), who instead emphasizes a fit between categories. Consequently, I did not include a core category in my analysis.

Establishing the 12 focused codes was a significant step in advancing the theoretical direction of the analysis (Charmaz, 2014). Participants expressed feeling overwhelmed and unable to prevent their voices from commenting and intruding. Participants also described fluctuating levels of agency with their voices and treatment. I interpreted this as participants mostly lacking agency but also experienced times of increased levels of agency. Memoing was a particularly useful method to help distinguish between some of the different codes during the focused stage. For example, the focused code 'Empowering self through action' included the codes 'Standing up to voices' and 'Having agency'. However, as the analysis progressed, it became difficult to establish sufficient meaningful differences between these. Consequently, I reviewed all three in relation to the interview data and it became evident that 'Standing up to voices' was too closely linked with 'Having agency'. As a result, I merged the two under 'Having agency with voices', which was more aligned with power over voices rather than empowering oneself.

5.6.4 Theoretical coding

Following the focused stage of coding, the data analysis progressed to the theoretical coding stage. This final stage began from around the 10th interview onward. Concurrent data collection and analysis led to the development of increasingly conceptual categories of codes. In her critique of the concept of theoretical saturation, Low (2019) stresses the importance of continuing this process, not to simply reach a point where no new information emerges from the analysis, but to ensure conceptual rigor. I continued concurrent data collection and analysis, exploring the categories and the relationships between them until, after interviewing 15 voice hearers, I felt confident that the analytical process had progressed to a conceptual level where no new information regarding the situations in which the codes appeared and relationships between codes would emerge from further interviews with voice hearers. At this point, I felt I had achieved sufficient conceptual depth in order to support theory development and reach theoretical saturation (Hennink et al., 2019). After a final review of all focused codes and primary data, I tentatively collapsed them into six theoretical codes (Table 5.5).

Table 5. 5: Developing focused coding to theoretical coding

12 Focused codes		6 Theoretical codes
Empowering self through action Voice hearing is about power & control	➔	**1. Agency**
Dominating influence of medication Fearing enforced or involuntary treatment	➔	**2. Biomedical treatment: limited involvement or fearing enforcement**
Making sense of voices	➔	**3. Making sense of voices**
Being persecuted by voices Voices don't like VH getting help		**4. Personal bully**
Practitioners failing to connect & understand Practitioners not talking about voices	➔	**5. Practitioners' actions**
Being accepted & supported Relating with voices Trust	➔	**6. Relating**

Following this, I tabulated all codes and corresponding participants' quotes (see Appendix 5). This helped me to check each of the theoretical codes in relation to each participant and develop a summary account of the coding against participants, which involved checking the interview quotations from each participant against each theoretical code. Although this helped to establish the quality of alignment between participants' interview data and the theoretical codes, the final stage of the analysis process involved writing and editing the findings section of the study. This helped to identify any underdeveloped theoretical code and refine relationships between codes. For example, an early draft included a theoretical code 'Amount & level of abuse', which included a code 'Being taunted or abused by voices'. However, upon writing and re-examining interview transcripts to confirm that the coding reflected participants' accounts, it became evident that 'Amount & level of abuse' code did not sufficiently reflect participants' accounts. Consequently, I changed this to 'Personal bully' and included an additional code 'Voices don't like VH getting help' to represent more accurately not only the persecutory and bullying nature of voices but also intrusive nature of voices for participants.

5.7 Chapter summary

In this chapter, I have provided a detailed account of the methods of data collection and analysis regarding interviews with 15 people who hear voices and with experience of mental health treatment. This has involved describing the analysis process in which I constructed six theoretical codes from the interview data. In the next chapter, I discuss these findings in more detail.

CHAPTER 6: Voice hearers' experiences of voice hearing during treatment: Findings

6.1 Chapter overview

In the previous chapter, I describe the process of applying a constructivist Grounded Theory methodology that led to the development of six theoretical codes grounded in the interview data of 15 voice hearers. I discuss these theoretical codes in this chapter. Participants' quotations are included to illustrate how the theoretical coding is grounded in the interview data (see appendix 5 for a more detailed record of all quotations relating to the theoretical codes). I first provide an overview of the sociodemographic characteristics of participants. Following this, I discuss each of the theoretical codes and illustrate how they tentatively explain voice hearers' experiences of voice hearing specifically in a treatment context. Finally, I conclude the chapter with a discussion of the limitations of the study and a rationale for further data collection from practitioners.

6.2 Socio-demographic characteristics of participants

Table 6.1 provides an overview of participants' socio-demographic information. Participants are identified by pseudonyms. Fifteen participants were recruited and interviewed, including seven men and eight women, aged between 18 to 63 years. Five of the participants were engaged in paid employment of some sort (Bella, Glenda, Hillary, Jenny, and Olivia) and one engaged in voluntary work (Edith). All participants had experience of one or more of the following mental health settings: inpatient mental health wards, community mental health, General Practitioner/ Primary Care. However, none were in a mental health inpatient setting at the time of interview. Eleven participants lived in their own home (either owned or rented); three lived in residential/supported accommodation in the community and one lived in a hostel.

Table 6. 1: Socio-demographic information of participants

Pseudonym	Age (& when voices began)	Gender	Ethnicity	Type of services received	Time receiving MH svs	Occupation status	Accommodation status	Brief context
Alan	50s (35)	M	White British	Residential F/T	15 yrs	Unemployed	Residential	Lives in large community house. Has physical ill- health. Hears 1 voice and feels the presence of another voice. Distant relationship with voices often reacts to derogatory / hostile comments.
Bella	40s (14)	F	White British	Previous inpatient. Long term therapy	On&off approx 20 yrs	Employed	Independent, tenant	Lives alone. Physical health needs contribute to increased distress from voices. 3 voices intermittently. Distant relationship with voices, similar pattern to relationship with other people.
Clare	40s (late teens)	F	White British	CMHT, previous inpatient	18 years	Unemployed / student	Independent, tenant	Lived alone for many years. Numerous voices, refers to feeling different energies. Can become very distressed by voices. Difficult relationship with voices but does engage and attempts to manage power struggle.
Diane	50s (20s)	F	White British	CMHT, previous inpatient	20 years	Unemployed	Independent, tenant	Lives with son. Numerous voices but 5 regular voices, links these to past trauma and feels over-powered by voices. Disclosed voices to only few people. Engaging with voices reduces their power.
Edith	30s (15)	F	White British	CMHT previous inpatient	17 years	Voluntary work	Independent, tenant	Lives with partner, hears 3 voices and a crowd. Links with previous trauma. Struggles to relate to voices, feels overwhelmed and self-harms for peace from voices.
frank	44 (14)	M	White British	CMHT, previous forensic MH & prison.	30 years	Unemployed	Independent, tenant	Lives with partner, has 6 voices, all linked to specific ages in childhood abuse. Never received support from MH service for voices, self-taught how to understand and engage with voices. Now relates positively and compassionate with voices
Glenda	63 (48)	F	White British	GP, Previous CMHT & Crisis Team	16 years	F/T Employed	Independent, homeowner	Lives alone. Has 1 voice, attributes this to previous medication for depression. Does not engage with voice, has distant relationship, can feel overwhelmed by it.
Hillary	40s (20s)	F	White British	CMHT	In total 20 yrs	F/T employed	Independent, tenant	Lives with partner, negative experiences in MH services. Hears 5 voices, linked with past trauma. Has learned to relate with voices and gives them time to listen to them. Has found this reduces their power.
Ian	48 (44)	M	White British	GP, previous CMHT & inpatient	4 years	Unemployed	Independent, tenant	Lives with partner and children, has 2 voices (previously 3), links 1 of voices that is abusive and overpowering to past abuse. Has confronted past abuse and power of this voice reduced. Positive experience of MH services.

Jenny	60s (30s)	F	White British	GP, previous CMHT, Inpt, Therapeutic Community	20 years	Retired staff nurse, P/T employed	Independent, homeowner	Lives alone, initially 2 or 3 voices but more emerged. Now less distressed by voices. Found MH services unhelpful. Helpful 18 months in Therapeutic Community where learned to understand connection between emotions and voices.
Kevin	23 (21)	M	White British	Residential	1 year	unemployed	Residential	Not sure if hears multiple voices or 1 voices pretending to be many voices. Hears abusive commentary, want to hurt him. Found MH inpatient services unhelpful, mainly treated with medication. Now prefers community recovery house.
Liam	29 (21)	M	White British	Residential	8 years	Unemployed	Residential	Hears 3 or 4 voices, usually negative commentary. Attributes voices to mental illness, relies mainly on medication. Resides in a community recovery house with other residents.
Mike	20 (17)	M	White British	AOT (CMHT)	3 years	Unemployed	Hostel	Hears a demon and several other voices. Has negative voices but has researched voices. Believes has had a spiritual awakening, voices are a guidance to help turn his life around. Believes has power and control over his voices.
Noel	18 (15)	M	White British	CMHT	3 years	Unemployed	Independent, tenant	Hears 3 voices: 1 is aggressive/ angry and a bully, 1 is his best friend and can relate to when he was 14/15 years old, and the other is quiet and neutral. Therapy has helped improve relationship with voices.
Olivia	40s (20s)	F	White British	CMHT, Social Services	10 years	P/T employed	Independent, tenant	Number of voices has reduced, now has 3 or 4. Voices are abusive family members. Can be distressing and has no control over them. Also has physical health problems. Lots of medication, which does not help with voices.

6.3 Theoretical codes

I discuss each of the six theoretical codes below.

6.3.1 Making sense of voices

Making sense of voices is a key theoretical concept that encapsulates the meaning participants constructed regarding their voices. It represents an ongoing process in which participants made sense of what they were experiencing from the early stages of voice hearing and which developed as participants learned more about their voices through self-discovery (i.e. reading and engaging with voices) and/or engaging with others.

Most participants said they physically felt and/or saw a presence they associated with their voices in addition to hearing their voices. They associated a visual image, or felt presence, with previous trauma and said this image could move around the room, closer and further away from participants. A case in point is Ian, who was sexually abused during his childhood by a local vicar. As an adult, Ian began to hear voices later in life, one of which was always accompanied by a clear image of a reverend, dressed in a long black cloak and hood. This particular voice would follow Ian and appeared in different locations, as he describes below:

> “when I've been driving the van I seen him in the passenger seat. I see him sometimes when I'm sat on the couch [at home]. He can be the other side of the room. If I'm down the farm he could be in the…on the field”. (Ian)

Other participants said they experienced different types of visual images related to their voices. For example, Olivia said she mostly only heard her voices but, when a visual image accompanied them, she became more anxious as she associated this with her being unable to contain them in her head and the voices becoming more powerful. Alan said he did not see a visual image of his dominant voice but he still sensed a physical presence and located his voice as being on the other side of a wall of any room he entered. Whereas Alan’s dominant voice was consistent in terms of its location (behind a wall) and out of direct sight, for other participants such as Diane images of voices moved around and closer or further away.

Participants were at various stages of making sense of their voices, which changed over time, and most had somehow learned to tolerate their voices. People described the sense they made of their voice hearing changed over time. Kevin had heard his voices for a relatively shorter time (under 2 years) compared to other participants and had yet to make sense of who or what his voices were or why he heard voices. As such, he had yet to examine voice hearing in general and, more specifically, had yet to find an effective way of relating with his own voices. It was difficult for Kevin to differentiate between himself and his voices:

> “so like the voices, sometimes it’s one person and they’ll say “it’s only me”. But then I get other voices saying “no, it’s me as well”. So like one voice says it’s only me and then another voice will come in and say, no, there’s loads, like there’s multiple people in my head, like well multiple voices. So I don’t know if it’s one person trying other voices on…[and later]…so sometimes I don’t know if it’s my fault or my voices putting ideas into my head…I don’t know if it’s my decision or my voices saying go and do this”. (Kevin)

Interestingly, some participants were similar to Kevin in terms of still trying to make sense of their voices but also different to him in that they attributed their voices to something external to themselves. For example, Liam did not know why he heard voices and Glenda perceived her voice as an alien, completely separate to herself. By contrast, Mike had heard voices for longer (8 years) and, in this time, had said he had changed his understanding of his voices through actively learning about them. As such, he had constructed his voices as being a guide to help appreciate a better perspective of life and learn how to “deal with things”. Similarly, Frank said he had also benefited from investing his time into understanding both his own childhood trauma and how this linked to his voice hearing. Consequently, he made sense of his voices as being linked to his own personal traumatic childhood and saw them:

> “…as different parts of myself, like split off parts of my personality, basically whenever I’ve had a tragedy in my life, my personality has split off at that point and it’s become a voice…[and later]….the five year old told me that it was a child and I worked out myself it was, because of the way it acted, it was the same way as I used to act when I was that age and that’s, sort of, gave me the indication that the rest of them were part of my personality as well”. (Frank)

Other participants were also able to identify their voices as being part of themselves. For example, Bella concluded that her voice represented paranoid and critical parts of herself. Similarly, Noel associated with his early teen self when he was quiet and had “shut down from the world". Identifying voices as being part of oneself was an important part of being able to accept voice hearing, accept oneself and relate more positively with voices. In so doing, most participants linked their voice hearing to early trauma of some sort. Some participants, such as Hillary, said she related her voices to early childhood trauma and believed that the nature of this trauma meant that she would always hear negative and distressing voices. However, Frank approached his voice hearing differently. For him, identifying his voices as being part of himself and understanding links between his voices and his childhood traumas were perceived by him as important in terms of how he subsequently learned to relate with himself and his voices:

> "It showed me first of all that I was worth loving, which meant that the voices must be worth loving too, because they were part of me. So I, sort of, started to try and see them in a different way and try and give them love. Especially the five year old, I mean, the 10 year old, seven year old and the 14 year old are not really interested, you know, but the five year old really craves it. So, yeah, it helped a lot". (Frank)

The Making sense of voices theoretical code encapsulates different ways in which participants described their understanding of their voices. The sense participants made of their voices at the beginning of their voice hearing changed as time progressed. The content of voices, and how participants interpreted this content, also influenced participants' understanding. I discuss voice content in the next theoretical code.

6.3.2 Personal bully

One of the participants, Noel, described one of his voices as being his "own little personal bully". All participants reported hearing critical and abusive voices and to have experienced hostile relationships with their voices. This involved participants feeling persecuted by their voices, hearing their voices swear at them and call them names, shout at them and insult them, instructing them to kill themselves, and hearing their voices say that they wouldn't ever go away. Participants also reported that they heard their voices taunt them and tell them they deserved their previous abuse. 'Personal bully' captures the often-incessant content of voices. For example, Ian heard a dominant voice that was particularly violent and abusive, which taunted him about his previous abuse:

> "[Dominant voice] was laughing. I can remember it clearly. Yeah, [he] was laughing. He thought it was very funny and he was showing me the abuse, and

> that. And he showed me the night before, the abuse, and that's the times when I was scared and distressed and acted on it and he said that I…you know, I should just kill myself, I shouldn't be here, and stuff like that". (Ian)

Participants also reported that their voices discouraged them from seeking help. For example, Kevin said that his voices called him a fool for wanting to help himself and Noel said that his voices hated him going to therapy and receiving help. Voices of some participants such as Clare became louder and more distressing whenever she tried to be kind to herself and Edith's voices similarly did not like her attending her appointments with practitioners. This could be particularly challenging for participants at times of distress and could potentially give the appearance to practitioners seeking to provide support that the participant is trying to avoid help.

All participants said they found it could be particularly challenging during their interactions with practitioners and other people. Voices could constantly 'chat away' while participants tried to engage in conversations with people. Some participants heard their voices contradict everything they said during an interaction with other people. For example, Noel heard his voices tell him during interactions with other people that he was stupid and that people did not believe him. Participants hearing voice content such as this may find it particularly problematic to engage in treatment interactions with practitioners. Hillary said she believed that practitioners had little respect for her, which was compounded by her belief that her voices also had no respect for her. This contributed towards a difficult dynamic in which she felt little self-worth both intra-personally with her voices and inter-personally with practitioners. One of the consequences of constantly hearing a voice as a personal bully during interactions with practitioners is that it can contribute towards participants becoming suspicious of practitioners' intentions. A case in point is Bella, who reported her voices:

> "…could, like, say negative things. Like, they were often undermining things, you know, the fact that I was stupid, or something. Or make some, you know, kind of comment, like, which would create fear, you know, like I was going to be sectioned, or something like that". (Bella)

These first two theoretical codes represent a longer term, background context experienced by participants. All participants began hearing voices before their first admission into mental health services and continued to hear them following their first prescription of treatment. Over time, participants constructed, and continued to construct, their perceptions of voices. All participants subsequently received ongoing treatment from mental health services and the sense they made of their voices and the way in which they felt persecuted by their voices was evolving before, during and after taking part in treatment interactions with practitioners. Their interactions with practitioners can be very difficult for voice hearers due to the disruptive nature and persecutory content of voices.

The following four theoretical codes are situated within the context of a treatment interaction.

6.3.3 Biomedical treatment: limited involvement or fearing enforcement

A common finding was the overwhelming experience of both enforced and involuntary treatment and a biomedical approach to understanding and treating voice hearing. This theoretical code encapsulates the use of medication as the predominant, and often only, treatment option for people distressed by their voices, and their perceptions that they have little choice but to accept this treatment.

Most participants reflected on their perceptions of an overarching force of mental health services and treatment, wherein treatment predominantly consists of medication and often administered involuntary or enforced. Bella described her fear of interacting with practitioners because she perceived a consequence of her voice hearing was being diagnosed with schizophrenia, which she then feared would lead to enforced medication. Other participants reported that they had experienced enforced medication and described it as traumatic. However, coercion also included softer approaches. For example, Glenda said she was threatened with detainment under the MHA for refusing to go into hospital voluntary; Hillary also said she was detained under the MHA when she attempted to leave hospital and, even when out of hospital, felt pressured to comply with medication for fear of being recalled back into hospital.

Medication was the dominant treatment experienced for voice hearing by participants, who said they accepted it because they feared their refusal would lead to it being enforced by practitioners. An example of this is provided in the quotation below from Hillary in her description of her previous experience of being forcibly medicated during a hospital admission related to her voice hearing:

> "As I tried to leave, I said this isn't for me, thought I was rational, gave my explanation. They said, your mum's gone, I said, it's alright, I'll get a taxi. They injected me with Acuphase. I didn't know it was Acuphase, until much later on, which knocked me out for 12 hours". (Hillary)

All participants had been prescribed medication for their voice hearing and associated difficulties. Participants had learned to accept oral medication in order to avoid involuntary or enforced treatment. For example, Mike reflected that he had learned that if he was not given a choice about treatment then he would follow practitioners' advice in order to avoid his fear of treatment being enforced.

Extending the discussion regarding softer forms of coercion, participants reported that practitioners were persuasive when encouraging them to accept medication. For example, Mike recalled that practitioners were 'pushing' medication on him straight away, participants such as Liam were advised and strongly encouraged by psychiatrists that medication was needed to treat his voice hearing. In capturing many participants' experiences, Frank summed this up as "the only thing practitioners are good at is giving me medication". The underlying pressure for participants to accept medication is captured in the following quotation from Kevin as he recalled a time when, distressed by his voices, he was visited by practitioners:

> "Practitioners were literally sat there for like 10 – 20 minutes looking at me, saying 'take the drugs'. And I was like no, and it got to the point where I was just sat there not saying a word and these two doctors were sat on the sofa just looking at me saying, 'take them'. And it got to the point where no one was speaking. They were just sat there staring at me". (Kevin)

Interestingly, participants developed a complex relationship with medication wherein, even though for many it was the only real treatment option and administered through increasing pressure by practitioners, they also perceived it to have some benefit, even if only limited. Frank described his medication as a 'chemical cosh' but he also said he valued the impact of it in terms of dampening down his emotions. Other participants, such as Liam and Kevin, similarly described their emotions being blunted as a result of the medication, which helped in terms of them feeling less affected by voices. Medication was also reported to have been helpful in terms of lifting mood for Ian and Diane, helpful in terms of feeling less stressed for Edith, and helpful for sleeping for Hillary and Bella.

However, although it is evident that medication was of some benefit to participants, this was limited and did not stop or sufficiently change participants' voices. Hillary was reflective in her assessment of the limitation of medication when she stated that she had "realised that all this medication was actually not stopping the issues that I had". Although other participants were less reflective of any underlying issues, they were nonetheless clear that they were still left with their voices despite trying a range of different types of medication. A case in point is Ian, who had also previously acknowledged that medication had helped to lift his mood to some extent, but was clear that it had little if any effect on his voices. Below is an excerpt from the interview with Ian:

> Interviewer: And what do the meds do for voices then?
> Ian: I can honestly say that they didn't do nothing for me, they didn't do nothing. No, they didn't stop the voices. They didn't help in…
> Interviewer: Did they change the voices?
> Ian: No.

Some participants also reported that they felt worse because of taking medication. Despite the benefits, participants such as Alan had previously asked to come off medication because he did not like the way it made him feel, it could also make some participants gain weight, in Bella's case this amounted to three stone in weight. Other participants didn't like the drowsiness effect of medication: it made Ian slur his words, and Olivia reported that she could hardly stand up or speak due to the high dose she had been prescribed. A further complication for some participants was that their voices rejected medication. A case in point is Edith, who reported how difficult it was because she had to overcome her voices in order to take her medication:

> "Getting my tablets down is quite a struggle, because one of my voices doesn't like me having the tablets. But I have kind of concealed tablets in hospital before, but I can do the tablets okay now. But that, again, is like a power struggle within". (Edith)

Consequently, because of the side effects of medication and the limited impact of it on voices, some participants expressed their wish to come off it. Participants reported either that they no longer believed they needed to use medication or they wanted to reduce their dosage of it. However, they also said that support by practitioners to help them reduce or come off medication was lacking. This led to participants such as Liam just stopping his medication overnight, only to find that shortly afterward he needed to go back on it. In another example, Olivia also tried to and struggled to come off medication and spoke to her psychiatrist about it, which resulted in her being prescribed back on it again.

An important factor underlying the use of medication is the extent to which participants perceived they were involved in treatment decisions. The primary data indicates that participants perceived that practitioners had involved them in treatment decisions to some extent. However, similar to the complexity related to using medication, the level of involvement in treatment decisions is also mixed. Some participants reported they had been involved but later would indicate that their involvement was actually quite limited, depending on whether or not they agreed to accept medication. Olivia captured this point when she described her limited choice regarding medication.

> "I don't really get a choice, no, they just say, oh, this and this, I can choose if I want lemon or tutti-frutti in the calcium tablets". (Olivia)

It is, therefore, questionable regarding how involved participants were in decisions about their treatment. Liam reported that he had been involved in treatment decisions and that practitioners had asked him about the right dosage of medication. However, he also later recalled that he was taking medication because his doctors had told him that he needed to; he also did not know what his treatment plan was. In other words, Liam perceived that he was involved in decisions made about his own treatment, but this was limited to involving him in discussions about *accepting* medication. As such, and similarly regarding other participants, it is questionable regarding how much genuine control or influence participants have over their treatment. The extent to which participants were involved in their treatment could also affect how engaged they were in treatment. For example, Clare said she became so frustrated with her lack of involvement in treatment decisions that she disengaged from services only to find further restrictions placed on her. She reported:

> "I have been in services a long time. Yes, that would be to do with being told what I can and cannot do, I should imagine, it's pushed all the wrong buttons, and so I've gone AWOL from hospitals, and all sorts of stuff. Harmed myself in hospital, or whatever, I've ended up going in section, after section, after section. Free will, I suppose, it's freedom, free will, being free". (Clare)

This theoretical code represents the long-arm reach of mental health services, which involves predominately medication as treatment for voice hearing, administered through practitioners and involving vary degrees of coercion. It is within this treatment context that the next three theoretical codes are situated.

6.3.4 Agency

Agency represents the power and influence participants perceived they had in relation to their voices and treatment. According to Hillary, "voice hearing is about power and control". Overwhelmingly, participants referred to power in their experiences of voice hearing. Mostly, participants perceived they had relatively little agency in their relationships with their voices. Most felt overpowered and overwhelmed by their voices, if not at the time of interview then certainly during earlier stages of voice hearing. Some participants, for example Alan, Ian, Edith and Mike also reported about power struggles between different voices and that some of their voices were dominant and some could be more neutral or friendly. Interestingly, some voices also attempted to be protective of participants and stand against dominant abusive voices. Ian differs from others in this respect as he witnessed and experienced a particularly violent relationship between his voices, as he described below:

> "I only had [male voice] for probably a month or two and then [dominant voice] hurt him and showed me like images of him dead". (Ian)

Ian recalled that after his dominant voice killed one of his other voices, the dominant voice would then show him images of the dead voice.

> "Around his belt…around his waist he'd got a belt with hooks on and he had (dead voice's] head on a hook and he used to show me that all the time". (Ian)

Ian reflected that this was done by his dominant voice in order to show Ian that the voice power.

> "Power to make me scared so that I would listen to him". (Ian)

This type of hostility led to difficult relationships for participants with their voices, in which they perceived their voices constantly attempted to be in control. A case in point is Edith, who described her daily struggle with her voices, below:

> "It's when you have that strength to be strong with them. Sometimes you feel like you can be the strongest person in the world and you can fight them, and you have that strength. Usually during the day when it's light and it's okay, and there's people around, you can cope, you can do it. But in the night when it's dark and you're on your own, and all you've got is them, that's that power struggle…they win". (Edith)

Constant battles such as this led to reciprocal retaliation between participants and their voices, which escalated to the point where voices became increasingly hostile and abusive towards participants. Participants mostly lacked agency and reflected on their inability to stop their voices from being interruptive, hostile, abusive and critical. Participants said they found this threatening and sometimes they acted on what their voices told them or they even harmed themselves, through behaviours such as cutting, due to the increased distress related to the voices. Edith illustrates this in the following quotation:

> "They have always had a hold on me…the things that they've made me do…they would go at me and go at me…to the point where I couldn't take it anymore. And then it would be too much. And then something would happen…it was that kind of power that they would have". (Edith)

Some participants hurt themselves in order to feel relief from the distress caused by their voices. The intensity of hearing distressing voices built up and became increasingly difficult to ignore and eventually participants self-harmed in order to bring about some relief. An example of this is with Edith, who reported that she hurt herself in order to make her voices go away:

> "It was very much kind of a double thing with the hurting myself, because I would hurt myself to do as they said, but also when I hurt myself, they would go away because they got what they wanted. So it would yeah. It would just be so much easier to hurt myself and have that peace". (Edith)

Other participants similarly engaged in self-harming behaviours because of their distress from voice hearing but used slightly different methods. For example, Glenda planned dates in the future where she planned to kill herself, which provided her with an end-point to her distress, or Ian would cut himself in order to feel a release of pressure, which involved seeing his blood. Olivia engaged in a slightly different and more graded approach by engaging in obsessive-compulsive behaviours such as counting things and, when the pressure from the voices escalated, she then harmed herself.

Most participants had attempted to empower themselves through engaging in behaviours or activities in order to directly or indirectly help manage difficulties in relation to their voices. Different participants were involved in different things. For example, Kevin volunteered at a local RSPCA and wanted to help other people, Bella found that playing a musical instrument helped to intercept her voices. She also had a lot of experience of working and found employment a helpful way of shifting her focus away from her voices, as did Glenda and Jenny. Hillary also maintained employment for similar reasons but, additionally, she found it was important to have developed a relationship with her voices. Frank also found it helpful to have developed a relationship with his voices, for which he found meditation a useful strategy to help him understand himself and his voices. Similarly, Mike had also researched about his voices. Clare practiced yoga and said she made conscious efforts to stop hanging on to what her voices said and Diane began attending a Hearing Voices Group in order to reach out and ask for help. Ian engaged in a different approach and, through the support of his therapist, confronted his traumatic past by contacting the police and the church. None of these activities were completely successful *per se* but the action of doing various activities helped improve participants' experiences of voice hearing.

Another method of empowering oneself involved disclosure of voices. Upon first hearing voices, participants kept them private and concealed from other people. Although all participants at some point had disclosed their voices to practitioners and other people, only two specifically mentioned the benefit from their disclosure. The following quote from Diane illustrates the power voices hold over participants and the empowering effect of disclosing them:

> "After you've been abused, you spend your life trying to be normal anyway, and you feel contagious. But [voices] latched onto that kind of thing because it was a secret, they could do all that in my head". (Diane)

[And…]

> > "When they're [voices] a secret in your head, they have a lot more power, you know, like I would hurt myself. I would just sit all day until my son came in from school, because I wouldn't let them win when it came to my

> son, because he's only eight. But the…but they just used to…I just sat there, it was just telling us how…the reasons things happened to us, because I deserved it". (Diane)

[And…]

> "So then because I was saying to the voices I'm not keeping any more secrets, this is the beginning, you start torturing us again and I'm going to speak up about it, it seemed for a little while anyway they backed off, and it wasn't constant you're useless, you know, go kill yourself, go and do this, and I got out a bit, you know? Out to meet friends in XXX and that, and going for a coffee, whereas before when I was just stuck there, I couldn't…the voices were too powerful, I couldn't answer the phone never mind meet someone for a cup of coffee". (Diane)

Like other participants, Diane was ashamed of hearing voices and her voices would taunt her about her childhood abuse, for which she felt ashamed and had spent years trying to keep a secret. Her disclosure helped her begin to address the power dynamic in her relationship with her voices.

Interestingly, participants said their voices did not like being ignored. The extent to which participants were able to acknowledge their voices was influenced by how much agency they had over their voices. For example, Alan found that his voices did not like being ignored but he had not addressed this with his voices and so he continued to lack any influence regarding the level of interruption from them. Other participants, such as Diane, Edith and Hillary had identified that ignoring their voices simply made them stronger, louder and angry and all three had made some progress in terms of making sure they spent time listening to their voices. Similarly, Glenda also tried giving her voices time but she found this had only limited effectiveness because her voices continued to "witter on". Interestingly, however, Noel achieved some success in following his therapist's advice to stop ignoring his voices and gave them time each day. It is notable that he had also acquired more agency over his voices. An exceptional example is Frank, who extended even further the notion of allocating time to focus on voices. In a fascinating account, Frank said he had constructed a garden in his mind where he would take his voices in order to help calm them down. By constructing this process of engaging with his voices, Frank had acquired a degree of agency and the ability to assert some control over his voices:

> "When I want to talk to my voices, I go to the garden myself and I talk to my voices in the garden and I found that I have a much better conversation with them there, because they're not out and seeing everything and being scared and they're in this nice relaxing place with a nice pool and trees and tree house and all sorts of nice things there, nice little stream". (Frank)

Other methods of empowering oneself included grounding techniques. For example, Clare reported that she found it helpful to, literally, ground herself to the pavement or to connect with people in order to 'check out' what was real and what was not. Jenny also used mindfulness techniques but also found writing poetry helped. Other participants found it helpful to set limits with their voices in terms of when they planned to respond to their voices. Although this could be difficult for participants to learn, it also became a useful method for some participants. Hillary found that, not only did setting limits help her to manage her voices more effectively, but this also helpfully impacted on other areas of her life:

> "And I try to say, you want me to do these things, but that's not what I want, and I have to be quite firm, and I have to set boundaries for myself. Not just with them, but in my life, I've found that I've had to do that. I've had to change my whole life, because of them". (Hillary)

Engaging in these activities required participants to take responsibility in terms of the part they played in addressing the distress caused by their voice hearing. For Clare this involved her commitment to stop using alcohol and cannabis and live a cleaner life to help her manage her voices. For Frank this involved accepting his responsibility for his actions following an incident when his voices had commanded him to assault a stranger and he learned how to manage future similar commands from his voices. Jenny captures the role of taking responsibility in the following excerpt:

> "Nobody else can hear these, these are mine. These are mine and I'm ready to own them. And I think that's the difference from that when I want to get rid of them, now I will take ownership and say, right, this is my issue". (Jenny)

[and later]

> Jenny: And I work differently. From that different perspective, that means, okay, they're my voices, therefore it's up to me to find out what's going on for me, because nobody else knows what's going on for me, do they?

> Interviewer: That ownership of your voices is a key thing.
>
> Jenny: I think so, yeah. Yes, but also knowing that there isn't anybody else speaks to me, this is brain…me, I've created them for some reason, my brain has created voices.
>
> Interviewer: So how do you actually get to own your own voices then?
>
> Jenny: By owning your emotions I think is the answer and realising that nobody else can get inside your brain and mess in there, you know, nobody's got the right to do that, apart from anything else.

This theoretical code encapsulates the concept of agency in terms of treatment and within a complex relationship between participants and voices and also between participants' different voices. It includes participants' general lack of agency but also their actions taken directly in relation to their voices, such as setting limits with voices, and also indirectly, such as engaging in activities that help empower participants in other areas of their life.

6.3.5 Relating

This theoretical code represents the concept of relating, both in terms of how voice hearers relate with their voices and with practitioners.

Participants said they found it difficult to talk about voices and related problems with other people. For example, Alan said he eventually stopped going to therapy to avoid talking about his voices. Bella found it difficult to talk about her past abuse. She was fearful that other people would not believe her past abuse and, instead, practitioners would interpret her experiences as 'delusional'. It was slightly different for Edith, who usually avoided talking about her voices because of the backlash from her voices afterwards. A significant factor in helping participants talk about their voices was their concern about whether or not other people would believe them. A case in point is Ian, who concealed his childhood abuse for many years for fear of not being believed. The significance for Ian of being able to find the courage to speak out and for others to believe him is illustrated in his quote below:

> "I couldn't even tell my mum and dad because I was scared of not being believed because, you know, somebody in the church, you know, he was like in a good with standing in the community, and that. So, I was just scared of not being believed". (Ian)

[And later]

> “Oh, a big weight off my shoulders, and that, to be believed, and that, and that's how I started to progress and become more positive”. (Ian)

Additionally, almost all participants reported their voices to be mood-related. Generally, the more stressed participants had felt, the worse their voices became. Given this emotional link and the difficulty of talking about voices, unsurprisingly participants reported the importance and value of feeling accepted and supported regarding their voice hearing. This almost exclusively derived from socialising with other people experiencing similar problems and several participants, such as Liam, Diane and Edith highlighted Hearing Voices Groups as especially supportive and helpful. Friends, family and peers were significant sources of support for participants.

However, there were also examples from most participants of feeling supported and valued by practitioners, if not consistently then at least at some point during their experiences in mental health services. This can be divided into two groups. In the first group, participants reported general interactions in which practitioners were supportive. For example, Kevin reflected on a practitioner from an inpatient unit who would talk with him about general issues. Liam valued practitioners who were caring towards him. Similarly, it was helpful for Noel to know that practitioners cared for him. Both Frank and Clare valued an approach in which a practitioner would facilitate them to problem solve. Interestingly, Bella valued practitioners who had listened to her and did not medicalise her. Olivia and Hillary both reflected on the value of feeling contained by practitioners at times of distress. Hillary extended this further by also recalling an important incident for her in which she was distressed and curled up into a ball on an inpatient unit and a practitioner not only helped her to contain her distress but also treated her with humanity:

> “She got, came down and sat on the floor with me. So she came down to the level I was at, and talked to me until I felt able that I could uncurl myself, and sit back in a chair. She didn’t threaten me, she didn’t tell me to stop being stupid. She realised I was in distress, and that was my safety, my position of safety, because of the battering I was taking from the voices, I just wanted to curl up in a ball, because I didn’t want to be there. I didn’t want to be alive, but I didn’t want to end it, so the safety position was to curl up in a ball. And she came down and sat on the floor, and talked to me like a human being. And gave me that time, until I could

> uncurl myself, and with her help, get sat back on the bed. And I realised, then, that she probably did actually care". (Hillary)

These examples of practitioner support were important for participants. However, this level of practitioner support is extended in the second group, which includes examples of practitioners focusing more directly on voice hearing. In addition to the above quotation, Hillary also experienced a particular practitioner who reassured her to accept that she heard voices and helped her to manage her voice hearing when in public situations. Extending this further, Jenny, Mike and Ian had engaged in therapy in which they specifically focused on their voice hearing. An example from Ian captures this, below:

> "From the start of the therapy things just started to get a little bit better with me understanding the voices, how they're associated, and how I control them now". (Ian)

Interestingly, all four of the participants in this second group (Jenny, Mike, Ian and Hillary) had developed relatively higher levels of agency, both in their relationships with their voices and with other people. They achieved this through the way they had developed their way of relating with their voices and managing voice-related distress and/or how they had successfully engaged in employment and managed relationships with other people.

In terms of feeling supported by practitioners, participants also spoke about the importance of trust, particularly the difficulty of being able to trust people. Edith, for example, said her childhood abuse left her unable to trust people, which was 'fed' by her voices. Participants recalled examples of trusting friends, work colleagues and practitioners, but acknowledged that it took time to be able to trust people. Interestingly, Glenda said she found that having a limited number of therapy sessions imposed on her made it difficult to trust and open up to practitioners within that time frame.

Issues of trust and feeling supported are relevant for participants during treatment interactions with practitioners. There is a degree of complexity, however, when also taking into consideration the intra-personal context between participants and their voices. Mostly, participants found it difficult to relate with their voices and described difficult relationships with their voices; for some, such as Ian, this had improved over time. However, others such as Kevin found it difficult to trust their voices and felt threatened by them. Olivia was terrified of her voices and recognised that she was unable to act like an adult with her voices and, instead, regressed into child mode. Interestingly, Clare had heard from other voice hearers about the value of relating more positively with her voices in order to improve the relationship but she struggled with this:

> "It was once mentioned that if I give them some love and attention, caring changes the whole relationship with them, it might help. It's just something I can't do with them. And, with some of the voices being so close, they're actually with me most of the time, I don't know how to love them, or give them that care and attention that they probably need". (Clare)

Given the difficulty of relating with voices, some participants also described their attempts to distance themselves from their voices. For example, Noel said he put his energy into blocking his voices out and Alan said he believed that the less he had to do with his voices the better. This also made it difficult for Alan to understand why practitioners might want to talk about voices. Bella employed a different approach. She consciously set out to develop an emotionally distant relationship with her voices, which she termed as 'minimal relating', which she describes below:

> "I'd worked on not having a relationship with them. I know that sounds a kind of statement that, it's almost like a kind of, well, you know, to not have a relationship with something that you hear, is quite a complicated thing. But what I mean by that is that, I choose to kind of have distance from it, and before it says something, just either in my head, question it, or dismiss it. Not kind of have any emotional connection with it". (Bella)

Bella had an interesting strategy, although this was not helpful for all participants. As reported earlier in the 'Agency' theoretical code, participants said their voices wanted to be acknowledged. As such, participants found that ignoring their voices made them worse. Here, however, Bella employed a strategy in which she had developed distance and an emotional 'disconnection' from her voices. By contrast, Jenny said that the more she tried to push her voices away, the more they would push back at her. During her earlier years of voice hearing, she recalled the difficulty of relating with her voices:

> "They would go at me, they were horrible to me, and I didn't want them anymore. And I would try not to engage with them, because I just think that would have

> encouraged them. I don't know if I'm right or wrong, I don't know because I've never tried it, I didn't want to". (Jenny)

In addition to the potential challenges during treatment interactions in terms of the inter- and intra-personal dynamics discussed above, most participants also reported their attempts at concealing their voices. Participants feared the consequences of disclosing their voices. They were fearful of receiving a diagnosis of schizophrenia and of receiving threats from their voices. Indeed, some participants had spent significant amounts of time in receipt of treatment and had successfully managed to conceal their voice hearing from practitioners. A case in point is Diane, who spent one year in a therapeutic community and successfully concealed her voices from peers and practitioners.

In terms of relating with voices, some participants reported that focusing on something such as work or engaging in conversation could be a useful distraction from their voices. Some participants, however, wanted to get rid of their voices. Liam, Noel, Bella, Diane and Glenda all reported that they would like to get rid of their voices, or at least dominant abusive voices. Interestingly, this aligns with previous discussion about the experiences these particular participants had regarding voice hearing in terms of the nature of the voice content and their distancing from their voices.

Given the above findings, it would be easy to assume that all voice hearing was negative and distressing for participants. However, in contrast to the above discussion regarding the difficulty of relating with voices, participants also provided examples of relating more positively with some of their voices. This contributes to a complex presentation wherein participants experienced distress from some voices, with which they had difficult relationships, but also experienced relatively positive relationships with other voices. As such, voice hearing is not problematic *per se*; instead, how participants relate with their voices determines how problematic (if at all) they experience their voice hearing. For example, Kevin reported that sometimes it was nice to have his voices when he was sat on his own doing nothing. Similarly, Diane reported that she would be lonely without her voices. Ian, Mike, Liam and Noel all had a good relationship with some of their voices. Interestingly, Noel said his positive voice encouraged him to go to therapy and, similarly, Mike said his voices were like a teacher or guide to him.

It was different for Jenny, Frank and Hillary. All three had previously had difficult relationships with their voices until they made a decision to change how they related with their voices in order to get on with their lives. For Jenny, she learned that her voices had served a function in supressing her emotions, which allowed her to get on and function in life to some extent. Hillary summarises the purpose of relating positively with voices for all three of them when she stated:

> "You can only do that for so long, I think. I tried to keep the voices at a distance, I tried to ignore, but they have an impact on all of your life. So if you're gonna try and get on with your life…I always remember saying to one doctor, I just want my life back. Maybe not to how it was, but I needed some sort of life. And if that means that I try to have a relationship with my voices, then so be it". (Hillary)

Finally, the way in which participants related with their voices was mirrored, to some extent, in the way they related with other people. For example, Noel barricaded himself in his room at home whenever his dominant voice became particularly hostile. In so doing, he tried to hide away from his voice and from other people. Clare reported that she had ran away from difficult situations all her life, mirroring her urge to run away from her voices and keep distant from the distress. By contrast, Frank reflected that after he had begun a stable relationship with his now wife, his voices suggested he cook her meals and buy her flowers, mirroring his actions of looking after his voices and looking after his wife. In the final example, Bella reflected on her way of relating with her voices and with people:

> "And I would say that my own kind of anxious avoidant pattern of relating, is manifested in the way that I've learned to relate to the voices". (Bella)

This theoretical code represents the complex intra- and inter-personal dynamics involved in participants' relating with their voices and practitioners. It is evident that the intra-personal experience with voices, which is often distressing and controlling, can impact on the inter-personal interaction with practitioners, and vice-versa.

6.3.6 Practitioners' actions

This final theoretical code represents participants' perceptions of practitioners' involvement in relation to their treatment for voice hearing. Practitioners' actions are significant in terms of the affect they can have on experiences of voice hearing. Whilst there are examples in the 'Relating' theoretical code, which refer to participants' experiences of being valued and supported by practitioners, mostly participants perceive practitioners fail to demonstrate sufficient understanding of their difficulties, generally, and voice hearing specifically.

For example, Mike said he believed that practitioners focussed on monitoring him in terms of risk rather than attempting to understand his difficulties. Diane felt unable to talk to practitioners and, similarly, Clare reported that practitioners did not genuinely listen to her about her experiences. Participants also said they believed that practitioners held negative attitudes. A case in point is Edith, who reported that practitioners failed to engage with her during her inpatient treatment, as illustrated in her quotes below:

> "And then you just get people in kind of the secure hospital and stuff and PICU, and just some of their attitudes, they're just like that they don't want to help, that they're just there for the money and just weren't very engaging, and just kind of sat there and didn't do things". (Edith)

[And later…]

> "But some of the healthcare assistants would just sit there and chat to each other, and wouldn't do anything with you. So you could see their attitudes and stuff. And when you're just sat there all day with nothing to do but sit and listen to your voices, it's not very helpful". (Edith)

[And later…]

> "All we did all day was just sit and watch the telly. And that's why you'd end up trying to find ways to hurt yourself, just to get that peace. And it's not easy to hurt yourself on a secure unit. But that's what you did because all you wanted to do was get that peace in your head, so you would try and hurt yourself because that's just…it was very, very –.what's the word – intense, very intense". (Edith)

Frank and Jenny both reflected that practitioners lacked sufficient understanding of their difficulties, specifically voice hearing and, consequently, struggled to offer meaningful support. Extending this further, both Bella and Glenda perceived practitioners had effectively written them off and lacked genuine hope for their recovery. Bella reported that she was told by practitioners to lower her expectations of life, Glenda perceived that practitioners had encouraged her to give up her employment due to stress when in fact she believed that her stress derived from her voices rather than employment. Hillary captures the perceptions of most participants in her quote below when she refers to practitioners' lack of appreciation of the impact of voices on a voice hearer.

> "And the staff, when I came back, their attitude was like, oh she's back, what's she gonna be up to. It wasn't because I was up to anything, didn't they realise the power of the voice, which I've always said, it's much more than people release. And they couldn't understand that, they were just like, they treated me with contempt". (Hillary)

In addition to participants' reports regarding practitioners' lack of meaningful engagement, practitioners failed to talk with participants in any meaningful way about their voices. For example, Kevin said he was surprised by the lack of discussion that took place during his inpatient treatment. Liam, Alan, Edith, Frank, Noel, Jenny, and Olivia all similarly reflected on their lack of discussion with practitioners about their voice hearing, which if anything only included simply checking if voices were better or worse. Diane provide a more concerning example, wherein she perceived that practitioners invalidated her voice hearing. Diane also reflected that practitioners simply did not feel comfortable talking about voices and, instead, would signpost her to a Hearing Voices Group. The following excerpt from the interview with Diane, below, captures the essence of other participants' experiences of a lack of meaningful discussion with practitioners about voice hearing:

> Diane: Because it makes people uncomfortable and practitioners, it makes them uncomfortable as well.
> Interviewer: What makes them uncomfortable?
> Diane: Hearing voices, and obviously not you because this is what you're studying but because they don't know…
> Interviewer: So you think practitioners find it uncomfortable when talking about voices? What do you think it is then that makes them uncomfortable?
> Diane: Because they can't just give you a pill.

Finally, participants reported that practitioners interpreted their voice hearing according to a medical diagnosis of some sort and being a symptom of a mental disorder. Participants such as Liam, Jenny, Mike and Oliva, for example, reported that their voice hearing had been framed within a diagnosis of schizophrenia. Bella feared this diagnosis, which had contributed to her concealing her voices for a long time. She said she inadvertently discovered that a doctor had diagnosed her as schizophrenic after he momentarily left the room and left Bella's medical notes open. Similarly, Mike reported that a practitioner slipped in his diagnosis during a conversation, as illustrated in his following quote:

> "Well when they told me the diagnosis they did it like the guy said it like so slyly, like he just like slipped it in there, just like, oh like, he was the first few, like one, maybe like the third sentence or something. He was like, do you know you're paranoid schizophrenic? And I was like, I just went, yeah, I do, but like I was a bit, yeah". (Mike)

Both Jenny and Olivia were given more than one diagnosis, schizophrenia and Borderline Personality Disorder. Furthermore, practitioners' suggested coping strategies such as walking or taking hot baths, which she found unhelpful and insensitive. Extending this further, Glenda did not appreciate practitioners trying to fit her voices and related difficulties into professional frameworks such as CBT or recovery models.

This theoretical code encapsulates participants' perceptions regarding a general lack of practitioners' meaningful engagement and, more specifically, a lack of meaningful discussion about voice hearing. Furthermore, when trying to make sense of participants' voice hearing, practitioners reframe voice hearing according to various professional frameworks, such as medical diagnoses and/or psychological theory such as CBT. As such, voice hearing is situated in the broader 'Biomedical treatment' theoretical code in terms of practitioners failing to talk about voices and also relying on medication as a way in which to respond, and treat, voice hearing.

Summary narrative of theoretical codes

Table 6.2 provides a summary narrative against each theoretical code for each participant. It illustrates that participants can be classified according to how they relate with their voices, their level of distress associated with voices, and their perceived level of agency. For example, six participants (Frank, Hillary, Ian, Jenny, Mike, and Noel) generally have comparatively more positive relationships with their voices, more perceived agency with their voices and treatment, are comparatively less distressed by their voices and value their voices to some extent. By contrast, nine participants (Alan, Bella, Clare, Diane, Edith, Glenda, Kevin, Liam, and Olivia) relate negatively with their voices, have a lack of agency with their voices and treatment, are comparatively more distressed from hostile and critical voices, and want to get rid of their voices.

Table 6. 2: Summary of narrative account for each participant in relation to theoretical codes

	Agency	**Biomedical treatment: limited involvement or fearing enforcement**	**Making sense of voices**	**Personal bully**	**Practitioners' actions**	**Relating**
Alan	Feels stuck in the middle of voices with no influence over voice hearing. Voice dominant, interrupts, does not like being ignored.	Medication main treatment but doesn't help with voices	Doesn't know where voices come from but thinks they're part of his mind, feels physical presence/position	Voice negative and abusive and responds negatively to practitioners. Makes VH feel depressed and angry.	Lack of connection with practitioners in terms of voice hearing. "We never used to talk about voices".	No engagement with voices, difficult to talk about, wants distraction from them, and very critical of voice. Tries to distance self from them.
Bella	Tries to set boundaries with voices so can get on and do things. Can find voices threatening & overpowering, and tries to avoid being left on own with voices. .	Previous negative experience of medication relies on it for stress rather than voices. Lacked involvement in treatment decisions. Fearful of implications of diagnosis.	Believes voices link to early trauma, feels physical presence. Believes voices are part of self, own fears manifest in them. Tires to dismiss them as just voices.	Voices critical and negative, feels persecuted by them. Can be disruptive especially when practitioners approach. Fearful of voices, afraid to confront them. Voices worse if tired or stressed.	Found therapist helpful but not MH services. Previously 'written off' and felt practitioners lacked hope for her. No practitioners attempted to engage with voices.	Conceals voices, would like rid of them, distances self from them and has similar anxious avoidant pattern of relating with voices and people. Support from trusted friends and therapist but not MH services.
Clare	Engages in activities and changed lifestyle to help cope with voices. But voices often overpowering disruptive and aggressive when with other people	Historically found MH services difficult, being told what to do, has gone AWOL when under MHA. Currently has positive relationship with CPN.	Voices can change and can sometimes be unrecognisable. Links voices to previous trauma. Has learned to accept voices over time.	Voices are nasty and goading, want her to die, do not like her receiving help from others. Worse, when low mood, tired and neglecting self.	Generally, found practitioners have failed to listen and understand her. Current CPN encourages her to apply coping skills.	Improved relationships with practitioners, benefitted from their encouragement. Struggles to relate with voices, tries to conceal them and distance self from them.
Diane	Attends HVG for support, disclosing voices reduced their power. Tries to set limits with voices and mute them but has acted on commands and mostly lacks agency.	Has previously benefitted from medication but generally they are not helpful even though doubled dosage. Lacks involvement in decision-making.	Believes voices are part of self, linked to family members and childhood trauma. Identifies 1 voice as big and powerful, can move position to try to dominate.	Voices are critical, saying deserved past abuse. Nasty when feeling most vulnerable and low in mood. Listens in and tries to interrupt conversations with others.	Has found practitioners to lack understanding, at times uncaring, dismissive of voices, lack of discussion about them. Thinks practitioners rely on medication.	Received support from HVG, encouraged to talk to voices. Reacts to voices, is critical of them, tries to conceal them even when in MH services, but also tries to look after voices.
Edith	Constant battle with voices, worse at night,	Has benefitted from medication but voices	Believes voices are linked to childhood trauma but does	Male voices are destructive, female voice	Practitioners have been unhelpful in MH services,	Does not trust people but support from partner and

	voices go away when she cuts self, which brings peace. No agency with voices, they react negatively to practitioners.	do not like her having it. Voices worse during enforced treatment. Has lacked involvement in treatment decisions.	not know what voices want. Voices can move position and can feel their physical presence.	is deceiving (best friend/ worst enemy) but tell her to do risky things. Do not like her getting help.	bad attitude, also bad experiences in A&E re anaesthetics. Lack of understanding and talking about voices and lack of productive treatment.	HVG, feels understood by HVG. Difficult to talk about voices, is critical of them, would like to push them away.
Frank	Empowered self through meditation and learning about voices. Took responsibility for behaviours and learned to control voices, now has lot of agency over them through negotiation.	High dose of medication, which dampens emotions rather than affect voices. Feels involved in treatment decisions.	Identifies voices as part of self, believes different voices linked to different childhood traumas. Learned to forgive past trauma and love self in order to learn to be calm with voices.	Voices are cautious about other people, comments / predicts people will let him down.	Found practitioners to have been unhelpful, only administer medication, lack of talking about voices. Only 1 CPN has ‘done anything’ helpful.	Current CPN helpful, advises regarding voices. Concealed voices for several years fearing consequences re treatment. Learned to look after voices, created a place in mind where to take and calm voices.
Glenda	Empowers self through working, disclosed voices to colleagues, has strong work ethic. Lacks agency with voices, lacks control and they dominate.	Believes medication for depression caused onset of voices. Now relies on medication, fears voices would be worse without it. Has feared involuntary treatment.	Perceives voices to be alien and not linked to self (emotions or thoughts) and unconnected to previous history. Learned to live with voices.	Feels persecuted by voices, commanding her to kill self. Voices can be disruptive in social situations. Knocks her self-esteem.	Receives general coping advice but not specifically about voices and with little hope about voices. Has found practitioners to generally lack understanding, lack hope and MH services as uncaring.	Supportive colleagues but not good relationship with voices, never accepted voices, wants rid of them. Largely conceals voices. Tries to be busy to distract self from voices.
Hillary	Strong work ethic, employed, helps ‘tune out’ of voices. “Voice hearing is about power”, found speaking back to voices gave her some power back. Sets limits and gives time to voices.	Has benefitted from medication but it does not change voices. Has had enforced treatment, which makes voices worse. Currently more involved in treatment decisions.	Believed voices linked back to childhood trauma, recognises physical presence and position. Sensitive to on-going difficult situations linked back to trauma.	Persecuted by voices, get louder, goads and laugh at her, getting worse if voices not getting attention. Commands to kill self, not worthy of help or respect. Want her to be alone.	Mixed experiences in MH services, some very negative, lacking understanding and interest in voices, mainly medication; current therapist and individual staff supportive.	Supportive partner, finds reassurance helpful. Valued by practitioner, helped change relationship with voices. Generally volatile relationship with voices but gives them private time to talk and listen.
Ian	Empowered self through reporting previous trauma. Through therapy learned to gain more agency over voices and	Lack of involvement when prescribed medication. It did not help nor change voices	Identifies voices to childhood trauma. Feels physical presence and power between voices. Voices now less active and distressing.	Tells him that deserved abuse, shows images of abuser/abuse. Voice can become abusive (should be dead, useless, bad,	Practitioners prescribed medication. When admitted to MH services, no practitioner talked to him about voices.	Difficult to talk about voices and problems, worried about being believed. Supported by therapist, helped understand and learn how to control

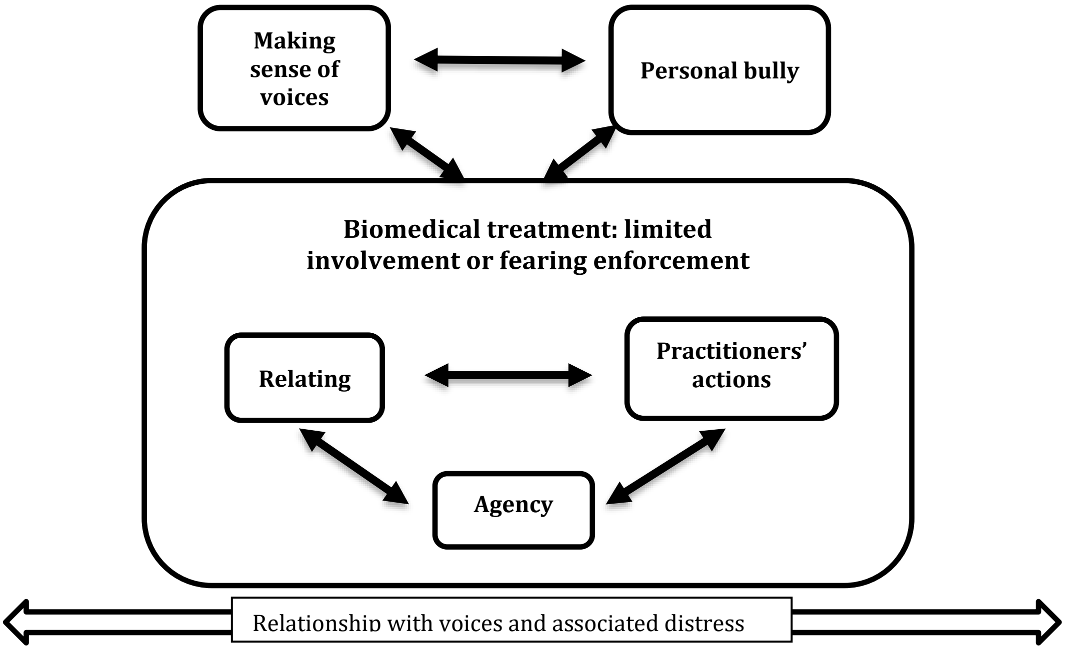
	stop acting on voices commands	and makes him feel drowsy.		dirty) and critical when VH in interactions with others.		difficult relationship with voices.
Jenny	Empowered self through working and engaging in grounding techniques, going to therapy. Gained agency over voices through therapy and learning about self.	Treatment consisted entirely of medication. Bad side effects and did not help voices. They also suppressed emotions, which hampered work on voices	Believes brain created voices as protection from difficult emotions. Links voices to childhood trauma. Believes function of voices helped shut down difficult emotions.	Persecuted by voices, critical comments. Voices angry and disruptive, being stressed makes them worse. Voices worried she will reveal something about past.	Critical of psychiatrists, only prescribed medication. Staff lacked interest in voices, relied on medication. Perceived practitioners lacked hope and understanding, did not talk with her about voices.	Felt supported in therapy and therapeutic community, helped her identify and understand emotions and role of these with voices. Learned how to relate better with voices and people.
Kevin	Voices try to change his thinking & he sometimes acts on commands. Feels threatened by voices. Mutual retaliation between him and voices.	Encouraged to remain on medication, although does help reduce his reaction to voices, but has led to weight gain.	Early stages of making sense of voices, sometimes unsure if self or voices, or if medication is helping. Voices want to hurt him. Feels physical presence of voices.	Voices are critical, insulting, and taunting. Can be disruptive when with others and discourages him from accepting help.	Found MH inpatient services as unhelpful, lack of meaningful activities, staff did not talk much about voices.	Benefits from supportive relationships with others, including some practitioners. Difficult to relate with voices, cannot trust them. Keeps busy to help cope with voices.
Liam	Lack of agency with voices, can’t stop them, sits and listens and waits for voices to go. Voices talking even when he is interacting with people.	Relies on medication to help, although does not stop the voices but they do subside a little. No other treatment options offered.	Not yet made good sense of voices, does not link voices to previous history. Can move distant and closer.	Voices talk to each other about him and directly to him, includes lots of swearing. Worse when stressed.	Lack of meaningful discussion about voices with practitioners, only superficial talking. Voices framed as a symptom of mental illness.	HVG is supportive. Does talk back to voices but tries to keep them at a distance and would like rid of them.
Mike	Empowered self through researching about voices and constructing voices as a gift with which to do good. Cannot control what voices say but has agency over how he reacts.	Did not want medication but pressured by practitioners/ family to take it. Reduced voices but did not like side effects. Stopped with support of CPN.	Believes voices are spiritual awakening and bridge to greater power or ‘highest self’.	Voices previously perceived as negative and comment on death and dying. Interrupts during interactions.	Initially found MH services as unhelpful, lack of focus on voice hearing, mainly just checking his risk, framing his experiences as a diagnostic illness.	Feels supported by family and CPN, generally positive relationship with voices. Voices reassuring and will joke and laugh together. Perceives voices as a guide and has a higher purpose.
Noel	Describes one of voices as a bully constantly following him. Scared of dominant voice taking over him. Has some	Wanted to take medication but it has not change voices and voices don’t like him taking them. Has felt	Constructed visual image of voices, which physically move around. Links voices to childhood trauma, identifies voices with parts of self.	Dominant voice ‘own personal bully’. Worse when feeling low and stressed. Voice hates him going to therapy, gets	Felt let down by MH services when he was a teenager and left without support.	CPN and therapy been supportive and helped him with voices. Has good relationship with 1 voice, who encourages him to get

	agency over voices but not over dominant one.	increasingly worse with side effects and considering coming off.		angry when people help, feels threatened that he will get rid of voice.		help. Tries to block out dominant voice and would like to get rid of it.
Olivia	Lacks agency with voices, they do not like her being in control. Voices overpowering and commanding. Previously harmed self as a result.	Prescribed various medications but these do not stop voices and makes her feel worse. Lacks involvement in treatment decisions.	Linked to childhood trauma, voices inside head but more distressing when move to outside of head when stressed.	Persecuted by voices, hears lots of taunting and references to past abuse. Voices do not like her getting help. Gets worse when stressed.	Previous bad experiences with psychiatrist; not listening to or understood. Voices framed as mental illness, no meaningful engagement in talking about voices.	Finds CPN/ individual practitioners supportive. Finds it difficult to relate with voices, worse when stressed, talks back to them and critical of them.

6.4 Integrating the theoretical codes

The six inter-related theoretical codes collectively provide a tentative explanation of voice hearing experiences during treatment interactions with mental health practitioners, illustrated below in Figure 6.1.

Figure 6. 1: Inter-related theoretical codes for voice hearers



Positive relationship with voices
Perceived agency re voices & treatment
Less distressed by voices
Values voices
(Frank, Hillary, Ian, Jenny, Mike, Noel)

Negative relationship with voices
Perceived lack of agency re voices & treatment
Distressed from hostile and critical voices
Wants rid of voices
(Alan, Bella, Clare, Diane, Edith, Glenda, Kevin, Liam, Olivia)

From this analysis, I propose that whilst voice hearing is an intra-personal experience informed by what the person hears and their sense-making of their voices, it is shaped by an inter-personal context.

For people in receipt of mental health treatment related to their voice hearing, they typically experience their voices before first coming into contact with mental health services and practitioners. As such, they have already begun to develop thoughts about their voices prior to contact with mental health services. How much 'sense' they have made of their voices varies and evolves over time. Prior to their admission, voice hearers will already have begun to experience their voices as hostile, abusive, and overpowering (Personal bully). Both their experience of 'making sense' and of being 'bullied' are longer term and develop both outside of, and within, the treatment-specific context. Voice hearers perceive this treatment context as lacking any real choice of treatment, with medication conventionally provided as the first line treatment option. Mostly, voice hearers perceive that practitioners expect them to accept medication as a treatment for their voices and, should they refuse, anticipate that practitioners will coerce them into complying.

Voice hearers experience their voices and interact with practitioners in this treatment context. Interactions with practitioners can further influence the sense people make of their voices and the extent to which they feel bullied by their voices. The three theoretical codes, 'Agency', 'Relating', and 'Practitioners' actions' subsequently contribute to voice hearing experiences during treatment interactions with practitioners. This involves a complex interaction of experiences and perceptions involving voice hearers, practitioners and the voices. It includes (1) the voice hearers' level of agency in terms of both their voices and treatment, (2) the way in which they relate both intra-personally with their voices and inter-personally with practitioners, and (3) practitioners' actions, both in terms of general treatment and support and, specifically, related to voice hearing.

It is also evident that this theoretical explanation of voice hearing involves power, specifically coercion. Power is evident in the nature and content of the voices. Identifying voices as a 'Personally bully' represents the overpowering effect of voices, contributing to the sense a person makes of them. This contributes to voice hearers' engagement during the treatment context. In terms of 'agency', although voice hearers may have some influence over their voice hearing experience (or at least acquire this) generally they perceive have little agency regarding their voices. Their voices will interrupt, be hostile and loud (even during inter-personal interactions), usually with the voice hearer unable to mitigate against this. Additionally, power informs the way in which voice hearers relate with their voices and practitioners. Feeling persecuted and lacking self-worth will understandably lead to a submissive way of relating with voices and a wish to push away voices. The evidence here suggests that intra- and inter-personal relating are mirrored. Finally, participants perceived that practitioners hold comparative power over them and may exhibit coercive behaviours during interactions and/or when administering treatment. As such, practitioners have a potentially significant role in whether or not voice hearers address their subjugated roles, intra- and inter-personally.

6.5 Study limitations

There was a lack of diversity in the sample of participants. All participants identified as White British, which reflects to some extent the population group in this region. Another limitation regarding the sample of participants is the broad demographic range. This was a difficult to reach population group and so the recruitment strategy intentionally remained broad in order to avoid under-recruiting. However, a consequence of this is the broad range of voice hearing and treatment experiences. In future studies, it would be valuable to investigate whether or not differences in the length of voice hearing, the number of years of receiving treatment, or the type of treatment compares with the study findings.

It is also possible that any impact of ‘power’ on participants extended to the interview process. Participants reported that their voices were reactive during the interview process and some voices reportedly commented or reacted to my presence and interview questioning. It is possible that participants either withheld information or felt obliged to disclose information either due to perceived ‘power’ attributed to me as the interviewer and/or due to the influence of voices.

6.6 Chapter summary

Six theoretical codes were constructed from my interviews with voice hearers; these explain voice hearing experiences through interactions between voice hearers and their voices and also between voice hearers and practitioners. A long-term process of making sense and being bullied by voices takes place for voice hearers both prior to and during treatment interactions with practitioners. During these interactions, a complex and dynamic interaction subsequently takes place between voice hearers, voices and practitioners, shaped by the voice hearers’ level of agency, by the way they relate to their voices, practitioners and treatment, and by the actions of practitioners. The way voice hearers relate with their voices offers a potential opportunity in terms of how this way of relating may be mirrored with other people. The extent to which voice hearers are able to acquire influence over their own life and control over their voices (agency) and their approach with their voices (relating) is a complex interplay between these concepts but is potentially a point in which practitioners can positively contribute.

These findings begin to address part (a) of the first objective of the thesis:

To understand how voices can influence, and be influenced by, mental health treatment, from the perspectives of: (a) patients who hear voices and received treatment and (b) mental health practitioners who provide treatment for patients who hear voices.

However, one of the theoretical codes I discuss above concerns ‘Practitioners’ actions’ and is from the perspectives of voice hearers. I wanted to investigate this further, but through the perspectives of practitioners. I also wanted to investigate the voice hearer – practitioner interactions from the perspective of practitioners in order to further develop the above theoretical explanation. Consequently, in the next chapter, I address part (b) of the above objective through investigating practitioners’ perspectives of voice hearing and provision of treatment.

CHAPTER 7: Practitioners' perceptions of voice hearing and treatment provision: Research methods and findings

7.1 Chapter overview

Following the analysis discussed in the previous chapter regarding the six theoretical codes of voice hearers' perspectives, I wanted to investigate practitioners' perspectives of voice hearing and mental health treatment in order to enhance the theoretical coding. The aim of this second stage of the study was to investigate how practitioners recall their experiences of their treatment interactions and provision of treatment for patients hearing voices. In this chapter, I describe the process of this and discuss the findings from mental health practitioners' perspectives. I begin with (1) a description of the recruitment process, data collection via focus group discussions and ethical considerations; then I discuss (2) the analysis of the focus group data; and (3) a report of the findings.

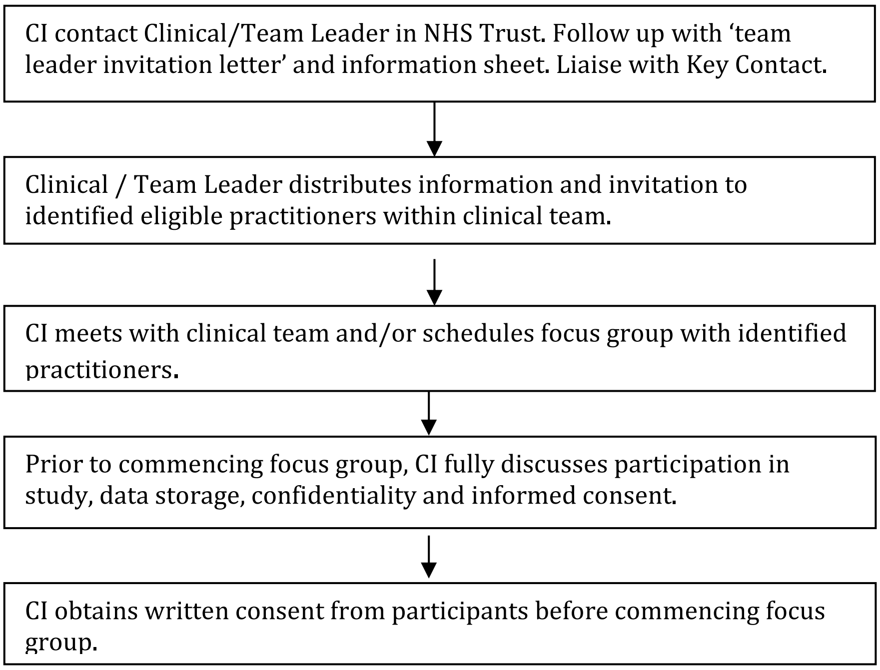
7.2 Recruitment & participants

Mental health practitioners involved in treatment interactions with patients hearing voices were recruited. Practitioners meeting the following criteria were considered eligible for the study:

- Mental health practitioner
- Experience of working in a mental health clinical setting in which treatment has been provided for patients who hear voices
- Minimum age 18 years
- English speaking
- Agrees consent to participation

Following the analysis of the previous voice hearer interviews, it was important to recruit practitioners from both inpatient and community settings. A key contact in a local mental health NHS Trust facilitated some of the recruitment by communicating on my behalf for several months with Clinical Team Leads and offered advice regarding clinical areas for recruitment. Figure 7.1 outlines the recruitment process.

Figure 7. 1: Process for participant recruitment and data collection



CI contact Clinical/Team Leader in NHS Trust. Follow up with 'team leader invitation letter' and information sheet. Liaise with Key Contact.

Clinical / Team Leader distributes information and invitation to identified eligible practitioners within clinical team.

CI meets with clinical team and/or schedules focus group with identified practitioners.

Prior to commencing focus group, CI fully discusses participation in study, data storage, confidentiality and informed consent.

CI obtains written consent from participants before commencing focus group.

Recruitment was particularly challenging due to real-world pressures within clinical mental health services at the time of the study. This included staff shortages, unpredictable staff availability, pressure on practitioners due to clinical demands, and an anticipated visit from the Clinical Quality Commission. These factors contributed to over five months of ongoing engagement with key contacts in the local NHS Trust before I could eventually recruit practitioners. During this time, I had to reschedule several interview dates with little notice several times due to practitioners' unavailability.

To help manage this, the recruitment process involved a combination of me: (1) directly liaising with a clinical lead of a mental health inpatient unit; (2) directly liaising with a community team; and (3) regularly liaising with the above key contact (Figure 7.1) in the local NHS Trust. This ensured that recruitment included practitioners from both inpatient and community services and across both the northern and southern regions of the NHS Trust. This also closely aligned participant recruitment with the clinical areas related to the voice hearer interviews, in which voice hearing participants reported their voice hearing experiences to have taken place.

7.3 Data collection

I collected data from 18 practitioners via three focus group discussions during a two-week period in October 2019. Whereas the individual interviews were an appropriate method of data collection by providing space for voice hearers to recollect and reflect upon potentially sensitive experiences, I chose focus group discussions as a method to generate group interactions between practitioners (Kitzinger and Barbour, 1999, Barbour, 2007). I was aware of how difficult it was for practitioners to make time for my study and so focus groups were a practical method of capturing the experiences of several numbers of practitioners at once.

The aim was to elicit information about the mental health team approach and culture within the treatment environment and the group dynamics of the clinical team. Morgan (1997) and Barbour (2007) advocate this as a method to enable the researcher to move closer to a more naturalistic environment, i.e. the clinical setting. This method enabled me to facilitate practitioners' interactions with one another beyond the extent that I had anticipated I would have collected from an individual interview and provided me with an insight of the team dynamics. In hindsight, I would have also liked to have collected observational data through spending time and observing practitioners' actions in the clinical environment, their engagement with voice hearers and administration of treatment.

All participants worked in mental health teams and had experience of providing treatment for patients hearing voices. Each focus group consisted of practitioners from either the same team (focus groups one and two) or same service (focus group three). Focus group discussions lasted for a duration of between 50 to 65 minutes. I developed an interview guide (Table 7.1), informed by findings from the voice hearer interviews, as an *aide-memoire* in order to keep questions and discussions focused on themes relevant to the further development of the theoretical coding reported in chapter 6.

Table 7. 1: Interview guide for focus groups

Professional framework re voices **1.** What do you understand about voice hearing and what informs this? **2.** How does this inform your work with voice hearers?
Talking about voices **3.** What sort of conversations do you have regarding voice hearing / what sort of words are used / who speaks first about voices / with colleagues and patients? **4.** How confident are you in terms of talking about / working with voices? **5.** What effect do you think your interactions have on voice hearers?
Decision making

6. What treatment choices are available for patients experiencing voice hearing (e.g. medication, talking, etc.)?
7. How involved are patients during treatment interactions?
8. How is decision making about treatment decided / who makes decisions?
9. Are there any circumstances where coercion is required (could include MHA)?

7.4 Ethical considerations

Ethics approval was originally granted in relation to interviewing voice hearers. Further approval was required in order to proceed with the focus groups with health care practitioners. Following amendments to the original research proposal (appendix 6), both the university's Research Governance Committee and NHS Ethics granted further approval regarding recruitment and methods of data collection.

Similar to the previous interviews, I informed practitioner participants about the aims and details of the study through an initial invitation letter to the Team Leader (appendix 7) and a Participant Information Leaflet (appendix 8). I stressed the voluntary nature of participation in the study prior to commencing focus group discussions so that participants clearly understood that they could request further information or change their mind at any point and cancel either before or during the focus group. All participants provided written informed consent. I assigned each participant a unique identification code to ensure anonymity of data. Only the consent forms included identifiable information to the unique identification. These were stored in a locked filing cabinet within a locked office at the University of York, which I subsequently scanned and securely stored electronically on a University of York password-protected secure server. The hard copies were then shredded. I recorded focus group discussions on a digital audio recorder, stored them as MP3 files and then uploaded them to a secure online transcribing service.

7.5 Data analysis

Due to the challenges I describe above regarding recruitment, the three focus groups took place over a period of two weeks and without sufficient time to complete concurrent data collection and data analysis between focus group discussions. As such, theoretical sampling did not occur between focus group data collection and, subsequently, analysis stopped short of theoretical coding. The rationale for the focus group data was to enhance the theoretical coding developed from the voice hearer interview data and so my analysis of practitioners' perceptions consisted of the initial and focused coding stages of coding.

7.5.1 Initial coding

The focus group data were analysed in chronological order. The first initial stage of coding involved a line-by-line approach to each of the focus group transcriptions in order to break down nuances of participants' recollections (Charmaz, 2014). Although the aim during this initial stage of coding was to remain open to identify concepts, this was influenced by the findings from the voice hearer interviews and the interview guide, detailed above in Table 7.1. I completed the initial coding stage for the practitioner data after line-by-line coding for all three focus groups. This led to the development of 42 initial codes (Table 7.2).

Table 7. 2: Initial codes

1. Alternative to biomedical approach to framing voices
2. Attributing voice hearing to trauma
3. Being curious about voice hearing
4. Being transparent with voice hearers
5. Building a relationship is important
6. Concerned about colluding with voice hearing
7. Constrained by professional accountabilities
8. Constructing voice hearing within a professional framework
9. Dealing with the side effects of voices
10. Detrimental effect of coercion on voice hearing
11. Difficulty of respecting VHs autonomy equally with professional accountability
12. Disempowering effect of treatment for voice hearers
13. Feeling anxious about speaking to people about their voices
14. Feeling conflicted regarding coercion
15. Feeling helpless with treatment resistant people
16. Feeling pressure to treat
17. Having hope is important for effective treatment
18. Historical attitudes discourage engaging with voice hearing
19. Justifying coercion
20. Lack of treatment choice
21. Medicalising and medicating
22. Medication traps people in MH services
23. Mental Health Act enables coercion
24. Normalising voice hearing
25. Offering a variety of treatment
26. Perceiving voices as too distressing to engage with
27. Power differential within MH services
28. Practitioner knows best
29. Protecting relationships from detrimental effects of MHA
30. Providing disjointed treatment
31. Removing the shackles of professional accountabilities
32. Respecting individual experience
33. Softening coercive actions
34. Struggling to distinguish between coercion and choice
35. Struggling to get VH to disclose voices
36. Struggling with lack of resources or support
37. Taking a team approach
38. Talking directly to voices
39. Trying alternative approaches is scary
40. Trying to balance power
41. Trying to make sense of voice hearing
42. Voice hearing is stigmatised more than other MH problems

Following the same approach used in the analysis of the voice hearer interviews, coding captured participants' actions where possible through using gerunds (Charmaz, 2014, Glaser, 1998, Strauss and Corbin, 1990). For example, 'Feeling pressure to treat' and

‘Softening coercive actions’ are examples of naming codes in a way that focuses on actions rather than personifying codes to participants.

7.5.2 Reflective account: Interviewing practitioners

Given my previous clinical experience, I was conscious during the focus group discussions that I felt empathy for the practitioners due to my own previous struggles when working as a mental health nurse. It became evident that practitioners wanted to give a good impression of their clinical work and so I was aware that I wanted to convey my appreciation of the challenges they experienced and that I could relate to these from my own experiences from working in clinical practice. However, it was striking that, on the one hand, the practitioners provided me with positive examples to illustrate their expertise in supporting people who hear voices yet, on the other hand, there was evidence suggesting that they lacked confidence and expertise. For example, during discussion in one of the focus groups, one of the senior practitioners said that staff were anxious about talking to voice hearers for fear of not knowing what to say or how to say it. Despite all other practitioners dismissing this at the time of the focus group discussion, two team leaders approached me immediately following the focus group (after the recording had stopped). They verified that the practitioner participants and wider staff group did indeed feel anxious and lacked confidence and they requested me to return to provide further training on voice hearing.

This made me wonder why this anxiety was not acknowledged more openly during the recorded focus group discussion and it raises ethical questions regarding the perceived influence of my role and my contribution as researcher and the recording of participants’ experiences. I was aware that, for some of the practitioners, I was not an anonymous researcher; some of the group knew me and associated me with providing education/training related to voice hearing. It perhaps reflects an ethical issue related to power during the research process, particularly in relation to my potential subconscious expression of empathy to practitioners during discussion and my role as a nurse and educator with many years’ experience related to voice hearing. It may also reflect something about the importance for the practitioners to feel perceived by others as possessing a degree of clinical expertise. This potentially effects the research process in terms of shaping practitioners’ responses to the focus group discussion and perhaps reveals something about the culture within the mental health team whereby there is some value placed on conveying a level of expertise.

Similar to the interview approach taken with voice hearers, the interview guide was used as an *aide-memoire* rather than script of listed questions and I continued to use a similar conversational approach (as I had previously during the voice hearer interviews) in which practitioners became a *"conversational partner in an extended discussion"* Rubin and Rubin (2005, p4). This seemed especially important given the sensitivities discussed above relating to practitioners' roles and my potential impact on the focus group discussion.

7.6 Findings

Three focus groups consisted of 18 practitioner participants (Table 7.3). This included mainly female (n=16) but also male (n=2) practitioners. All practitioners were White British, ranging in age from 20s to 60s (years), and an NHS Agenda for Change grade banding from 4 to 8b. Across the focus groups there were Registered Mental Health Nurses (RMN; n=9), associate practitioners/support workers (n=4), Occupational Therapists (n=3), a Clinical Psychologist (n=1), and a Family Therapist (n=1). There was a wide range of clinical experience both in general and specifically related to voice hearing across participants (6 months to 47 years). Focus group 1 consisted of practitioners from the same inpatient unit; focus group 2 consisted of practitioners from the same community team; and focus group 3 consisted of practitioners from across two community teams specialising in treating psychosis. All practitioners worked for the same NHS Trust and treated people distressed by voice hearing.

Table 7. 3: Focus group participant demographic information

Pseudonym	Age range	Gender	Ethnicity	Professional group & banding	Experience working in MH services	Experience working with voice hearing
Focus group 1						
Anne	32	F	White British	AMH Associate Practitioner, Band 4	12 years	12 years
Beth	40	F	White British	Clinical Psychologist 8B	17 years	15 years
Carrie	26	F	White British	RMN Clinical Lead, Band 6	5 years	5 years
Debbie	30	F	White British	RMN Clinical Lead, Band 6	7 years	9 years
Ellie	40	F	White British	RMN Clinical Lead, Band 6	23 years	20 years
Fiona	38	F	White British	AMH Associate Practitioner, Band 4	16 years	16 years
Grace	27	F	White British	AMH Associate Practitioner, Band 4	9 years	9 years
Hannah	28	F	White British	Occupational Therapist Assistant, Band 3	8 years	8 years
Izzie	24	F	White British	Occupational Therapist, Band 5	6 months	6 months
Focus group 2						
Jack	40s	M	White British	RMN, Band 7	19 years	19 years
Ken	32	M	White British	Support Worker, Band 4	7 years	7 years
Lucy	40s	F	White British	RMN, Band 6	21 years	19years
Focus group 3						
Mary	40s	F	White British	Family Therapist, Band 7	22 years	7 years
Naomi	20s	F	White British	RMN, Band 5	6 years	1 year
Oriette	20s	F	White British	RMN, Band 5	7 years	3 years
Penny	40s	F	White British	RMN, Band 6	27 years	27 years
Rose	60s	F	White British	RMN, Band 6	47 years	47 years
Sarah	40s	F	White British	Occupational Therapist, Band 6	7 years	7 years

7.6.1 Focused coding

Focused coding involved reviewing and grouping together initial codes where there was commonality. Common meaning across initial codes helped to group these together to form six focused codes (Table 7.4). The aim of the focused coding stage was to develop the initial coding to a greater conceptual level. This was in order to synthesise the findings from the focus group discussions with the voice hearer interviews at a later stage in order to complete the construction of the overall theory (as I discuss in Chapter 8).

Table 7. 4: Focused codes

Focused codes (6)	**Initial Codes (42)**
Challenges related to coercive practice	Detrimental effect of coercion on voice hearing Difficulty of respecting VHs autonomy equally with professional accountability Disempowering effect of treatment for voice hearers Feeling conflicted regarding coercion Justifying coercion Mental Health Act enables coercion Protecting relationships from detrimental effects of MHA Softening coercive actions Struggling to distinguish between coercion and choice
Dominating medication treatment for voice hearing	Lack of treatment choice Medicalising and medicating Medication traps people in MH services Voice hearing is stigmatised more than other MH problems
Engaging with voice hearing	Alternative to biomedical approach to framing voices Attributing voice hearing to trauma Being curious about voice hearing Being transparent with voice hearers Building a relationship is important Having hope is important for effective treatment Normalising voice hearing Offering a variety of treatment Respecting individual experience Trying to make sense of voice hearing Talking directly to voices Trying to balance power
Feeling constrained	Constrained by professional accountabilities Feeling helpless with treatment resistant people Feeling pressure to treat Power differential within MH services Providing disjointed treatment Removing the shackles of professional accountabilities Struggling with lack of resources or support Trying alternative approaches is scary
Privileging practitioners' interpretations	Constructing voice hearing within a professional framework Practitioner knows best Taking a team approach
Struggling to know how to support voice hearing	Concerned about colluding with voice hearing Dealing with the side effects of voices Feeling anxious about speaking to people about their voices Historical attitudes discourage engaging with voice hearing Perceiving voices as too distressing to engage with Struggling to get VH to disclose voices

7.7 Findings: Six focused codes

The final stage involved tabulating all quotations and the corresponding codes in order to check the 'fit' (see appendix 9 for details). I discuss each of the focused codes below.

(1) Challenges related to coercive practice

Practitioners discussed during the focus groups how they felt challenged by coercive practice. In terms of mitigating against administering coercive treatment, which predominantly involves medication, practitioners said they should be transparent with patients, for example acknowledge with patients the unpleasantness of the situation when administering coercive treatment. Practitioners said they sometimes found it difficult to balance their respect for patients' autonomy against their own perceived professional accountabilities. It could be particularly difficult for practitioners. For example, they said they felt anxious and conflicted, when concerned about the effect of patients' distress on other people or the general public safety.

Practitioners recognised the potential negative impact of this on their relationship with patients, such as losing their trust. They said this made it difficult to form equal, collaborative relationships with patients. Furthermore, they spoke about the Mental Health Act (1983) as a mechanism to enable the administration of coercive practice. Practitioners also said this undermined the potential to create therapeutic relationships with patients. Some reflected on the negative impact of the MHA contributing to 'synthetic' relationships with patients. Discussion in the second focus group captured the undermining effect of the MHA on relationships:

> Lucy: But also you've got the CTOs [Community Treatment Orders] and that. The amount of people who are on CTOs who hear voices or who don't hear voices. That's another massive barrier.
> Ken: They're not openly accessing our service, are they? They're not engaging with you because…
> Jack: That's power.
> Ken: …they want to. There's that power, isn't there?
> Jack: It's just total power, isn't it?

However, although practitioners where sympathetic to situations in which treatment was coercive, they also valued the MHA in terms of it legally permitting coercion. This was captured by Carrie (1st group):

> “It's like a legal framework and it's kind of this idea, isn't it, if that legal framework didn't exist would we put another one… Would there be a different one? And we'd just call it something else. Because it's obviously come about in some way. Because I think we'd probably all agree that if someone is very, very distressed by voices, it's kind of heart-breaking, isn't it? You want to intervene. It seems cruel not to do something. And so if the Mental Health Act didn't exist would there be something else in the place”? (Carrie, group 1)

Although practitioners said they valued having a legal framework to support coercive approaches, they also reported several detrimental effects of coercive treatment (typically associated with medication) on voice hearing, wherein voices became increasingly difficult for patients. For example, Jack (2nd group) commented that there is a “power threat”, wherein voice hearers and their voices can feel threatened, suspicious and paranoid as a consequence of coercive treatment. Practitioners also reflected that recalling patients to hospital under a Community Treatment Order (under the legislation of the MHA), usually due to failing to comply with prescribed medication, can increase patients’ anxiety. Interestingly, they also spoke about examples of coercive treatment such as this as unhelpfully strengthening patients’ beliefs in their voices because it can confirm previous warnings of threats that patients’ hear from their voices.

Practitioners spoke about feeling “horribly conflicted” regarding coercion. For example, Carrie commented:

> “I suppose you're damned if you do it and damned if you don't do it. Sometimes it feels like you're stuck between a rock and a hard place”. (Carrie, group 1)

In response to the negative impact of coercion on practitioner-patient relationships, some practitioners tried to protect these relationships by removing other key practitioners (with whom there were positive relationships) from the coercive treatment situation. Practitioners also felt conflicted when they said they believed it was in the patients’ best interests to administer medication even when patients begged not to have it. Injected medication was a particularly sensitive issue, especially where a patient had a history of abuse, as Ken (2nd group) commented (below):

> "I think the reviews of medication on where it's administered, you know, we work with a lot of people, experience sexual abuse, depot medication, usually in the rear. I don't think that's ever considered that much". (Ken, group 2)

Given the conflicted feelings related to coercion, practitioners spoke about the importance to be able to justify their coercive practice. Some said they believed that patients improved because of coercive interventions. Furthermore, some were able to normalise coercion and considered it as an everyday phenomenon occurring between people. This is captured in the following interaction in the 3rd focus group:

> Rose: I think coercion is a two-way street. I think we are coerced by our staff and peers into doing stuff that we haven't got the time to do it. And we do coerce our patients; it's not documented how we got Joe Blogs and we coerced him into. It's down as gentle persuasion or encouragement or whatever. It's the transparent tool that sometimes has to be used, mainly the path of least resistance. [Agreement] That's what it is. We do it with kids and everything.
> Oriette: And it's about the best interest of the patient, isn't it?
> Rose: Of course it is. And we do it with kids.

Practitioners also considered longer-term benefits to help justify coercion and their resultant distress of coercively medicating patients. For those working on an inpatient acute unit (1st focus group), this involved observing patients engage in activities on the unit (e.g. occupational therapy groups) and believing they were helping patients recover towards discharge.

Practitioners also discussed the importance of softening the impact of coercion on patients. They predominantly did this by being transparent with patients when anticipating a need for coercive treatment. For example, practitioners from focus groups 1 and 2 discussed potential coercive actions with patients and patients' preferred part of body for potential injections of medication. Those in focus group 3 said they believed it was important to be present during coercive practice, such as staying with patients during detainment under the MHA or trying to settle patients with a cup of tea while simultaneously trying to arrange a MHA assessment and potential detainment.

An additional challenge relating to coercion was practitioners' struggle to differentiate between coercion and choice. For example, practitioners from focus group 1 spoke about being unsure whether they were being coercive by being honest with patients regarding the implications of their refusal of treatment when detained under a Community Treatment Order. They struggled in determining whether they were being open and honest or coercive when offering patients a choice between accepting an injection of medication or oral medication.

Some treatment approaches described by practitioners were not coercive *per se* but worthy of closer inspection. For example, Sarah's (3rd group) visit to a deteriorating patient isn't representative of coercion *prima facie*, however it is important to contextualising the interaction within a broader treatment approach. This involved a planned visit in order to keep the patient compliant with medication and remain in contact with the team. Arguably, assertive engagement involving gently persuading a patient to remain in contact with practitioners in order to accept treatment and against a backdrop of threats of firmer interventions under the MHA is a subtle form of coercion (see Table 3.1 in chapter 3 for further details regarding a range of coercion). This is arguably problematic in terms of defining coercion but Anne (3rd group) captured (below) the significance of the MHA in relation to defining coercion in mental health practice and influencing practitioners' perceptions about coercion:

> "I think without the Mental Health Act you would absolutely think it's coercion. But because that's there it's almost…it's giving people some choice within…a lack of choice". (Anne, group 3)

Challenges related to coercive practice encapsulate the complexity and difficulty experienced by practitioners in relation to administering coercive treatment to patients distressed by their voices. Interestingly, practitioners struggled to recognise coercion but, when it is recognised, it illustrates that respecting individual patients' autonomy can impinge on practitioners' sense of professional responsibility to both patients and the general public. It also illustrates that the MHA is a double-edged sword for practitioners in terms of it being a welcomed mechanism for administering coercive treatment but it also undermines their relationships with patients. It is evident that practitioners manage these challenges by trying to soften the impact of coercion on patients and justifying to themselves the overall benefits for patients by administering coercive treatment.

(2) Dominating medication treatment for voice hearing

Overwhelmingly, the conventional treatment approach described by practitioners was one that results from the medicalisation of voice hearing and involves medication as the predominant type of treatment. Practitioners were critical of the over-reliance in mental health services of medication and lack of treatment choice available to patients distressed by their voices. Interestingly, some practitioners (1st group) reported that other practitioners on inpatient acute units seldom work with patients in a way that attempts to understand historical links to their voice hearing and help them make sense of voices. Instead, patients identify with diagnoses such as schizophrenia and some practitioners aligned with the medicalisation of voice hearing. This is reflected below in Penny's (3rd group) comments, which infers that patients lack insight unless they conform to the conventional belief that their voices are a symptom of schizophrenia:

> "I think it's very dependent on the patient's level of insight and how motivated they are in terms of acknowledging what's going on and what they can do about it. I have patients on my caseload who have been in service 30, 40 years and they still don't have the insight to be able to work on their shared symptoms and their voices because they don't acknowledge that they're as a result of mental health problems, of schizophrenia, of psychosis; they don't acknowledge that at all". (Penny, group 3)

Practitioners also said they believed that medication had a disempowering effect on voice hearers. They said that voices serve a purpose and that some patients were worried that practitioners would take away their voices through treatment. Practitioners were also concerned that, without their voices, patients could feel lonely and lose their identity and sense of purpose. Some practitioners were also concerned that medication stops patients from feeling and thinking and said that, subsequently, patients perceive they cannot cope with their voices or stress without medication. Furthermore, this can lead to a cycle of using medication to take away or quieten down voices but also taking away opportunities for patients to understand their voices. As a result, some patients ask for medication rather than talk with practitioners about their voices and failed to learn how to manage their distress. Of more concern, practitioners (2nd group) reported that being prescribed medication traps patients in mental health services because their risk to self and/or others is too high for them to be discharged from services:

> Jack: No, I think we do, but I'm just on about the predominant thing of what keeps people in mental health services, is medication.
> Lucy: And I would probably think that’s the first treatment that's offered.

Practitioners’ observations and discussions encapsulated in this focused code illustrates the dominating influence of medication and the lack of genuine choice and treatment options for many voice hearers. Interestingly, practitioners reflected that voice hearing is stigmatised more than other mental health problems, which is perhaps unsurprising given the medicalisation of voice hearing experiences within mental health services.

(3) Engaging with voice hearing

This focused code encapsulates aspects of practitioners’ attempts to engage with voice hearing. Practitioners reflected on the importance of being curious about voice hearing and respecting and learning from patients about voice hearing. Jack (2nd group) reflected on this:

> “As you get more experienced at doing it you get more confident over the years. It's alright to ask questions about people's voices. It's alright to ask them about if they've got a name, how old are they, do they come from the inside, do they come from the outside of your head. Or is there anywhere else they come from? And when you do the mapping of when they hear them from as well, you get more used to it, don't you? And you're like oh god, yeah. And it destigmatises it for you as well”. (Jack, group 2)

Practitioners considered being transparent with patients, particularly in relation to risk and decision-making, is an important element of engaging with people hearing voices. The following extract between practitioners (2nd group) illustrates how important they believed it was to collaborate with patients as much as possible:

> Jack: I think foremost…I guess the other thing is are you…because it's that thing, are you speaking behind a client's back or are you… Because the clients I work with, I will say I’m……
> Lucy: I'm going discuss it, yeah.
> Jack: Yeah. Do you know what I mean? I'm clear with them that there are these processes that are here for me that helps me figure out working with you. And also I'll try and talk to you about what I'm talking about at times, about when I go

> to supervision, I'm going to go and ask them about this. Because I think it's that thing about that open transparency, that we're not hiding or colluding or making decisions about them without them being aware of what we are…
>
> Interviewer: So having that transparency about it, does that mean that you have…the kind of conversations you'll have with each other is similar to the conversations you'll have directly with the voice hearer?
>
> Jack: Absolutely.
>
> Ken: I'd certainly like to think so, yeah.

Practitioners across all focus groups stressed the importance of building a rapport with patients. They believed an effective relationship is important for engaging, gaining trust, and encouraging patients to talk about their voice hearing. Without effective relationships, practitioners believed it would be difficult to have conversations with patients about their voices. They also discussed the importance of normalising voice hearing. Jack (2nd group) shared with patients his own experiences of anxiety and rumination and Naomi (3rd group) reassured patients that other people also hear voices. Whereas Jack normalised voice hearing through relating with his own experiences, Naomi offered reassurance that other people hear voices and can recover:

> "Actually this is normal, this does happen to people quite often, that's why there are teams developed around it, that's what we're here for. And getting them to understand that it's just another illness; it's something that you can recover from, something that you can get better". (Naomi)

There is a difference between the above two approaches to normalising. Naomi places importance on "getting [the patient] to understand it's just another illness". This may normalise voice hearing in terms of reassuring a patient that other people can hear voices but it also attributes voice hearing to an illness within a medicalised framework in which voices are a symptom of (typically) schizophrenia. This viewpoint of medicalising distressing experiences informs a medical intervention such as medication to remove the distressing experiences. Practitioners also commented in a previous focused code (Dominating medication treatment for voice hearing) that patients then, inadvertently, interpret this as being unable to cope with their voice-related distress without medication. As such, it can have a disempowering effect on patients.

Whilst the dominance of medication featured strongly in the discussions around managing voice hearing, practitioners also reflected on the importance of offering a variety of treatment for patients. They discussed that not all patients want to be treated with medication and some practitioners offered alternatives such as talking therapies and occupational therapy. However, it is also important to note that practitioners were critical of the lack of sufficient resources, especially psychological support, in mental health services, which undermined the intention to offer these alternative treatments. Such limited resources hampers even the best intentions to provide a wider range of treatment choices.

Extending this last point further regarding a lack of resources, practitioners inferred that the provision of treatment choices alternative to medication relied on individual practitioners rather than a broader service-wide provision. For example, some practitioners had engaged in Voice Dialogue with patients, which as I discuss in Chapter 1 is a method of talking directly or indirectly to patients' voices. It is important, however, for practitioners to be cautious given the lack of support and supervision provided for their learning to develop and practice this approach. For example, practitioners (2nd group) referred to the difficulty of working in this way and the resultant anxiety for them; Rose (3rd group) recounted her dialoguing with patients' voices:

> "I've coerced with the voices and I've coerced with the patient and I've said to them, would it help if I told your voice to go away and talk to your voice. I won't tell you sometimes the terms I say. You've got to talk in a language with your patients that they use. I'm not saying you have to eff and blind. And I've got permission off the patient and I've spoken to the voice in a coercive manner and I've asked the patient if – a lot of the times it hasn't made a bit of difference, but a few times the patient has said the voice is listening to you and it doesn't want you to be here and it doesn't want you to talk to it. And I've said, but is it getting less. And they've said, yes they're going away". (Rose, group 3)

In the above example, there is a potential risk of practitioners' replicating coercive approaches with both the patient and their voices and, inadvertently, disempowering the patient. Again, a lack of resources and support may hamper practitioners' access to appropriate supervision to support this approach.

Finally, some practitioners (2nd group) reflected on the imbalance of power in terms of their relationships with patients and the importance of trying to address this. This included not only trying to respect patients as equals but also refraining from imposing practitioner-led perspectives onto patients, as captured by Ken and Lucy below:

> Ken: I think you've got to give them enough space to work a lot of things out themselves as well, to come to their own conclusions. I was working with somebody recently and they dropped in there that actually their voices might be related to some anxiety. And I thought that was…they'd come to their own…So we explored that further and the potentials of that and what that meant and the reactions that causes them or the impacts that it might have on them. So yeah, I think it's important not to go in with the full, this is the right explanation, this is… I mean it is a lot of guesswork, isn't it? And it's important that they guess as much as we guess really.
>
> Lucy: And you have experiences, don't you? I did the other day where we were talking to someone about their mental health has deteriorated and I was open and honest about what my thoughts were on that. And then when I asked about voices they were…no, no. No voices there. And I felt it was because I was looking at it from a mental health point of view. So I'd got that…not that power, but do you know what I mean? It's what I can do with it when you're telling me now that…

Practitioners reflected on their attempts to respect patients as individuals and potentially help empower patients distressed by their voice hearing. Although an isolated example, one practitioner (Mary, 3rd group) had benefited from family therapy training, which enabled her to develop an alternative way to the conventional medicalisation of voice hearing and to appreciate multiple interpretations of voice hearing:

> "I guess for me I learnt about never being married to the model. The model is just a model. All these are just ideas and we offer them out to people, and then they take up what they think is helpful to them. And once I get married to the model and believe that that's the only thing and the right thing then I'm in danger then of cutting off everything else to the person". (Mary, group 3)

The above example from Mary illustrates the importance of enabling and supporting practitioners to develop and apply their knowledge specifically related to understanding the complexities of mental health, generally, and voice hearing more specifically. In absence of supporting practitioners' development, it is telling that only one of the eighteen focus group participants recounted this broader perspective of working with patients and making sense of their distress.

Practitioners also spoke about voice hearing as an understandable response to trauma. This is captured by Jack (2nd group):

> "Because for me I don't think it's a diagnostic thing like schizophrenia. I don't believe in that label. I think it's a formulation…it's come as a result of people's trauma, it's a way of coping with life. And I think there's a lot of metaphor in voice hearing, for what people experience. And if they're paranoid or unsafe, it normally seeps down to something that's happened to them that's made them feel that way. And to cope these voices have come as a result of that, of almost helping keeping them safe. But I think that's a different perspective. Actually even though the voices might be negative, they're actually maybe helping keeping them safe". (Jack, group 2)

Practitioners from across all three focus groups recognised the importance of respecting patients' experiences and preferences, which was a key ingredient in their attempts to help empower patients. For example, both Debbie (1st group) and Jack (2nd group) stressed the importance of this and of understanding patients' attributions related to voice hearing. Similarly Sarah (3rd group) spoke about the importance of understanding whether or not patients like their voices or feel distressed by their voices.

Practitioners from across all focus groups also discussed their approaches in trying to make sense of voice hearing. For example, Penny (3rd group) valued gathering as much information as possible from the patient and family members. Mary (3rd group) extended this further and stressed the importance of making sense and meaning of voice hearing with the family not just the individual patient. Oriette said it was important to make sense of voices through working together with patients to form a shared understanding of voices. However, whereas Rose (3rd group) stressed the value she placed on being informed by patients, she also said she formed her judgement based on her own observations and interpretations. However, as noted previously, there is seldom evidence of practitioners being reflexive in practice to help disentangle their own interpretations from patients' reports. For example, construing voice hearing as an illness and treating with medication may not be a shared approach between practitioners and patients. The following excerpt from a discussion between Jack and Lucy (2nd group) reflects the importance of avoiding importing professional interpretations:

> Jack: Yeah, I think we get away from symptoms, don't we? None of us want to use the word symptoms, because I can't stand that. It's not a symptom, it's an experience of someone, isn't it?
> Lucy: I don't think we do call them symptoms at all.
> Jack: No.
> Lucy: We don't as a team. I think it's very much…yeah, factual about what they're… We might make links about it, about what that might mean, might we.

In summary, practitioners attempt to engage more positively with patients regarding their voice hearing in a number of different ways. Against a backdrop of conventional medicalising of voice hearing, practitioners reflected on their experiences of trying to develop helpful relationships with patients and to reassure patients that their distress can be treated.

(4) Feeling constrained

Practitioners talked at length around feeling constrained in their attempts to support patients distressed by voice hearing. They felt constrained by their professional accountabilities, which sometimes influenced their perceptions of patients' risks. Lucy (2nd group) was frustrated that her colleagues had "to tick boxes…you've got to do that as part of your job". Consequently, practitioners reported that their time with patients could be taken up by tasks they were required to do as part of their professional role, e.g. administering a depot medication or completing a specific assessment. They managed these "duty bound" responsibilities by being transparent with patients regarding what they were expected to do. However, Penny (3rd group) commented that this sometimes resulted in practitioners being prevented from "looking at really proactive coping strategies for voices…and that's really, really frustrating…"

Some practitioners (2nd group) reflected on the importance of being 'human' with patients in order to build relationships but also felt obliged to perform various procedures (i.e. risk management, encourage medication compliance) in order to respect their professional responsibilities. Interestingly, Ken (2nd group) believed that because he was not a registered practitioner, he felt "freer" and didn't need to "push medication". Some practitioners were cognizant of their perceived pressure to treat patients for voice hearing and questioned practitioners' perceived need to make patients' voices and distress go away. This pressure included their requirement to complete standardised assessments within specific timescales to inform treatment. However, in practice, patients did not always work to these timescales. Practitioners also acknowledged that offering treatment was their own need for "self-gratification" and reflected the value of their role of believing they were able to make a difference for patients.

However, practitioners said they also felt helpless with patients who they believed were "treatment resistant" (those patients with a long-standing diagnosis and poorly responding to medication). Instead, they anticipated "results" with patients they perceived had "recovery potential". As such, they acknowledged they needed opportunities where they could make positive differences for patients. Practitioners became upset at the thought of being unable to help patients. For example, Sarah (3rd group) stated:

> "I cried last week because there's absolutely nothing, absolutely nothing I can do for this lady apart from go and visit once a week. It doesn't matter what I do it's not going to improve her quality of life". (Sarah, group 3)

Contributing to feeling helpless was a perceived lack of resources. Practitioners were hindered by an absence of psychology in mental health services, which left them feeling unsupported and anxious when managing large caseloads and trying to support patients with experiences of trauma. This negatively impacted on the team by failing to provide support and contain distress for team members. Rose (3rd group) describes the impact of this:

> "It massively impacts on how we do and what we do because we can only do some much in the time constraints that we've got. And is still astounds me that we're working in a field called psychosis which the most common symptom is voice hearing that we don't have the policy in place or a strategy or a group or a specialist or somebody within a psychosis team that deals with that". (Rose, group 3)

Given this perceived lack of support, the requirement to "tick boxes" and the dominance of medication, it is unsurprising that some practitioners felt nervous about trying alternative treatment approaches such as Voice Dialogue. Instead, they spoke about a hierarchy of power within mental health services, in which medicine is the dominant approach to treatment and led by medical practitioners. For example, some practitioners (2nd group) were critical that a diagnostic-led approach within mental health services has led to most patients being administered medication and, as a result, patients tend to ask for medication rather than consider non-medication interventions. Rose (3rd group) reported that she avoided including medical practitioners in appointments with patients in an attempt to help patients consider non-medication treatment options. However, she also acknowledged that usually medical practitioners would later become involved and prescribe medication if there were no improvements for patients.

Power difference also exists between different teams within the same mental health service, as observed by Jack (2nd group):

> “We do go and try and influence it from our own formulation perspective. But I guess it feels like at times the power differential between us and the wards is…the difference is almost like they're the patient, they make the decisions. Whether that's discharge, stay in, medication, choices, are all there. Obviously we work with that, work with the clients and sometimes it's easier than others if we're in agreement. But when there's disagreements that's when it's harder, isn't it…And that's when it becomes conflictual and we don't…and the person always seems to get forgotten I think”. (Jack, group 2)

Practitioners discussed power difference also extended to differences or gaps in treatment approaches between different teams within the same mental health services, resulting in a disjointed treatment experience for patients. For example, community-based treatment approaches for voice hearing did not continue when patients were admitted to inpatient services. Consequently, practitioners commented treatment became “segregated” wherein practitioners “insulate” parts of patients’ experiences rather than addressing their distress.

The practitioner experiences captured here represent some of the challenges they face when trying to provide treatment for people hearing voices within mental health services. In this treatment environment, practitioners reportedly feel, at best, constrained but typically disempowered and helpless to support patients distressed by their voices.

(5) Privileging practitioners' interpretations

It became evident during focus group discussions that practitioners' perspectives can have a dominant influence when making sense of voice hearing, which can subsequently inform the treatment approach. As such, it represents the power that practitioners and mental health services can have over patients in terms of framing voice hearing experiences.

Some practitioners reflected patients were aware that their refusal of treatment could result in being recalled (under the MHA) back into hospital in order to receive treatment. They commented their peers typically assume and decide what they think is best for patients distressed by their voice hearing. Furthermore, in educating patients and their families about patients' experiences, there was a notable absence of acknowledging patients' experience or expertise regarding their own voice hearing. Debbie (1st group) spoke to this issue below:

> "And there's people screaming bloody murder that they don't want this medication. But yet as a clinical team there's been a decision made that in the best interests of that person at that time, because they are incapacitated, and they're so unwell". (Debbie, group 1)

Extending further the notion of 'practitioners know best', many practitioners understand voice hearing according to a professional framework. Beth (1st group) reflected that voice hearing is considered from a "mental health point of view". Jack (2nd group) was critical of this mental health perspective and of mental health services, including psychology, for being diagnosis-led. He believed that people hearing voices were consequently diagnosed with schizophrenia, inevitably leading to medication treatment and interpreted by patients as them being unable to cope with their voices or stress without medication.

Rose (3rd group) reflected practitioners understand voice hearing by observing patients and by engaging in professional education and literature. Although some practitioners tried to use patients' language rather than professional language, there was a lack of appreciation of any influence of structural power of 'psychiatry' in shaping practitioners' observations and informing professional education and literature. This was illustrated at different points in focus group discussions. For example, practitioners referred to the importance of whether or not voices were heard from the inside or outside of the patient's head, or whether they were "true voices", or whether patients had their own thoughts or could see links to social stressors, and whether practitioners believed these experiences to be true and valid. Determining factors such as these informed practitioners' perceptions regarding whether voices are linked to trauma or whether patients dissociate or even "truly" hear voices.

Finally, an important element of this focused code is the collective team approach taken by practitioners. Some reported that teams had regular meetings in which practitioners shared information gleaned from and about patients. Where decisions were made, for example to administer a forcible injection, then this became a collective team decision. Whilst this may be helpful in terms of team working, it may also inadvertently strengthen interpretations and treatment approaches according to practitioners' perspectives and at the exclusion of individual patients' interpretations.

The practitioner experiences captured here represent an imbalance of power between practitioners and patients experiencing distress related to voice hearing. Although there were examples of participants' acknowledgement of patients' frame of reference regarding their experiences, mostly professional agendas shaped treatment approaches.

(6) Struggling to know how to support voice hearing

During focus group discussion, practitioners referred to their difficulty in knowing how to meaningfully engage with patients about their voice hearing. They referred to historical and cultural beliefs within mental health services that has been dismissive of personal meaning associated with voice hearing. They also commented that practitioners are discouraged from talking to people about their voices for fear of colluding with voice hearing. Some (2nd group) were critical of mental health services for continuing to fail to genuinely listen to patients about their voices and ignoring discussions about voice hearing for fear of colluding. Debbie (1st group) believed that this fear of collusion is still evident in current practice:

> "I think sometimes there's conversations about if you're maybe engaging with the fact that that voice hearing is there and that is something that for that person is in reality at the moment. If you accept it into your reality are you colluding? And I think that's… Yeah, I think there's sometimes questions about that, about are we benefiting that person by engaging in that"? (Debbie, group 1)

Rather than engaging more meaningfully with voice hearing, practitioners reported it is common practice to manage side effects associated with voice hearing, such as anxiety. This is not to say practitioners were always dismissive of voices. For example, some reflected on the value of listening to and reassuring patients, as illustrated by Debbie and later Fiona (both 1st group) in the following examples:

> “But I think there's sometimes a bit of comfort in somebody that is actually listening and validating them, if you're listening to what they're saying about their voices, rather than dismissing it”. (Debbie, group 1)

And

> “Sometimes we get people hearing that they're an awful person, getting told all these horrible things. And I think sometimes it's just…I know people have said that it's nice just to get that reassurance that they're not…when they tell you what they've experiencing you can try and help them work through it a bit. Maybe saying well, you know, you're not an awful person”. (Fiona, group 1)

However, it was evident from focus group discussions there was a lack of confidence, knowledge and expertise regarding what else practitioners could do to help patients distressed by voice hearing. As such, practitioners reframe voice hearing within a professional/practitioner perspective and avoid further exploration of voice hearing with patients. Sarah (3rd group) provided an example of this:

> “So, rather than asking him and distressing him by what they were saying, because he would never tell me, and he’d say you know because they’re actually talking to you because I can hear them, so he could hear the voices talking to me, but I would just say are they inside your head or outside. And then that would give me an aim to say, okay let’s distract that. Whereas if they were inside his head I’d just leave them because he was quite happy with those voices”. (Sarah, group 3)

Furthermore, practitioners also reported colleagues feel anxious about speaking to patients about their voices and struggle to know how to have a conversation about voices with patients for fear of what might happen. As such, practitioners sometimes avoid discussions with patients about their voice hearing. Practitioners also reported that sometimes patients were excluded from occupational therapy activities due to practitioners’ concerns about patients’ voice-related distress. A discussion between Jack and Lucy (2nd group) illustrates this avoidance by practitioners:

> Jack: People can't deal with distress. They can't deal with somebody else's distress, that's what it is for me. We haven't got a tolerance for someone's distress.
> Lucy: And then what does that say? It's about all emotional regulation stuff, that we can't deal with that. We're trying to stop your emotions, when actually we need to be teaching people more about how to manage their own distress and know that it's alright to be really sad and really happy or whatever. Or we'll give you some diazepam for that.

Finally, practitioners across all focus groups reported they had either experienced or observed that it could be difficult to encourage patients to disclose information about their voice hearing. Practitioners believed that patients' reluctance to disclose had been due to their fear of potential consequences such as practitioners' increasingly becoming concerned, which could lead to hospitalisation.

7.8 Summary of analysis

I present a summary narrative of the focused coding below (Table 7.5). Without exception, practitioners reported that medication is the dominant form of treatment for patients distressed by voice hearing. This largely excludes alternative approaches such as talking therapies or engaging/talking directly with voices. In addition to practitioners' criticism of medication, it is largely inseparable from coercion. That is, practitioners use softer coercive approaches to persuade patients' compliance or apply harder coercive approaches to enforce medication through the MHA and/or through physically enforcing medication.

Some practitioners recognise that coercion and medication can further disempower patients distressed by voices. The analysis reveals that coercion is paradoxically both helpful for practitioners in terms of administering treatment but also hindering for them in terms of the conflict felt by practitioners and their subsequent attempts to form relationships with patients. Contributing to this, practitioners find it difficult to determine whether their practice is coercive or not. When treatment approaches are recognised as coercive, it is important for practitioners to justify it and, preferably, to soften and reduce the impact of it on patients.

Table 7. 5: Summary narrative of focused coding

	Focus Group 1	Focus Group 2	Focus Group 3
Challenges related to coercive practice	Feel conflicted regarding inevitability of coercion and impact on VHs. Important to agree as a team and justify coercion by reassuring selves that medication/treatment is helpful long-term. Believe MHA enables coercion but recognise this is also an important mechanism that is sometimes needed. Soften coercion by being transparent, discussing situation with VHs. However, difficult to distinguish between being honest and being coercive.	Managing professional accountabilities (i.e. safeguarding, risk) makes difficult relationship with VHs. Difficult balancing individual versus public risk. Cannot have an equal relationship with VHs because of MHA. Conflict between client and MH service interests. Feel conflicted regarding injecting medication with people with history of abuse. MHA enables power over VHs and coercion. Soften coercion by talking about situation and repeatedly encouraging treatment compliance. Recognise negative impact of coercion on voice hearing, i.e. threatening, paranoid, and mistrusting.	Difficult to support VHs whilst also respecting professional accountabilities. Feel conflicted regarding coercion and risk and maintaining engagement with VHs. Believe coercion is important but is documented as persuasion or encouragement, normalised as something that happens in everyday life with people. MHA enables coercion but try to protect relationship from effects of MHA and try to soften the impact of coercion on VHs. Coercion negatively impacts on voices and VHs, can be fearful that treatment will get rid of voices.
Dominating medication treatment for voice hearing	MH services can cause detrimental effect for VHs through altering or taking away voices. Lack of treatment choice in MH inpatient services. Recognise medicalising of problem (e.g. schizophrenia) and treatment (medication) yet also rely on administering medication to manage distress from voices. Recognise stigma related to voice hearing.	Believe that medication is not treatment but reinforces that VHs cannot cope with voices or stress, where aim is to fix / take voices away rather than help VH to understand. Critical of medication and Big Pharma. Medical model dominates MH services, agenda to encourage VHs to take medication.	Medical model and medication dominant. VH needs to have level of insight and motivation (i.e. recognise symptoms of schizophrenia) and learn to accept medication, but then become trapped in MH services. Stigma and lack of understanding about voices to some extent reflective of practitioners.
Engaging with voice hearing	Advocate just being curious and talking about voices, learn from VH without feeling the need to solve anything. Recognise importance of building relationship with VH, being transparent, trying to offer variety of	Experience and confidence can help to engage in voice hearing. Recognise importance of building relationship with VH, being transparent, and having hope. Importance of normalising voice hearing, offering variety of	Importance of being transparent and building relationships with VHs, especially building trust. Believe that having hope for VHs is a significant factor in treatment. Also, recognise importance of normalising

	medication (although previously acknowledging dominance of medication). Practitioners attribute voice hearing to trauma but also important to respect individual VHs experience. Try to make sense of voices and understand an explanation.	treatment, including voice dialogue, and balancing power differential with VH. Attribute voices to trauma but also important to respect individual VHs experience, the VHs are the experts. Try to understand and make sense of voices.	voice hearing and alternative approaches such as voice dialogue. Considering alternatives to biomedical model of voices and shared understanding of voices (although previously acknowledged dominance of medicine). Respect individual VH experience.
Feeling constrained	Recognise professional accountabilities and MH service expectations, especially risk, can come into conflict with individual quality of life. MH service expectation to treat.	Professional accountabilities, and feeling of professional responsibility, can impinge on advice and discussions with VHs. MH service expectation to treat. Can feel disempowered, MH services provide disjointed care. Providing alternative care is anxiety-provoking.	Professional accountabilities and MH service expectations to treat (reduce or get rid of voices). When medication fails construct people as 'treatment resistant'. Large caseloads and lacking resources, especially expertise in voice hearing and psychological support.
Privileging practitioners' interpretations	Recognise MH services/ practitioners often associate voice hearing with trauma and a diagnosis. Assumption that practitioner knows best interests for VH, about what the VH wants and that practitioners need to educate VHs/families. Ensure staff on board with a team approach.	Recognise that even psychology services are diagnosis led. Also recognise that VHs know that practitioners/MH services recall VHS into hospital if any deterioration.	Framing voice hearing according to professional narrative, i.e. inside or outside of head, and formal assessments, and 'doing' psychoeducation to VH. Practitioners' decide what is best for VH. Culture of team working to determine understanding and then share with VHs.
Struggling to know how to support voice hearing	Can question whether or not colluding with voice hearing and reinforcing loss of reality. Focus on dealing with side effects of voices, e.g. anxiety. Practitioners feel anxious talking to VH about voices, especially when voices are distressing. Struggle to get VHs to disclose. Historic MH services culture of not talking about voices, they are not real, ignore them.	Historical attitude, practitioners told to ignore and not collude with voices. Believe some practitioners lack confidence regarding talking about voices, dealing with VHs distress, instead use medication to shut down voices. Recognise struggle to get VHs to disclose due to their fear of being hospitalised (coercion).	Historical culture of not talking about voices, concerned about making voices worse for VH. Practitioners focus on side effects such as stress related to voices rather than directly address voices. Recognise struggle to get VHs to disclose, who try to hide voices for fear of being hospitalised (coercion).

The analysis suggests that practitioners' perspectives and their professional agenda typically dominate treatment decisions and approaches. In assuming 'practitioners know best', there is little if any evidence of practitioners remaining cognizant of their own lack of agency in terms of shaping treatment approaches. It is therefore unsurprising that practitioners do not always know how to meaningfully engage with voice hearing but, instead, avoid meaningful discussion in terms of understanding voices and 'treat' side effects such as anxiety.

Practitioners' attempts to engage with patients include normalising voice hearing. However, seldom do they attempt to disentangle their own perceptions of 'normalising' from a broader medicalised narrative that shapes the language in mental health services (i.e. 'illness' or 'schizophrenia') and informs a medicalisation of voice hearing. Working within a medicalised context can negatively impact on practitioners, wherein they can feel constrained and conflicted by their professional accountabilities and personal values. Practitioners can feel conflicted when their own personal preferences regarding treatment approaches do not align with their 'duty bound' expectations or when they feel unsupported within mental health services.

7.9 Study Limitations

Similar to the sample for the voice hearer interviews, there was a lack of diversity in the sample of practitioners. All participants identified as White British, which reflects to some extent the population group in this region. The sample group were also predominantly female (16 females, 2 males). In future studies it would be valuable to investigate how more diverse practitioner groups compare with the study findings in terms of experiences and perceptions related to voice hearing and working within mental healthcare providing treatment for people distressed by their voices.

It was also evident from analysis of the practitioner focus group data that power is administered through coercive treatment and through practitioners' use of language. There is potential for dominant discourses to be reproduced by individuals within mental healthcare. Although this study has focused on individual practitioners, these findings support my findings from my examination of coercion literature in Chapter 3, in which I concluded that coercion is common in terms of a broader structural context and exercised by practitioners.

It is also possible that my role as researcher impacted on focus group discussions. This was evident when some practitioners chose not to participate in a discussion regarding their anxiety and lack of confidence regarding voice hearing during the audio-recorded discussion, but approached me afterwards to acknowledge their anxiety and request further training on voice hearing. It is possible that my role during the focus group discussion may have influenced the extent to which some practitioners felt comfortable when disclosing information about their practice.

7.10 Chapter summary

The practitioners' perspectives from focus group discussions suggest that practitioners administer medication as the main form of treatment for voice hearing and they commonly use coercion to ensure patients receive treatment. Interestingly, the focus group data provides further insight into some of the complexity of coercion for practitioners, wherein they can perceive it as both helpful and hindering. Practitioners also struggle to know how to engage with patients about their voice hearing and they tend to rely on professional frameworks to inform their understanding of voice hearing rather than learning from individual voice hearers.

CHAPTER 8: Synthesis of findings from voice hearers and practitioners

8.1 Chapter overview

To complete the construction of a grounded theory regarding voice hearing, in this chapter I discuss how I synthesize the findings from the voice hearers' interviews and practitioners' focus group discussions in order to complete the theoretical coding. First, I compare and contrast the two sets of findings and illustrate how these are complimentary or divergent. Second, I discuss how a tripartite relationship theory of voice hearing, grounded in voice hearers' and practitioners' perspectives, explains experiences of voice hearing within a treatment context. Finally, I revisit the broader 'treatment – voice hearing – relationship' thesis framework I set out in Chapter 1 and illustrate how the first three objectives of the research question are addressed in this chapter.

8.2 Synthesis of findings

The purpose of synthesising the findings was to complete the development of a theoretical explanation of voice hearing within a tripartite voice hearer–voice–practitioner relationship, situated within a mental health treatment context. Synthesizing the findings involved:

1. Returning to the voice hearer and practitioner coding.

In revisiting the voice hearers' (interviews) and practitioners' (focus groups) findings, it became evident that the interview and focus group analyses included coding that encapsulated experiences and perceptions about similar issues but from different perspectives (for example, difficulties talking about voices or difficulties related to coercion).

2. Comparing and contrasting the findings

Using the theoretical coding constructed from the voice hearers' interview analysis as a starting point, the final stage of synthesis involved listing on either side of this the two sets of voice hearers' and practitioners' coding. I listed the voice hearers' initial coding and focused coding on the left-hand side; on the right-hand side, I listed the practitioners' initial coding and focused coding. I then reviewed these in relation to each other in order to advance the theoretical coding. Through an iterative process of comparing and contrasting the two sets of findings, by first reading the code names and then reading selective quotes assigned to the codes, I reviewed the arrangement of the list of the practitioners' focused coding against the theoretical code and voice hearers' focused codes. I then re-ordered the list so that the theoretical coding encapsulated both voice hearers' and practitioners' complimentary experiences. For example, it became clear that the practitioner focused codes ‘Feeling constrained’ and ‘Challenges related to coercive practice’ are experiences related to the theoretical code ‘Agency’ and touch on similar findings from the voice hearer interviews but from a different perspective. See Table 8.1 for further details.

Evidence of a parallel process between voice hearers and practitioners became clearer through comparing and contrasting the findings. There is an interesting dynamic between voice hearers and practitioners regarding treatment and voice hearing. For example, whereas practitioners perceive they are restricted in their practice and administer medication because they fear the consequences of failing to administer it, similarly voice hearers accept medication because they also fear the consequences of failing to take it. Many practitioners construe voice hearing as a symptom of a mental illness and ‘treat’ by administering medication to stop that symptom. Voice hearers feel shame about trauma they associate with their voices but report that their voices feel threatened by practitioners’ intentions/attempts to get rid of them. Consequently, voice hearers feel increased intensity in their voices that can prevent them from disclosing information about their voices to practitioners.

These examples of interactions and dynamics within the voice hearer – voice - practitioner relationship suggests that voice hearers and practitioners are misaligned with a different agenda and skirt around core issues underlying voices. Voice hearers and practitioners are not engaging in interactions that facilitates voice hearers to talk directly about their voices. Instead, the aim seems to be less about supporting voice hearers to understand their voices and improve their way of relating with their voices to reduce distress but more about attempting to get rid of the voices through medication.

Table 8. 1: Synthesizing the analyses

VHs initial coding	VHs focused code (7)	VH theoretical codes (6)	Practitioner focused code (6)	Practitioners initial coding
Acting on what voices say **Feeling threatened by voices** **Having agency with voices** **Hurting self for relief from voices** **Lacking agency with voices** **Power relations between voices** **Voices wanting to be acknowledged**	Voice hearing is about power & control	**Agency**	Feeling constrained	Constrained by professional accountabilities Feeling helpless with treatment resistant people Feeling pressure to treat Power differential within MH services Providing disjointed treatment Removing the shackles of professional accountabilities Struggling with lack of resources or support Trying alternative approaches is scary
Importance of being involved in treatment decisions **Lacking involvement in treatment decisions**	Fearing enforced or involuntary treatment		Challenges related to coercive practice	Difficulty of respecting VHs autonomy equally with professional accountability Feeling conflicted regarding coercion Justifying coercion Mental Health Act enables coercion Protecting relationships from detrimental effects of MHA Softening coercive actions Struggling to distinguish between coercion and choice Detrimental effect of coercion on voice hearing Disempowering effect of treatment for voice hearers
Feeling valued by practitioners **Importance of being believed** **Talking about voices & problems is difficult**	Being accepted & supported	**Relating**	Engaging with voice hearing	Being curious about voice hearing Being transparent with voice hearers Building a relationship is important Having hope is important for effective treatment Normalising voice hearing Offering a variety of treatment Talking directly to voices Trying to balance power Alternative to biomedical approach to framing voices Attributing voice hearing to trauma Respecting individual experience Trying to make sense of voice hearing
Experiencing MH services as uncaring **Perceiving practitioners lack hope**	Practitioners failing to connect & understand			
Finding it difficult to relate with voices ***Being active and distracted is helpful*** ***Being critical of voices***	Finding it difficult to relate with voices			Concerned about colluding with voice hearing

Concealing voices ***Distancing self from voices*** ***Linking relating with voices & relating with people*** ***Voices interacting with emotions*** ***Wanting to get rid of voices*** **Relating more positively with voices** ***Looking after voices*** ***Perceiving voices are a guide***			Struggling to know how to support voice hearing	Dealing with the side effects of voices Feeling anxious about speaking to people about their voices Historical attitudes discourage engaging with voice hearing Perceiving voices as too distressing to engage with Struggling to get VH to disclose voices
Feeling physical presence of voices **Identifying voices as part of self** **Linking voices with trauma** **Living with voices**	Making sense of voices	**Making sense of voices**	Privileging practitioners' interpretations	Constructing voice hearing within a professional framework Practitioner knows best Taking a team approach
Framing experiences according to professional interpretation	Practitioners not talking about voices			
Being persuaded to take medication **Benefiting from medication** **Coming off medication without support** **Medication not helping voices** ***Feeling worse from medication*** ***Medication suppressing emotions*** ***Wanting to reduce or stop medication***	Dominating influence of medication	**Biomedical treatment: limited involvement or fearing enforcement**	Dominating medication treatment for voice hearing	Lack of treatment choice Medicalising and medicating Medication traps people in MH services Voice hearing is stigmatised more than other MH problems
	Practitioners failing to connect & understand Practitioners not talking about voices	**Practitioners actions** (merged with 'Relating' & 'Making sense of voices')	n/a	
	Being persecuted by voices	**Personal Bully** (only applicable to VHs)	n/a	
Voices being disruptive	Voices don't like VH getting help			

Further editing and refinement of the synthesis involved writing and revising a theoretical explanation of voice hearing. This led to the removal of the voice hearers' theoretical code 'Practitioners actions', which included collapsing the focused code 'Practitioners failing to connect & understand' with 'Relating' and the focused code 'Practitioners not talking about voices' with 'Making sense of voices'. It was also evident that the voice hearers' theoretical code 'Personal bully' was not applicable to practitioners, only to voice hearers.

8.2.1 Broader interpersonal and social context

Through completing the process of comparing and contrasting the two sets of findings, it was not only evident that voice hearers and practitioners are united by complimentary experiences and perceptions, but the theoretical coding further developed so that it encapsulated a broader tripartite relationship of voice hearer-voice-practitioner. I assigned new names to theoretical codes to represent this. Rather than the more individual-centric explanation of the voice hearers' and practitioners' findings, the final theoretical coding (Table 8.2) conceptualizes voice hearing within this broader interpersonal and treatment context.

Table 8. 2: Completion of theoretical coding

Theoretical codes before synthesis (6)		**Theoretical codes (and themes) after synthesis (5)**
Agency	➔	1. **Level of agency** (Constrained by coercion; Varying ability to influence change)
Relating	➔	2. **Interpersonal dynamic** (Extent of collaboration; Acknowledging or avoiding voices)
Making sense of voices	➔	3. **Who's making sense** (Dominant narratives; Collective search for meaning)
Biomedical treatment: limited involvement or fearing enforcement	➔	4. **Medication: helping or hindering** (Agreement on its purpose; Control over treatment decisions; Lack of alternative)
Personal bully	➔	5. **Personal bully**
Practitioners' actions		*(merged with 'Interpersonal dynamic' & 'Who's making sense')*

8.3 Tripartite relationship theory of voice hearing

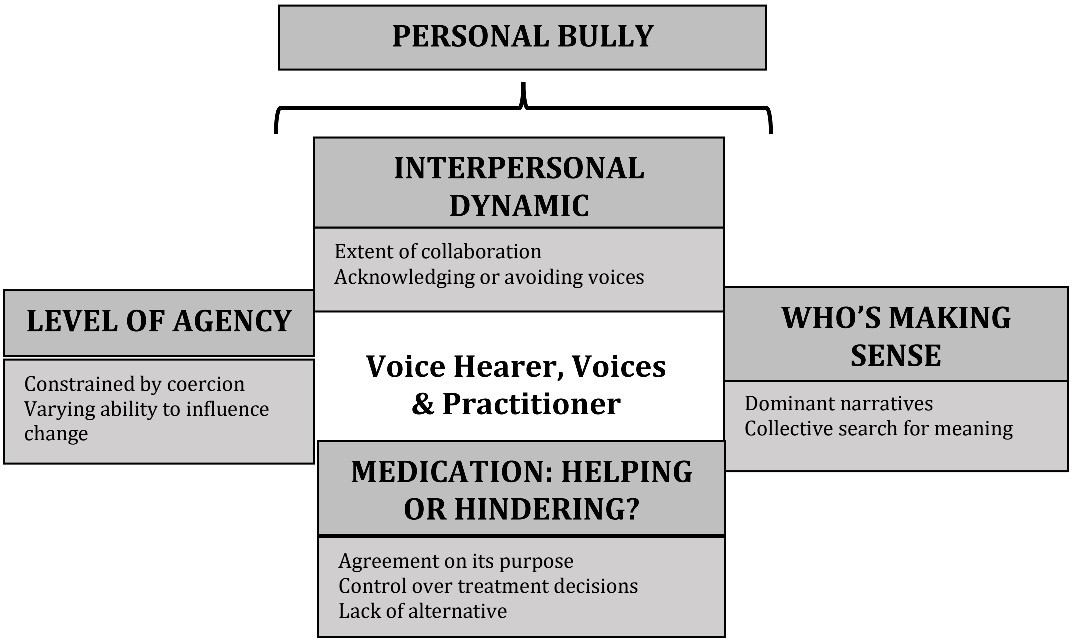
The final constructed theory arising from the synthesis consists of inter-dependent theoretical constructs that, collectively, explain experiences of voice hearing within a tripartite relationship and mental health treatment context.

With this theory, I propose that although voice hearing is a personal experience of the voice hearer, both intra-personal (between the voice hearer and their voices) and inter-personal (between the voice hearer and practitioners) relationships influence their voice hearing experiences. Both voice hearers and practitioners similarly experience challenges regarding their relative lack of power, their struggle to relate with voices, make sense of them, and find medication treatment can help but also hinder recovery.

This shifts the spotlight that currently focusses on individual voice hearers when they come into mental health services. In moving away from exclusively focusing on individual voice hearers, it raises the importance of including practitioners as part of the interpersonal relationship shared between voice hearers and practitioners and within the treatment context. This supports the notion that improving voice hearing experiences and working towards recovery within clinical contexts takes place within relationships between voice hearers and practitioners. As such, practitioners can provide a significant contribution to the success or failure of treatment of distress related to voice hearing.

Voice hearing within the treatment setting, therefore, concerns actions and processes between voice hearers, their voices and practitioners. Within the tripartite relationship, complimentary experiences and perceptions of voice hearing are influenced by the level of agency, the interpersonal dynamic, how voice hearing is understood, and the extent to which medication (as the dominant, sometimes exclusive form of treatment) helps or hinders voice hearing. Additionally, both influencing this and being influenced by it, is the way in which people experience and hear their voices speak to them, which is typically of a bullying nature. A tripartite relationship theory of voice hearing encapsulates these theoretical constructs and is illustrated below in Figure 8.1.

Figure 8. 1: Tripartite relationship theory of voice hearing



Coercion, levels of agency and the interpersonal dynamic within the tripartite voice hearer-voice-practitioner relationship influence how dominant narratives and different agendas can inform different explanations of voice hearing, and the dominance of medication treatment that marginalises other treatment approaches. Importantly, the theoretical constructs I discuss below collectively contribute towards an *active* and *changeable* tripartite relationship that influences voice hearing experiences and subsequent treatment.

8.3.1 Level of agency

The level of agency involves dynamic relations involving power, control and influence between voice hearers, voices and practitioners and the subsequent impact on voice hearing, situated within broader structural power of psychiatry. It encapsulates power that is fluid rather than fixed and varies within the tripartite relationship. As such, the level of agency can be greater in one area compared to another. For example, voice hearers may have some degree of control over their voices but have relatively little influence over their prescribed medication; by contrast, practitioners may be able to influence the prescription of medication but have little (if any) influence regarding the impact of voices on voice hearers.

Constrained by coercion

Coercion pervades mental healthcare and is experienced as challenging for both voice hearers and practitioners. Voice hearers can perceive they lack sufficient power and control in their relationships with their voices, practitioners and treatment. In terms of their relationships with voices, voice hearers' perceive their voices can make credible threats, which they believe will be realised unless they act upon the threats. By definition, this is coercive. Furthermore, whereas voice hearers can often feel marginalised and coerced by practitioners, similarly practitioners can also feel marginalised within a mental healthcare hierarchy, in which they believe they are expected to administer treatment even by coercion. Despite contrasting perceptions about coercion, voice hearers can experience both their voices and practitioners as coercive and controlling. Importantly, however, it is the *perception* about coercion that matters most and *how* practitioners are perceived to administer coercive actions that effect relationships more than the coercion *per se*.

In terms of perception, a further potential complication for the tripartite relationship is that practitioners can find it difficult to differentiate between being coercive and offering choice. That is, where practitioners can believe they are offering a choice, voice hearers can believe they are being coerced. This typically arises during conflicts with medication. For example, if a voice hearer refuses oral medication, practitioners typically respond by explaining that failure to accept oral medication will lead to enforced medication by injection. For practitioners, this can be perceived as providing a choice. By contrast, for voice hearers, this is typically perceived as an actionable threat and, therefore, coercive.

In effect, both voice hearers and practitioners can contribute more positively towards reducing voice-related distress by challenging coercion within the mental healthcare culture: voice hearers in terms of being coerced, practitioners in terms administering and failing to distinguish coercion. This is illustrative of fluid power wherein levels of agency are changeable within the tripartite relationship and influenced by perception. Whereas voice hearers mitigate their dominant voices typically by either complying or compromising their behaviour, practitioners also comply or compromise through mitigating their administration of coercion by either justifying their actions and/or attempting to administer softer types of coercion (for example, persuasion first, then negotiation, then issuing threats in order to avoid physical enforcement). These complex power relations between voice hearers, voices and practitioners are not necessarily static but can be changeable within the tripartite relationship.

Varying ability to influence change

In order to reduce voice-related distress, voice hearers' and practitioners' levels of agency is how much both can effectively bring about change to the voice hearing experience. Voice hearers benefit from practitioners who can practice with a sense of agency in terms of their perceived ability to think independently of a prevailing biomedical treatment approach and be cognisant of coercive actions. Similarly, practitioners feel less challenged and constrained when trying to support voice hearers who have sufficient levels of agency in order to resist some of the commands made by their voices and even talk about their voices. Practitioners who believe they can make a difference and bring about positive change for people who hear voices can have a positive influence on the way voice hearers can begin to address their own power imbalances: it can help voice hearers increase their perceived level of agency with their voices, with practitioners, and in terms of their treatment.

However, generally, both voice hearers and practitioners perceive they lack agency: voice hearers in terms of their ability to influence their voices and treatment; and practitioners in terms of the extent to which they feel constrained to provide effective treatment to reduce voice-related distress within their level of expertise and professional responsibilities. Whereas voice hearers wish for something to happen to either make their voices go away or to make them less distressing, practitioners wish for more professional resources and support to help improve their understanding of voice hearing and to help increase their expertise in order to help stop the person’s voices or for voices to become less distressing. As such, voice hearers can feel helpless in terms of coping with their voices but practitioners can feel helpless in terms of *helping* voice hearers to cope with their voices.

The level of agency is also influenced by whether or not, and the extent to which, medication is perceived to be helpful within the tripartite relationship. For example, depending on medication to help dampen emotional voice-related distress does little if anything to help voice hearers’ long-term development of more control over their voices. Instead of developing their confidence and ability to manage their way of living with their voices, trust is put into an external agent (medication) with the hope that it will bring about positive change. The Level of agency is also influenced by how voice hearing is understood. For example, voice hearers believing their voices to be omniscient and omnipotent will likely result in a relative lack of agency with their voices. Finally, arising from the synthesis, the level of agency is also influenced by the Interpersonal dynamic in terms of the way in which voice hearers and practitioners relate with each other and towards the voices.

8.3.2 Interpersonal dynamic

The Interpersonal dynamic encapsulates a complex set of interpersonal interactions between voice hearers and practitioners within a clinical context. These dynamics occur whilst simultaneously the voice hearer is interacting with their voices (or perhaps concentrating on avoiding interacting) and also observing or hearing internal interactions amongst their voices. As such, the Interpersonal dynamic involves active and variable relations within the tripartite voice hearer-voice-practitioner relationship. These interactions contribute towards a complex, chaotic and stressful internal and external dynamic for voice hearers but also a challenge for practitioners when trying to determine how best to engage with voice hearing experiences.

Extent of collaboration

Although talking about voices is an important element of effectively addressing voice-related distress, it is generally difficult to do for both voice hearers and practitioners. Both can avoid this through various strategies to minimise meaningful engagement with voice hearing. This can create obstacles within the voice hearer–practitioner relationship and lead to both having contrasting perceptions of each other's intentions. Voice hearers might be fearful that practitioners will attempt to elicit their confession that they hear voices or, worse still, information about their voice hearing (which in turn might provoke their voices to react aggressively). By contrast, practitioners may perceive voice hearers are concealing their voice hearing due to their mental illness. The degree to which both voice hearers and practitioners are working towards the same goal significantly impacts on the tripartite relationship. The more they are able to reach agreement on the purpose of treatment and work collaboratively during interactions, the greater the impact on reducing voice-related distress.

Acknowledging or avoiding voices

Interestingly, whereas voice hearers believe practitioners can avoid talking to them about their voices, practitioners can struggle to know *how* to engage meaningfully with voices. This can be difficult for practitioners if they perceive that voice hearers are reluctant to talk about or even disclose their voice hearing. Furthermore, they struggle to know how to actually make a difference in order to reduce or stop distress associated with voice hearing. Instead, conventional treatment approaches such as medication and/or focus on symptom management (such as anxiety) are often relied upon rather than direct engagement with experiences of voice hearing. Furthermore, whereas voice hearers may emotionally distance or distract themselves from their voices, practitioners' similarly distance themselves from voices through their emphasis on medication and symptom management.

Consequently, the quality of the interpersonal dynamic can vary. In terms of poor quality, voice hearers can struggle in a mutually hostile and critical relationship with their voices, desperately wanting rid of them, and can perceive that practitioners fail to effectively engage in voice hearing or provide sufficient support. Similarly, practitioners can struggle with their own lack of confidence and struggle to relate with voice hearing in terms of not knowing how to meaningfully engage and so can typically avoid this by focussing on voice hearers' emotions (i.e. anxiety) and behaviours (i.e. social withdrawal) that can be a reaction to distressing voices. However, better quality involves voice hearers relating more positively in less distressing relationships with their voices and feeling more valued and supported by practitioners. Similarly for practitioners, they can become more curious and talk to voice hearers about their voices and emphasise the importance of building relationships with voice hearers in order to help to build up supportive conversations and relationships.

A greater sense of perceived agency influences a more positive interpersonal dynamic. That is, where voice hearers feel generally less threatened and controlled by their voices and more involved in treatment decisions, they are likely to find it less difficult to be with their voices and with practitioners and less fearful of perceived consequences of disclosing their voices to practitioners. This, in turn, also increases opportunities for more engagement with practitioners. Voice hearers' interpersonal confidence and ability regarding their voices and practitioners is also influenced by practitioners' interpersonal qualities in terms of being genuinely collaborative, their ability to genuinely listen to the individual, and to engage with their voice hearing experiences.

8.3.3 Who's making sense?

A key element of both living with and treating voice hearing is to understand individuals' experiences of voices and the reason for why they are present. This is significantly informed by *how* voice hearing is understood. Although both voice hearers and practitioners attempt to make sense of voice hearing, even sometimes informed by the same literature or theoretical source, there is a lack of jointly working in partnership when attempting this. One consequence of this is a prevailing influence of professional explanations of voice hearing. As such, a key element of the tripartite voice hearer-voice-practitioner relationship, and more specifically experiences of voice hearing, is to be clear about how sense is made about voice hearing and who is actually influencing this.

Dominant narratives

It can be difficult for both voice hearers and practitioners to be cognisant about how they have come to understand voice hearing and to suspend pre-conceived beliefs about voice hearing influenced previously by other sources. Making sense of voice hearing is inextricably linked with power, both within the tripartite relationship and within the broader clinical context. As such, constructing an understanding of voice hearing can be influenced by the voices themselves (in terms of the voice content and their presence) and also by the voice hearers' beliefs and interpretations of their voices. For example, some voice hearers believe that their voices are omniscient and omnipotent through listening to what and how the voices speak/communicate. Additionally, understanding voices can also be influenced by practitioners' knowledge and beliefs about voice hearing. However, voice hearers' and practitioners' understanding of voice hearing is typically against a backdrop of a broader social and cultural structure in psychiatry in which a dominant medical narrative construes voice hearing as a symptom of mental illness and requiring medication as treatment, which marginalises the connection between voices and life experiences. Through more effective collaboration, voice hearers and practitioners can identify different narratives that influence voice hearing and the subsequent influence of these on how voice hearing is constructed and understood.

Collective search for meaning

The level of agency and the interpersonal dynamic influence how voice hearers and practitioners make sense of voice hearing. In terms of developing an understanding, challenging voice content and subsequent beliefs about the voices involves voice hearers interacting with their voices and, when in mental healthcare, interacting with practitioners. Whereas voice hearers may perceive they have little agency, struggle to relate with their voices, and have little understanding of why the voices are present, practitioners can also struggle to understand and, even more difficult, know how to support voice hearers to understand their voice hearing experience. Furthermore, how practitioners make sense of voice hearing is not always in synchrony with people hearing voices and, consequently, their understanding can lack sufficient meaningful engagement with voice hearers.

Voice hearers can struggle to disentangle their emotions (largely fear and anxiety) from the voices and practitioners can struggle to disentangle their own professional interpretations from their understanding of voice hearing. Consequently, an important ingredient missing in terms of making sense is a collaborative endeavour. A lack of collaborative exploration with individuals about their voices can lead to an increasing reliance by both voice hearers and practitioners on a professional framework and explanatory models and for practitioners to subsequently develop a shared understanding not with the individual voice hearer but with their professional colleagues. This, however, can exclude the individual voice hearer from the process of making sense. As such, identifying power relations in determining *who* is making sense of voice hearing, and *how* this is informed, is an important contribution towards reducing voice-related distress.

8.3.4 Medication: helping or hindering?

Both voice hearers and practitioners overwhelmingly experience medication as the primary treatment to the extent that the real treatment option is, mostly, regarding the specific type and dosage rather than whether or not it will or should be prescribed. The key issue regarding the use of medication is to determine whether or not it is helping or hindering voice hearing experiences and for voice hearers and practitioners to reach an agreement on how best to use it (including coming off it) in a context of limited treatment options.

Agreement on its purpose

Both voice hearers and practitioners have complex relationships and mixed experiences with medication and, therefore, it is important to determine whether it is helping or hindering voice hearing and to agree on how best to use it. Although both generally perceive there is benefit to some extent from using medication, equally, they also believe it can be harmful but either struggle or lack sufficient agency to stop using it. Voice hearers can benefit from it relieving voice-related distress to some extent but it can have insufficient impact on voice content and voice presence and cause unwanted side effects. Similarly, practitioners rely on medication as a means of responding to voice hearers' distress but also recognise that there are longer term negative implications, such as dependency, side effects and stigmatising consequences related to using it. As such, the challenge for both practitioners and voice hearers is to develop confidence and sufficient agency to change distressing voices through appropriate treatment, including agreement on the purpose of using medication.

Control over treatment decisions

Voice hearers in this study feel disempowered regarding decisions made about their own treatment but, similarly, practitioners can also feel disempowered in terms of changing or influencing some treatment decisions. The extent to which practitioners can involve voice hearers in treatment decisions influences voice hearing experiences. A key issue, therefore, is the extent of control over treatment. Voice hearers may wish to stop or reduce using medication but receive insufficient support from practitioners, who can similarly feel unsupported by their colleagues to help voice hearers reduce or discontinue medication. Voice hearers' knowledge that practitioners can enforce medication, and practitioners' knowledge that sometimes changing medication can be beyond their influence, entangles medication with power and a perceived lack of agency within the tripartite relationship.

Furthermore, voices can also comment on medication and either encourage or discourage voice hearers to take it.

Both voice hearers and practitioners recognise that medication is often accepted because of a combination of practitioners' persuasion and voice hearers' fear that refusal will result in it being coercively enforced. Consequently, using medication exerts a power over voice hearers in terms of trapping them in mental health services and a power over practitioners in terms of them becoming dependent on administering it at the cost of talking to voice hearers about their voices. As such, both benefit to varying degrees from using it at some point whilst, simultaneously, experience negative consequences from the dominant role that it plays in treatment.

Lack of alternative

Given the dominance of medication, both voice hearers and practitioners perceive they are in effect stuck with it due to a lack of treatment choice and/or a lack of agency and support to reduce or discontinue it. The extent to which practitioners can provide a range of treatment options greatly influences voice hearing experiences. However, where there is a lack of agency, insufficient collaboration, a lack of meaningful understanding of voice hearing, and within a treatment context in which medication is heavily relied upon, both voice hearers and practitioners can become over-reliant on medication and lack confidence on alternative treatment options. Consequently, both contribute towards a pattern wherein voice hearers intermittently comply with prescribed medication, and potentially use other non-prescribed medication, and practitioners engage in a longer term process of monitoring voice hearers' compliance. This illustrates that the extent to which medication is used and perceived as either helpful or hindering is influenced by the level of agency, the interpersonal dynamic and dominant narratives influencing how voice hearing is understood within the tripartite relationship.

8.3.5 Personal bully

The above four theoretical constructs both influence, and are influenced by, the Personal bully. This is uniquely experienced solely by voice hearers and initially appears before their first admission into mental healthcare but continues beyond this point and impacts on the tripartite voice hearer-voice-practitioner relationship. Through voice hearers increasing their level of agency, developing more effective relationships, finding a meaningful explanation and taking greater control regarding if and how they use medication can all positively impact on the Personal bully. This is to the extent that it can change the perceived function of voices (or negative way in which they are experienced and heard by voice hearers) through voices no longer being perceived as bullying. It can also change the function of voices to become more supportive, even protective, for voice hearers.

8.4 Revisiting the 'treatment – voice hearing – relationship' framework

I introduced the 'treatment – voice hearing – relationship' framework in Chapter 1 to encapsulate the broad aim of this thesis. To recap, this is to understand voice hearing within a mental health treatment context in which voices are experienced; and, more specifically, within a tripartite relationship of voice hearer-voice-practitioner. By synthesising the two sets of voice hearers' and practitioners' findings, I have addressed the first three objectives of the research objectives set out in Chapter 1:

1. To understand how voices can influence, and be influenced by, mental health treatment, from the perspectives of: (a) patients who hear voices and received treatment and (b) mental health practitioners who provide treatment for patients who hear voices.
2. To understand whether "coercion" exists within the tripartite relationship of voice hearer-voice-practitioner in the context of mental health treatment.
3. To use the above to develop theory that explains how patients' experiences of voice hearing can be mitigated (either attenuated or exacerbated) by the voice hearer-voice-practitioner relationship during mental health treatment.

Through the tripartite relationship theory, I propose that improving our understanding of voice hearing and the support provided can be achieved by broadening the current conventional emphasis in mental healthcare that solely focuses on the individual intrapersonal context to, instead, emphasize the clinical and relationship contexts in which voice hearing is experienced. Within this broader context, voice hearing is mediated through tripartite voice hearer – voice - practitioner relationships. Encapsulated within the active and complex tripartite relationship are fluid movements of power and control, which influence how voice hearing is understood, and are influenced by a complex relationship with medication.

Through working more closely together, this fluid power can become a positive energy within the tripartite relationship. Experiences of voice hearing can be positively influenced through the tripartite relationship by increasing voice hearers' and practitioners' levels of agency, collaboratively exploring effective ways to engage with voice hearing, developing meaningful understandings of voices, and identifying a role for medication (if to be used at all) through meaningful collaboration in treatment decisions. This not only values the personal experience and internal dynamics associated with voices for the voice hearer but, importantly, also recognises that power struggles, interpersonal challenges, developing knowledge and functioning within a treatment context that predominantly uses medication as a primary treatment are challenges that are experienced within an interpersonal context involving voice hearers, their voices *and also* practitioners. This recognises the experience of voice hearing as personal but emphasizes the importance for practitioners and voice hearers to work in partnership and, therefore, engaging collaboratively in order for treatment approaches to be successful.

Conventional treatment approaches place the emphasis on practitioners to assess, diagnose and treat people who hear voices. As such, the spotlight has traditionally been firmly placed on practitioners' expertise to treat voice hearing and for voice hearers to accept this treatment. However, with this conventional approach, not only are practitioners separate to voice hearers' *experience* of recovery but they can also struggle to reach a sufficient level of expertise to effectively treat voice-related distress. Instead, conceptualising practitioners as being part of a tripartite voice hearing experience extends their responsibility of administering treatment by also firmly placing them as part of the process of recovery. This invites practitioners to attend to their own levels of agency and re-evaluate their own professional development and expertise in order to increase their therapeutic value for the treatment process for voice hearers.

Finally, if practitioners are to be of genuine therapeutic value in reducing voice-related distress, they must examine how they can positively make a difference for voice hearers, how interpersonally effective they are in relationships with voice hearers, how they might support voice hearers to make sense of voices, and the extent to which they collaboratively determine whether medication is helpful or hindering. Therefore, in addition to voice hearers engaging in change to help their own recovery, this sets out expectations for practitioners to also change if they are to be of therapeutic value in the process of recovery.

8.5 Chapter summary

Based on the synthesis of the findings from individual voice hearer interviews and practitioner focus group discussions, I propose that voice hearing is mediated by the following factors/experiences within a tripartite voice hearer – voice - practitioner interpersonal relationship. First, by the level of agency for both the voice hearer and practitioner in terms experiences of voices and treatment, particular regarding whether or not the voice hearer and practitioner perceive they can influence change and whether or not they feel constrained by coercive practice. Second, by the interpersonal dynamic between the voice hearer and their voices and practitioners, particularly regarding the level of collaboration and acknowledgement of voices. Third, by the approach taken to make sense of voice hearing and the extent to which the voice hearer and practitioner collaborate to reach an understanding of voice hearing. Fourth, by the role of medication in voice hearing, particularly regarding the level of collaboration between the voice hearer and practitioner in treatment decisions. Finally, by the way in which the voice hearer perceives their voice(s) as a personal bully.

CHAPTER 9: Discussion

9.1 Chapter overview

In this chapter, I discuss my study findings in relation to established theory and relevant literature and examine how the tripartite relationship theory supports and expands on current literature related to voice hearing by discussing each theoretical element. These findings compliment key elements of contemporary psychosocial approaches, including relevant qualitative and previous Grounded Theory studies, psychosocial approaches, Relating Theory (and associated Relating Therapy), and the Hearing Voices Network approach (initially through the work of Romme and Escher).

I began this thesis by discussing my observations from my clinical practice of difficulties related to voice hearing for people hearing voices and for practitioners providing support and treatment. This included my observations of practitioners' treatment approaches inadvertently contributing to voice hearers' distress. Consequently, I investigated experiences of voice hearing, situated specifically within in a mental health treatment context, in order to develop theory about voice hearing grounded in voice hearers' and practitioners' experiences. My study findings, discussed in Chapter 8, contribute towards a philosophical shift in terms of situating voice hearing within a broader clinical context rather than the conventional medicalized approach that locates problems in the individual voice hearer. This contributes to current knowledge about voice hearing through its emphasis on locating distress related to voice hearing, and subsequent treatment and recovery, within an interpersonal context in which both voice hearers *and* practitioners contribute. This also emphasizes the importance of acknowledging dominant narratives and agendas associated with experiencing and treating voice hearing.

This is an under-researched area, in which previous empirical literature has largely taken an individual-centric approach to understand predominantly voice hearers' internal context but has (inadvertently) marginalised voice hearers' external contexts. This challenges the emphasis of policy drivers to broaden the current steer influencing practitioners to develop psychosocial expertise to treat voice hearing through their application of professional frameworks (such as CBT) and predominantly in conjunction with medication. Practitioners face real world challenges in mental health practice when striving to develop sufficient 'expertise' and voice hearers continue to experience distress under conventional approaches in which they are expected to accept practitioners' expertise and treatment approaches. Furthermore, psychosocial interventions have only low to medium effect (Bighelli et al.,

2018) and opportunities for practitioners to develop expertise and receive sufficient support to deliver these interventions are limited (Gilburt, 2015).

9.2 Previous Grounded Theory literature related to voice hearing

To my knowledge, this is the first study to develop a grounded theory that conceptualizes voice hearers' concurrent intra- and inter-personal interactional experiences relating to their voices and practitioners. No previous research has examined voice hearing through an interpersonal relationship that encapsulates voice hearers' simultaneous internal and external interactions with their voices and practitioners respectively or collectively brought together the range of similar constructs (Personal bully, Level of agency, Interpersonal dynamics, Who's making sense, and Medication: helping or hindering) found in this study to account for voice hearing experiences.

Few studies have previously utilised Grounded Theory methodology to explore specifically voice hearing. In their investigation of voice hearers' explanations of their voices (n=15), Fenekou and Georgaca (2010) emphasize the importance of meaning through: (1) the function of voices (what voices say and how voice hearers react to them); and (2) their understanding of voices (the way voice hearers explain the source and origin of voices). They suggest that practitioners do not routinely ask voice hearers about their voices, which can unhelpfully increase withdrawal from others to develop potentially unhelpful ways of being with their voices. I also found in my study that practitioners typically do not talk to voice hearers about their voices. Fenekou and Georgaca suggest that this lack of practitioner engagement is due to the conventional 'psychiatric' approach wherein practitioners frame voices as symptoms rather than meaningful experiences. By contrast, although practitioners in my study recognized a long-standing culture in mental healthcare in which voices are perceived as a medical symptom, they also recognized voice hearing as meaningfully linked in some way to voice hearers' life history. Instead, I found in my study that practitioners mainly lacked confidence, knowledge and expertise in order to know how to engage in meaningful discussion about voices and felt pressured to administer conventional medication to 'treat' voices. This suggests incongruence between cultural and individual practitioner values.

Jackson et al. (2011) investigated how people (n=12) develop positive relationships with voices, including factors affecting these and how they change over time. Their model suggests that reducing fear (through greater understanding and closer relationships with voices), establishing control (developing healthier relationships with voices and integrating voices with life experiences), relational closeness (with voices and connecting with their community), and developing a personally meaningful narrative regarding voices are all core components of positive relationships with voices. The findings from my study concur with the model developed by Jackson et al by including all four of these elements in the tripartite relationship theory. In terms of reducing fear, establishing control and relational closeness, I found these are achieved through increasing the perceived level of agency, improving the quality of the interpersonal dynamic, and establishing a collaborative approach to determine the role for medication (if at all). Developing a personally meaningful narrative in the tripartite theory is represented through the 'making sense' construct.

Holt and Tickle (2015) examined voice hearers' (n=8) understanding of their voices and found important factors included voice hearers' search for meaning and the framework they used to understand voices (specifically stress, trauma, attachment difficulties, anxiety and depression, spirituality, and rejection of others' theories). Whereas Jackson et al stress the importance of engaging with a community, Holt and Tickle propose that voice hearers actively search for meaning and attempt to construct an understanding of their voices through three main frameworks (intra personal, interpersonal, and parapersonal) but is effected by voice hearer's sense of agency, stigma and sense of hope(lessness). Interestingly, Holt and Tickle also found that practitioners failed to ask voice hearers' about their voice hearing experiences and sometimes voice hearers' attempts to gain an understanding about their voices were met with increases in medication. I also found these two issues in my study. I also concur with Holt and Tickle in terms of their assertion that voice hearers are presented with a limited range of explanatory frameworks, that practitioners' dominant position privileges a professional meaning regarding voice hearing, and the difficulty for practitioners to balance professional knowledge with remaining open to alternative frameworks about which they have little knowledge.

McHale et al. (2018) proposed a model of engagement in mindfulness-based group therapy from semi-structured interviews with voice hearers (n=13) and therapists (n=3). Their model illustrates that voice hearers negotiate their commitment to groups through investing their time and energy and then subsequently evaluating the value of their commitment. Interestingly, they found that voice hearers' previous treatment experiences influence their current engagement and motivation for treatment. I concur with this and encapsulated practitioners' contributions in the tripartite relationship to help account for broader experiences of treatment.

The findings from my study support all four of the above previous Grounded Theory studies regarding the importance of functioning, relating, active searches for meaning, and control related to voice hearing. However, whereas the above studies emphasize an individual-centric theoretical account regarding voice hearing, I conceptualized in my study voice hearers' broader interpersonal context that includes contributions from voice hearers, their voices, and practitioners. Extending the findings of the above studies, I found that voice hearers' relating with their voices, their level of control over their voices and influence in treatment decisions, and their development of a personally meaningful narrative are significant factors explicitly recognized in through the tripartite relationship theory. Furthermore, the role of power is emphasised in my study through the tripartite relationship theory, including its influence on understanding and meaning and also in terms of voice hearers and practitioners being cognizant about who or what has influenced the way in which voice hearing is understood and the subsequent treatment.

9.3 Personal bully

Although previous studies have identified abusive/aggressive voice content, there has been less attention given to investigating the way in which voice hearers experience their voices specifically during interpersonal interactions or within a specific mental health treatment context. In my study, I developed the Personal bully to represent voice hearers' perceived overall experience of their voices, which impacts on and is impacted by, their interactions with practitioners. By emphasizing the impact of the perceived role and content of voices through the Personal bully and within the tripartite relationship, my study findings support current literature regarding voice hearing. My findings concur with the phenomenological findings of Woods et al. (2015) in terms of people experiencing multiple voices with distinct characteristics, which can be commonly abusive or violent, and can change over time. The Personal bully, however, is more than the incessant abusive content and taunting of voices; it is also voice hearers' experiences of their voices following them around everywhere with their high levels of hostility and the way in which they disrupt social interactions and discourage voice hearers to seek help.

CBT approaches to voice hearing have targeted voice hearers' beliefs about voices, hypothesizing these to be more impactful than voice content *per se* (I discuss this later in the chapter). Consequently, relatively little attention has been given in the literature to voice content. However, given the low effect size of CBT for voice hearing and its insufficient impact on negative voice content, as I discuss in Chapter 2, there has been a recent growing interest amongst scholars to identify interventions that directly target voice content (Larøi, 2019).

The findings from my study support this shift. Interestingly, Larøi et al propose that culture and voice hearers' negative relationships with their voices influence negative voice content. The findings from this study concur with Larøi et al in terms of encapsulating the contribution of both of these factors but also including voice hearers' *positive* relationships with some voices and the important contribution of practitioners within this relationship. The influence of culture is dispersed across the different theoretical constructs of the tripartite relationship theory. For example, it is emphasized through perceived levels of agency in terms of the impact of the mental health treatment environment on voice hearers' and practitioners' ability to influence change; and the dominance of biomedical approaches in understanding voice hearing and influencing treatment (and often involving coercion). For voice hearers these influence, and are influenced by, the Personal Bully and collectively encapsulate a broader concept than voice content *per se* to include the perceived presence of voices and their subsequent perceived nature in terms of the way in which voice hearers interact with them.

9.4 Agency and voice hearing

> "Voice hearing is about power and control". (Hillary, research participant and voice hearer)
>
> "It is a massive power difference you're having to overcome" ....[and later, referring to challenges of the team hierarchy influencing treatment involves managing]…"the power differential between us and the wards". (Jack, research participant and practitioner referring to working with voice hearers)

In terms of literature related to voice hearing, power is described in terms of voice content, voice hearer's appraisals of voices, in relations between voice hearers and their voices, and in terms of practitioners' administration of treatment. Less attention is given in the literature to power relations between different voices, to the impact of coercion on voice hearing, or to the effects of an interpersonal dynamic between voice hearers, voices and practitioners. The findings from my study contribute to current knowledge about voice hearing by explicitly including these elements in a theoretical conception of voice hearing experiences.

I found in my study that voice hearers typically experiencing a constant "power battle" (Edith, research participant and voice hearer) with their voices but also often with practitioners. The above quotes from Hillary, Jack and Edith are examples from the study findings that illustrate the central role of power associated with voice hearing affecting voice hearers *and* practitioners. Although voice hearers describe their voice-related experiences as being about power and control, I found in my study that this extends beyond voice hearers' interactions with their voices to include practitioners.

In Chapter 2, I briefly introduced Hearn's (2012) conceptual reference grid, consisting of five sets of pairs of terms that reflect the complexity of defining power. In his first set of terms, Hearn contrasts physical and social power. In my study, both voice hearers and practitioners spoke about physical power such as physical restraint and enforced medication. Hearn's description of social power as involving power through the "application of some invisible force" (p5) is also useful in terms of explaining perceptions that voices have the ability to carry out threats or senior practitioners have the ability to influence practitioners' application of their professional responsibilities. Hearn's second set of terms, power 'to' and power 'over', contrasts power as a capacity to realize ends with power as the control of one agent over another. This is also described as a relational concept in the sense that an individual's ability to exercise power is structured by social relations (Pansardi, 2012). In my study, voice hearers mostly described examples of either their voices or practitioners demonstrating power over them, such as physical enforcement (in the case of practitioners) or exercising verbal threats to bring about an action (in the case of practitioners and voices). Voice hearers described the power relations between different voices, whereby for example one voice asserts dominance over another voice, and which causes distress for the voice hearer. Practitioners also described examples of their perceptions that their employer also have power 'over' them in terms of constraining their practice.

In terms of the tripartite relationship, power is fluid, active and dispersed between voice hearers, voices and practitioners and situated within a mental health treatment context. This relates to the voice content heard by voice hearers, the interpersonal relationships and level of agency voice hearers experience with their voices and practitioners, the influences relating to how voices are understood, and how treatment (medication specifically) is decided. Hearn argues that power concentrates in particular areas and within a "web of relations" (p9) and hierarchies, which is a useful conception when applied to the tripartite relationship. That is, there is an asymmetrical rather than balanced distribution of power within the voice hearer-voice-practitioner relationship and, additionally, for voice hearers and practitioners within the mental health treatment environment. Although much of the focus in my study is concerned with an 'agent' conception of power, the tripartite relationship theory is situated within the structure of mental healthcare.

The evidence synthesis of coercion literature, as I discuss in Chapter 3, establishes mental healthcare as commonly involving coercive practice through a range of softer to harder coercive approaches and that coercion negatively affects relationships and treatment within mental health services. From this I concluded that coercion is commonly experienced in mental healthcare, administered by practitioners, and encapsulated by three themes: Less than therapeutic relationship, Journey through the system, and Losing a sense of self. My study findings support and extend this. Empirical evidence is informed predominantly by an individual-centric approach of patients' and/or practitioner' experiences regarding coercion. Less attention has been given in the literature to the effect of coercion on interpersonal relationships between voice hearers and practitioners, and none specifically concerning coercive relationships between voice hearers and their voices. Through the tripartite relationship theory, my study extends current knowledge about coercion in terms of emphasizing the contribution of voices to voice hearers' overall experiences of coercion, wherein voices are perceived to be coercive, in addition to practitioners' coercive treatment approaches. Furthermore, I also found in my study that practitioners can perceive they lack sufficient agency and/or expertise to sufficiently challenge coercive practice, or even recognise coercion, and potentially also perceive they too are being coerced within their hierarchy of peers to administer specific treatment approaches. As such, coercion should be conceptualized within voice hearer-voice-practitioner relationships in order to compliment current understanding about its influence on treatment experiences.

In terms of voice hearing and power within the psychosocial literature, voice hearing has been examined largely within a CBT framework and conceptualized in terms of beliefs related to voice hearing. Earlier CBT approaches were closely aligned with the findings by Chadwick and Birchwood (1994), who concluded that voice hearers' beliefs about voice power (omnipotence), identity and purpose (malevolent or benevolent) determine their level of distress and their voice-driven behaviours. The findings from my study contrast with this earlier premise that voice hearers' beliefs should be targeted as the most *significant* factor regarding understanding and treating voice hearing. Recent psychosocial approaches consider factors beyond voice hearers' beliefs, expanding the focus from early CBT approaches on behavioural and coping-focused interventions (Thomas et al., 2014) to incorporate a shift to challenge the conventional approach that conceptualizes problems within individual people to give greater importance to meaning, social context and life circumstances (Cupitt and Cooke, 2018). The findings from my study support this psychosocial evolvement but additionally include practitioners within an interpersonal voice hearer-voice-practitioner dynamic, the process of making sense of voices and the treatment approach that influence (and are influenced by) the content and nature of the voices.

I also found in my study that both voice hearers and practitioners actively avoid voice hearing, which can contribute towards the continuation of voice-related distress. Such avoidant behaviour, arguably, act as safety behaviours utilized in the belief that they will prevent harm. Hacker et al. (2008) investigated whether voice hearers' (n=30) use of safety behaviours were influenced by their beliefs about their voices' omnipotence. They concluded that voice hearers monitor for three sources of threat: (1) harm, (2) public shaming and (3) threat of loss of control, and their use of safety behaviours is associated with increased voice-related distress (only relief in the short term) and mediated by beliefs about voice omnipotence and malevolence. By including practitioners in developing an understanding of voice-related safety behaviours, my study compliments Harker et al. In terms of the tripartite relationship theory from my study, practitioners may inadvertently encourage (or fail to discourage) voice hearers' use of safety behaviours through their own lack of engagement in voice hearing, which in itself is influenced by their own level of agency, their understanding of voices, and their treatment approach. As such, including practitioners' actions contributes to current knowledge regarding voice hearers' use of safety behaviours. Furthermore, findings from my study propose that practitioners may also use safety behaviours. For example, through lack of agency and treatment options, practitioners can lack sufficient confidence to positively impact on voice hearing and so avoid meaningful engagement with voice hearers. Future investigations are needed to examine in more detail practitioners' avoidant behaviours regarding voice hearing, including the functioning and purpose of it (i.e. avoid, escape or mitigate perceived threat to their perceived value or professional worth).

The importance of agency in mitigating distressing voice hearing experiences is also recognized by Bjornestad et al (2017) in their thematic analysis of patients (n=20) recovering from psychosis They found that 'Establishment of subjective self-agency' is important for voice hearers' recovery, which involves their increased awareness of self-agency, increased control and positive involvement of others and reduced anxiety. Interestingly, they also found that, although voice hearers believe medication is helpful in the short term, it is incompatible with self-agency in the long term. I similarly found that voice hearers generally believe that medication can be helpful to some extent in the short term but problematic longer term. This compliments Bjornestad et al by proposing that increased agency involves greater clarity regarding the role of voice hearers and practitioners in the decision-making process, which typically involves medication, and whether medication is perceived as helpful or not.

9.5 Interpersonal relations

In terms of interpersonal relations, previous empirical literature has focused on relationships between practitioners and patients and relationships between voice hearers and their voices. Regarding the latter, examining how voice hearers relate with their voices has become an area of increasing interest. Previous empirical literature has examined voice hearers' personification of voices (McCarthy-Jones et al., 2014, Woods et al., 2015) and through a relational framework (Hayward et al., 2014) but there have been no previous investigations to my knowledge that specifically focus on a tripartite relationship between voice hearers, voices and practitioners. The findings from my study compliment current thinking regarding a relational approach by expanding on the current voice hearer-voice emphasis that has informed theoretical development of relational approaches by including practitioners within the voice hearing relational process.

My study finding that both voice hearers and practitioners typically find it difficult to talk about voices supports previous research findings for both voice hearers' (Bogen-Johnston et al., 2020) and practitioners' (Coffey and Hewitt, 2008, McMullan et al., 2018, Harris and Panozzo, 2019). For example, in a recent study examining the early career experiences (first five years) of Australian nurses regarding their responses to voice hearers, White et al. (2019) found that, despite educational changes to improve voice-hearing support, nurses had little confidence in knowing what to actually do other than administer medication. Similarly, Bogen-Johnston et al. (2020) concluded that, even within an Early Interventions in Psychosis service (with a specific remit to engage with and treat voice hearers), practitioners do not always feel comfortable having conversations about voices. Furthermore, they found that, having initiated conversations, practitioners' level of confidence, training and understanding of voices (in addition to whether or not voices are concerning for voice hearers) are important factors that determine whether or not their conversations about voices continue (Bogen-Johnston et al., 2020). Finally, Kramarz et al. (2020) also concluded from their interviews with practitioners (n=18) from acute psychiatric wards (n=5) that, despite good intentions, practitioners lack sufficient understanding and confidence to effectively support voice hearers. These findings support the importance of theoretical development regarding voice hearing in my study in order to expand current knowledge regarding voice hearers and practitioners meaningfully engaging in discussion regarding voice hearing.

Findings from earlier studies such as Hayward (2003) and Birchwood et al. (2004) that associate voice hearers' relating with voices with their social interactions, and by Thomas et al. (2009) mapping of a wide range of interpersonal relating patterns onto voice hearing, support the argument for contextualizing voice hearing within an interpersonal context. The findings from this study compliment the evidence base by expanding the concept of relating to include voice hearers' and practitioners' complimentary behaviours, which encapsulates treatment experiences for the voice hearer and the clinical effectiveness of the practitioner. However, in contrast with Hayward and Birchwood et al, the findings from this study propose that relating is not a permanent dominant-subordinate style but can be dynamic and changeable. Although I found in my study that most voice hearers experienced subordinate relationships with voices and practitioners, some developed more positive relationships with their voices and this was mirrored with more helpful relationships with practitioners. Additionally, the inclusion of practitioners in the interpersonal dynamic (not just the dyadic voice hearer – voice relationship) extends current thinking to acknowledge that practitioners can also feel subordinate, helpless and less effective in treatment, which negatively affects voice hearing experiences.

From their review of the 'relating' literature (n=33 articles), Hayward et al. (2011) recommend that theoretical models need to: (1) recognize voice hearers' potential to feel empowered in their relationships with voices and people; (2) include the concept of distance both in terms of relating with voices and others; and (3) recognize the adaptive nature of voices. My study findings include these recommendations in the tripartite relationship theory: voice hearers can potentially perceive increased empowerment in their relationships with their voices and other people (Level of agency), utilize the notion of distance in terms of their relating with voices and practitioners (Interpersonal dynamic) and experience their voices change and/or changes in how they perceive their voices (Personal bully).

My study also concurs with the theoretical merger by Paulik et al. (2013) and Hayward et al. (2017) of relating (through the Interpersonal dynamic) and CBT approaches (broadly through the Level of agency and Who's making sense). Paulik et al propose targeting voice hearers' beliefs about voices to enable a more assertive approach when engaging with voices. Hayward et al developed Relating Therapy (merged Relating Theory and Birchwood's interpersonal CBT model of auditory hallucinations), which aims to modify negative interpersonal relating associated with voice-related distress (submissive or aggressive relating and intrusive relationships) with voices and others. However, whereas Paulik et al. and Hayward et al. target beliefs and negative relating respectively in order to reduce voice-related distress, I propose from the findings of my study that relating is only one element of voice hearing experiences. This both influences, and is influenced by, other factors (personal bully, agency, making sense, treatment decisions/involvement), all of which involve practitioners' contributions and contribute towards the voice hearing experiences.

Exploring voice hearers (n=9) experiences of Relating Therapy (from the above Hayward et al, 2017 study), Hayward et al. (2018) found that increased assertiveness led to voice hearers feeling stronger, experiencing an improvement in mood and in their relationship with their voices, which also positively influenced relationships with others. Hayward et al. make an interesting observation from their findings to conclude that a negative and submissive relationship is a necessary condition for the presence of voices and that voices are unlikely to persist if the voice hearer – voice relationship improves. By contrast, I found in my study that voice hearers can have negative relationships with their voices but these can change and later be perceived as positive and continue to be heard (i.e. a negative and submissive relationship is not a necessary condition for their presence). There are commonalities between the Interpersonal dynamic and Level of Agency constructs from my study and the findings from Hayward et al in terms of changes to voice hearers' perceived level of influence and their relating with voices. Additionally, my study encapsulates practitioners' contribution towards this. Finally, I concur with Hayward et al in that some voice hearers do not have communicative content with some voices and, hence, lack a "speaker behind the voice". For example, one participant (P01) in my study referred to a *presence* (rather than content) regarding one of his voices, which was always being just behind the wall in any room he entered and out of direct sight.

9.6 Making sense of voice hearing

It is evident from my study findings that both voice hearers and practitioners would benefit from remaining open-minded in order to consider different explanatory frameworks regarding voice hearing. To help facilitate this, key underlying issues encapsulated within the tripartite relationship theory include identifying dominant narratives and developing a personal understanding (rather than narratives being imposed). Although the above studies make important contributions towards understanding voice hearing, it is the work of Romme and Escher and the subsequent Hearing Voices Network that have been most explicit in terms of encouraging voice hearers to socially connect with their peers (and others) in order to consider their own meaning associated with their voice hearing. In this respect, the findings from my study support the importance placed on the potentially empowering act of constructing meaning and making sense of one's own experiences and, ideally in terms of a clinical context, through supportive relationships with practitioners.

The mental health treatment context, in which the tripartite relationship theory is situated, influences experiences related to voice hearing and subsequent understanding. As I discuss in Chapter 3, this context commonly includes coercive treatment. Several studies have contrasted the influence of this context on voice hearing with that of the Hearing Voices Network (and associated Hearing Voices Groups). Oakland and Berry (2015) found from their interviews with voice hearers (n=11) that, in contrast to mental health treatment environments, Hearing Voices Groups provide a meaningful forum in which voice hearers feel valued, empowered and more in control. They infer, through a sub theme 'it's their rules', that patient-practitioner relationships in mental healthcare are undermined by a power imbalance and are potentially conflictual.

Similarly, Dillon and Hornstein (2013) contrast the powerful effect of identity shaped by psychiatry with the Hearing Voices Network/Hearing Voices Groups, in which the former portrays voice hearers as becoming unreachable and incapable and the latter creating an "alternative, experientially grounded perspective" (p.287) to shape a different identity. They argue that a dominant psychiatric narrative constructs people as "chronic" or "treatment-resistant", despite it being the medication (rather than the person) failing to prevent distressing voices. I also recognize this from my observations in clinical practice and, as I discuss in Chapter 2, the expansion of mental health community services from the early 2000s included specialist teams with a remit to treat "difficult to engage" patients typically with "chronic" and "treatment-resistant" mental illness (for example, Assertive Outreach Teams) . Similar to Oakland and Berry, they highlight power imbalances and contrast traditional hierarchies and power structures within mental health treatment contexts with mutually respectful relationships within Hearing Voices Groups. Dillon and Hornstein importantly also note that, although voice hearers arrive at Hearing Voices Groups with their own framework for their experiences (either their own ideas or what practitioners have told them), they are exposed to peers and other ways of thinking about voice hearing to help construct their own narrative.

In another more recent study, this time involving a national US sample (n=113, of which 15 were further interviewed), Hornstein et al. (2020) also found that the style of Hearing Voices Group interactions and discussion content were two key elements that enabled change to occur. They developed a three-phase model (discovery, reframing and change), which encapsulates the importance for voice hearers to explore meaning (being open to explanatory frameworks), develop new ways to respond to voices, and for social interactions to share experiences without potential implications of power hierarchies experienced in mental healthcare (i.e. non-medical language, absence of professional roles, voluntary nature). A key finding within the change element (phase 3), which is relevant to the findings from my study, was that "voices became less bullying" and led to "more limited and targeted use of medication, or tapering off it entirely" (p7). In my study, participants (Frank, Hillary, Ian, Jenny, Mike and Noel) who experienced their voices as less bullying and more limited or targeted use of medication also described more positive and less distressing relationships with their voices and greater perceived levels of agency regarding their of voices and treatment. Returning to Hearn's (2012) conceptual grid, these are examples of voice hearers' power 'to' in terms of positively changing how they relate with their voices and treatment.

Finally, de Oliveira Couto and Kantorski (2018) also recommend a Hearing Voices Network approach to talk about voices, exploring characteristics about voices and exploring whether this relates to voice hearers history. They found from their systematic review (n=35 articles) that meaning is often informed by trauma, religion, cognitive processes, depression, and culture, and is associated with higher levels of anxiety, depression and negative beliefs about oneself. Furthermore, it also influences relationships with voices, the social relationships of voice hearers, levels of distress and power and control over voices. Aligned with earlier Relating literature (discussed above), de Oliveira Couto and Kantorski also found complimentary elements of relating with voices and social relating and evidence that relationships with voices can change (for some) through interactions with voices.

The findings from my study concur with those of the above four studies (Oakland and Berry, 2015, Dillon and Hornstein, 2013, Hornstein et al., 2020, de Oliveira Couto and Kantorski, 2018) in terms of the potential impact of the mental healthcare context on voice hearers. As previously discussed, this context includes coercive practice. The authors also extend the findings of these studies by contextualizing meaning and relationships with the contributions of both voice hearers and practitioners towards improving voice-related experiences. Whereas the above four studies stress the value of the Hearing Voices Network (and associated Hearing Voices Groups) as a forum in which voice hearers can make sense of their voices without pressure of adopting particular narratives, I propose that my study findings can replicate these values in a treatment environment. That is, voice hearers have the potential to experience increased support in the treatment environment that align with the values of the Hearing Voices Network. This emphasizes the importance of strengthening therapeutic relationships in mental health treatment settings.

Finally, the findings from my study also compliment, and can be applied to encapsulate, a first person account of voice hearing by Ellerby (2018). His description of his recovery can be summarised in four stages. First, building trust with his voices and therapist. Second, talking to voices (therapist talked directly to his voices). Third, shifting the power balance (therapist developed authority over voices and challenged their criticism of Ellerby, who in turn began to feel less ashamed and criticized by his voices and found his own compassionate inner voice). Finally, making sense of voice hearing (relating to personal history, which reduced their power). I encapsulate the process Ellerby undertook in the tripartite relationship theory. In terms of the shifting power balance, the tripartite relationship theory makes explicit the delicate balance of shifting positions involving voice hearer, voices *and* practitioner, and proposes the potential for positive energy through fluid and active power. Through the interpersonal dynamic, this compliments the importance Ellerby assigns to the role of building trust and engaging with his voices. The Level of agency and the Interpersonal dynamic support the shifting power balance Ellerby reflects upon in terms of his experiences with both his therapist and his voices. The Who's making sense construct aligns with Ellerby's own making sense of his voices but extends this by making more explicit the importance of identifying *how* sense is made and *who* contributes to this process. The findings from my study also additionally include more explicitly the processes involved in treatment decisions (typically regarding medication) and how voice hearers and practitioners contribute towards this.

9.7 Treatment decisions (Medication: helping or hindering)

As I discuss in the synthesis of my study findings in Chapter 8, both voice hearers and practitioners experience complex relationships with medication, which can be both helpful and harmful. Key underlying issues within the tripartite relationship theory concern how treatment decisions are made, levels of agency involved, and how limited treatment options are managed. These compliment key findings from a growing body of literature regarding treatment decisions, which give recognition to the importance of patient involvement, but also acknowledges that power relations and coercion influence decisions, and that patients' and practitioners' perceptions can differ regarding the extent to which treatment decisions are shared.

I found in my study that voice hearers and practitioners have contrasting perceptions regarding the extent to which treatment decision-making is shared, which supports the findings in the literature. For example, an integrative literature review of experiences of mental health services by Newman et al. (2015) found that patient involvement, empowerment and shared decision making were lacking and requires a fundamental shift in the patient-practitioner relationship in order for increased participation in care. I concur with the findings of Newman et al in terms of the need for a fundamental shift in how therapeutic relationships, specifically relating to voice hearing, are conceptualized.

In terms of treatment decisions, Mikesell et al. (2016) recognize the dynamism between patients and practitioners in their exploration their experiences related to communication, informed choice, and antipsychotic medication treatment. They found that shared decision-making is a complex and dynamic process. For example, although patients may wish to be fully informed about treatment, it can also be overwhelming; and although practitioners value truthfulness, they perceive it to be therapeutically valuable to conceal information. The authors spoke about a dynamic relationship between practitioner authority and patient autonomy and beliefs about participation in medication decision making centering around perceived epistemic status. The authors also discuss the discordance of patient-centeredness and coercion, which arguably stems from perceptions that practitioners are expected to promote simultaneously both patient autonomy and treatment adherence. Both my study findings and Mikesell et al identify that the patient-practitioner relationship is complex and dynamic and involve a dichotomy related to empowerment (autonomy, involvement, etc.) whilst simultaneously recognize practitioners' perceived pressure to ensure treatment adherence. I expand on this in my study findings in terms of making more explicit the fluid, active role of power through the level of agency within the tripartite relationship and calling out for greater transparency regarding the role of medication and treatment decisions related to this.

In terms of facilitating increased control over treatment decisions, I found in my study that practitioners sometimes assume they already provide sufficient opportunities for voice hearers to participate. Joseph-Williams et al. (2017) similarly found this but also that sometimes practitioners have misconceptions that patients do not want to be involved in making treatment decisions. In summarizing key challenges from a 3-year training programme reporting on the Health Foundation (UK) commissioned MAGIC (Making Good Decisions in Collaboration) programme, they recommend cultural changes within healthcare in which clinicians view shared decision making as routine practice and for it to become embedded in nursing and medical curricula. Interestingly, they also emphasize the need to increase patient agency and acknowledge a strengthening of the practitioner-patient relationship in terms of bringing together shared expertise rather than assuming there will be complete agreement. As such, they stress the importance of avoiding construing patients as ‘non-compliant’ and practitioners as ‘overly paternalistic’ where there are differing opinions. The findings from my study support those by Joseph-Williams et al. For example, within the tripartite relationship theory, there is a strong emphasis on the interpersonal dynamic between practitioners and patients. This includes practitioners’ attitudes towards shared decision-making and the need for a better understanding of each other’s perspectives (i.e. non-compliant versus paternalistic), the role of power influencing the level of involvement of patients (i.e. need to increase their agency) and pressure perceived by practitioners due to a lack of resources.

It is evident from my study that practitioners’ concerns regarding voice hearers’ wellbeing can influence treatment decisions, including their administration of coercive treatment to ensure voice hearers’ treatment compliance. This was similarly found in a recent multiple case study by Felton et al. (2018), in which they examined how tensions relating to practitioners’ coercion, and their responsibilities to manage risk, compromised their focus on patients’ recovery. Their findings revealed that practitioners constructed patients as risk objects and, consequently, their concern and anxieties dominated their treatment decision-making and their limited sharing of involvement with patients, and consequently undermining the therapeutic relationship. Additionally, they found that in order to manage their clinical concerns and their own related anxieties, practitioners made decisions at a distance from patients. For example, nurses spent time and made treatment decisions in offices rather than directly with patients (due to staffing constraints). This also resulted in practitioners’ being distant from patients’ personal narratives and treatment decisions made without due consideration of those narratives. The findings from my study support those of Felton et al in terms of medication, distancing, and practitioners’ anxieties. Similar to my findings, medication is the only treatment option discussed by the study participants in Felton et al (a practitioner becomes concerned about a voice hearer and assumes they should be prescribed medication), although the authors do not explore this any further. Similar findings are encapsulated within the tripartite relationship theory.

In another study revealing the reliance on medication and the impact of practitioners’ anxiety on shared decision making, Forsberg et al. (2018) conducted the first (constructivist) Grounded Theory model of practitioners’ (n=12) decision-making processes regarding neuroleptic discontinuation. They found that service culture and practitioners’ awareness of professional responsibility and potential risk heavily weighed on their minds, which reinforced preferences to prescribe rather than discontinue medication. They also found that practitioners’ communication styles changed, depending on their judgement of patients’ risk factors and predicted outcome from discontinuing: it would become collaborative if practitioners considered it acceptable to discontinue; by contrast, it would become increasingly persuasive and coercive if practitioners considered it inappropriate to discontinue. They concluded that practitioners' desire for a collaborative approach conflicted with personal and professional influences, which can lead to increased coercion and responses to prevent harm to themselves, the patient and the public. The findings from my study support those of Forsberg et al in terms of the level of agency in treatment decisions, especially regarding patients' experiences of increasingly coercive approaches being dependent upon their level of adherence to medication, and the interpersonal dynamic between voice hearers and practitioners involved in this process. However, my study expands on the model proposed by Forsberg et al by emphasizing a lack of genuine treatment options and a perceived lack of agency and expertise in offering alternative approaches, which includes difficulties in differentiating coercion from choice.

The findings from my study regarding the influence of power imbalances between voice hearers and practitioners on treatment decisions concur with the literature. I found that addressing power imbalances within their relationship with practitioners were important factors for voice hearers in their treatment decisions. This supports findings from Stovell et al. (2016), interviewing 'psychotic' patients (n=7), who concluded that power pervades patients' experiences regarding treatment decision-making experiences: in terms of the construction of mental illness and impact of the medical model and lack of alternative treatment options, the process through which decisions are made (e.g. tribunals), lack of agency, power relations and coercion. Through the tripartite relationship theory, my findings encapsulate the significant role of power in terms of the inter-dependent links between decision-making, the interpersonal dynamic between voice hearer-voice-practitioner, and understandings of voice hearing. Additionally, I also propose through the tripartite theory that the important issue regarding medication is to determine to what extent it is helpful or not.

A significant element of the tripartite theory is for voice hearers and practitioners to become increasingly collaborative in treatment decisions but this can be undermined by a failure to address power imbalances between voice hearers and practitioners. This is an important future research area that can build upon the findings from my study. This was also recognized in another Grounded Theory study, by Dahlqvist-Jönsson et al. (2015), in which was found that patients and practitioners have contrasting perceptions regarding the extent to which patients are genuinely involved in treatment decision-making. From examining patients' (n=20) participation in treatment decisions, Dahlqvist-Jonsson et al found that they experienced a paternalistic approach in which practitioners made decisions based on their professional judgement regarding the best interests for them, often without their input. Furthermore, patients felt constrained due to lack of information about medication and lack of any real treatment options. The authors stress the importance of participation, meaningfulness and empowerment as being central to the recovery process and suggest targeting power relations to encourage participation in decision-making. The findings from my study support those of Dahlqvist-Jonsson et al in terms of the significant contribution of power in the process of recovery and particularly in terms of the 'Level of agency', 'Interpersonal dynamic', and 'Medication: helping or hindering'. However, my study compliments the individual-centric approach taken by Dahlqvist-Jonsson et al by proposing that power is fluid and active within the tripartite relationship and both voice hearers and practitioners can become empowered to inform the decision making process but this requires *both* to address this imbalance.

Finally, I propose through the tripartite relationship theory that improving the process of treatment decisions involves improving the quality of the interpersonal relationship, but which is also influenced by shared understandings of voice hearing and sufficient levels of agency to influence change. In this respect, there is an emphasis on the interactional qualities between voice hearers and practitioners rather than factors external to this such as decision-making tools. As such, my findings do not support some of the conclusions from the final two studies that recommend the use of decision-making tools. In the first of the final two studies, Harris et al. (2017) examine divergent stakeholder (psychiatrists=10, CPNS=2, pharmacist=1, service users=9, carers=11) opinions regarding antipsychotic medication shared decision making. They recommend the need for decision making tools and found that practitioners did not fully recognize the influence of power imbalances on their own efforts to collaborate, their perceptions of patients' level of insight and acuity, or their subsequent coercive enforcement of treatment under the MHA. In the second study, similarly regarding the development of a decision making tool, Kaar et al. (2019) examined the experiences of (antipsychotic) medication treatment decisions for people diagnosed with psychosis (n=20). They concluded that the side effect profile, including whether or not negative medication-related experiences outweighed positive ones, was a key factor for patients in making decisions about medication.

I similarly found in my study, aligned with Kaar et al, that practitioners engaged in a range of attempts to ensure medication compliance, which challenges the notion of genuine empowerment in treatment decisions. But, overall, the findings of my study do not support the conclusions of both Harris et al and Kaar et al, wherein there seems to be an underlying assumption that evidence based decision tools are helpful for shared decision making (seemingly for medication). In terms of the Kaar et al study, there is an underlying tone suggesting that a decision aid is used as by practitioners as a method to engage patients in discussion in order to find a 'work around' the side effects, i.e. negotiate the mode of administration, the side effect profile, etc. and subsequently nudge them into medication compliance. Whereas both Harris et al and Kaar et al recommend the need to develop frameworks and evidence-based tools to support shared decision-making, by contrast findings from my study stress the importance for practitioners to address their own levels of insight in relation to their role in providing treatment, which includes decision making *with* voice hearers about medication. As such, my study findings do not support a reliance on tools to aid shared decision making, which instead place the emphasis on external agents in order to facilitate treatment decisions rather than responsibility on practitioners and voice hearers to work together in partnership and develop more meaningful and collaborative relationships. Only when this type of relationship has developed will evidence based tools be appropriate.

9.8 Chapter summary

The study findings of a novel tripartite relationship theory of voice hearing compliments current literature by theoretically conceptualising voice hearing within a clinical context and explicitly including both the intra- and inter-personal relations to which voice hearers, voices and practitioners contribute. By including the additional contribution of practitioners in a dynamic tripartite relationship of voice hearer-voice-practitioner, these findings complement current relating literature. This contrasts with the emphasis given to voice hearers' beliefs from the earlier CBT literature and, instead, proposes that other factors within the tripartite relationship theory are equally significant and, as such, concurs with contemporary, psychosocial approaches. The findings also compliment current coercion literature by proposing that potentially coercive voices in addition to practitioners' coercion, their difficulty in differentiating coercion, and their potential perceptions of being coerced, should also be included when conceptualizing coercion.

The findings from my study also support recent interest in the literature to develop interventions aimed at voice content. They also concur with literature relating to the Hearing Voices Network but propose that, in order for voice hearers in mental healthcare to experience increased support aligned with the values of the Hearing Voices Network, the quality of so-called therapeutic relationships (within a tripartite relationship) needs to improve. Finally, although these findings concur with those from the literature regarding treatment decision making in terms of the reliance on medication and power imbalance, they also emphasize the importance of improving interactional qualities between voice hearers and practitioners rather than factors external to this such as decision-making tools.

CHAPTER 10: Recommendations

10.1 Chapter overview

In this final chapter, I make recommendations that aim to improve treatment in terms of both the administration of it by practitioners and the experiences of receiving it by people distressed by their voices. Given the broader mental health treatment context in which the tripartite relationship theory is situated, these recommendations are considerate of broader policy and service level change, in addition to recommended changes for practitioners and voice hearers. In so doing, I address the fourth and final research objective of the thesis:

4. To make recommendations about how mental health practitioners can change their relationship with patients who hear voices, and with the voices themselves, in the form of attitudes and behaviours during treatment, to attenuate or prevent exacerbating the voice hearing of patients.

As discussed in Chapter 2, national policy informing the treatment of voice hearing steers treatment through the development of specialist service delivery (for example, Early Interventions in Psychosis with a remit to specifically treat people distressed by voice hearing) and through practitioners' application of specific interventions (for example, medication and CBTp). However, evidenced in both this study and the empirical literature, practitioners and voice hearers find it difficult to talk about voices. As such, despite current policy and varying levels of expertise (voice hearers and practitioners), meaningful conversations about voices are typically limited or avoided. To support the application of the findings from this study, I make several recommendations aiming to address these difficulties. After I set out my recommendations, I reflect on the study findings in relation to the COVID-19 pandemic regarding treatment for voice hearing. Finally, I discuss strengths and limitations of the study and suggest recommendations for future research.

10.2 Recommendations for improving treatment experiences

It has been my aspiration throughout the development of this thesis to make a positive difference to mental health practice for people distressed by voices and for practitioners. These recommendations are not intended to replace formal therapy but, instead, to provide a framework for practitioners and voice hearers to help improve therapeutic relationships and, consequently, enhance standard treatment approaches. This can help improve treatment experiences while voice hearers are waiting for formal talking therapy to commence. It is clear from my study that voice hearers and practitioners both want to reduce voice-related distress but experience challenges in trying to achieve this. They can often fail to achieve this for the reasons I have discussed throughout this thesis. It is clear that voice hearing experiences and subsequent mental health treatment is complex; it would be folly to simplify this through isolating problems and/or required changes to any one stakeholder. Instead, changes are required at all levels relating to mental healthcare. As such, I aim the following recommendations at policy, service and individual levels.

10.2.1 Policy level

To help tackle dominant biological narratives regarding voice hearing, there is a continuing need to shape policy that informs wider societal views to help construct a 'normalised' perception about voice hearing rather than the prevailing view of it being a symptom of a mental illness. This is to help challenge the portrayal of voice hearing as a biological symptom and, instead, support a narrative that normalises voice hearing as an experience rooted in life experiences.

There is a need to develop educational strategies aimed at improving understanding of voice hearing across different practitioner groups and across both undergraduate and postgraduate level. This should include a focus on building effective therapeutic relationships that are considerate of collaboration and power imbalances to reduce potential (and inadvertent) abuse of power through relationships and the subsequent influence on treatment approaches.

There is also a need to increase curricula content specifically relating to voice hearing, and including involvement of expert by experience, across all professional programmes concerning all practitioner specialities. This should include a broader aim of supporting future practitioners to develop the ability to effectively identify and challenge cultural barriers to working more effectively to treat voice hearing.

10.2.2 Service level

Healthcare organisations need to develop local strategies that facilitates practitioners to engage in critically reflexive discussion and practice regarding treatment and related interpersonal dynamics.

Healthcare organisations also need to explore how its culture, and the professional hierarchies within it, can effectively reduce coercive treatment approaches as reported by both patients and practitioners.

Finally, healthcare organisations also need to review clinical team approaches regarding treatment decision making with the aim of facilitating genuine shared treatment decisions, including mechanisms when disagreements about treatment might occur.

10.2.3 Individual level

(i) Level of agency

To help address power imbalances between practitioners and voice hearers, practitioners need to be aware of the potential for abusing power. To help achieve this, practitioners need to be more cognisant about the remit of their role and their potential contributions towards coercive practice when administering treatment.

Practitioners, therefore, need to be reflexive in terms of their level of influence regarding coercion, both in their administration of treatment to voice hearers and their perceived role within the team hierarchy, including their potential responses to various treatment agendas that result in coercive practice.

Practitioners also need to increase their knowledge and understanding of coercive practice to help become more cognisant when differentiating treatment choice and coercion.

Practitioners need to become cognisant regarding their level of influence within mental health services. They need to be able to construct personal development plans, through their annual independent development review meetings, in order to develop greater insight into how their level of influence impacts on their professional practice.

Practitioners also need to focus on facilitating voice hearers' ability to increase their own level of agency, in terms of their voices, relationships with other people and in terms of their own treatment.

Voice hearers need to develop a reflective approach regarding their own level of agency with their voices and subsequently identify strategies to help respectfully challenge their voices.

Voice hearers would also benefit from developing confidence (and communications skills where needed) to enable them to respectfully challenge coercive practice.

(ii) Interpersonal dynamic

Practitioners need to be reflexive in their relationships with voice hearers and develop confidence to be with and listen to individuals' experiences of voices.

Practitioners need to be aware of research evidence suggesting that positive voice hearer-voice relationships mirror positive voice hearer-practitioner relationships.

Practitioners need to be cognisant of the social context in which voice hearing is experienced and to which they contribute. As such, they need to be aware of their direct impact on voice hearing experiences. To help support this, they need to be mindful of potential internal dialogue voice hearers can experience with their voices during their social interactions and to be self-aware regarding both their non-verbal and verbal communications to avoid potentially and inadvertently increasing distressing voice activity.

Practitioners need to look for opportunities to encourage non-threatening conversations about voices. This should include respectful conversations about voices both directly with voice hearers but also more openly within the treatment environment.

Practitioners need to increase their self-awareness regarding the power dynamics in relationships, including their own in relation to their peers and professional hierarchy, and the potential impact of this on treatment approaches.

Voice hearers need to develop confidence to engage in conversations about voices with practitioners.

Voice hearers also need to reflect on how they prefer to relate with their voices, if at all, in order to reduce relational hostility and, instead, increase harmony. In so doing they may benefit from reflecting on potential mirroring of interpersonal relations with voices and socially with others.

Extending the above point, both practitioners and voice hearers need to increase their awareness of the potential for mirroring between intra-personal and inter-personal relations. As such, practitioners need to recognise the importance of supporting voice hearers to develop assertive, respectful and empathic relations within the practitioner-voice hearer relationship (especially in terms of addressing power imbalances) that can influence voice hearers' relationships with their voices.

(iii) Making sense

Practitioners need to review their own level of knowledge and understanding regarding voice hearing and consider potential for multiple explanations. This may help reduce perceived pressure arising from their attempts to impose a professional level of 'expertise' and, instead, maintain an open mind to understanding individuals' experiences and explanations about voices.

Extending the above point, practitioners need to avoid imposing pre-conceived narratives onto voice hearers. This includes refraining from acting on their own pre-conceived beliefs about voice hearing and conventional treatment agendas.

By contrast, practitioners need to support voice hearers through exploratory discussion to develop their own understanding and meaning about their voices.

Voice hearers also need to invest their own time and energy in developing their own personal construction of their voice hearing and may benefit from identifying additional potential opportunities for this outside of the mental health treatment environment (for example, with their peers or Hearing Voices Groups).

(iv) Medication/treatment decisions

Practitioners need to avoid 'treating' voices as a symptom of an illness and, instead, begin to understand underlying difficulties related to voices through actively listening to individuals about their experiences of voice hearing.

When supporting individuals to reduce their voice-related distress, practitioners need to be cognisant of the importance of identifying a logical link between developing a meaningful understanding of voices and subsequent treatment approaches.

Practitioners need to be reflexive regarding their personal beliefs and subsequent treatment they offer/administer. As such, they need to be cognisant of the potential for these to influence treatment decisions.

Practitioners need to be clear regarding the purpose of medication and engage in discussion with voice hearers about their preferences regarding medication.

Extending the above point, practitioners need to facilitate voice hearers' involvement in treatment decisions, including engaging in dialogue where there are disagreements. Additionally, practitioners need to be mindful of the varying interpersonal dynamics influenced by periods of acuity/recovery and, consequently, how this might impact on shared treatment decisions.

Voice hearers need to explore their own preferences and beliefs about treatment and how this potentially impacts on their relationship with voices.

10.4 Recommendations in relation to COVID-19

In terms of the recommendations set out in this chapter, the pandemic places even greater emphasis on the importance of the tripartite relationship theory for both voice hearers and practitioners. It also poses greater challenges. For example, temporary legal measures (see Chapter 2, section 2.2.1) increase the potential for coercion. Increased telehealth and digital technology may be beneficial in terms of enabling voice hearers to access elements of care remotely but there are also challenges in terms of how this might affect relational elements of voice hearing experiences such as those discussed in my study findings. COVID-19 has already exacerbated work-related pressure for healthcare workers and this pressure will likely continue for several more months if not years.

It may be additionally challenging to develop effective therapeutic relationships in situations where practitioners are under extraordinary levels of pressure and are required to communicate to voice hearers wearing Personal Protective Equipment (PPE) or through telemedicine-type mechanisms. These may potentially act as barriers due to the constraints they place on communication, particularly in terms of body language. It may also contribute towards increasing the amount of negative voice content for voice hearers, which in turn may also act as a barrier to engagement with treatment, although there is currently no empirical evidence to support this assumption. These challenges place even greater importance on the quality of the voice hearer - practitioner relationship, the need for clarity regarding levels of influence for potential changes to voice hearing, making sense of voices, and genuine shared treatment decision making.

10.5 Study strengths and limitations

A strength of this thesis is that a Grounded Theory methodology has been utilised in order to develop novel theory regarding a complex phenomenon. In terms of generalisability, my study has revealed a complex tripartite relationship that influences experiences of voice hearing, grounded in the experiences of people who hear voices and practitioners, and situated within a mental health treatment context. Although generalising qualitative research has sparked debate in the literature given that generalisation is inherently associated with quantitative research, Grounded Theory methodology aims to answer research questions that can be applied in response to a lack of existing knowledge/frameworks (Gheondea-eladi, 2014). The research methods of data analysis, in which specific initial coding is developed into abstract theoretical coding involves generalisation (Polit and Beck, 2010, Carminati, 2018). Transparency throughout the thesis of my research process enables the reader to judge to the credibility of this study. As such, although the theory is grounded specifically in voice hearer and practitioner data, the concepts are still applicable to other stakeholders such as peer support, in which similar issues regarding agency, interpersonal dynamics, how voices are understood, and issues related to treatment will be relevant.

Upon reflection, some of the voice hearers' experiences reported during interview, specifically relating to the actions of their voices during clinical interactions with practitioners and others, more detail regarding the effect of practitioners on voices could have been explored in even more depth. However, this was clearly a sensitive area to explore during interview and it was important for participants to remain in control. However, more detailed information may have provided richer analysis and, consequently, influenced the study outcome.

Applying this point to the practitioner participants, a particular issue that I could have explored further is the incongruity between practitioners' reported confidence and expertise during one focus group discussion and a confession contrasting this after the recording had stopped. This raised a fascinating opportunity that, with hindsight, I would have liked to have investigated further. Upon reflection, observing practitioners in practice would be helpful as an alternative approach to analyse practitioners' behaviours.

10.6 Future research

This study has led to the development of a novel theoretical explanation regarding voice hearing that encapsulates complex interpersonal dynamics within voice hearer – voice - practitioner relationships. This raises interesting insights for further research. It would be useful to empirically test the theory in clinical settings to measure the impact on patient care and practitioner effectiveness. Utilising different methods of data collection such as participant observation could also provide alternative and interesting information. Further exploration of practitioners' behaviours during interactions with voice hearers could also provide further detail regarding the interpersonal dynamic with voice hearers. A particularly interesting area for future research is to explore in more detail the voice(s) activity during social treatment interactions, particularly any interactions between different voices and the impact of this on the voice hearer. Future investigations are also needed to explore the types of practitioners' behaviours used in order to avoid engagement with voice hearing (avoid, escape or mitigate perceived threat to their perceived value or professional worth) or to manage their perceived lack of influence within the treatment environment.

10.7 Conclusion

This study set out to investigate experiences of voice hearing. From the study findings, a novel grounded theory proposes that, in order to expand and deepen current knowledge about voice hearing, conceptualising voice hearing experiences must extend beyond the conventional individual-centric perspective and encapsulate the relational and clinical context in which voices are experienced. When situated within a mental healthcare context, this typically involves interactions between voice hearers, voices and practitioners. To improve therapeutic interactions and treatment outcomes for both voice hearers and practitioners, we need to encourage policy makers, healthcare organisations, practitioners (and individuals within healthcare organisations) and voice hearers to consider how to effectively nurture a genuinely service-user orientated culture, which fosters reflexive practice regarding interpersonal dynamics, levels of agency, shared understandings and treatment decisions.

Appendix 1. Participant Information Leaflet

UNIVERSITY of York
The Department of Health Sciences

Participant Information Sheet

IRAS 248530

Title of Study: Exploring the experiences of voice hearing during mental health treatment.

You are invited to take part in this research study. But before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read through the following information carefully and, if you wish, please discuss with friends, relatives and others. Ask questions if anything you read is not clear or you would like more information. Please take time to decide whether or not to take part.

What is the purpose of the study?

The purpose of this study is to collect information from people about their experiences of voice hearing during their interactions with practitioners when receiving mental health treatment. The term 'treatment interaction' refers to any interaction with a practitioner during treatment and in any healthcare setting. For example, it may include an informal conversation with a practitioner or a discussion about treatment; or it may include a more formal discussion within a meeting or involve the administration of medication or other form of treatment.

Research evidence suggests that the relationships people have with their voices can be influenced by their relationships with other people. However, greater understanding is needed about people's experiences of voice hearing during treatment interactions with practitioners to inform the education of healthcare practitioners, improve practitioner-patient relationships and supportive approaches facilitating recovery.

Who is doing the study?

This study is part of a PhD project by Rob Allison at the University of York (rob.allison@york.ac.uk). Rob is the chief investigator and is a Registered Mental Health Nurse and Senior Lecturer (University of York), with experience of working across a variety of clinical settings. The study is supervised by Dr Kate Flemming and Dr Lina Gega (both in the Department of Health Sciences, University of York) and funded by the University of York.

Why have I been invited?

People who hear voices and with experiences of mental health treatment are invited to take part. The study gives an opportunity for invaluable contributions from people who hear voices to talk about their experiences of voice hearing and treatment. If you meet the following criteria then you are eligible to take part:

- Hear voices, either self-defined or diagnosed by a responsible medical officer
- Received mental health treatment (either currently or previously, including all health settings)
- Minimum age 18 years
- English speaking
- Agrees consent to take part

Do I have to take part?

No, taking part is voluntary. It is entirely your choice whether or not you decide to take part in this study. If you have any questions about taking part you can talk to Rob Allison, chief investigator for this study (contact details at the end of this leaflet).

If you do decide to take part then, in addition to this information sheet, you will be asked to sign a consent form, which will be stored securely at the University of York. And if you do decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect you in anyway.

What will happen if I take part?

You will be asked to take part in an interview as part of this study. The interview is designed to enable you to provide information about your experiences of voice hearing and treatment. Examples of questions you might be asked include: *Can you tell me a little bit about the voices you hear?* Or, *can you tell me about a time when you interacted with a practitioner during treatment and what happened?*

The interview will take place at an agreed time and location, such as the University of York or your home. Interviews will last for approximately 60 minutes. The interview will be conducted by the chief investigator (Rob Allison) and audio-recorded. This recording will then be transcribed word-for-word by a transcription service (1st Class Secretarial Services), which will then be stored on a secure computer at the University of York. The audio recording will then be deleted.

You may also be asked to take part in a follow up discussion in order to clarify or expand on information provided during the interview. Please note, however, that you can choose to decline a follow up discussion. All information collected from participants during interview will be made anonymous by assigning a unique identification code to each participant, which will only be known to the chief investigator.

What will happen if I don't carry on with the study?

You can withdraw from the interview at any point. You can also withdraw from the study the information you provide during the interview but you will need to do this within 7 days of the interview. Please note that information after this 7-day period may have already been analysed and integrated with the rest of the study.

What are the possible benefits and risks in taking part?

The purpose of the study is to contribute to the broader knowledge base about voice hearing and mental health treatment. It is intended that this will lead to improvements in treatment experiences for people who hear voices.

It is unlikely that you will experience any harm as a result of taking part in the interview but you may discuss sensitive issues during it. If you do become upset during the interview then the interview will be stopped and resumed only if you are happy to continue. If further support is required, you will be encouraged to make contact with either a healthcare professional or family member/friend. You are also welcome to ask a family member or friend to wait for you outside of the interview for support.

Inconvenience of attending the interviews will be minimized by restricting the interview up to approximately 60 minutes (depending on your time constraints) and scheduling it at an agreed time, date and venue. You will also be reimbursed for any travel expenses.

Who do I contact if I have a complaint?

If you have a concern about any aspect of the study, you should speak to the chief investigator (Rob Allison) who will do his best to answer your questions (see contact details at the end of this leaflet). If you remain unhappy and wish to complain formally you can contact:

PhD Programme Lead
Dr Lorna Fraser, Senior Lecturer, Department of Health Sciences, University of York.
Tel: 01904 321889. E-mail: lorna.fraser@york.ac.uk

Will information obtained in the study be kept confidential?

Yes. This study will be conducted in line with the current data protection legislation. All information collected about you during the course of the study will be kept strictly confidential and anonymous.

The interview will be audio-recorded, which will then be transcribed and stored on a secure computer. The audio-recording will then be deleted. Handwritten notes may also be recorded during the interview but these will not contain any personal details and will be secured in a locked filing cabinet until transferred to a secure computer at the University of York. The handwritten notes will then be securely destroyed. Direct quotations may be used in the completed study and future publications but these will be anonymised. All your contact details will be destroyed less than 3 months after the end of the study.

What will happen to the results of the study?

This study is part of a PhD project and will be academically assessed. Some of this work will be submitted for publication in a peer-reviewed journal, presented at conferences and also included in education materials to nursing students. Data collected from this study will be archived at the University of York on completion of the PhD. In line with University policy, information will be kept at the University for 10 years but this will not be identifiable to you. After this point, the data will be securely destroyed. You may also wish to receive a summary of the results of the study.

If you would like to take part in this study, ask further questions or have any concerns about the study then please contact:

Rob Allison, Chief Investigator and PhD Student, Department of Health Sciences, University of York, Heslington, York, YO10 5DD.
Tel: 01904321689
E-mail: rob.allison@york.ac.uk

Thank you for taking the time to read this information sheet

Data General Protection Regulation (DGPR) and Data Protection Act (2018)

The University of York is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of York will keep information about you, but which will not be identifiable to you, for 10 years after the study has finished. Identifiable information about you will be destroyed less than 3 months after the end of the study.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at https://www.york.ac.uk/about/departments/support-and-admin/information-services/information-policy/index/policy-on-the-publication-of-research.

When you agree to take part in a research study, the information about your health and care may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you or to affect your care. It will not be used to make decisions about future services available to you, such as insurance.

Tees, Esk and Wear Valleys NHS Foundation Trust may use your name, NHS number and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study.

Appendix 2. Study flyer

UNIVERSITY of York
The Department of Health Sciences

Do you hear voices? Would you like to take part in a study exploring experiences of voice hearing during mental health treatment?

If you are interested please contact me on:
Rob Allison
01904 321689
rob.allison@york.ac.uk

If you would like to know more about this study or if you're interested in taking part then it would be great to hear from you.

Taking part will involve me asking you questions about your experiences of voice hearing during your interactions with practitioners when receiving mental health treatment.

If the criteria below is relevant to you then please feel welcome to contact me:

- You hear voices
- You have received mental health treatment
- You are aged 18 years or over

UNIVERSITY of York
The Department of Health Sciences

Appendix 3. Consent form

Participant Consent Form
IRAS 248530

Title of Study: exploring the experiences of voice hearing during mental health treatment

ID Code allocated -	**Please initial to confirm agreement**
I have read and understood the participant information sheet [21.08.2018, version 3]	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand my participation in the study is voluntary and I am free to withdraw at any time without giving reason and I. If I withdraw from the study up to seven days after the interview, I can request my interview data will not be used in the study. This data will then be destroyed. II. If I withdraw from the study more than seven days after the interview, data gathered from the interview may have been initially analysed and cannot be removed from the study.	
I understand that the interview will be audio-recorded and hand-written notes may be taken by the researcher during the interview.	
I am aware that I may be asked at a later date to clarify or expand on information raised during the study. I am also aware that I have the right decline to take part in this.	
I give permission for information collected during the study to be seen by researchers supervising the study (Dr Flemming, Dr Gega).	
The procedures regarding confidentiality and secure storage of information have been clearly explained to me (e.g. anonymising personal information, information kept on secure computer).	
I understand that if at any time the researcher becomes aware of any activity that potentially threatens patient safety and/or indicates professional misconduct, this would be reported via routine incident reporting mechanisms.	
I understand that any information I give may be included in published documents but all information will be anonymised.	
I agree to take part in this study	
I would like to receive a summary report of the findings from the study	
Participant Signature Date	
Name of Participant	
Researcher Signature Date	
Name of Researcher: Rob Allison	

Appendix 4. Study protocol

Study Protocol

FULL/LONG TITLE OF THE STUDY

Exploring the experiences of voice hearing during mental health treatment.

SHORT STUDY TITLE / ACRONYM

Voice hearing and treatment interactions.

PROTOCOL VERSION NUMBER AND DATE

VH-treatment interactions-Protocol.v.1

RESEARCH REFERENCE NUMBER

IRAS Number: 248530

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publically available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Funder:

Signature: Date:

Name (please print):

Position:

Chief Investigator:

Date: 19/04/18

Signature:

Name: (please print): ROB ALLISON

LIST of CONTENTS

KEY STUDY CONTACTS

Chief Investigator Rob Allison Senior Lecturer in Mental Health Department of Health Sciences Seebohm Rowntree Building University of York, YO10 5DD Tel: 01904 321689 Email: rob.allison@york.ac.uk	**Funder** University of York (Department of Health Sciences Faculty of Sciences Seebohm Rowntree Building, YO10 5DD University of York)
Study supervisor Dr Kate Flemming Senior Lecturer Department of Health Sciences University of York York, YO10 5DD Tel: 01904 321345 Email: kate.flemming@york.ac.uk	**Study supervisor** Dr Lina Gega Reader in Mental Health Department of Health Sciences University of York York, YO10 5DD Tel: 01904 32(1870) Email: lina.gega@york.ac.uk

STUDY SUMMARY

Study Title	Exploring the experiences of voice hearing during mental health treatment.
Short title	Voice hearing during treatment.
Study Design	Qualitative
Study Participants	People with experience voice hearing (auditory hallucinations) and mental health treatment.
Planned Size of Sample (if applicable)	15-20 participants
Follow up duration (if applicable)	No follow up period
Planned Study Period	12 months
Research Question & Objectives	**Research question** How do people experience voice hearing during mental health treatment interactions with practitioners? **Objectives** 1. Understand how people who hear voices perceive their treatment interactions with practitioners. 2. Explore meaning people attribute to their voice hearing and how this is experienced during treatment interactions with practitioners. 3. Examine how people relate to their voices and practitioners during treatment interactions. 4. Develop theoretical explanation about voice hearing experiences during treatment interactions.

KEY WORDS: Voice hearing, treatment interactions.

STUDY PROTOCOL

Exploring the experiences of voice hearing during mental health treatment.

1 BACKGROUND

Evidence suggests that life experiences can influence voice hearing. For example, trauma is associated with the onset of voice hearing (e.g. McGrath et al, 2017; Read and Bentall, 2012) and human relationships can influence voice hearing experiences, i.e. how people relate to their voices can replicate their way of relating with other people (Birchwood et al, 2004). Conceptualising voice hearing within a relational framework is a recent area of inquiry (Corstens et al, 2012) and supports the notion that recovery can be achieved through treatment that focuses on improving relationships with voices.

The relationship between people who hear voices and practitioners is widely acknowledged as being central to effective mental health treatment. Professional standards for practitioners stipulate the importance of trusting and respectful relationships with patients to promote autonomy, empowerment and shared decision-making (Nursing & Midwifery Council, 2015, Royal College of Psychiatrist, 2014, National Collaborating Centre for Mental Health, 2012).

2 RATIONALE

How voice hearing is experienced in a context of treatment interactions, predicated on a relational framework with practitioners, is under-researched. Greater understanding is needed to understand whether an individual’s relationship with their voices is influenced by interactions with healthcare practitioners. Through gaining this understanding this will inform education of healthcare practitioners to improve their support of people who hear voices and help practitioners avoid inadvertently contributing to a context in which voice hearing is triggered or exacerbated.

3 RESEARCH QUESTION & OBJECTIVES

3.1 Research question

How do people experience voice hearing during mental health treatment interactions with practitioners?

(Please note, the term ‘treatment interaction’ refers to any interaction with a practitioner within a treatment context (in any healthcare setting), e.g. an informal conversation, a discussion about treatment, discussion in a formal meeting of some sort, administering medication, etc.).

3.2 Objectives

1. Understand how people who hear voices perceive their treatment interactions with practitioners.
2. Explore meaning people attribute to their voice hearing and how this is experienced during treatment interactions with practitioners.

3. Examine how people relate to their voices and practitioners during treatment interactions.
4. Develop theoretical explanation about voice hearing experiences during treatment interactions.

4 STUDY DESIGN & METHODS of DATA COLLECTION AND DATA ANALYIS

This is a qualitative study informed by constructivist Grounded Theory methodology (Charmaz, 2014).

Information will be collected via in-depth semi-structured interviews. The CI will discus and obtain written consent from participants prior to interviewing and inform participants that interviews will be recorded on a digital recorder and stored as MP3 files. These will be transcribed onto a word document and transferred onto a qualitative computer software package (ATLAS.ti). Audio recordings will then be deleted. Interviews are expected to be for duration of approximately 60 minutes.

Interviews will focus on asking participants to recall their experiences of voice hearing during and following their treatment interactions with practitioners. A semi-structured interview guide will include initial questions informed by the 'Voice Dialogue / Talking with Voices' method (Corstens, Longden & May, 2012), the CI's clinical experience and from consultation with the Bradford Hearing Voices Group (see section 5).

However, the interview guide will act as an aide-memoir rather than script. Following theoretical sampling, interview questions will largely be constructed from participants' responses and, thus, evolve over the course of data collection. This will include 2 main themes with example questions underneath each theme.

Experiences of voice hearing:

1. Tell me a little bit about the voices you hear? (Prompts: how many do you hear? Are they positive/negative/neutral/dominant? Do they have names? Do they represent anything for you?).

2. Can you tell me more about how your voices communicate to you? (Prompts: are they commanding/advisory/commentary? How do they affect you? Do they have a visual presence? Where are your voices in relation to you? Does this ever change?).

Experiences of treatment interactions:

3. I am interested in hearing about your experiences of treatment. (Prompts: can you tell me about a time when you interacted with a practitioner during treatment and what happened? What were your perceptions of the practitioner during the interaction(s)? How did you interact with one another? What sense did you make of the interaction? How typical for you was this example of a treatment interaction?).

4. How did you experience your voices at that time? (Prompts: what did your voices say? How did your voices respond? Did your voices have anything to say about the interaction? Or about the practitioner? Where were your voices in relation to you? Did this change?

How did your voices at that time compare to before and after the interaction? How did it compare to other treatment interactions?).

Qualitative data from the interviews will be recorded and then transcribed verbatim. Transcriptions will then be transferred onto a qualitative computer software package (ATLAs.ti) to manage and improve transparency of the data analysis process.

Data analysis will involve 3 stages of coding the interview data: initial, focused and theoretical. During initial coding, each transcript will be analysed line by line in order to select key words. During focused coding the most significant initial codes will be classified into categories. Theoretical coding will involve specifying possible relationships between these categories. Constant comparative analysis will be used to identify similarities and differences between codes and develop theoretical ideas.

After each interview and during coding the CI will complete memo writing of personal reflections and insights in order to develop ideas, record relationships between the codes and identify areas to explore in the development of categories and theory. Diagramming will also be used to make visual representations, or links, of relationships between categories.

5 PATIENT AND PUBLIC INVOLVEMENT (PPI)

The Bradford Hearing Voices Group (HVG) advised on the development of this study. As part of the international Hearing Voices Network, HVGs are self-help groups for people who hear voices, providing a space for people to meet weekly and talk about their voice hearing experiences and exchange ideas for coping and gaining control over voices.

Prior to attending one of the Bradford HVG meetings, study documents (Flyer, Participant Information Leaflet, and Consent Form) were sent to the group facilitator and the CI subsequently met with the group for discussion. The HVG helped to shape the re-drafting of these documents and helped develop the initial interview questions.

The group provided invaluable advice regarding the use of language, how to support participants' potential distress during interviews and advice about participants' potential benefits from taking part in the study. All group members stated that they commonly refer to the terms 'voice hearer' and 'people who hear voices' (consistent with literature) but especially did not like terms such as 'schizophrenic', 'mental illness' or 'mental disorder'. As such, the terms 'voice hearers' and 'people who hear voices' are used here.

In terms of managing potential distress during interviews, group members suggested that an information leaflet before the interview would be helpful but, additionally, it would also be helpful for this to include some example questions to give participants some indication of what they might be asked. Further, group members were strongly of the view that they would not want a practitioner to be contacted should there be any concern relating to a participant's distress. All group members stated that this would be a breach of trust and lead to an unhelpful situation for them afterwards. Instead they were strongly of the opinion that each participant will be different and stressed the importance of asking the participant about who should be contacted should they need additional support. It was also suggested that participants could be encouraged to bring along with them a family member or friend to be available after the interview.

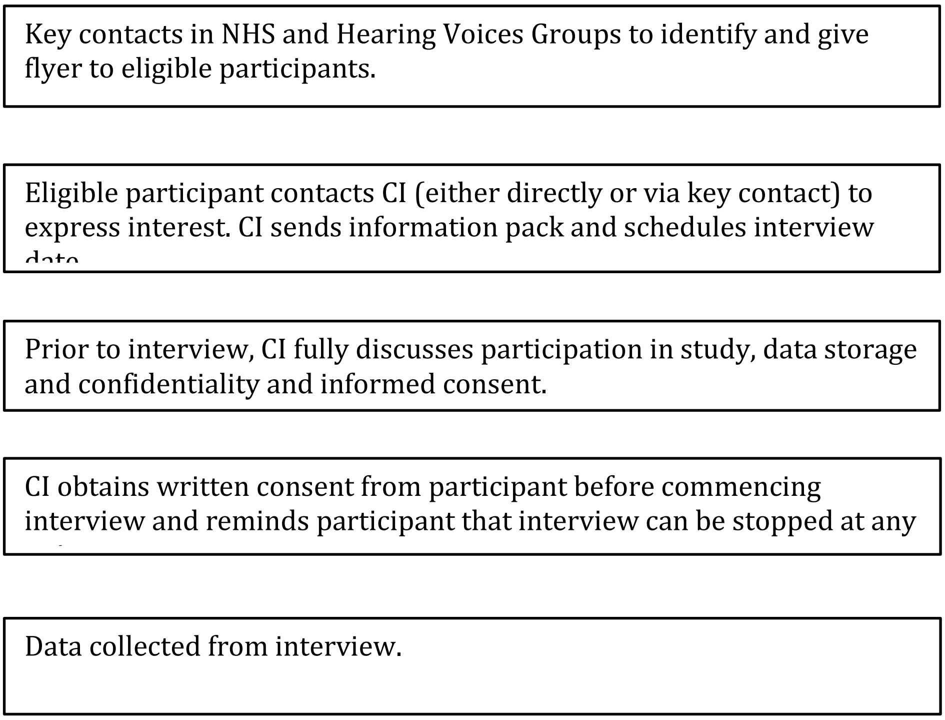
In terms of potential benefits, group members were of the view that taking part in this study would be a helpful opportunity to talk about previous experiences and could provide an important contribution to improving future treatment experiences for other voice hearers.

6 STUDY SETTING

People with experience of voice hearing (either currently or previously) and mental health treatment (including all health settings) will be invited to take part in an interview. Participants will be invited to meet either at the University of York or at participants' homes (or, if necessary, in the participant's hospital / clinical setting).

7 RECRUITMENT AND SAMPLING

The CI will approach key contacts within local NHS mental health services in the Tees Esk and Wear NHS (TEWV) Trust and in local Hearing Voices Groups to request they identify and give a flyer (Appendix 1) to potential participants meeting the eligibility criteria for the study. Figure 1 illustrates the process for identifying and recruiting participants.



Key contacts in NHS and Hearing Voices Groups to identify and give flyer to eligible participants.

Eligible participant contacts CI (either directly or via key contact) to express interest. CI sends information pack and schedules interview

Prior to interview, CI fully discusses participation in study, data storage and confidentiality and informed consent.

CI obtains written consent from participant before commencing interview and reminds participant that interview can be stopped at any

Data collected from interview.

Figure 1 Process of participant recruitment and data collection

If interested in taking part in the study, eligible participants will be asked to inform the CI (either directly via the contact details on the flyer or indirectly through the key contact) to express their interest. The CI will send a research pack to the participant and schedule an interview date. This pack will include a cover letter (Appendix 2), a participant information leaflet (Appendix 3) and a consent form (Appendix 4). The CI will make it clear to participants that they can request further information or change their mind at any point and cancel the scheduled interview date.

Interviews will be face-to-face and take place in participants' homes, on University of York premises or, where necessary, on the participant's clinical premises.

7.1 Eligibility Criteria

7.1.1 Inclusion criteria

People will be approached to participate in this study if they meet all of the following criteria:

- Experienced voice hearing (either currently or previously), either self-defined or diagnosed by a responsible medical officer.
- Received mental health treatment (either currently or previously, including all health settings).
- Minimum age 18 years
- UK location
- English speaking.
- Agrees consent to participation.

7.1.2 Exclusion criteria

People will be excluded from this study if the following applies:

- Lacks mental capacity (determined by the Mental Capacity Act).

(Key contacts will not identify anyone clinically determined to be lacking capacity. For all other eligible participants, it will be assumed that each has capacity. Aligned with the Mental Capacity Act (2005), exceptions may occur where the CI has concerns during interview relating to a participant's retention and understanding of information and their subsequent communication of any decision).

7.2 Sampling

Predetermining sample size prior to qualitative research is debated in literature, the essence of which is captured in a recent review as generally being one of a justification between pragmatic / practical considerations and methodological considerations (Sim et al, 2018). Whilst it is difficult to be precise about the sample size in advance of this study it is anticipated that a purposive sample of 15-20 participants will provide sufficient depth and breadth to address the research question.

Data collection and analysis will occur concurrently. It is anticipated that through this process of collecting and analysing data initial theoretical ideas will begin to emerge. This will influence the questions subsequent participants will be asked (see section 4) in order to follow up these theoretical ideas.

8 ETHICAL CONSIDERATIONS

8.1 Informed consent

As stated in section 7, participants will receive a research pack prior to the scheduled interview date, which will include a cover letter, an information leaflet about the study and a consent form. Participants will have time to read through these documents prior to the interview in order to consider whether or not to take part. Participants can also contact the CI for further discussion about the study.

Prior to the interview, the CI will discuss and answer questions participants might have about the study. Informed consent will be fully discussed and the participant will be requested to provide written consent before commencing the interview. The process for obtaining informed consent will be in accordance with Good Clinical Practice (GCP). Details of the study will be explained to participants using the participant information sheet and participants will have sufficient time to ask questions regarding their participation. This will include details about data recording, storage, confidentiality and the right to stop the interview or withdraw interview data. Participants will be asked to sign and date a consent form before taking part in an interview. Participants will keep one copy of the consent form and the CI will keep a further copy.

Participants will be informed via the consent form that information they disclose is confidential accept in cases of potential harm to the participant and/or others. Participants will also be reminded of this at the beginning of the interview. It is possible that information related to inappropriate treatment, which might be potentially harmful to participants/others, is disclosed during interview. Should this occur, the CI will discuss with participant that this information might need to be reported to an appropriate clinical lead.

Undue influence. Emphasis on the voluntary nature of research interviewing will be given and participants will not receive any financial incentive to take part. However, travel costs will be fully reimbursed upon presentation of receipts so that participants do not endure any financial sacrifice in taking part.

Withdrawal. Participants will be informed that they can withdraw from the study at any time before or during the interview. They may also withdraw their interview data up to 7 days after the interview without providing any reason. Following this period, data will be used for the study.

8.2 Confidentiality

Participants will be issued a unique identification code, which will be used on study documents and electronic files. The CI will complete transcriptions. No identifiable information will be provided in any reports. Data will remain anonymous and confidential with the exception of any information suggesting serious risk to the participant or someone else (e.g. plans of harm). Should this occur, the appropriate course of action would be discussed with the CI's supervisors and escalated where necessary.

8.3 Data storage and retention

Data management will be compliant with the current data protection legislation and in line with the University of York (UoY) Research Data Management Policy. The CI will be the data custodian and responsible for managing the data. Paper copies of consent forms and contact details will be stored in a locked filing cabinet within a locked room in the UoY, then scanned and hard copies will be shredded.

Electronic files will be stored on a UoY password-protected secure server. Consent forms will be scanned and stored in a separate file to other data. Audio recordings of interviews will be transferred securely to an electronic file until transcription is completed and then deleted. Only the CI and his study supervisors will have access to the original data. In accordance with the UoY Research Data Management Policy, study data will be stored securely on the UoY server for 10 years after the end of the study for audit purposes. Participants' personal contact details will be destroyed once they have been sent a summary of the study findings, if they requested the summary, within three months of the study ending.

Interview data will be recorded on a digital audio recorder and stored as MP3 files. These will be transcribed and saved as a word document and transferred onto a qualitative computer software package (ATLAs.ti) to manage and improve transparency of the data analysis process. The audio recording will then be deleted. The MP3 files will be stored on the UoY centrally managed network and in the CIs personal filestore (p:drive), which is regularly and automatically backed up by IT services. The CI will use the Virtual Private Network (VPN) to connect to the personal filestore to work on/add to files when away from UoY. Research participants' responses will be stored in a locked cabinet within a locked office at UoY. Only the CI will have access to the cabinet.

The CI will also record memo writing throughout the study to document reflexive accounts during data collection and analysis. The CI will also record diagramming to help make conceptual links during stages of coding. These will be stored as described above. Interviews will be recorded on an encrypted passcode-protected Digital recorder (as described above). These recordings will be transferred and stored on the UoY centrally managed network, which is password protected, until transcribed and thereafter destroyed.

Participants will be anonymised and coded with an ID number. Direct quotations used in published work will anonymised and any information that might directly identify participants (e.g. identity of clinical setting) will also be anonymised.

8.4 Risks to participants and researcher

Risk to participants. There are no expected potential harms to participants in taking part in this study. However, it is possible that participants may feel distressed during and following conversations about treatment-related experiences. As such, participants will be reminded that their participation is voluntary and they can choose to decline to answer questions during the interview and/or stop and withdraw from the interview. Should this happen, participants will also be informed that they can withdraw their interview data from the study up to 7 days after the interview.

It is possible that participants' voices might be present and active during interviews. This might be particularly evident when discussing personal issues related to participants or issues that voices might consider threatening, e.g. perceived attempts to get rid of the voices. The content of the voices might affect how participants engage during interviews. For example, voices can make derogatory comments to participants, be critical or even command the participant to do or abstain from doing things.

Therefore, it is important to consider the affect the voices might have on the participant during interviews. During interview, the CI will be alert to signs of distress from participants and will discontinue the interview if necessary. The CI will also check with participants before and during interviews whether they would like to continue with the interview. Should a participant remain distressed after the interview, the CI will discuss with the participant what contingency plans they might usually have and encourage they contact sources of support, e.g. family member, friend, GP, healthcare key worker, Crisis Line.

Taking part in the interviews may inconvenience participants. To mitigate this, participants will be offered a choice of times and location (e.g. UoY premises or home) for interviews and any travel expenses will be reimbursed.

Potential harm to researcher. It is not anticipated that any harm will come to the CI during the interviews. But there is potential harm given that interviews may take place beyond UoY premises and possibly outside usual working hours. Therefore, all research will be in accordance with UoY Department of Health Sciences lone worker policy and, where necessary, a fieldwork risk assessment will be conducted prior to interviews.

8.5 Potential benefits to participants

It is important that voices are accepted as real by the person hearing them and accepted as real by other people (Romme et al, 2009). As such, participants might find it beneficial to talk about their voice-related and treatment-related experiences, which might enable space for reflection and further validation about their experiences.

According to the Bradford HVG (see section 5), participants might also benefit from contributing towards making positive differences to the treatment experiences for other people.

Table 1 Research timeframe

Activity	*Duration / possible calendar month (2018-2020)*
Approval from NHS Research Ethics Committee Develop data collection processes and materials	Aug / Sept 2018
Information to prospective participants	9 months (Oct 2018-June 2019)
Data collection	10 months (Oct 2018-July 2019)
Transcription	11 months (Oct 2018-Aug 2019)
Data analysis	11 months (Oct 2018-Aug 2019)
Write up and dissemination	7 months (Sept 2019-April 2020)

7.5 Indemnity

The University of York is the research sponsor and provides insurance and indemnity for research.

9 DISSEMINIATION

Participants who wish to receive a summary of the findings, as indicated at the time of informed consent, will be sent an executive summary of the results. Papers will be submitted to peer-reviewed journals and presented at appropriate conferences and research seminars. Findings will also inform nursing curricula and educational workshops for healthcare practitioners.

10 REFERENCES

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11. APPENDICIES

Appendix 5. Voice Hearer tabulated codes and corresponding participant quotes

	Agency	Biological treatment: involvement or fearing enforcement	Making sense of voices	Personal bully	Practitioners' actions	Relating
P01	**Voice hearing is about power & control** What do you mean, I was in the middle, same as I always am, with [voice] telling me he's not going to do it. Reference 2 - 0.27% Coverage I don't know. I don't know what he prefers. I know he's happier when he's mouthing off, that's what I know. Reference 3 - 0.74% Coverage P01: He's just listening in, trying to get genned up on what he's going to say next. I: Because that's what I was going to ask you, I was going to ask you why do you think he's listening and not talking? P01: So, he can find something smart-eyed to say when he's got time, when he gets his chance. **Lacking agency with voices** P01: He tries to be more dominant, yes.	**Benefitting from medication** P01: I think it helps to keep me on an even keel but… I: So, keep on an even keel, what does that mean? P01: Stopping me from going psychotic. Reference 2 - 1.00% Coverage It keeps me on an even keel and stops me being psychotic, thinking all sorts of things and stops me jumping, diving through windows like I did once when I was in hospital when I dived headfirst out a window. That's when I had all the windows covered up after that. That must have cost a fortunate. I cost them some serious money when I dived through that window, because they had to redo the whole hospital. Reference 3 - 0.21% Coverage I don't know, I just think it's the medication that stops me from going psychotic. **Medication not helping voices**	**Making sense of voices** I: But he'll say things that gives you the impression that somebody else is listening to the conversation? P01: Yes. I: Okay. And this someone else who's listening to the conversation, have you also identified who that is? P01: Yes, his wife. I: Okay. So, Mrs [voice name]? P01: Yes. Reference 2 - 0.13% Coverage I don't know. It makes me wonder what he thinks. Reference 3 - 0.45% Coverage P01: There is nothing they can do to help. You get them or you don't, you know, unfortunately I do. I: You mean you get voices or you don't, do you mean? P01: Yes. You get voices.	**Being persecuted by voices** Totally negative, he's never positive, he's always negative. Reference 2 - 0.58% Coverage P01: He's my tormentor…is the only way I can describe it. I: Okay. And do you think he's here to torment you or why do you think he's here? P01: Yes, that's his sole purpose. That's all he does. I should suffer, that's what he says. Reference 3 - 0.09% Coverage Because he thinks I deserve it. Reference 4 - 0.50% Coverage Because I always say to him…I'm always telling him to leave me alone and he says he won't	**Practitioners not talking about voices** We were talking about anything and everything, really. We never used to talk about the voices. Reference 2 - 0.45% Coverage P01: Yes, I would say so, yes. Not wanting to. I: Yes, so did the psychologist know that you did hear voices but it's just you didn't like to talk about that experience? P01: Yes.	**Feeling valued by practitioners** I just thought that she had a sympathetic ear. **Talking about voices & problems is difficult** Yes, but then I didn't go, I didn't want to go back anymore. Reference 2 - 0.56% Coverage I: Yes? And what was that like to have those sorts of questions asked of you? P01: It was all right for a while. I: Just for a while? What happened after…? P01: I was doing most of the talking and I didn't like that. Reference 3 - 0.77% Coverage

	I: Okay. And typically, what things would he do to try and be more dominant? P01: He’d tell me what to do, tries to tell me what to do. I: Okay. Are you able to give typical examples of what he might tell you to do? P01: Well, just recently he’s been saying…telling me to kill myself and do everybody a favour. Reference 2 - 0.11% Coverage He just keeps going on, he won’t shut up. Reference 3 - 0.13% Coverage Even when I ignore him, he still goes on and on. Reference 4 - 0.13% Coverage I don’t know. He never seems to go away though. Reference 5 - 0.17% Coverage He doesn’t turn off, it doesn’t affect him, he just keeps going on.	I: So, what does the medication that you take, what does it do to [voice]? P01: Nothing. **Feeling worse from medication** P01: Yes, they tried everything, they even tried putting me on a depot, and that was horrible, that was the most horrible thing I hated was getting put on that depot injection, it was awful. I’m lucky I’m not on that anymore. I hated that. I: What was awful about that then? P01: Just the way you felt. It was terrible. I didn’t like that at all. I: With the medication inside you, do you mean? P01: Bloody awful. Reference 2 - 0.35% Coverage I don’t know, it was more like desperation. Once you get your depot, it worked its way into your system…it just was very, very unpleasant. Reference 3 - 0.36% Coverage It didn’t help me, it definitely didn’t help, that’s why I asked to come off it because it wasn’t doing me any good. It was totally unpleasant. Reference 4 - 0.49% Coverage	Reference 4 - 0.33% Coverage Where do I think he comes from? I don’t know, I don’t know where he comes from. He must be in my mind but it’s how I perceive it. Reference 5 - 0.35% Coverage He must be a figment of my imagination, at the end of the day, but some of the vocabulary he uses sometimes is worse than I would ever say. Reference 6 - 0.95% Coverage I: So, I know you said before [voice name] thinks it’s because of your past history but what do you think has made you so unlucky to have then gone on to hearing [voice]? What’s been so unlucky, do you think? What’s happened? P01: I’ve no idea. I really don’t know. If I could answer that question, I’d have a lot more idea of what else I could do to get rid of him, but...I just can’t answer it.	leave me alone, and that’s the end of it, he says I don’t deserve to be left alone, I deserve to be tormented. Reference 5 - 0.38% Coverage Always very negative. He never says anything positive, it’s always negative. So, if he does make a comment, it will be on the negative side of things. Reference 6 - 0.55% Coverage P01: Yes, he used to take the piss out of my friends sometimes as well when I used to live at West Moorland. He’d slag my mates off as well. I: Okay, so… P01: Calling them drug users and what have you, good-for-nothings… Reference 7 - 0.21% Coverage Because he wasn’t going to be wanting to do anything that was going to benefit me.		P01: Just the fact that it was me that was talking all the time. I: Okay. And was it always like that or did it get more and more where you were asked to talk more and more? P01: That’s why I stopped going there. She was saying less and less all the time and I was doing most of the talking, a lot of talking. Reference 4 - 0.33% Coverage Yes, it wasn’t so bad when I first started. She would talk more but after a while it was all me and that was the bit I didn’t like. Reference 5 - 0.15% Coverage Just a feeling of wanting to be out of that situation. Reference 6 - 1.20% Coverage I: So, in terms of treatment then, so

	Reference 6 - 0.23% Coverage He's loud. He's as brash as they come. He's loud. That's why I can't get away from him. Reference 7 - 0.06% Coverage He won't let it drop. Reference 8 - 0.37% Coverage I: What have you found helps when you're in places like this? What can people do to help? P01: Nothing. Nothing at all. It doesn't make him go away. Reference 9 - 0.31% Coverage There's nothing they can do, is there? There is nothing you can do about it, there'll be nothing anybody can do about it. Reference 10 - 0.24% Coverage There is nothing they can do to help. You get them or you don't, you know, unfortunately I do.	I: And what about [voice], was he harder to be with or easier to be with when you were on the depot? P01: I can't remember. I don't think there was any difference. Just the way the depot made you feel.	**Feeling physical presence of voices** P01: He's behind the wall, on the other side of the wall. I: Okay. So, behind a wall that's…in relation to where you are now, would it be behind the wall that's behind you or…? P01: Yes, behind me. **Living with voices** I suppose I'm just getting used to dealing with the voices on a day to day basis and learning to live with them.	Reference 8 - 0.16% Coverage He just treats me the same as normal, abuse and more abuse. Reference 9 - 0.23% Coverage He's loud. He's as brash as they come. He's loud. That's why I can't get away from him. Reference 10 - 0.07% Coverage His language is terrible. Reference 11 - 0.08% Coverage He swears all the time anyway Reference 12 - 0.25% Coverage Yes, I would say he's against them. It being his aim to torment me and discredit me all the time. Reference 13 - 0.38% Coverage It would be a better one, obviously but he's not like that, he's too nasty. He's		you said there was a psychologist that a few years ago you would regularly meet, and then it got to the point where you just wanted to get out of there because you were having to talk more than you wanted to, is that right? P01: I used to turn up in tears with her sometimes, I used to be in a right state, I used to tell her about everything, but I don't know, it wasn't going anywhere, I wasn't getting any benefit from it, so I never went back there. Reference 7 - 0.82% Coverage I: Yes, shall we start bringing it to an end? Yes? What's it been like talking about all these things now? P01: Not very nice, to be honest. It exacerbates the situation. I: With [voice]? P01: No, with the way I feel about it all. It plays on my nerves. If

	Reference 11 - 0.76% Coverage There’s only one way to help me in my situation and that’s give me a lethal injection. That’s the only thing I would think that would get rid of the voices, for good, because I can’t think of anything else that anybody could do to try and help me properly, because I don’t think there is anything they can do. **Power relations between voices** And sometimes he’ll address her, tell her to keep her mouth shut or keep her nose out. **Voices wanting to be acknowledged** He didn’t like it when I try to ignore him, he doesn’t like that either.			always nasty all the time. You never get anything positive out of him. Reference 14 - 0.09% Coverage Yes, he just told me to fuck off. **Voices being disruptive** P01: The manager here, he wanted to come and talk to my voices, but my voice said no. I: Oh, you told me that, yes. P01: Just gave her a flat no, I’m not doing nothing like that. So he might be disappointed about that but there’s nothing I can do about it, because it was going to be a waste of time me asking him because there would be nothing coming back. Reference 2 - 0.40% Coverage P01: Don’t try and drag me into your…what do you call it…don’t try and drag me into what you want to do with Mark, I don’t know, I can’t remember the right words.		I have to keep talking about it for a long time, it gets me down. Reference 8 - 0.24% Coverage Questions get me down after a certain amount, I don’t know how long we’ve been going now but… **Finding it difficult to relate with voices** P01: Because he won’t tell me his name, I’ve asked him but he won’t tell me his name. I: Okay. So, [voice], you’ve named him XXX? P01: I’ve named him XXX. I: Okay, because he won’t tell you his name? P01: No, he won’t tell me. **Being active and distracted is helpful** I haven’t got anybody to distract me. When I’m on my own, I’ve got nobody to distract me from him.

				Reference 3 - 1.03% Coverage I: Okay. So, when XXX came, that example you gave there, because that was just, what, a few weeks ago, it wasn't too long ago, was it? So, on that occasion, XXX's approached you and asked if he could talk directly to [voice], and [voice] made it clear he didn't want to do that. Did he make negative comments to you on that occasion then? P01: Yes, he told me not to try and pull him in on things that he didn't want to do. Reference 4 - 0.64% Coverage I: And was he like that when [voice] approached you and asked to talk to him? The same sort of… P01: Oh yes, he was straight there, don't even think about asking me, he was saying to me about voice dialogue he said you've no chance. No chance of me taking part. Reference 5 - 0.53% Coverage		Reference 2 - 0.31% Coverage I: So, when you're with company, does that mean you can be distracted from [voice]? P01: It helps me to distract from him, yes. **Being critical of voices** Nothing. I might have a go at him. It depends how I feel Reference 2 - 0.95% Coverage He can't be much if his sole purpose is to make my life a misery. He can't have much about him if that's one of his main goals in his life is to prey on other people. That's not a character that's got anything decent about him. And the way he talks to his wife sometimes is worse, he dominates, he's a domineering type, and he talks to her telling her to shut her

				I: If you were to guess, how do you think [voice] would view people who were trying to talk to you or help you or…? P01: Yes, I would say he’s against them. It being his aim to torment me and discredit me all the time. Reference 6 - 0.60% Coverage I: Did [voice] respond similarly when XXX tried to talk to him? P01: Yes, he was quick enough to say he wasn’t interested. I: Did he put it as strongly as that or…? P01: He was there straightaway, don’t try and effing pull me in, he said.		mouth and what have you. Reference 3 - 0.38% Coverage P01: His language is terrible. I: Right. And does that ever get worse or…? P01: He doesn’t sound like an educated man at all. He sounds like a yobbo. Reference 4 - 0.10% Coverage I’m glad he’s not one of my family. Reference 5 - 0.39% Coverage P01: Yes, I’ve been very unlucky, yes, to end up with [voices], Mr Smiler, smiling to himself. I: Is that what you call him? P01: He doesn’t like that much. Reference 6 - 0.14% Coverage

						He thinks he's too clever, he thinks he's Mr Smart. Reference 7 - 0.09% Coverage He won't do anybody any favours. Reference 8 - 0.10% Coverage He's just a nasty person all round. **Distancing self from voices** Nothing. I might have a go at him. It depends how I feel, but I do tend to…the less I have to do with him, the better, I think. Reference 2 - 0.18% Coverage Why would he want to talk to my voices anyway? I don't understand that. Reference 3 - 0.30% Coverage He hasn't got much of a life himself. So, I just try and read as

						much as I can and try and get him out of my system. **Voices interacting with emotions** Well, it depresses me all the time, because he never shuts up, he just keeps going on and on and on. Reference 2 - 0.06% Coverage He makes me angry. Reference 3 - 0.41% Coverage I don’t know. I’m all right talking about my voices and that, but sometimes it just gets me down, even the talking about the voices gets me down sometimes as well. Reference 4 - 0.33% Coverage Yes, trying to but it’s hard when he keeps on all the time. I have to just sit and listen to him, and it can be quite depressing.

P02	**Empowering self through action** And because I, as a child and teenager, I did a lot of music training. I was on a music scholarship at school, and I found that when I played an instrument, like the cello, if I played a cello, then it can sound like the voice is maybe a bit more distant. Reference 2 - 0.10% Coverage So I think actually the action of, the activity of doing the music, somehow intercepts the voice hearing experience. Reference 3 - 0.10% Coverage So when I was having cello lessons with my cello teacher, it felt like the voices were in the garden almost, yeah. Reference 4 - 0.11% Coverage No, often when I play, it just stops altogether. And actually, I've actually used music as a therapy in that sense for myself.	**Dominating influence of medication** I was hearing voices, and immediately, you know, quite soon after that, that prescription was written. Reference 2 - 0.15% Coverage What would be unhelpful, would be the attitude of this psychologist that I met, who thought that everybody who heard a voice was psychotic, and should be on medication. Reference 3 - 0.15% Coverage So, you know, I'm not anti-medication, you know, I just don't think people should be doped up so much, and put on about three different, or two different antipsychotics. Reference 4 - 0.14% Coverage Because, you know, the people that I interviewed for my job, if they were to say that they were hearing voices to a clinician, their medication would be upped. **Benefitting from medication** And now, I kind of like, if I'm distressed by the voice hearing I take a low dose of amisulpride. But I don't take it all the time, I just take it for brief periods.	**Making sense of voices** So it was actually, you know, kind of, an auditory experience, which was like actually somebody was, a man was having a conversation with another man. So it was very disembodied, it was like there were actually people there. So it kind of had this kind of persona, and it had, you know, an identity, and it was like it was two people speaking to each other. And it was so real to me, that I actually went out of the flat to see if there was somebody there. Reference 2 - 0.10% Coverage And at that point, it sounded as if there were people standing, you know, in the ceiling above me, speaking about me. Reference 3 - 0.10% Coverage So yeah, sometimes when I was at home, it would be like the voice, there were people standing up in the room above. Reference 4 - 0.19% Coverage	**Being persecuted by voices** I felt quite persecuted by the voice hearing experience. Reference 2 - 0.10% Coverage Just, it would like, kind of, say the kind of negative, critical things my own mother would have said when I was younger. Reference 3 - 0.07% Coverage But the voice hearing experience could still be critical, negative and frightening. Reference 4 - 0.10% Coverage But I guess, one example would be, you're gonna fail it, sort of, about my doctorate, because I thought I was gonna fail. Reference 5 - 0.16% Coverage Yeah, so when I was put on olanzapine when I was 28, and put on all that weight, yeah, the voices became very critical	**Practitioners failing to connect & understand** And literally, a week after giving up my job, no, two weeks after giving up my job, I had a meeting with a social worker who told me I could be on benefit medium to long term. And basically got, you know, it felt like I got written off my mental health services. Reference 2 - 0.62% Coverage So, really poor treatment interaction was when I was sitting in the lounge area, where patients were. This night nurse sat next to me and basically asked what I'd been doing before, so I said I'd been at Oxford, and I think he thought it was delusional. Because he said, what year was James Joyce born, as if that's really kind of a question which can actually indicate whether or not you can actually be a Joycean scholar. So I answered the question, and he looked surprised. So he must've thought that I was actually delusional, saying I'd been at [university], studying James Joyce. So it was an indication that, obviously,	**Being accepted and supported** And you know, and I found that, actually, my friends have been particularly helpful to talk about voice hearing. Like, one of my friends, who mentored my PhD, who I've been friends with for 18 years, I can say anything about the voices to him, and he doesn't ever, he doesn't stigmatise me, he doesn't freak out or anything. Reference 2 - 0.38% Coverage And there, you know, I know other people who, I know somebody else who's a voice hearer, who was in the NHS for 30 years as a staff nurse. She was there at my launch, you know, quite comfortable with the approach that I have to voice hearing. The professor who invited me to be an individual partner in the collaborating centre

	Reference 5 - 0.18% Coverage I think what I do in my life is I try to kind of make sure that I don't get put in positions of having no agency. So if I think that’s happening, I do things to kind of give myself more control and power. **Setting limits** So that I could challenge what they said, I could change the relationship, I could create boundaries with it. Which then led to me, in my own research, to look at spatial boundaries for voices. Reference 2 - 0.04% Coverage I would try and ignore it. And I did ignore it. Reference 3 - 0.11% Coverage That there was actually a boundary, like a, you know, between me and what I said to the therapist, and actually the outside world. Reference 4 - 0.10% Coverage	And I agreed that with the psychiatrist that I was under a few years ago. He was very helpful to me, actually. And I've just been under a GP for the last few years. And I take diazepam, partly because of my back, because I live with chronic pain, but I'm not addicted to it. Reference 2 - 0.07% Coverage So, for me, a low amount of medication at times has actually been a helpful thing. Reference 3 - 0.25% Coverage Yeah, and then if I get to, like, when I want to go to bed, like at ten thirty, if I'm still, if I can't sleep, I just take medication to sleep. Because, you know, I don't take sleeping pills, I just take a low dose of amisulpride, and like, or like diazepam, so I can relax and sleep. Reference 4 - 0.12% Coverage And so, with the voice hearing experience, it's not been too bad, because I'm just taking some medication in the evening to be able to sleep. Reference 5 - 0.17% Coverage But you know, there's a bit of medication taking going on at	And then when I was teaching, it was like, yeah, and I guess, really, the noise of the traffic in the street, maybe that amplified the voice hearing experience. It felt like people were shouting up from the street, yeah. Reference 5 - 0.10% Coverage I think it's helpful, actually. Because by challenging it, and by questioning it, I can dismiss it as just voices. Reference 6 - 0.14% Coverage And so I chose, when I entered the pathway of recovery, to actually understand that these are just voices. And the therapist that I saw helped me to appreciate that. Reference 7 - 0.16% Coverage Where the voices actually have a physical presence, and they feel very, very separate, almost like disembodied, that this fits more of a DID profile than	about my size. And my bulimia has never been worse than it was then. Reference 6 - 0.06% Coverage I cannot think of anything which has been positive about this experience. **Voices being disruptive** I: How did the voices respond when practitioners approached you, then? P02: It was just, I would try and ignore it. And I did ignore it. But it was kind of more, it would be a bit louder, but it sounded separate, as if it was in the next room. Reference 2 - 0.37% Coverage I: Did their way of talking change when practitioners approached? P02: They could, the voices could, like, say negative things. Like, they were often undermining things, you know, the fact that I was stupid, or something. Or make some, you know, kind of comment, like,	he'd read some manual about kind of grandiose theories, and all that. Reference 3 - 0.08% Coverage Yeah. And so I found that really negative, 'cause I thought, well he must think I'm lying. Reference 4 - 0.22% Coverage So there was no attempt, really, to engage with me, you know, as a human being, you know. There was no attempt to really build any trust with me. The nurses kind of sat in their office, and then when they did come out, they came with their clipboards. Reference 5 - 0.49% Coverage And when I expressed to her that I would have liked to have gone back to finish my [university] doctorate, it was suggested to me by the clinical psychologist in that research team, that I adjust my expectations, i.e. lower my expectations. He actually said, you know, only about one per cent of	in [city], is a former psychiatrist, he's quite happy with the approach I have to voice hearing. Reference 3 - 0.27% Coverage I've not met anybody who, well I have met some people who do want voices, but I haven’t met anybody who finds the voices negative and critical, who actually wants to court a secure attachment with them, you know. So, and many people that I've interviewed, do have ambivalent, anxious patterns of attachment. Reference 4 - 0.05% Coverage But I think it was the neutrality of it that helped. Reference 5 - 0.26% Coverage But it's actually aiming to empower the voice hearer to say what they think is

	And if I hear the voices, I either ignore them, tell them to shut up, or think to myself, I'll listen to them later. Reference 5 - 0.13% Coverage And then, in my head, like, maybe give them half an hour, at seven o’clock, for half an hour, listen to what they're saying, and just ignore them again. Reference 6 - 0.04% Coverage Yeah, so I have these kind of rules to function. Reference 7 - 0.17% Coverage the last time I heard voices, yeah, I was actually with my friend. And I heard the voice, and then just thought, I don't want to hear the voice, and just ignored it, and carried on talking to him. Reference 8 - 0.10% Coverage But basically, you know, I just have this boundary on myself that, you know, come	the moment because I just, you know, so I can sleep at night, and stuff. And actually, that’s, for me, that’s a stress strategy, yeah. **Feeling worse from medication** And she put me on a medication, like olanzapine, and it made me put on three stone. Reference 2 - 0.41% Coverage And I'd had anorexia as a child, and I found it so distressing. And then it caused bulimia, again. So basically, I hadn’t had bulimia really badly since my early 20s, and because I was put on that medication, all my bulimia came back. And then, when I got taken off it, I put on all this weight, and I just couldn’t accept myself like that. And then, I was put on a different antipsychotic, what was the next one, erm, aripiprazole, and that caused terrible anxiety. Reference 3 - 0.18% Coverage But I didn’t like the way the medication thing was handled 12 years ago, like, it was like, I was put on too much, it had terrible side-effects. And it didn’t help with the voice hearing experience either. Reference 4 - 0.29% Coverage	actually, kind of a psychotic one. Reference 8 - 0.07% Coverage But it didn’t sound like my own fears, it sounded like it belonged to the voice. Reference 9 - 0.23% Coverage So I wouldn’t say that the voices say really inaccurate things. So, the idea that they're messengers, they're people, you know, at some level, it's kind of metaphorical. Because it's not exactly, you know, what I would write down, but it's kind of somehow linked. Reference 10 - 0.18% Coverage And I was really overwhelmed with the voice hearing experience, and it felt like the voices were figures standing outside the room. And it was like they were, you know, people were actually physically there. Reference 11 - 0.16% Coverage	which would create fear, you know, like I was going to be sectioned, or something like that. So it was often, my own fears were kind of externalised in the voices.	people have doctorates, you know, so, why don't you do something else, essentially, that’s what he was saying. And so he basically, you know, told me to kind of, you know, suggested I took the medication, and adjust my life expectations. Which I didn’t find particularly helpful. Reference 6 - 0.21% Coverage So I found it particularly unhelpful, when this psychiatrist, the one in [city], you know, told me to readjust my expectations, and told me, you know, that there's evidence to suggest that people should be on medication long term, and all this. Reference 7 - 0.21% Coverage So I think that, like a clinical setting, where people, you know, want to like know, what kind of voices people are hearing, because they want to do, like a PANNS scale to rate the psychotic experience, that’s an uncomfortable kind of approach.	helpful. And that kind of listening to the voice hearer and giving them that space to actually say what they think would be helpful, rather than coercing them into something they don't want to do, I think is really important. Reference 6 - 0.17% Coverage And it was really hard going down then, hearing about kind of, the kind of community cases that she used to deal with as a psychiatric social worker back in the ‘60s, or, you know, whenever it was. Reference 7 - 0.14% Coverage Because I do think it actually helps with the voice hearing experience to have that kind of network of connection with people who actually share the same ideas.

	11 o’clock, I want to go to sleep. Reference 9 - 0.14% Coverage it's not something I've chosen, and I have to live with it at times. And, you know, I think, you know, boundaries with it, has been the most helpful thing, really. **Voice hearing is about power & control** And for me, it was overwhelming, initially. But you know, when that then led to kind of me, you know, giving up my job, and then ending up in, you know, secondary mental health services, and having a really dreadful time, in having that experience. **Lacking agency with voices** It sounds crazy to say it now, but because the voice hearing experience was so overpowering, and frightening, I didn’t want to be alone in my flat, and I didn’t have a job to go to.	But I did, three months ago, have a problem, when I was in so much severe physical pain, and taking so much codeine, because of my back problem, that it actually affected my mental health. And I think codeine can affect your mental health, actually. And I, you know, kind of felt slightly manic, actually, because of all the codeine. Reference 5 - 0.17% Coverage I don't know if there's been any medical research on this, but I do think, codeine, if you are actually a voice hearer, taking loads of it, can actually somehow make the voice hearing more problematic. Reference 6 - 0.09% Coverage I was vomiting three, four times a day, and I was vomiting up blood at times, it was just awful there. **Fearing enforced or involuntary treatment** I: Can you just talk me through, then, that experience of voice hearing. So at the time when practitioners were approaching you, can you remember what effect that had on your voices?	I was able to accept they're just voices, dismiss them more. See, you know, I'm a person, and I just sometimes hear voices when I'm distressed. I could see my sense of self more clearly. Reference 12 - 0.22% Coverage So I'd say that the voice, the female voice is a bit like my mother’s voice. But it's not her, it sounds like, it's got a different sound to the way my mother speaks, but the comments are similar to the kind of negative, critical things that she used to say. Reference 13 - 0.33% Coverage And then, the male, kind of like, slightly critical voice, is kind of like, probably a composite of the kind of, I have no relationship with any of the men in my family, I haven’t seen my brother since my grandmother’s funeral three years ago. And I hadn’t seen him prior to that for like, about, ten years. And I've never met		**Experiencing MH services as uncaring** And that’s what really irritated me about mental health services, they’ve got such a reductive view of looking at it. Reference 2 - 0.28% Coverage Uh-huh. And then, what I found also very difficult with the medical model, you know, I've looked at kind of, you know, in my job, hospital that this PANAS scale, you know, you’ve got this whole grid of symptoms that people are supposed to have, like excitability, grandiosity, delusions, the list goes on, and on, and on. **Perceiving practitioners lack hope** I would love that psychiatrist, when I was 28, to know that, she wrote me off essentially. **Framing experiences according to professional interpretation** P02: Yeah, and then, when he went out of the room, I looked at what he'd written on the sheet, and he'd also	Reference 8 - 0.12% Coverage But because of the way I've handled it for years, I have a small group of friends who I can mention voices to, and they don't bat an eyelid. Reference 9 - 0.07% Coverage So it's kind of actually, to be honest, it's having a social network, isn't it. **Feeling valued by practitioners** But he has a more balanced viewpoint, because he actually recognises there are social factors involved in psychosis, as opposed to just the medical model. Reference 2 - 0.26% Coverage And she actually went through my medical notes, and seen I'd been in foster care, you know, read the notes, and I didn’t have to kind of talk

		P02: I think it made the voices more negative and critical. Because I guess I was more frightened of them, in a sense, because of the implications of actually hearing voices. Reference 2 - 0.27% Coverage I: Okay. And what was it that you were fearful and anxious of, if practitioners were approaching you? P02: Being diagnosed with schizophrenia. I: What is the fear about being diagnosed with schizophrenia? P02: Because then, people get like, you know, forcibly medicated, that's what my understanding of it was then. Reference 3 - 0.24% Coverage I: So, just, remaining in that situation, then. The practitioner approached you, you were already fearful and anxious, because you didn't want them to find out that you heard voices, I guess. P02: Yeah. I: Because that would give you a different diagnosis, and enforced treatment. Reference 4 - 0.21% Coverage And, you know, sometimes, actually, that audience of one's	my two stepbrothers, who are like, in their 40s. Reference 14 - 0.09% Coverage And I'd say that the male voice is maybe a composite of their kind of critical comments when I was younger. Reference 15 - 0.28% Coverage I just see it as voices, you know. Like if I was sitting in a room, on my own, you know, they're my voices aren't they, no one else can hear them. If somebody else is sitting in the same room, they can't hear the voices. You know, it's something that I experience, it's not something that happens to anyone else, you know. **Feeling physical presence of voices** And in the third year of my doctorate, I started to hear, like, footsteps above my head. And it was like people would be talking, kind of in whispers, like, above my, you know, in the room upstairs. And I realise now, there was, it		mentioned about kind of possible Asperger's. So I found that really, really damaging, and unhelpful. I: So, when he went out the room, you saw he'd written that down? P02: Well I, because we'd been talking about it, I looked at his notes. But yeah… I: So how did that affect it when he came back in the room? P02: I just didn't really say much, and then I missed the next session.	about it all. And, you know, because she was a very thorough psychiatrist, and she doesn't just drug people up, unnecessarily. And you know, I found that helpful. Reference 3 - 0.24% Coverage And, you know, and she had a very different approach to the psychiatrist in [city], you know, different training, I think, because she saw that there was a strong trauma component, different take to it than the psychiatrist in [city], who just thought it was all biomedical. Reference 4 - 0.17% Coverage So as I say, my current therapist and my previous therapist were both helpful. And they just had the approach where, you know, you hear voices sometimes but you

		own friends, is a better audience than mental health professionals. Because you don't have the risk of saying you're hearing a voice, and then ending up getting sectioned, you know. Reference 5 - 0.19% Coverage And I think if they think you're a mental health professional, or they think you've got some kind of power over them, people stop talking, they don't want to talk, because they think there's gonna be, you know, a consequence. Reference 6 - 0.22% Coverage I think if somebody is a clinician, if they're able to give somebody a space where they can actually speak, and articulate kind of what's going on with them, without, you know, thinking they're gonna be sectioned the next minute, I think that is helpful. **Importance of being involved in treatment decisions** And because the therapist shared with me, the understanding that, you know, often, even if people take medication, they often still hear voices. And in psychiatry, that there's this like myth that you	could have been somebody's quiet voices, but I think I was hypersensitive. Reference 2 - 0.16% Coverage Which sounded like it was somebody in the room, it turned out it was actually the garbage shed, but it felt like there was somebody there, and it felt like it was somebody speaking about me. Reference 3 - 0.11% Coverage And when I had that job, it was like the voices would shout from the street, up to where I was teaching, on the second floor. Reference 4 - 0.54% Coverage Erm, at that time, it was very much that the voice was separate to me. So it sounded like it was in the next room. I remember being in the hospital bedroom, and trying to sleep, and it sounded like the three voices were upstairs, like, listening to a radio. It sounded like there			get on with things, and you do things. Reference 5 - 0.17% Coverage And, you know, and then, so what are the voices saying, are they saying anything which is troubling you, you know. There's that kind of attitude which I find very helpful. It's not judgemental. Reference 6 - 0.04% Coverage But it was that space, of not being judged. Reference 7 - 0.15% Coverage So, you know, I think if somebody is a clinician, if they're able to give somebody a space where they can actually speak, and articulate kind of what's going on with them Reference 8 - 0.03% Coverage

		take a pill and it's gone. The therapist didn't have that illusion. Reference 2 - 0.09% Coverage And you know, she didn't try and sell me lies, like, take a pill and it's all gone, kind of thing. Reference 3 - 0.28% Coverage I think, you know, I have met some good mental health professionals in the last few years. And both the therapist that I've had, the one that I had for eight and a half years, and the one I've had for the last year, just over a year now, they just, it's like person centred, they just go with what I want to do, you know. Reference 4 - 0.38% Coverage And they're encouraging and helpful. And where I find it difficult to achieve some things, like the first time I went to Switzerland to see my best friend out there, who I went to school with, I found it difficult to travel to Switzerland, because I hadn't been abroad on my own. And I was able to talk through it before I went, and then, you know, I coped with it, and I went back to Switzerland in July for a week, and had a nice holiday.	was that auditory experience going on in the room above me. But I don't think there was anything there, I think it was, I think I was, the psychiatric ward was on the top floor of the building. So I don't think there could have been anything there, so it was just, you know, it was an auditory hallucination. Or hearing voices, anyway. Reference 5 - 0.07% Coverage And on one occasion, I went upstairs, just to check there was nobody there. Reference 6 - 0.06% Coverage I can hear them a bit, actually, like, they're in the next room. **Identifying voices as part of self** It used to be kind of like spiteful. And saying negative things. It sounded a bit, it was almost like I was jealous of myself. Because if the voice was part of myself, I'd be jealous of myself. Which sounds a strange kind of			To actually talk to the person. **Importance of being believed** And then, because I, you know, it's in my medical records going back years, I was actually abused, and then like, you know, I look at this kind of grid, and think, gosh, somebody could say, that's a delusion. Or somebody could say that it's a delusion that I said I was at Oxford in my 20s. And suddenly, there's this whole kind of meta level to what was just hearing a voice, a whole kind of, you know, list of, like, symptoms and experiences people are supposed to be having alongside this. Which makes it a much more complex thing. **Talking about voices & problems is difficult** So another example would be, with my male friend in my flat, he said to me, when

		Reference 5 - 0.38% Coverage But this GP has been very helpful over the last nine years, because rather than her telling me what to do, she kind of works with me, and helps, you know, I make my own decisions. But I obviously listen to her medical guidance. And she did refer me to a psychiatrist, nine years ago, which was this psychiatrist who I found really helpful, who actually changed the diagnosis to, well she said it was BPD, and then has decided it's PTSD. Reference 6 - 0.24% Coverage And, you know, because she was a very thorough psychiatrist, and she doesn't just drug people up, unnecessarily. And you know, I found that helpful. And she said that, you know, with the kind of presentation I had, you know, medication for short term periods would be okay. Reference 7 - 0.10% Coverage I still think that the person, if possible, should be on side, you know, the person should have some say in it. **Lacking involvement in treatment decisions**	thing to say, but it sounded like a jealous, spiteful voice. So if that was part of myself, that's my relationship to myself, isn't it. Reference 2 - 0.06% Coverage So it was often, my own fears were kind of externalised in the voices. Reference 3 - 0.22% Coverage So, you know, it was, the process of psychotherapy that I've had for several years, the previous therapist really helped me to understand that the voice hearing experiences are my own fears, manifesting in the voices. So it is, at some level, myself. Reference 4 - 0.08% Coverage But that, because it's my own fears, it's hard to interpret that as being part of myself. Reference 5 - 0.54% Coverage			we were in a different space in the bathroom, he said, well what are the voices saying, tell me what they're saying. And I couldn't even tell him. And I tried to articulate what one of them was saying, and that was with somebody that I trust more than anyone else. So you know, even in that situation, it's difficult to articulate what they're saying sometimes, you know. Reference 2 - 0.28% Coverage Not because they're…they're just making comments, you know, they never make any commands, or anything. I just think it's difficult to articulate actually. But if you ask me now, what do the voices tell you, I couldn't actually really say that easily the things they say. Just because it's

		And because I'd already had a diagnosis of bipolar disorder when I was 21, I just saw it as like, you know, they just want to kind of, you know, put people on medication. And so, I was actually very wary. Reference 2 - 0.31% Coverage I: So going back to olanzapine, was that something that you agreed to, was it discussed, how did it come to be that… P02: Oh, it wasn't discussed. That was what was prescribed. Because I'd had, like, I was used to kind of following what a doctor said to do, because of my back issue, so I just took the pills. And didn't realise I was gonna put on three stone. Reference 3 - 0.37% Coverage And there was no discussion or negotiation about what medication I would take. No, I wasn't told about the serious side effect, that it was actually used with anorexia patients, to make them put on weight. You know, I wasn't told any of that. And I'd actually been in remission for my eating disorder for some years. And that sparked my eating disorder again. And so it was a very, it was a kind of neglectful medical decision.	Because actually, in the voices have been things which I haven't been able to talk to people about. So actually, I realise, in a way. And to be honest, comments like, that I'm stupid, that's probably how I think of myself sometimes, you know. Because I tried to learn French, and I did French very basically at school, and when I was in Switzerland visiting my friend, I tried to speak French at the airport, with somebody who was French. And you know, at the time, you know, the voice said, that's rubbish. And it was rubbish, you know, because I couldn't speak fluently. And so, it is actually how I think of myself. Reference 6 - 0.15% Coverage I do think the voices, this is what my therapist says to me, they are maybe the paranoid part of yourself, and the negative critical part, the part that you're scared of. **Linking voices with trauma**			difficult to put it into words. Reference 3 - 0.10% Coverage I just couldn't talk about the abuse that I'd experienced, it was that bad, and I just couldn't articulate it. **Being active and distracted is helpful** And then if I'm doing something stressful, like…actually, I didn't hear any voices on the day of my book launch. Oh, actually, I did briefly, I was with my friend, and I briefly heard them for about ten minutes. But on that day, I was so busy and focused on organising all these things, I just didn't, I actually heard no voices. **Concealing voices** But I just, you know, carried on like this, but I didn't even want to tell them I was hearing voices. Reference 2 - 0.07% Coverage

		Reference 4 - 0.08% Coverage And so basically, social services had this control over my life, and I think I was 14, then. Reference 5 - 0.13% Coverage And so, at a young age, I hated social workers. Because the social workers had all of a sudden made a decision about my life, and I couldn't even go home. Reference 6 - 0.28% Coverage when I was in mental health services, when I suddenly got, you know, was in the psychiatric ward when I was 28, and suddenly a social worker told me I would be long term unemployed, and I'd only had a job two weeks earlier. You know, again, they had that power. And I think it's that power dynamic,that I find really difficult.	But unfortunately, I had the experience of meeting my biological father when I was 35, and I hadn't seen him since the age of two. So I had 33 years of no contact at all. And this is actually in my medical records, so I'm not kind of breaking any confidence here, or saying anything new, which isn't already in my medical records. But I was sexually abused by my father, when I was 35. Reference 2 - 0.19% Coverage And it was so terrible, that afterwards, I sometimes heard, erm, well heard his voice, for a brief interval. It stopped, the voices, some time ago, but I think it was a kind of traumatic reaction to what happened. Reference 3 - 0.12% Coverage But basically, yeah, so I had that brief experience, which makes me, now I understand, that on some level, it's linked to trauma, I think. Reference 4 - 0.09% Coverage			And I didn't say I was hearing voices at that point, I was told I was bipolar. Reference 3 - 0.14% Coverage And then the next day, I really was hearing voices, and was trying to conceal the fact. And then, unfortunately, when I have no sleep, I tend to talk too fast. Reference 4 - 0.17% Coverage And actually, nobody actually asked me if I was hearing voices, until this social worker spoke to me, and then I lied and said I wasn't. Because I knew that was a cardinal sign of schizophrenia. Reference 5 - 0.31% Coverage I: So, in that period of time when you were in hospital, nobody asked you whether you heard voices. But

			Because when I was in foster care, when I was a teenager, I was abused, and I couldn't cope with that. Reference 5 - 0.11% Coverage And I spent six months in care, and then I was abused. And that was supposed to be the care of the government, you know. Reference 6 - 0.31% Coverage And at that point, you know, I was taking loads of codeine because of the pain, because I was doing loads of sitting, because I was trying to get through the work. Because I just wanted it signed off. And then I started drinking alcohol, very foolish. And basically, at that time, the voices were troublesome, because, you know, of sleep deprivation. Reference 7 - 0.18% Coverage I think maybe, because I've had, you know, a difficult life, in some ways, and had			did you say a social worker asked you? P02: A social worker asked me, and I said, no. I: Okay. And you said no, because you anticipated, by admitting to hearing voices, that would, what would that mean? P02: That would mean a different diagnosis. Reference 6 - 0.15% Coverage So, but whereas if I was in a clinician's room, I'd be acting more that I was fine, because I wouldn't want them to know about the voices, so there would be more pressure there. Reference 7 - 0.35% Coverage And obviously, I am pleased to have the job, and I do want the job, but there was the fact that I was hearing voices sometimes, and then I had my own office at that

			some traumatic experiences, maybe for me, the voices came when I couldn’t cope with certain things at an emotional level. **Living with voices** I've moved to that place because, one, I've done all that research, and I've learned different strategies for coping with it. Reference 2 - 0.11% Coverage I've realised that hearing a negative, critical voice, I've still been able to do what I want to do, it hasn’t stopped me doing it.			point, but then I didn’t want them to think I was so mentally ill, I couldn’t do my job. So I was putting on a bit of an act, having to store some bags of clothes in the room, because I actually had been chucked out of the previous flat **Distancing self from voices** I then got referred to a day centre, and there were some really mentally ill people. And because I was actually really afraid of the voices, I would actually go into this mental health centre thinking that I could somehow have some cocoon from the voices. Reference 2 - 0.44% Coverage But I would say that, with these voices, because, like, in a way, I'd worked on not having a relationship with them. I know that sounds a kind of

						statement that, it's almost like a kind of, well, you know, to not have a relationship with something that you hear, is quite a complicated thing. But what I mean by that is that, I choose to kind of have distance from it, and before it says something, just either in my head, question it, or dismiss it. Not kind of have any emotional connection with it. Reference 3 - 0.32% Coverage And for me, that’s been a really helpful strategy. In my own PhD thesis, I have a section on minimal relating to voices. As opposed, you know, at the other end of the spectrum, to people having rich colourful relationships with their voices. And for me, actually, the minimal relating thing has worked, actually. I think that’s a helpful

						way for me to look at it. Reference 4 - 0.11% Coverage And I also found in my research, that people who were able to function better with it, I found, did have minimal relating strategies. Reference 5 - 0.18% Coverage I: Because that would give you a different diagnosis, and enforced treatment. Can you remember, then, what the voices were doing? P02: Erm, at that time, it was very much that the voice was separate to me. Reference 6 - 0.18% Coverage I: So has anybody tried to actively directly engage with your voices? P02: No. I: No. What are your thoughts about that?

						P02: Never wanted to do it. Just because I have this minimal relating strategy. Reference 7 - 0.22% Coverage And so to actually court the relationship with that, and you know, build up relationships with characterful voices, you know. I wrote a whole section on this in my thesis. I just don't want that, you know. So that's why I've gone for the minimal relating. Reference 8 - 0.30% Coverage So, also, I was tutoring a 15 year old GCSE English in the University library cafe. And I didn't hear any voices when I was doing that, and even if I had done, I would be able to distance myself from that experience, you know. And I am able to kind of, you know, run workshops and things, and distance

						myself from any voice hearing experience. Reference 9 - 0.22% Coverage With the voices, this kind of ambivalent, avoiding attachment, I think I have with the voices, I think that I'm probably better at dealing with the voices, and having distance from them, to somebody who would have more secure connections with people. Reference 10 - 0.15% Coverage I've learned, you know, this kind of strategy of minimal relating which, you know, I'm actually really interested in at the moment, because I think, you know, that is a strategy. **Linking relating with voices & relating with people** I went to boarding school when I was 16, on a music scholarship, really, to

						get away from my grandparents, because you know, they were nice people but they were so strict. Reference 2 - 0.10% Coverage So I have an extremely difficult mother. And basically, you know, I have a very bad relationship with her as well Reference 3 - 0.11% Coverage I would say that over the years I've become more self-assertive, and more mindful of my own boundaries with other people. Reference 4 - 0.14% Coverage But basically, because I've been in that woman's flat, I haven't been able to really assert any boundary with her, because I'm worried about being kicked out.

						Reference 5 - 0.23% Coverage I have no relationship with any of the men in my family, I haven’t seen my brother since my grandmother’s funeral three years ago. And I hadn’t seen him prior to that for like, about, ten years. And I've never met my two stepbrothers, who are like, in their 40s. Reference 6 - 0.30% Coverage I haven’t been on speaking terms with my stepfather for many years. And I haven’t seen one of my uncles since the funeral, and I hadn’t seen him for years before that, I'm not on speaking terms with him either. And I don't see my other uncle. So, and I have no contact with my father. And so I have no contact with any of the men in my family.

						Reference 7 - 0.11% Coverage So basically, I don't really, I'm good at relating to people on a level where it's a professional level, and I have no involvement. Reference 8 - 0.12% Coverage But with everybody else, I just kind of relate to them in a professional way, but I don't get involved, really, well not that involved. Reference 9 - 0.12% Coverage And I would say that my own kind of anxious avoidant pattern of relating, is manifested in the way that I've learned to relate to the voices. Reference 10 - 0.30% Coverage When I was a child, I had a really good relationship with my grandfather, you

						know, who was a very nice man. And I've never, ever heard a voice which has ever sounded like him. Which makes me think that, actually, if you have a good relationship with some people, they're not, they're probably not gonna manifest in your voice hearing experience. **Voices interacting with emotions** But I hear voices if I'm tired, or if I'm under stress. Reference 2 - 0.06% Coverage But it hasn’t gone away totally, and I do hear voices when I'm stressed. Reference 3 - 0.09% Coverage But I had this experience when I was stressed, this sense of these voices shouting up from the pavement.

						Reference 4 - 0.14% Coverage And it was a kind of, it had a big of a hyper manic pattern to it all. But with, you know, lack of sleep and stuff. But you know, at the time, this is how I operated. Reference 5 - 0.05% Coverage And because I was actually really afraid of the voices Reference 6 - 0.09% Coverage Yeah, I sometimes hear those. I'd say, like, in the evening when I'm tired, that's when I hear voices. Reference 7 - 0.22% Coverage And so, basically, the presentation was a bit fast, but I was really hearing really difficult voices that day. And was trying to just get through the experience. And it was, you know, that

						was the worst day of voice hearing I've had in about three years. Reference 8 - 0.06% Coverage So, which shows it's stress and no sleep, are two serious triggers. Reference 9 - 0.26% Coverage And I was able to kind of say the things the voices had said, but I could never really confront the voice. You know, she said once, to imagine the voices on the chair, what would you say to the voice, and I couldn’t do it. So it just shows, at some level, I was fearful of the voice, you know. Reference 10 - 0.35% Coverage Well, to be honest, the voice hearing experience, is a kind of, it kind of criticises me, and it actually focuses on whatever I'm particularly doing.

						So if I was worrying about my lack of completion of my James Joyce doctorate, the voices would pick up on that. If I was worried about being sectioned, the voices would pick up on that. So it shifts focus depending on what I'm worried about, really. Reference 11 - 0.24% Coverage And I heard all this stuff, and then I started to kind of have this fear that if I didn’t take medication I'd be put on a depo, and then this fear became externalised in the voice hearing experience. So sometimes the voices would say that, as a threat almost, you know, yeah. Reference 12 - 0.20% Coverage But a lot of the time, I don't have to take medication, I can just

						go to sleep because I'm so tired. But that's the kind of boundary that I've set, I guess. Because I know I have to have a certain amount of sleep to function. Reference 13 - 0.03% Coverage So I try to manage my level of stress. Reference 14 - 0.07% Coverage because I have to keep the stress down, because I wouldn't be able to function. Reference 15 - 0.14% Coverage And I have this thing of, no alcohol, having enough sleep, keeping the stress down. And literally writing in my diary each night, what I'm gonna do the next day. Reference 16 - 0.04% Coverage

						And to keep the stress at a manageable level. Reference 17 - 0.07% Coverage And the voice hearing experience was difficult at night, because I couldn’t sleep. Reference 18 - 0.31% Coverage Because otherwise, that can affect my mental health. And I've realised, actually, being mindful myself, of my limits, is really important. And it applied to voice hearing, it limits your voice hearing, you know. The voice hearing will become more intrusive, and more difficult, if I'm really stressed. So it's knowing that I have to keep the stress down. Reference 19 - 0.25% Coverage Like, when I was finishing up the

						thesis, it was really stressful. And I'd hear voices, like, above my head some of the time. And I thought I lacked agency then, but I was just trying to focus on getting through the work, you know, because it was really stressful finishing the thesis. Reference 20 - 0.05% Coverage it's something which is really like a barometer of stress Reference 21 - 0.09% Coverage You know, like some people get migraines when they're stressed, some people hear voices when they're stressed Reference 22 - 0.49% Coverage I think that what I've discovered during the PhD, is that maybe voices, if somebody really represses their emotion, or suppresses it, even at

						a conscious, or an unconscious level, that might mean that they hear a voice. That's what I do think, actually. And there is some research on that at the moment. And the more emotion is suppressed, the more louder and aggressive the voice might be. Which is why I think it's helpful for people to learn to release their emotions in different ways. You know, even by laughing, or by like kind of crying, or whatever. Reference 23 - 0.11% Coverage I think, because I now know that if I get really stressed I hear voices, that you know, for me, I understand that about myself. **Wanting to get rid of voices** And because music was my first thing, I guess, I prefer, I love music, and I love

						sound. And you know, I'd rather have music and sound than voices, I find voices, you know, the whole…even though I love English. I find it, you know, I wish I wasn't a voice hearer. **Being able to trust is important** I: In terms of an interpersonal interaction that you're having with someone, where are the voices when that's happening? P02: So, one example of this would be, yeah, like I used to have a flat in [city], and one of my closest male friends would come round and stay sometimes. And because that's the person I most trusted about the voice hearing experience, we could be sitting having a cup of tea on the sofa, and it could still feel like the voices were outside the flat, or they were above my head. But because he was there, and I trusted

						him, I felt a bit safer in that space. **Trusting people is difficult** I don't, I only trust a small number of people who I've actually built up relationships, friendships with, over many years. Reference 2 - 0.08% Coverage You know, I don't like being let down by people, so usually, I just don't trust somebody. Reference 3 - 0.14% Coverage And then, over years, I learn to trust somebody, and I've got, I'd say, about ten close friends, people, they're not all in one place, they're in different places. Reference 4 - 0.22% Coverage A man started asking all these curious questions about voice

						hearing, and I didn’t want to answer them. And it was kind of like, almost like a voyeurism, of what it's like to be a voice hearer. And it was really uncomfortable, and unpleasant, actually. Reference 5 - 0.24% Coverage Whereas, like, the therapist that I've got was recommended by my previous therapist, and that therapist was recommended by my GP. I've got this kind of tree going back, of trust, of like, recommendations. But then, when you're in a new area, a new city, you haven’t got that
P03	**Empowering self through action** but it does subside, it does pass. And, that’s what I have to keep telling myself, it does subside, it passes. And, the harsh reality of it is that, I’ve got a lot of	**Importance of being involved in treatment decisions** So, I can find my own way through it, yes. But, it is because I’ve had some positive input, particularly from people that I’ve seen recently, and I trust them. They know me well, and they give me the belief and the hope, so that I can have the	**Making sense of voices** They’re quite calm at the moment, however, I’ve noticed recently, over the last six months they come in massive bursts like tidal waves, it’s like a rhythmic thing. They will come in tidal waves each month,	**Being persecuted by voices** just wham me, and the, kind of, nature of them is pretty arcane and detrimental, derogatory. How can I say this? Yes, arcane, it can feel quite evil	**Practitioners failing to connect & understand** I think practitioners that haven't been too positive in my life, have been text book, tick boxes practitioners, practitioners who tick boxes. I think on the negative side of things, I think there’s been too	**Feeling valued by practitioners** I’ve got two current team members who have been continually there, so there’s been continuity with the same two people that I’ve put my trust in, and who know me

	knowledge that I can get through it and let it pass. Reference 2 - 0.19% Coverage Forever letting them go, instead of attaching to them, it’s like holding onto hot coals and just saving them up myself. Reference 3 - 0.05% Coverage I don’t like to hang on to them. Reference 4 - 0.47% Coverage You can get tranced out with it, but I chose to step out of it, and that’s my choice at the moment, is to step out of it, if I’ve got something to focus on to do that. I think it’s uplifting and empowering to continue with the day and not avoid the day, because of them, that’s how I felt this morning. Reference 5 - 0.39% Coverage And, the other day, I thought, well, where have I been all my life, I did	hope and belief in myself. But, I’m the only one that can find that hope and belief in myself and feel it for myself. At least, they’re giving me reminders that I can do it, because I’ve been here before. **Lacking involvement in treatment decisions** I have been in services a long time. Yes, that would be to do with being told what I can and cannot do, I should imagine, it’s pushed all the wrong buttons, and so I’ve gone AWOL from hospitals, and all sorts of stuff. Harmed myself in hospital, or whatever, I’ve ended up going in section, after section, after section. Free will, I suppose, it’s freedom, free will, being free.	Reference 2 - 0.70% Coverage They change. They can change, and sometimes I recognise them, sometimes I don’t recognise them. Sometimes, it can be people…I can be thrown a sentence, a sentence or something dictated to me in my mind, and it can change throughout the sentence. So, if you had a wave line, it could change from male to female, through age group, gender, whatever, throughout a full sentence. It can be really changeable, yes. Or, it might be just a one word thing. Reference 3 - 1.00% Coverage I: You’re saying you can’t say how many, but it sounds like there are several voices. P03: I’ve lost count. They’ve changed, they’re changeable, and they can be from people I’ve met, historically speaking, can be filtering back in. It’s like a filtering system, like a coffee filter, they can either drip feed different people that I’ve met, and	Reference 2 - 0.20% Coverage The majority of the time, I get the odd word, or sentence, or they’re not pleasant by any nature, anyway, they’re not pleasant. Reference 3 - 0.12% Coverage The dominating thing, the factor, is not pleasant, it really isn't pleasant. Reference 4 - 0.47% Coverage It’s really nasty. Well, I think it’s nasty. Like, this morning, for instance, just every five seconds, even throughout waking up, from 6 o’clock, or whatever it was, it was die, die, die, you know, drip feeding all the death stuff. And, they don’t want me to live, basically, when it gets like that, Reference 5 - 0.47% Coverage They still goad me into my thinking, I’ve been less with negative thinking, because the	much…in the beginning, there was too much, sort of like, text book – how do I say this – ticking of boxes, I’m not just a name or a number with x, y, z, a, b, c, d, e, do I fit these criteria. Because, no human being fits a criterion, we’re all individuals, and it’s a holistic point of view that they should be taking, I think. Reference 2 - 1.03% Coverage I’ve had a lot of practitioners that are just, kind of, said the law, said what the rules are, said what’s law, and it hasn’t taken in the holistic view, the roundedness of the view, if you like. Whereas, where I am now at, and how I’m interacting with services now, in the last 25 years has come around full circle into a more – sorry this is going to sound really funny – more humane. The whole holistic, whole, it’s not just text book, kind of like, it’s a bit like a politician going straight out of university and then running the country, you can’t do that, you’ve got to live a bit. You’ve got to be	really well now, know me quite well. Reference 2 - 0.43% Coverage But, I’ve got to take control of myself, I have to empower myself, so services were reiterating the fact that I’ve got tools and strengths that I can use, and I’ve been here before, I can do this. I have got the strength, I do want to get through this, and I can move forwards. Reference 3 - 0.54% Coverage But, to have services involved, they, kind of, reiterate and point out the fact that I have got my skills, I have got my strengths, and positively remind me. Because, it can get lost within it, and it’s teasing out the threads of the positives to remind me, constantly reminding me to try and get back on the

	something really good and I thought, where have I been all my life, I can do this. So, I've had a lot of breakthroughs just this last year, this last week, these last months. Reference 6 - 0.32% Coverage The last couple of years I've started doing Yoga. I've had continuation of Yoga, so I've managed to do that, empower myself with getting to university to study a little bit. I'm starting to empower myself, Reference 7 - 0.25% Coverage So, I've got to empower myself in the positive aspects, and the only person that can do that for myself, is myself with the empowering things I know can do that. Reference 8 - 0.33% Coverage But, I can only do it for myself, and I can think for myself. Because, that gets taken away sometimes, you lose your own identity, you lose your own thinking		depending on circumstances, or environment, or where I am, or what I'm doing, might trigger more. But, if they're overwhelming then I've got a lot, I've got a majority of so many different ones, and I can't think straight, because I, obviously, get the visuals with them, and things like that. Reference 4 - 0.29% Coverage I: So, you have these voices, and these can change, but also even one voice can change throughout that sentence. P03: Yes. I: From male to female, back to male. P03: Age, gender. Reference 5 - 0.63% Coverage And, I've had some just bizarre stuff, educational, I used to have…well, I thought it was Confucius talking to me, because he used to go, Confucius saying, and give me all this information that I've never read in my life. Or, they can be helpful, I've had	highs would be enhancing, creatively enhancing in some respects. I'm better off for that, definitely better off for that. But, as far as the voices are concerned, they will do anything to take me down, take me out. Reference 6 - 0.21% Coverage I think it goes back to that fact of always wanting to crucify myself and be persecuted by them, they want to keep me under the thumb. Reference 7 - 0.28% Coverage P03: I have no idea, I don't know. They don't like it, excuse me. I: Are they becoming more negative now? P03: Yes. They're telling me to fuck off or something, excuse me. **Voices don't like VH getting help** P03: Yes, I think the rebellion, I think they're just rebellious. I don't want it to sound like it's… I think maybe because	in it to live it, to know it, to be that person. Reference 3 - 0.26% Coverage I had one doctor who just wouldn't listen, I had a lot of doctors who just wouldn't listen, but then that caused a lot of aggravation for me for about eight years.	golden thread, the positive thread. Reference 4 - 0.69% Coverage It sounds a little bit harsh. But, that wasn't my word, that was a word used, it seems harsh but you're going to have to just try, you know you can do it, have belief in yourself. And, you know, all the good positive tools, they even mentioned the words tools… Yes, at the end, you know, the million dollar question is, what can we do for you, how can we help you, that is such a hard question, because if I can't answer it, nobody else can. Reference 5 - 0.70% Coverage But, it's good to be reminded, it's so good, because I can get lots on the voices, and lost within it, it's good to have a human being with me

	abilities. So, I've got to think for myself, sometimes. Reference 9 - 0.21% Coverage It's like a lesson, isn't it, it's like a harsh reality that I've been here before, I maybe have, I have to empower myself a little bit. Reference 10 - 1.04% Coverage I would encourage myself to try and keep believing and find that belief in myself to move forward without getting sucked into all the drama of the arcane black evil stuff, because it's not all like that. And, trying to not let the drip feed keep filling me, the vessel, with all the negative, drip feed or filter out all the negative stuff, and try and believe in all the good stuff, and reiterate it and remind myself. That kind of power, I think, is the most enhancing power that I think I could believe in and do believe in somewhere in here. I've had glimpses of it, so I know it exists, and it does feel good. I think that can only be good, good, good and good.		helpful ones. Educational, helpful, but it's the arcane ones I can't deal with. The black entity, kind of thing, that's freaked me out the biggest. Reference 6 - 0.60% Coverage Well, when things are appearing real, and you're hearing all this really arcane black stuff, all evil stuff, all black stuff, all arcane stuff, or foreign stuff, even if it's alien to you, I mean, I get used to interruptions, it's really hard to recognise things as they are. It's like I'm morphing and it's evidence that's not appearing as it should, so it puts you off doing something. Reference 7 - 0.48% Coverage And, it's judgement, as well, I guess, it's judging, judgement from that, it gives my belief in judgment in something else, or another person, or a car, or whatever has wronged me in life. Well, I, kind of, go through it being a bit of a cosmic detective	people are trying to help me in that respect, I know they're right, but the voices don't like that. I know that the people that are encouraging me to help myself are right, but my voices don't like it. I: The voices don't like the fact that they're trying to help you? P03: Yes, I'm trying to help myself and let people help me. Reference 2 - 0.27% Coverage And, if I start taking any, sort of, TLC against myself, for myself, tender love care towards myself, or listen to people's good advice, they get louder and louder and louder. Reference 3 - 0.52% Coverage The voices just interfere, not listening to anybody else, and don't like it if I'm starting to listen to the good stuff. They just don't like it if good stuff comes along, and they'll do anything to get at me. A lot of the good stuff gets destroyed to them, I don't like that. I'm trying		to remind me. Because, friends don't do it, but a human being, a real human being is what people need in life, isn't it, and to have that actually… I don't mean to sound needy, but just to be reminded that there are other people there that know what it's like, they know that you can empower yourself. Reference 6 - 0.03% Coverage A sense of humour. Reference 7 - 0.93% Coverage And, probably, looking at things from a different approach to how things were 20 odd years ago. When I first came into the system, how I thought it should be, it's all come around, more openness approach to things. And, also, what I've noticed is, not the hierarchy versus them, kind of like,

	Grounding oneself checking out what’s real and what’s not real, but by avoiding stuff you’re never going to check out what’s real in life. What the pavement feels like or what people have to say for themselves, or the interest in other people that I used to have building up, and building a relationship with people, and places, and hobbies and things. Reference 2 - 0.44% Coverage Yes, or being the scientist in life, like cosmic scientist of life. It sounds a bit weird, but it’s probably not. It’s working it out, working out how it’s made, how life is, it’s a bit journey everybody is on, and my journey is to try and stick grounded, stay grounded, and focused. Reference 3 - 0.35% Coverage but I’m not sure which is trickier, being spaced out all the time or actually sober. I’ve been catching up on seven years for the last, what, 20 or 30 years, and being sober for seven years		sometimes, investigative, if you see what I mean. Reference 8 - 0.29% Coverage That’s how it started, being a bit of a cosmic detective, and I’ve never quite let go of that. But, the detective side is okay, because you’re checking out what’s real and what’s not real, Reference 9 - 0.37% Coverage Yes, I get tapping on my nose, as well. You know, the characters can feel like they’re actually physical, and I do see them sometimes, I do actually physically see them or feel them. And, taste and smell, as well, can come into it. Reference 10 - 0.09% Coverage they definitely, definitely change, they definitely change. Reference 11 - 0.39% Coverage I: What might the voices be rebelling against?	to enhance my life, and they don’t like it. **Voices being disruptive** I: Is that one of the voices? P03: Yes, I’ve got a load saying, play the game, play the game Reference 2 - 0.56% Coverage I: When you’re in those interactions, and practitioners are doing these things to help you be reminded, what’s happening with your voices at the time? P03: It depends, they can either become submissive, or don’t like it, or I’ve got to unpick it somehow, try to understand myself better, to grow and keep moving forwards. Yes, the voices don’t like authority. Reference 3 - 0.40% Coverage I: Can I just go into a bit more detail about where the voices play a part in that. So, what do you think about the voices in that situation, what would they normally do		service user, I don’t know what, practitioners or what, I think it’s integrated as one whole now. If it was integrated as one long line, as a…, or versus them, like, a ranking hierarchy, sort of, ladder system, a tiered ladder, there’s more of a balance, isn't there, now, which I think is more helpful. Reference 8 - 0.82% Coverage P04: I was really angry with them for a long time and they said one word to me and that was just, have belief in yourself. And, no pill, potion, lotion, hospital, anything, has quite the effect that that word had on me, and it was the belief word, you’ve got to have belief in yourself, you just don’t know it yet. I: And, that was, obviously, a powerful thing to hear. P03: And, that was the most powerful thing that turned my

	is a completely bizarre reality **Taking responsibility** Change the content, change my dynamic with me and, hopefully, not avoiding stuff, because I've avoided stuff for too many years, decades. Reference 2 - 0.41% Coverage It's taken a long time, but I'm getting there, yes. I'm realising the positive effects, because I've got a lot of tools in my mind that I can use, it's teasing them out from what I've learnt through services and through… It's just trying not to avoid anymore life Reference 3 - 0.17% Coverage I did used to take quite a number of misuse alcohol and smokes. I'm off all that now, I'm seven years clean. Reference 4 - 0.90% Coverage I: What was it that influenced you into becoming sober? P03: I think there was a pinnacle period where it		P03: I think it comes back down to judgement, I think that's what it is, judgement. And, I, kind of, can't really assume anything, I try not to assume, I'm trying to go through a period of not assuming. Reference 12 - 0.30% Coverage I: That's okay. I was wondering what the voices were rebelling against, and you said it was about judgement. P03: It's like I'm the judge and jury sometimes, with myself and my relationships. Reference 13 - 0.56% Coverage Yes, because it might sound a bit…assume, if you break it down, the way it's actually spelt, to me and my voices, all making judgements, or misjudgements and stuff, assume means, not you, but an ass of you and me, assume, the voices assume, I assume, so it can make an ass of them as well as me, assume. Do you see what I	when you're hearing a member of staff giving you advice in that way? P03: Rebel. Reference 4 - 0.35% Coverage I: Okay. Have the voices been quiet up until now, while we've been talking? P03: Yes, not bad. I: But, they've just started coming on, now that I've asked that question. P03: Yes. I: Okay. That's interesting. Reference 5 - 0.51% Coverage I: And, how do your voices respond to those two different situations then? P03: I think that they prefer more free will, they're happier if I'm free, freer to express myself, rather than being detained in a solid structural, you will do this, you won't do this, you will do this, it's time to do this, it's time to do that. Reference 6 - 0.17% Coverage		life around, about my thoughts surrounding that doctor, and I said, yes, you're absolutely right. Reference 9 - 0.43% Coverage I was, actually, an in-patient, but it was relief at that point, it was absolute relief, because I was in torture anyway. Yes. At that particular point it was relief, and I'll never forget that, that was quite a turning point for me, with regards to that one particular doctor. **Finding it difficult to relate with voices** So, I don't particularly want to continue my life reacting with them in that respect. I think if I showed them… It was once mentioned that if I give them some love and attention, caring changes the whole relationship with them, it might help. It's just something I can't do with them. And, with some of the

	couldn’t have got any worse, there was a massive catastrophe, just with myself, my life, I lost my dad, there were various things going on. I ended up being sectioned, again, and then I met a man, got in a relationship, and I thought, no, I’m going to sober up, for myself. I think those would be the pinnacle issues, really, but for myself I thought, well, nobody else is putting this down my throat, actually forcing it down me, it’s me that’s forcing it down myself. Reference 5 - 0.60% Coverage I’m better for knowing myself, and better to be known, I think, without, it definitely has made a difference, yes. But, it’s left me with referred whatever, it’s just good to be sober, yes, really good to be sober, because I’m learning more. Otherwise, I think, that was avoidance, that was avoiding life, being spaced out all the time, just avoidance, it’s a different level, totally. Reference 6 - 0.60% Coverage		mean, about the broken down language? Reference 14 - 0.50% Coverage I: What do you think they want you to do with your life then? P03: They don’t want me, they do not want me. Some of them do not want me on the planet, in earth in life. But, I think I want to be here, but it’s taken a long while to be here, to stay here, but that’s what I’m empowering myself and believing, I’m here. **Linking voices with trauma** Yes, and then, sometimes, they will just, like, they don’t like… I don’t know what the word is, I will hit a wall with them, where it stops me from functioning. Like a freeze zone, like you freeze with it. So, I guess, that’s to do with trauma, really. Reference 2 - 0.46% Coverage It’s like a trigger point, and that’s another thing, yes, it’s like a trigger point of, like, actively pressing the wrong button, pulling a	I: So, even though your voices might rebel when it’s a positive interaction. P03: There’s paradoxes in that. Reference 7 - 0.33% Coverage I: So, that relationship between you and your voices, how does that play out when another person becomes involved in that interaction? P03: Well, they didn’t like it earlier, when we were talking about authority. Reference 8 - 0.55% Coverage If it was a complete stranger, from the service that I hadn’t met and didn’t know me well, and I didn’t know them, then I think my voices would be suspicious and I would be suspicious, which would impact negatively. But, if it’s somebody that I do trust and know, I think that’s more likely to calm me, which would calm my relationship with the voices.		voices being so close, they’re actually with me most of the time, I don’t know how to love them, or give them that care and attention that they probably need. Reference 2 - 0.26% Coverage P03: Change the relationship with them. I: But, that’s something that you find difficult to know how to do that? P03: Yes. I: Okay. P03: I find that hard. Or, I just tell them to just fuck off. **Concealing voices** And, the other good thing is, I know it’s masking, I know people mask, and I do it myself, I mask, but there’s times when you’ve just got to, kind of, have some sort of…it’s about losing your dignity, isn't it, and screaming and shouting, because I used to do

	On and off, well, I first started when I was 15, but then I've had periods of time where I have been sober, but nothing as long as seven years, completely off any illegal substances. And, it's the best thing I would advise anybody to do, stay clear, I really would. I can't change any of that, I can't undo any of that, but I would strongly recommend people don't go down that route. Reference 7 - 0.31% Coverage Yes, and I just perpetuated the cycle, because I was addicted, and the cycle, and feeding into each other, and not the recidivist, again, stepping out of it, so I stepped out of that, I had to do it. Reference 8 - 0.72% Coverage But, it was quite a reality check, because I've been in services a long time and I have to think for myself and implement it. So, the reality check is, I have to do it myself, as well, implement what I know. Again, it's a bit like that substance misuse thing, only I can feel the rain		trigger, which I've had before. I've actually physically seen shotguns pointing at me, like, pulling the trigger, and can just blast me off with the action. **Living with voices** I sometimes think, you know, I just can't be bothered with you, I think enough is enough, I can't be bothered with you, I've got things to do. If they're really attacking me, it's just listening and not reacting to them, it's that not reacting.	Reference 9 - 0.42% Coverage I: But, if it's someone that you don't know, and you don't trust, you would be more suspicious and that, in turn, will make your voices more difficult. P03: Quite aggressive, react negatively. And, that would feed the power, I suppose, that would feed the power, yes.		that all the time. I'm not saying that that is losing your dignity, but it can be disturbing for someone else to see. So, yes, if I'm being attacked in public, and I'm in a café or something, I'd rather leave, than get really disturbed by it. Or, if I'm on a bus, I get off buses, and things like this. **Distancing self from voices** most of the time, I'm a bit like an Ostrich, I'll stick my head in the concrete and try and ignore them. But, it doesn't help, because you've got to come up for air. Reference 2 - 0.35% Coverage There was one stage where I thought, if I went swimming all the time, and swam in the water for as long as I possibly could, they couldn't follow me, but they did. So, it proved the point

	for myself, or put the alcohol around that, I can do that. The self-harming side of things with alcohol, substance misuse, whatever, but nobody is actually doing that to me. Reference 9 - 0.14% Coverage But, I'm the only one that can find that hope and belief in myself and feel it for myself. Reference 10 - 1.01% Coverage Yes, by the way I mean submissive, I think it's my response and reaction to it. If the voices are kicking off really badly, I can either go off the ball with them, that's a polite way of putting it, excuse me, I had to think there. React strongly towards them, because they're reacting strongly to me, the voices, it's a bit like having the wrong button pressed, an alarming thing. And, I'm trying not to react in any detrimental way from having those buttons pressed, and the harsh reality is, yes, I've got to try and simmer down to stop					that, no, they will get me anyway. Reference 3 - 0.36% Coverage So, there is a distance thing, there's a relationship with distances. Sometimes, I can be on the same bus, and they're attacking me, I can deal with it, sometimes I can be on the same bus they're attacking me, and I have to get off. **Linking relating with voices & relating with people** Over the last month I had a bit of a crisis, a bit of a wobble, and I shot through a bit. I shot through slightly, and I, kind of, took myself off for two or three weekends, about two weeks in total, just to relieve myself from my stressful environment in my accommodation where I live. I thought, a change of scenery would help, I know that sounds a bit like escapism, but I

	them from going nought to, whatever, 300, in about two seconds. So, I'm responsible for myself, in a way. **Voice hearing is about power & control** powering that way, and I have a bit of a battle, it's quite overpowering like that, Reference 2 - 0.13% Coverage But, when it's happening, in really big bursts, it can be overpowering, overwhelming, Reference 3 - 0.13% Coverage And, it can be a bit of a battle, but you know it does subside and it can fizzle out. Reference 4 - 0.32% Coverage Yes, and then, sometimes, they will just, like, they don't like… I don't know what the word is, I will hit a wall with them, where it stops me from functioning. Like a freeze zone, like you freeze with it. Reference 5 - 0.67% Coverage					thought it would give me some respite. Reference 2 - 0.55% Coverage Yes, I've absconded, or AWOL, because if you get that mindset, and people can be pretty determined with the mindset. If my mind has been in that frame of mood, or mind, or disturbed with voices, when I believed in that strongly, or not liked. It's pretty scary when people are walking up with briefcases and suits on, or police, or whoever, whoever. Reference 3 - 0.30% Coverage Partially an issue I've never let go of, that authoritative thing has maybe kept ongoing since then. Because, that would be about the same time I first ended up going into psychiatric services. Reference 4 - 0.58% Coverage

	I think it's like a repetition, drip feeding, it's like being drip fed, almost tortured, like a drip feed. If they're constantly, constantly, constantly drip feeding you with this misinformation, you start believing in it. And then, the source behind it, its origins, and things like this, it's maybe way off the map of anything really logical, realistic to somebody else, but maybe not for myself, although I'm experiencing it. Reference 6 - 0.35% Coverage It is a form of torture, yes, it just drips, drips, drips, and you start believing in it, which enhances, it feeds it, and then you believe it, you start to believe them, and that's a spiral down, rather than a spiral out of it. Reference 7 - 0.08% Coverage It's almost a power battle, like an empowerment thing. Reference 8 - 0.10% Coverage					I: That's interesting. So, earlier on you took your voices and your brain, you said, about this authoritative thing. Does that suggest that you had earlier experiences of running away from authorities? P03: I've run away all my life from them, for bits and bobs. Even as a child I was running away from home. Avoidance, most of my life, avoidance, I've got a lot of it. **Voices interacting with emotions** And, maybe occasionally, I will get something funny, or humorous, depending on the state of my body, my anxiety levels, or environment where you are, who you're with, different circumstances, different environment, different people.

	The power, the energy you give to them, the power you give to them Reference 9 - 1.34% Coverage It's mental energy, raiding the brain, sort of thing, like, it pulses and impulses, I don't know, neurons, and whatever, impulses, magnetics. It's like being a magnet what you attract, it's like levels of attraction, what you're attracting or releasing. And, it can be draining, it can be absolutely exhausting, so I've got chronic fatigue through it. Also, it's balancing out my energy levels, because normally people's energy levels fluctuate rhythmically throughout the day, but if I've got voices that are attacking me first thing in the morning, I'll be exhausted for the rest of the day. Or, they can elevate your mood at the same time, it is an energy thing, I've always seen it as a battery that can attract or repel. Or, a bit like an elastic band that's stretched from the earth up into the cosmos, sort of thing, bouncing backwards and forwards.					Reference 2 - 0.66% Coverage I think that's mood related, physically mood related and biologically mood related, and life, if things are going well. I don't have a great opinion of myself, when my mood is lifting, and my mood is elevated, and I'm trying to believe in myself and the good side of things, then they don't drip feed so strong and I cannot hang onto the voices. I try and release them, try and let go, which is what I'm learning to do. Reference 3 - 0.69% Coverage I: So, when information is being given to you by the voices, dripping in, sometimes it is believable and sometimes it's not, but that is influenced by the mood that you are feeling at that time?

	Reference 10 - 0.83% Coverage It's like I call them my golden threads, or my elastic band effect. If I get a bit carried away with what I'm listening to it can, like, creatively it's like offshoots, bubbles, offshoots bubbles, doesn't want to know, does want to know, doesn't want to know, does want to know. And, it can set off all these bubbles, so I can get carried away with it on a bit of a mission, if it's a good one and, also, I can be dragged back into a darker side of it, if I pay it that energy. So, it's a bit like La La Land either way, sometimes. Reference 11 - 0.97% Coverage I always maintain that I was a bit like a conduit, that I was a receptacle, a conduit, receiving information, from where, that's where the belief goes a bit squiffy. It's only squiffy in the respect that it's harmful to myself if I start believing in them. But, yes, I've always thought I was a bit of a conduit to start off with, and that's why I think it's taken so long to					P03: Yes. Moods, it can be anything throughout the day, energy levels, moods, emotion is another one. Emotions strongly influence each other, don't they, it's like a tennis match, in terms of whatever I'm receiving I can hear back, all this. Reference 4 - 0.86% Coverage So, if I'm in a really anxiety provoking situation. I can give you an example, I might be going somewhere to do something, I can be tortured before I go out, and then I've got to go enough, enough, enough, and just try not to avoid doing something, otherwise I will be there with them all day. And, it's recidivist, you have to step out the cycle, I'm trying to step out of the cycle with them and face whatever is…you know, even if it's just going out to

	realise that I’m above that, and I’m worth more than being some sort of negative vessel for this, receiver. Receiver, conduit, energy source. I don’t know why I get these messages, but I just do get this language going on in my head/brain. Reference 12 - 0.13% Coverage I could dismiss them and just forget them, and put them aside, but it took two hours. Reference 13 - 0.77% Coverage But, I don’t want to resonate on that level, so I’ve got to lift myself out of it somehow. And, I had things to do, so I was, like, come on, come on, come on, and then it’s a bit like a journey, so if you can step out of it and move away from the situation, even when they’re attacking me, then I move myself out that situation and they’ve stayed down, and I’ve left them behind for now. I suppose, it’s a bit like a nine to five job, where you have to turn off or lock the door, or something.					put the bins out and I can’t quite do it, if I do it, it lessens the power of them, hopefully. Reference 5 - 0.20% Coverage Yes, I can move them, or they move the distance, I think it’s mood related, energy related, my energy levels, and mood related. Reference 6 - 0.27% Coverage Getting through it, a different route forward, yes, instead of having a boxing match. I had a lot of anger about it, and probably a feeling of injustice, as well, sometimes. Reference 7 - 0.46% Coverage Just anger, really, and injustice at myself, I guess, others, as well, I’ll admit to that. And, I think then they’re at their most intense, is when I’m

	Reference 14 - 0.32% Coverage Well, sometimes I can focus to try and alleviate and get rid of them, and I'm trying to function, just getting up and getting ready, but it leaves you in a trance state, almost, if that's what you mean. Reference 15 - 0.55% Coverage Like, a cycle like, recidivist is a good word I've learnt recently, and I'm like a washing machine, I'm obsessed by washing clothes, even if they don't need washing. So, it's a bit like that with my brain, going around and around, and it's drip feeding off a word or voices, and I'm trying to not put the washing machine on and step out of that cycle. Reference 16 - 0.13% Coverage That's my elastic band attracting forces that probably shouldn't…I don't want them. Reference 17 - 1.12% Coverage					feeling angry about something, or they make me angry, yes. But then, they can't make me angry, I keep telling myself, they can't do this to me. Reference 8 - 0.23% Coverage I suppose, it's like feeding them, isn't it, if I'm very weak and tired and exhausted from them, they get worse, because I'm not looking after myself. Reference 9 - 0.28% Coverage And, they will feed off that, and that lowness, that mood lowness, and if I'm feeding them the time and my energy, my not looking after myself, they love it, they'll have a party. Reference 10 - 0.33% Coverage Even if they're on a party where I'm feeling a bit stronger,

	Oh, right, right. Well, the worst ones are usually the closest, and you can physically feel them, I can physically feel them in my body. Which is why I was like a conduit, because it feels like a pulse, and impulse, like, zapping through me. I call that body surfing, like they start surfing me, the characters. Yes, so sometimes they are really close, and sometimes they're actually in me. I get sensations of someone talking to me, I get sensations it's like zapping me, I suppose, it's a bit like an electrician used to have those igniter things, like a taser, I suppose, ignition things you get in boilers. You zap yourself with it, bing, it feels a bit like an electric impulse. There's all sorts of things. Reference 18 - 0.17% Coverage they do influence you, they do, I try not to let them have that power, but that was quite a funny one, yes. Reference 19 - 0.42% Coverage					or I used to take case of myself, they'll still have a party, but as long as I can take care of myself, which is a struggle, I'm struggling a bit. Reference 11 - 0.34% Coverage I: So, if you're looking after yourself, they're still there, but it sounds like it has less of an impact on you. P03: Yes. Looking after myself, the impact isn't as great, I think. Yes, I believe in that, I think. **Being able to trust is important** Yes, but if it's people that I recognise, trust, know, I feel comfortable with, and I know aren't going to harm me… That's something I didn't mention, that they're not going to be harmful to me and respectful, then that's okay, I'm more likely to respond and appreciate myself and what they have to say, and what's been

	Currently, this last week or so, I've got to take the power on myself, not avoidance, but take the power from myself to release them, just releasing them, not hanging on to them like hot coals, because it will be me that gets burnt if I do. So, it's about letting them go. Reference 20 - 0.40% Coverage I'm trying to respond differently with them, as I've had this power struggle, a bit of a boxing match all the time. And, that just goes round and round it didn't get anywhere, because I've been a bit of an Ostrich for a long time, denial maybe, as well. Reference 21 - 0.15% Coverage There's a paradox and parallels to all of it, different wavelengths, different energy lengths. Reference 22 - 0.10% Coverage But, I've got to take control of myself, I have to empower myself,					reminded, and how to look after myself. But, if I'm descended on, it just sends me into chaos, by people I may have not met before.

	Reference 23 - 0.65% Coverage It doesn’t like me saying, I’ve been here before, how can I have been here before, it’s a different date, it’s a different time, it’s a different subject matter, it will be the same but it’s different, if you see what I mean. To remind you of the positives, just tease out the strengths that I’ve got to do it for myself, and to be reminded that services are around the peripheral, but in the centre core is myself. Reference 24 - 0.10% Coverage They will have a riot, I haven't got the strength to fight them. Reference 25 - 0.28% Coverage I: So, how does that then influence the power between you and your voices? P03: That weakens my resistance to them. I can go from panic, or freak out quite quickly, changeable. **Lacking agency with voices**					

	But, I guess, it’s belief that’s attached with them. Reference 2 - 0.67% Coverage I think it’s like a repetition, drip feeding, it’s like being drip fed, almost tortured, like a drip feed. If they’re constantly, constantly, constantly drip feeding you with this misinformation, you start believing in it. And then, the source behind it, its origins, and things like this, it’s maybe way off the map of anything really logical, realistic to somebody else, but maybe not for myself, although I’m experiencing it. Reference 3 - 0.35% Coverage It is a form of torture, yes, it just drips, drips, drips, and you start believing in it, which enhances, it feeds it, and then you believe it, you start to believe them, and that’s a spiral down, rather than a spiral out of it. Reference 4 - 0.32% Coverage I don’t know, I’m always thinking I’m going to get					

	murdered or something, just because the voices can be really bad, I get really suspicious of other people, because it's the content it's, again, that belief.					
P04	**Empowering self through action** But when I went to the hearing voices, it shattered them because, like, everyone there had voices and I put myself in that situation. I didn't know what was going to happen to us when I went into that situation. Reference 2 - 0.86% Coverage I: Do you sometimes hear those messages and disagree with what the messages are? P04: I have to, yes. I: Because earlier on in the interview you said that you believed particularly [voice], I think you were saying you believed [voice], but it sounds just from what you're saying there… P04: I have to…there must be something in us that has to fight back because otherwise I don't think I would be able to lift my head off the pillow.	**Benefitting from medication** I: Has it ever been helpful? P04: I took Prozac once,that was helpful. That was a few years ago Reference 2 - 0.18% Coverage But I remember feeling depressed before and then when they gave us that Prozac I felt better. **Feeling worse from medication** I: So do you take tablets now then? P04: Yes. I: And what do they do for you, the tablets? P04: Nothing. The last ones they gave me…I was just screaming no, I told them to fuck off. Part of it was the voices, part of it was me though. And I said I'm sick of the medicine, I said I'm still crying all the time, I'm still having very hot flushes. But I've been saying it to them for about a year and I had to really lose my temper before they listened. Reference 2 - 0.21% Coverage	**Making sense of voices** There's my brother, my eldest brother. One's very soothing, nice. There's one I just wish was the only thing because their ideas is best for everything. I find that they find me… Reference 2 - 0.52% Coverage I: Yes? So when you were advised in the hearing voices group to talk back to the voices then, what did you do? P04: The first thing I said was just fuck off. I: You said that? P04: Yes. I: Right. P04: Yes, like out loud so I knew it was my voice. Reference 3 - 0.43% Coverage P04: Yes, at first I didn't really take them that serious, and I just thought it was me, you know, like,	**Being persecuted by voices** I think it was…because my brother's always saying how useless I am and I think it's just the one voice, his, sometimes it feels like him and my dad, but I think it is just him, you know, and he tells us to kill myself and tells me how horrible I am and how useless I am Reference 2 - 0.19% Coverage So, like, they knew what they were doing, you know, to make us feel like that, saying I'm useless Reference 3 - 0.18% Coverage It's more like who do you think you are? Like trying to knock us down kind of thing. Reference 4 - 0.23% Coverage	**Practitioners failing to connect & understand** Because there isn't really that many professionals that you can talk to apart from whoever's facilitating the group. **Experiencing MH services as uncaring** But [MH unit] had started him off, it was like…this sounds really ridiculous but you know like in the movies when Dracula got up out the coffin, I never saw him or anything like that, but you know that feeling when you used to see it, like scared? Then I think he came after I left [MH unit]. **Practitioners not talking about voices** P04: I went to a place called [MH unit], have you heard of it? I: I have, yes. P04: And when I got there I was told voices are ridiculous, they don't exist. I: Okay, by who?	**Being accepted & supported** The three [voices] are pretty much around all the time but going to the hearing voices group, that…because they were all just jumbled up, if you know what I mean, and I felt like that there was just loads of snakes in my legs, you know, and it was just horrible. And then over time, because it sounded ridiculous, talking back to them, and I thought that's a ridiculous notion, but more and more of the group were saying, like, just give it a go, try and put them in their place. Reference 2 - 0.95% Coverage I think the shame of having voices and the shame that they

	Disclosing voices reduces their power I: How did your voices react to those two different situations then? P04: Shock, they were very shocked, yes. I: Shocked in what way? P04: That I would get past the shame and expose them kind of thing…because when they’re a secret in your head, they have a lot more power, you know, like I would hurt myself. I would just sit all day until my son came in from school, because I wouldn’t let them win when it came to my son, because he’s only eight. But the…but they just used to…I just sat there, it was just telling us how…the reasons things happened to us, because I deserved it. Reference 2 - 0.42% Coverage Because I think after you’ve been abused, you spend your life trying to be normal anyway, and you feel contagious. But they latched onto that kind of thing because it was a secret, they could do all that in my head.	I: No, I don’t, I’m just wondering whether it’s helpful or not helpful. P04: No. I: It’s not helpful? Reference 3 - 0.22% Coverage I: But they’re not helpful? P04: No, they’ve doubled the dosage and there was not one bit of change in us. **Fearing enforced or involuntary treatment** and I didn’t…probably it was lucky that I stayed on my own and just sat there the whole day, because probably I would have got sectioned or something. **Lacking involvement in treatment decisions** I: why do you think you’re still prescribed them then? P04: I don’t know. Reference 2 - 0.40% Coverage But I think this time around, you know, I think it was over the last 12 months, they’ve changed the tablets, they’ve doubled the tablets and I kept saying to them it’s not depression, it’s something else.	in my mind, if that makes sense. I: That’s a really good point. P04: How do you know whether it’s you or not? Reference 4 - 0.70% Coverage There was one voice that just kept making us relive things that I’ve never thought of before since it happened, do you know what I mean? It’s never entered my head before. I knew what had happened but never…and it was, like…it sounds really silly when I say it, but the voices seemed to know so much about it that I didn’t think that they could know all that. Reference 5 - 0.49% Coverage I: It does, yes. How do you think they did know then? P04: Well, they don’t know everything. I know that 100 per cent, because there’s a bit of us…because I block it from me they can’t…and maybe it’s because I don’t think about it that they can’t…	I think it’s just that voice just being that awkward voice, really, I think no matter what I did it would be critical. I: And you were saying that you had shame in your life, from your childhood and your voices knew what they were doing by saying these things. P04: That’s it, to make us realise, to separate that it wasn’t me. Reference 2 - 0.24% Coverage but they just used to…I just sat there, it was just telling us how…the reasons things happened to us, because I deserved it. Reference 3 - 0.42% Coverage Because I think after you’ve been abused, you spend your life trying to be normal anyway, and you feel contagious. But they latched onto that kind of thing because it was a secret, they could do all that in my head.	P04: I’ve forgotten her name now. I: Practitioners? P04:Yes….. I: And you were told voices are ridiculous? P04: Yes. I: Okay, what did you make of that? P04: And that it was just my imagination and just like talking to yourself. Reference 2 - 0.64% Coverage But they did that through shame, by keeping us quiet, and then once it got validated by that woman, that voices were ridiculous, it was just…I think that might have been the worst thing she could have ever said, because it was just…they were like, “see, you can’t tell anybody about us”, and it was like a big secret in my head. Reference 3 - 0.61% Coverage I: So just now that I’ve heard you say that, when you go into [MH unit] and you hear a member of staff say voices are ridiculous and you didn’t tell anybody for a year, what was	made us feel on the whole, because the one that used to say that I was useless and nobody wants us and they used to say things that had happened to us, like bad things that had happened to us, and used to say all the time that it was my fault because nobody wanted to be near us, nobody…not everyone just wants something for you…so in real life it was this group that sort of validated me as a person that they wanted to talk to. Reference 3 - 1.11% Coverage I: What was it do you think about that particular group of people then, the hearing voices group, that, I suppose, enabled you to have that way of talking about your voices that you didn’t do in [MH unit]? P04: Because they could do it, I know some of them are like

	Reference 3 - 0.57% Coverage Like when I went to the hearing voices group and admitted that I was hearing voices, the shame scale came a lot down. They didn't have as much power over us. They couldn't make us sit there from morning until…from half eight until ten past three without anything to drink, nothing to eat. Reference 4 - 1.43% Coverage P04: Well, a lot of the shame went straightaway. I think as I walked in the door, that was leaving us. And then there was one little voice like na-nah-nah-na-nah, I'm not stupid anymore, kind of thing, and it was relief. But I was mad as well, because you're sitting in your group and everyone is sort of, like, surreal, it's…and that's all I said, I remember I said I'm having an awful time, you know, it was quiet and I went, I'm having an awful time at the minute with mine, and as soon as I spoke, I felt, like, not free but like I'd lifted the lid on them kind of thing. They		Reference 6 - 0.59% Coverage I: Yes, well, are you still trying to work that out then and make sense of that? P04: Yes, because you can't really…like you think you've made sense of it and then something'll happen and… Like when John came, that was a shock. I didn't think that would happen. I blocked out I even had a brother. Reference 7 - 0.55% Coverage That's when I thought I was possessed because I'd died and then I thought, oh, I must have brought some spirits back with us or…it was a lot easier thinking that. It's a lot harder knowing that you've got these voices and are they ever going to leave, do you want them to leave? Reference 8 - 0.44% Coverage P04: It does sound mad. I: Have you ever shared that with other people to see whether that's similar	**Voices being disruptive** I: How did your voices respond to hearing someone say voices are ridiculous? P04: I think it was just…"I told you it wasn't real". I: Yes, that's what you heard them say? P04: Yes, and that no one would believe us, so…I never told anyone else. Reference 2 - 0.61% Coverage I: So if you're talking and your brother's voice is there, he will say things like that in order… P04: He says disgusting things… I: Why do you think he's saying those things? P04: It's just I'm more hurt, I think, because he's like you'll never get rid of us. But I am serious, I want to get rid of him. Reference 3 - 0.57% Coverage I: And are they around now then as we've been talking? Have they been here? Yes? What are they doing while we're talking then?	happening to you and your voices then during all that time? P04: It was an awful time, it was all negative, well, mainly negative. Reference 4 - 0.86% Coverage I: Very serious, yes. And have there been times when you've been able to talk to practitioners about your voices or have there been times…? P04: They don't want to know. I: So you gave me an example before at [MH unit] where you said you heard it was ridiculous, is that a typical response for you then? P04: If the doctor says to us, or the psychiatrist says to us are you still hearing voices, and I say, yes, they go, oh. Reference 5 - 0.56% Coverage P04: Are you still going to the group? Yes. Good. So… I: So they ask you whether you are hearing voices, but I'm guessing they don't ask you about the voices and	silly arses, but you know, there are some of them that can at times laugh at the voices like I can, because I try and find humour in everything, and they have a lot of humour, some of them, so them teaching us…not to embrace them but just to accept that they're there and stop trying to fight it. Reference 4 - 0.74% Coverage But like that was funny when, you know, one of them says just tell them to fuck off. And it was funny when I said it, and I've actually said it, you know, when I'm angry now, just fuck off, but at the time, at that very first time, I was just, like, this is not real, I've met other people just like me, and they can smile about it and they're not saying keep it all in your head.

	weren’t that thick within my head. And then I got a bit more confident and I said, actually, they feel less powerful already, just from us being here. Reference 5 - 0.58% Coverage And I think it was the shame of keeping secrets. I think it was the shame of having voices, because I mean, you do feel shameful, because you think, well, you know it’s not normal, but you don’t think that there’s going to be a group there to talk to about it, because I thought I was possessed. Reference 6 - 1.09% Coverage So then because I was saying to the voices I’m not keeping any more secrets, this is the beginning, you start torturing us again and I’m going to speak up about it, it seemed for a little while anyway they backed off, and it wasn’t constant you’re useless, you know, go kill yourself, go and do this, and I got out a bit, you know? Out to meet friends in [town] and that, and going for a coffee, whereas before		to what they experience as well? P04: No, I don’t think so because I think I just haven’t realised how mad it is. Reference 9 - 0.34% Coverage I: Why do you think you and other people hear voices? P04: Maybe we have an insensitivity. I don’t know, maybe you’re vulnerable and… I don’t know, I mean, I don’t know Reference 10 - 0.38% Coverage I think the voices and depression don’t necessarily come hand in hand. I think they can get you down sometimes but I think everything in life can get you down sometimes, no matter how good it is. Reference 11 - 0.26% Coverage They’re never in the shower, so they’re never around when I’m in the nude, I don’t know what happens to them, they must all be shy.	P04: The calm one was laughing, just like giggle…I know you’re talking about us. John’s there, but I’m not entertaining him. I said, no, he’s not allowed in. Reference 4 - 0.48% Coverage I: Do the voices comment on the things I’m saying or how we’re talking now? Yes? And is that okay for you or is it making it difficult? P04: No, it’s not making it difficult. Sometimes I can’t hear properly what you’re saying and then, but yes… Reference 5 - 0.75% Coverage P04: The only reason he can’t get in now is because you’re strong. If you were a woman sitting there, I think it would be different. I: Oh, okay. P04: I think he would have got in. I: Oh, right, okay. So that’s interesting, so depending on whose company you’re in, that	how you’re experiencing them? P04: Can you be hurt by the voices or…they don’t ask any questions or anything like that. Reference 6 - 0.85% Coverage P04: Because it makes people uncomfortable and practitioners, it makes them uncomfortable as well. I: What makes them uncomfortable? P04: Hearing voices, and obviously not you because this is what you’re studying but because they don’t know… I: So you think practitioners find it uncomfortable when talking about voices? What do you think it is then that makes them uncomfortable? P04: Because they can’t just give you a pill. Reference 7 - 1.31% Coverage P04: To me, it seems like it’s an awkward…like when they ask the question it’s awkward and then when they ask are you still going to the group, that bit seems	Reference 5 - 0.86% Coverage It started off at the beginning sort of, like, well, I can’t make any sense of yous, I think it was Sarah who said it, just start off little and say you’re not making any sense when it’s all just muddled up, I don’t know who’s there, and that was… I mean, I can’t even look at myself in the mirror and like talking to myself was, like… I suppose after a while I stopped thinking about it until now when I just realised how mad it all is. Reference 6 - 0.48% Coverage I’ve got really good…I’ve got two boys, and they’re brilliant. They are. One’s eight and one’s 18, and they really are good. They make my life, and they say that I’m strong. They say that I’m lovely. And I feel it off them, they make us strong.

	when I was just stuck there, I couldn't…the voices were too powerful, I couldn't answer the phone never mind meet someone for a cup of coffee. Reference 7 - 0.12% Coverage And they were less powerful, because they weren't a secret. Reference 8 - 0.43% Coverage I: So are you saying it's not so much you want to have a conversation about curing your voices, it's more having the chance to talk about it more so you feel less shameful about your voices? Is that right? P04: Yes. **Setting limits** The power…they had a level that was completely all of it, and then after I started talking in the group and they were giving us tips and advice and things, I could start bargaining with them, you know, and I could set times. It doesn't work all the time, but it's give and take.		Reference 12 - 0.18% Coverage I've just realised that as we're talking, they never are when I'm…or if I've got a towel on. Reference 13 - 0.32% Coverage I think it's only when I'm in my birthday suit they're not there. I've just realised that. I can't think of any time when...when I've been in the shower or anything. Reference 14 - 0.55% Coverage So if I was six, he'll have been 17, you know, there's 11 years' difference between us, a big difference. So he's always been more powerful but I'd blocked out that I had a brother. I said I just had one brother, that was the brother that's nearly the same age as me and he's nice. Reference 15 - 1.08% Coverage	influences how active he is now or…? P04: I think how evil he can be or how powerful it will be. Reference 6 - 0.67% Coverage P04: So if you stood up to him, because, like, if you told him to fuck off and stay away until this was over, it would mean just as much as I'd said it. I: Okay, so your voice would listen to other people saying something? P04: Yes. Not other people, I'm just saying in those moment today, this is how it is. It's never happened before Reference 7 - 0.47% Coverage He's sort of over there on the side-lines. I: Right, so you're pointing to your left, so is that where he actually is? P04: Yes, that's where the voice is, it's like over there. If it was a physical thing it would be over there.	awkward. It's like they have to ask as an afterthought. I: Do you know whether your voices have a particular view about you talking to practitioners about your voices? P04: There's one, like, the helpful one says, go on, I dare you, but I know that they don't really want to talk about it. I: Who don't? The practitioners don't? P04: Yes, they don't want to talk about it, they just say, are you still going to the group? They're not asking you in a way…it's an afterthought, as you're leaving. Reference 8 - 0.48% Coverage They say that as an afterthought to me as I'm leaving the room, but they spend a lot of time saying, oh, she hears voices, she hears voices, they don't talk about it, like do they know why I have them? Have they got any answers? I'd ask her. Reference 9 - 0.58% Coverage	**Finding it difficult to relate with voices** The first thing I said was just fuck off **Being critical of voices** Because I know deep down he's a coward. **Concealing voices** P04: I've never let it. I don't tell people I hear voices. It's not something you go around telling people. I: Okay. P04: I think XXX's dad, the guy who drives us around, he thinks I facilitate. I: What do you mean, he thinks you facilitate? P04: At the group. I: So he thinks you facilitate the group? P04: Yes, on a voluntary basis. I: Does he know you hear voices? P04: No, he thinks I just go and help other people. Reference 2 - 0.51% Coverage

	Reference 2 - 0.69% Coverage I would say that they can’t keep us mute and fixed in one place, and that I would see someone and make them disappear altogether, but I didn’t know if that could happen but that seemed to work a bit, and then I would say I don’t need to hear you in XXX’s time, and then when he’s gone to bed then I’ll make time and you can have all evening to blah on. Reference 3 - 0.26% Coverage When I think about it, it does have an effect on XXX because I don’t allow that, I definitely don’t allow him anywhere near my kids. Reference 4 - 0.15% Coverage Like I wouldn’t allow anything that he said in my head to come out my mouth or… **Voice hearing is about power & control** Because before the group, like even on a morning, trying to do breakfast and		I don’t know if…he used to be a lot but that would make us try and kill myself, you know, like, knock in front of a bus or a lorry, so it looked like an accident, not tablets or anything, I wouldn’t do that to my children, making it look like it was an accident, he used to talk to us in great detail about it and it used to terrify us, and I used to say, “Sean, what if he does it”? “What if he wins and then I’ve gone and I can’t come back”? But touch wood, he’s eased off a little bit, really. I don’t know what the change has been. Maybe the HRT. **Feeling physical presence of voices** I: Can I ask then, so that position where you’ve described him, does he ever move? Does he ever get closer or further away or…? P04: In this discussion today? Yes. I: Okay, so… P04: He’s tried. I: So he has moved around then? P04: Yes, tried to get in, yes.	Reference 8 - 0.37% Coverage I: Okay, so if I was a female, what would he do right now, do you think? P04: I probably wouldn’t have been able to go on. He would have just been going on about what he’s done to us. Reference 9 - 0.41% Coverage I: Okay, so what happens when our conversation starts changing and we talk about other things, where does it go then? P04: Just sort of trying to get in any crack that he could in our conversation. Reference 10 - 0.67% Coverage I: Okay, and with me being a male, what difference does it make to the position that he’s in? P04: More fearful and respectful. I: Do you know why that might be? P04: Because you’re a man. I: And do you think he worries about what I	I: So whether they can explain why? P04: Yes, what do they think it is? Because you know the word curable? It’s like that’s the wrong word but probably that’s what they would ask is do you think that we can cure you, but it’s not a cure, is it? It’s not something that you can put tablets on. Reference 10 - 0.61% Coverage I: Okay. And you’ve just not had those opportunities when you’ve talked with professionals? P04: They keep putting it to one side kind of thing and just make sure you go to the group or make sure we give you some tablets to shut them up, and I don’t know how a tablet can shut them up, unless you’re asleep.	It was an awful time because I had to spend a year at [MH unit]. Never mentioned them once, and that was supposed to be, you know, you were in the closed environment, you’re supposed to be honest, so I felt it was a year out of my life was a waste of time. Reference 3 - 0.13% Coverage Yes, but I got away with it because I would talk normally to them. Reference 4 - 0.76% Coverage [MH unit] kept you busy so there wasn’t a lot of time for my voices to come anyway, but I used to have to pretend I was asleep and I would just put my head down like that and then they would be just like blah-blah-blah… I: So you used to pretend you were

	talk to him, like homework and stuff, it was…well, I couldn't, but luckily I was poorly so I could blame a lot on that. I was physically ill so I could blame a lot on that. Reference 2 - 0.44% Coverage P04: But I try not…they're there but I try not…I try not to let them sort of rule the day anymore. You know, I've got a voice that will say… I: You've got your voice? P04: Yes, where probably before it was mungled up with… **Acting on what voices say** Yes, the notion of it, when they first said it, I thought, how on earth can you do that? I thought just accept it, just go with it. Reference 2 - 0.54% Coverage P04: I was with the surgeon and I'm allergic to penicillin and he asked us if I had any allergies and I said no, that was when I was nearly dead. I: Okay, so you did have an allergy, penicillin, but you said no? P04: My voice wouldn't let us tell him I had an allergy.		I: So can you just describe that a bit more then? P04: Sort of, like, when you're talking a bit intense, he thinks we're busy talking so he can just slip then and take whatever. I: Okay, so in those conversations, does he come in closer? P04: Yes. I: And how close would he get to you? P04: Kind of surrounding the top of us. I: Okay, so he's all around you? All right, and then does he remain there all the time or does he move from there? P04: No, like, he can be above us or… **Identifying voices as part of self** They already knew but I didn't realise that they could, because at the beginning it was everyday things, you know, I was useless at, and everything… It wasn't really deep. And then they started talking about…one started talking about things that had happened, they didn't necessarily have to be bad, and then I realised, well, I haven't told them that. It's not my thought. So how	might do or…? Why do you think he's fearful? P04: I think he knows that you're powerful. P04: I don't think it's a cure that's needed, but…I think if it was talked about more, got rid of some of that shame, yes? I: So that's… P04: I mean, it's not talked about enough.		asleep so you could dialogue with your voices? P04: Yes. I: And it would, what, conceal to practitioners…? P04: Yes. Reference 5 - 0.84% Coverage If I do say any nutty stuff, they just think, well, it's part of my sense of humour so I can get away with it, I can work around it, so it doesn't look like…but other people, they can be having exactly the same experiences but maybe they just… I can't think of them just off the cuff, but I know there's been times where, like, I've shouted at somebody or acted some way and then I've just turned it into some kind of stupid joke. **Linking relating with voices & relating with people** I: Okay. And what does that do for you

	Reference 3 - 0.70% Coverage P04: I’m sure I have, where they’ve said that “you’re fucking useless” to the doctor. I: Your voices said that? Right. Did you speak that out to them as well? Yes? P04: Yes. I: So the voices said that and you spoke it out? P04: I’m sure, with the doctor, I’m sure it is that I’ve actually said it, “they don’t fucking care”. I’m sure I have. **Lacking agency with voices** when you’re feeling vulnerable, I’ve said to the CPN and the psychiatrist, it’s all right you saying it will be okay but what about if I listen to it? You can’t come back from death. What if it gets us? Because, you know, I don’t want to kill myself, but I believe that voice and there’s no way I could get that voice to turn around and say something else or control it… Reference 2 - 0.11% Coverage		did they know? And then I came to the conclusion that it’s my head, they’re all connected… Reference 2 - 0.78% Coverage I: So you came to the conclusion that it’s your head and they’re all connected? P04: Yes, because you can spend too much time thinking how do they know that? I’ve never gone to find the answer around that. And you think has it come from your subconscious? Like the voices have always been there in your subconscious and they’ve just come forward? And that’s how they know? I don’t think that’s right. Reference 3 - 0.14% Coverage Yes, I think he knows that I wouldn’t be here so he wouldn’t be here. **Linking voices with trauma** I did have a lot of shame, yes, and I suffer a lot of shame of being abused as a child.			then if he’s fearful and he’s thinking I’m powerful? P04: Well, it’s like I said to Sean, my CPN, if I got married, it would all disappear. If I had a big strong man, and he doesn’t get us. I: Okay. So does that mean then that if you were in a relationship with someone who was… P04: I think it would be different. **Voices interacting with emotions** Then there’s…like, when I’m really low, at my most vulnerable, then there’s nasty ones that come in. Reference 2 - 0.24% Coverage P04: Yes, it was the shame, you know, it came with shame, they made us feel shameful. I: About? P04: Having voices. Reference 3 - 0.21% Coverage

	Yes, I couldn't do anything, it was like I was paralysed. Reference 3 - 0.16% Coverage Apart from the one when my brother or my dad comes, I have no control over that. Reference 4 - 0.60% Coverage I: So I'm really interested to hear the relationship that you have with that voice and what is it about that voice that keeps that voice as much more powerful than what I'm thinking you're describing the other ones to be? P04: Because as a person, he's always been a hell of a lot more powerful than me. Reference 5 - 0.16% Coverage And because he has the capability of destroying us, taking everything away from us. Reference 6 - 0.54% Coverage P04: I don't think I'd be able to get in a relationship, I		Reference 2 - 0.22% Coverage Because I think after you've been abused, you spend your life trying to be normal anyway, and you feel contagious. Reference 3 - 0.22% Coverage There was one voice that just kept making us relive things that I've never thought of before since it happened Reference 4 - 0.53% Coverage I had a drink problem for years, but I haven't since 2011 and that was the time that the voices came. Oh yes, and it was around the time I had an anaphylactic shock and died, it was really serious and I was lucky to be alive and then it was after that they got bigger. Reference 5 - 0.24% Coverage I don't know if it's filling in the gaps, because I think some of the trauma I kind			So, like, they knew what they were doing, you know, to make us feel like that, saying I'm useless and… Reference 4 - 0.27% Coverage It's like when I say something out loud that's when…it's not if I say anything in my head, they don't react then. It's if I say it out loud… Reference 5 - 0.30% Coverage The voices can influence me, if I'm sad, they can make us smile or if I'm too happy they can bash us on the head and say, oy, you're supposed to be ill. Reference 6 - 0.26% Coverage I think they're quite well synched now, but yes, of course it does, yes, it can happen when you're

	don’t think they would let us. I: Your voices? P04: I don’t think John would let us. I: What do you think he would do? P04: I don’t know. Just make us feel…I’m someone useless and I’m from bad stock. **Voices wanting to be acknowledged** P04: Now they’re just all jumping in, I can’t understand anything now. I: Are they jumping in now as you’re talking? P04: Yes. The one that I said who thinks everything’s…oh yes, he wants to be here. Reference 2 - 0.35% Coverage And when I say they knew what they were doing, to get us to notice this isn’t me and my imagination, this is really what’s going on and we are real and we’re not going anywhere. Reference 3 - 0.41% Coverage I: Do you think your voices like to be recognised and		of skip over it and go to the next bit. Reference 6 - 0.23% Coverage And the things he did to me was more powerful than anyone’s ever did before. No one’s ever hurt me like that before. Reference 7 - 0.71% Coverage I: He says you’re from bad stock? P04: No, someone used to say it to us, it was that feeling, I don’t know, that I’m dirty, I’m…too damaged. [Becomes tearful]. I: Okay. Is that upsetting to think about? P04: Yes. I don’t know. I’ve tried to have myself as strong and…but I don’t…I don’t like to agree but I’m going to…I like to think of us as strong… **Living with voices** Can I take you back to the hearing voices group then? So when you went into the hearing voices group, and you described you were with a group of people who are talking about voices,			depressed one voice can be happy. Reference 7 - 0.91% Coverage P04: About how I dress and my mood… I: Right, so the voices will comment more about how you dress? P04: My appearance. I: Okay, that’s interesting then. So what have you noticed there then? P04: I can get dragged down, you know, like I can think to myself, you know, like, that’s nice, I’ll put that on today, and then a voice will say, what? You’re not wearing that, really? I: Okay, so they’ll comment on what you’re wearing then? P04: Yes. **Wanting to get rid of voices** I: Do you want to get rid of your voices? P04: I would like to get rid of [voices]. Reference 2 - 0.15% Coverage

	acknowledged that they're there? P04: My brother does. I: So he wants to be recognised that he exists? P04: Yes, even now while I'm talking to you. Reference 4 - 1.60% Coverage I: So if you're talking to someone who is not showing a great deal of interest, what does that do for your voices then, particularly your brother's voice? P04: It's like he's standing in my head, I can't see him standing in my head, it just feels like that. Like he's more important than what we're talking about. I: So what difference does it make then if you're talking to someone who is interested in your voice, particularly your brother's voice, how do your voices react then? P04: He stops us. He'll like say so much and then stop. I: Can you explain… P04: And I'm left with, well, what happened then? You know? Like now, he wants to say about the rubbish tip I was on looking for food…like why? Why do you want to		and they suggested why don't you talk to your voices and you thought it was ridiculous, what happened then? Did you go on and talk to your voices or…? Yes? And how did you do that? Like sometimes before things just used to come out my mouth and I didn't have any control and the things were right, but I could have had a different way of saying it, the way I would have said it. But now I go I'm not bloody saying that, you know? And I won't say it whereas before things just used to fall out and I know I used to have them all in stitches because I was like that.			I: The EMDR? P04: Yes. If I'm eligible for it, it might get rid of [voice]. **Relating more positively with voices** And then the one that's easy-going is like a little dog, can I come, can I come? So I would say, oh, you can come to listen to the story at bedtime Reference 2 - 0.09% Coverage I would be pretty lonely without them. Reference 3 - 0.70% Coverage P04: Yes, because when you live with it, you don't think about it, but when you're saying it to someone else that I'm saying to a voice come and listen to the story and I'm looking and I can feel that voice is a nice…I wish I could find the word, because it's like a being but it's a voice that has feelings.

	say that? Why would you want to tell someone that? That's what I had to do.					I: So it has its own identity? P04: Yes. **Looking after voices** And then the one that's easy-going is like a little dog, can I come, can I come? So I would say, oh, you can come to listen to the story at bedtime, Reference 2 - 1.03% Coverage P04: No, my voices seem happy. They've had a nice time. I: Are they commenting on anything that we've spoken about? P04: Yes, just saying it wasn't that bad, was it? And then my voice is saying, no, it wasn't, was it? I: So you're having an internal dialogue? P04: Yes. I: And does that make a difference if they're thinking it wasn't that bad? P04: Yes, it just makes it a bit easier, you know, instead of, well, why didn't you…what was it that

							you didn't like, and I would have to sit here annoyed and…
P05	**Voice hearing is about power & control** it's when you have that strength to be strong with them. Sometimes you feel like you can be the strongest person in the world and you can fight them, and you have that strength. Usually during the day when it's light and it's okay, and there's people around, you can cope, you can do it. But in the night when it's dark and you're on your own, and all you've got is them, that's that power struggle, that's that they win thing. Reference 2 - 0.47% Coverage PO5: …I used to have horrendous nights, really horrendous. I feel now that with somebody, I have more strength. And the voices don't like that. I: They don't like? PO5: That, that I have more strength. It's definitely a power struggle. Reference 3 - 0.30% Coverage	**Benefitting from medication** I: So what happens to your stress levels then when you're in those situations? PO5: Yeah. Well, I'm on Pregabalin. I: And does that help you? PO5: Yeah. **Medication not helping voices** Getting my tablets down is quite a struggle, because one of my voices doesn't like me having the tablets. But I have kind of concealed tablets in hospital before, but I can do the tablets okay now. But that, again, is like a power struggle within. **Fearing enforced or involuntary treatment** I: restrain you and inject you with… PO5: Yeah, really distressing and traumatic. Yeah. I: And what were your voices like in those situations? PO5: They have been extremely traumatic situations, yeah, screaming, horrible. Reference 2 - 0.35% Coverage PO5: Yeah. Absolutely, I can't go back there, I can't. I can't, no.	**Making sense of voices** Yeah. There's usually two men that I know and then I've also got a visual, one that's a visual hallucination as well, called [name of voice]. And then there's also one that's like a crowd, which is like constant, just un – what's the word – kind of, you can't always pick out what it is, it's sometimes just mumbling. Reference 2 - 0.35% Coverage I don't know. I don't know what they want. It's hard to know what they want, because I don't talk about the voices much, it's hard to know what they want. I do listen, yeah. **Feeling physical presence of voices** I: Okay. And for all three, in terms of their proximity to you, how close or how far away from you are they? PO5: [voice] varies. [voice] will come and go, but the men come from here.	**Being persecuted by voices** I: How would you describe them? PO5: Very destructive. Reference 2 - 0.30% Coverage I: Okay. And when you say destructive, what is it that makes them destructive to you? PO5: The things they say, they want me to cause harm to myself. Reference 3 - 0.45% Coverage I: Okay. And whereas the men are destructive, how would you describe [female voice]? PO5: She's a character. She can be both. She can be like my worst enemy or my best friend, but mainly towards enemy side. She's very deceiving. Reference 4 - 0.79% Coverage	**Practitioners failing to connect & understand** PO5: Some of them just aren't helpful, they're not helpful at all. I: So how do you come to form a view that some are helpful as a practitioner but some aren't? PO5: Some of their attitudes towards you are not very good. Reference 2 - 0.85% Coverage Say, A&E, if you've self-harmed, I've had some A&E doctors ask if I want anaesthetic while I get stitched up, whereas if someone else had presented with a normal cut, they wouldn't even ask, they would just do it immediately. So why should I be any different for self-harming. And they put iodine straight on it without even doing anaesthetic first, they put the iodine on the cut before the anaesthetic, which was horrendously painful.	**Being accepted & supported** I don't struggle as much any more because I now live with my fiancé, so I don't struggle as much at night any more. Reference 2 - 1.04% Coverage P05: I think the best thing that's happened to me for the voices was the hearing voices group. I: Yeah, other people have said that as well. PO5: Just to understand and be around people who…you're in the same boat. You don't have to say anything, they just understand. And you can just…you can go weeks without saying anything, even though you're getting the support, and then you can come out with an issue and it's just understood, understood. It's fab.

	I: And how do you exist within that power struggle, how do you get on and do the things that you need to do day by day? PO5: I don't know sometimes. Reference 4 - 0.59% Coverage So it is a constant, this power struggle thing, constant, just to kind of…but I don't want to…I've got so much good things in my life now that I don't want them to win, because I know they will destroy these good things in my life, whereas before, there was nothing good in my life for them to destroy. Reference 5 - 0.35% Coverage I: Okay. So are you saying that you haven't found a way of standing up to your voices? PO5: Not to the point of telling them to come back in half an hour, only stuff like this. Reference 6 - 0.49% Coverage	I: And that was happening while… PO5: Quite often in the secure unit, yeah. It was pretty horrific times. **Lacking involvement in treatment decisions** I: So you've had a lot of not being involved in decisions about your treatment? PO5: Yeah. I was in a secure unit, so yeah. Reference 2 - 0.60% Coverage I've been on, like, so many different tablets, all different antipsychotics and stuff, a lot of medicine and stuff. So surrounding my medication, I haven't had much involvement in it. I've been put on this, this, this, this and this, and then ended up on Clozaril. So I didn't have much treatment in that. Reference 3 - 0.12% Coverage I've been restrained a lot and had Acuphase and Haloperidol. Reference 4 - 1.65% Coverage I started off where I was taken to [young person's unit] when I was 17 and I spent nine months in [young person's unit] when I was 17 and 18. And then I was discharged from services when I	I: So right behind your right ear? PO5: Yeah. I: And in terms of sensing their presence then, are the men always close to you? PO5: Yeah. Reference 2 - 0.47% Coverage Yeah. Well, she's around as though you are in front of me, so yeah, she just comes and goes like a normal person, she'll walk beside me if I'm going shopping around town, or she'll sit in the chair in the living room, watching TV with me. Reference 3 - 0.54% Coverage PO5: She's just [voice], it's what she does. She's been there since I was 18, she's just… I: Okay. So she comes and goes into different positions, as she chooses to do? PO5: Yeah. I: Okay. But the two men are always very close behind your right ear? PO5: Yeah.	I: And then you said she was…I made a note of it… PO5: My best friend or my worst enemy. I: Deceiving was the word, yeah. So if I imagine that for me, that's very difficult to know where you stand with someone. PO5: Yeah, she's my best friend and my worst enemy. I: Yeah. How does that happen? How does someone become your best friend and your worst enemy? PO5: She's a bit of a bitch. Reference 5 - 0.73% Coverage I: Okay. And with the voice…so I'm thinking of [voice] here, but with a voice that can be deceiving, how do you know where you stand with… PO5: With [voices]h? I: Yeah. PO5: Oh, you don't, you really don't. She can be telling me what to do, how to do something one minute, and then telling me to throw myself off a bridge the next minute. She's very unpredictable.	Reference 3 - 0.55% Coverage And then you just get people in kind of the secure hospital and stuff and PICU, and just some of their attitudes, they're just like that they don't want to help, that they're just there for the money and just weren't very engaging, and just kind of sat there and didn't do things. Reference 4 - 0.69% Coverage Because like a lot of…I mean, I was in the secure unit for three and a half years, so a lot of the…it was long days, very long days for three and a half years in hospital. And when you're stuck on the ward, a lot of the healthcare assistants would, like, play card games with you or board games, or stuff like that, just to help pass the time and things. Reference 5 - 0.54% Coverage But some of the healthcare assistants would just sit there and chat to each other, and wouldn't do	I've been going for six years now and it's just amazing, absolutely amazing. Reference 3 - 0.80% Coverage I think if educators on voices, so kind of were, like, told how to help someone hearing voices, so like a group and stuff like that. And then maybe it would be easier for them and more helpful for them. So that's why I think the voice group's better because it is about understanding, that kind of real understanding each other, compared to someone who's never understood it before and never experienced it. Reference 4 - 0.87% Coverage But I think it's just helped me in a way because it just does, it just makes me feel that bit stronger. And I do, I go for weeks without saying

	Getting my tablets down is quite a struggle, because one of my voices doesn't like me having the tablets. But I have kind of concealed tablets in hospital before, but I can do the tablets okay now. But that, again, is like a power struggle within. Reference 7 - 0.64% Coverage P05: Also, it's exhausting. So you wake up in the morning and you think, yeah, I'm going to fight these voices, yeah, I can deal with them. Get to the end of the day, you're fucking – sorry, excuse my language. I: That's alright, don't worry. PO5: You're absolutely exhausted, because it's just been a whole day and you're just… Reference 8 - 0.40% Coverage PO5: I think it's always come down to the power of the voices. I: In what way? PO5: The kind of hold they've got over me and what they've always had over me. Well, since I was, what, 17 years old.	was 18. And then I ended up back in services when I was over in [city]. So I was in and out of services there. And then I ended up back over here at [local town] in and out of services. Then got sent to the PICU unit in [city] a couple of times. And then I think the third time I ended up in the PICU unit, they said we're not sending you back, we're going to send you to a more permanent place. I was in the PICU unit a couple of months because they couldn't find a permanent place for me. And then they sent me to the secure unit down in [city]. So I had no say in my treatment, it was just you're going here, you're going here, you're going here. Reference 5 - 0.44% Coverage Yeah. Well, we were going to talk about reducing my Clozaril and then I went to talk about reducing my Clozaril and I ended up on Pregabalin. So that didn't really work. So I'll have to see then about what's going on, yeah.	Reference 4 - 0.26% Coverage They vary, they can come and go, but it's their decision, not mine. So I'd love to be able to have that control of where they are. **Linking voices with trauma** I: Okay. What sense do you make of your voices? PO5: I believe they've come from trauma. I: Right. So things that have happened earlier on in your life? PO5: Yeah. Reference 2 - 0.33% Coverage I believe [voice] came after a traumatic event to look after me at first. She was very nice and very kind at first. And she arrived to look after me, after a trauma. Reference 3 - 0.33% Coverage So it's a vicious circle, like you say. I think everything, the whole my mental illness, my voices, everything comes down to me not trusting the world from the trauma	**Voices don't like VH getting help** P05: So I think the good things in my life are winning over the voices. And they don't like that. I: They don't like hearing that? PO5: They don't like it. I: Okay. All of them? PO5: Yeah. [P05 becomes distracted] I: What did they just say to you then? PO5: Something not very nice. I: Okay. They're making it clear that they don't like what they've heard? PO5: Yeah. Reference 2 - 0.77% Coverage But no, my voices don't like me going to any appointments that are going to help. And I do have to kind of sit and I do turn up early to everything, as you'll see this morning, I do, I turn up early to everything because I have to sit and kind of gather myself, and I will get a barrage before I go into anything. But I know it's the best for me,	anything with you. So you could see their attitudes and stuff. And when you're just sat there all day with nothing to do but sit and listen to your voices, it's not very helpful. Reference 6 - 1.19% Coverage all we did all day was just sit and watch the telly. And that's why you'd end up trying to find ways to hurt yourself, just to get that peace. And it's not easy to hurt yourself on a secure unit. But that's what you did because all you wanted to do was get that peace in your head, so you would try and hurt yourself because that's just…it was very, very –.what's the word – intense, very intense. In some ways, it was helping, it was containing you and keeping you safe and everything, but you only had your therapy once a week, sometimes twice a week, and the rest of the time you were just contained. Reference 7 - 0.80% Coverage	anything, because people do. We do, we don't need to say anything, it's just that we have this thing that we keep saying that our weeks run from Tuesday to Tuesday, because you go and you get that boost and then you carry on for the week, and then you go and get that boost and then you carry on again. Reference 5 - 0.52% Coverage PO5: It's the hearing voices group, the most helpful thing. I: Yeah. So what is it that you get from actually keeping in contact with services? PO5: Understanding. Understanding that it is…I need that place to offload and that I can express what is going on. **Talking about vices & problems is difficult** I don't often talk about what my voices say because of what I get back in return. So

	Reference 9 - 0.10% Coverage I think I give my voices power when I give into them. Reference 10 - 0.56% Coverage I: And your voices were difficult at that time and screaming, you were saying? PO5: Yeah. It was the most horrific times of my life, I don't remember a lot of what was going on at these times anyway. It was literally me trying to kill myself, doing anything possible to kill myself. **Acting on what voices say** I: So what do you mean by they would win? PO5: I'd hurt myself. I: Okay. So does that mean the voices win and you would hurt yourself, that they were trying to get you to hurt yourself? PO5: Yeah. Reference 2 - 0.43% Coverage PO5: As soon as I hurt myself or do something that they want, it'll…this intensity will go back down to, say, zero.			so I deal with that before I go in anywhere. **Voices being disruptive** I: Okay. So does that mean that they demonstrate their – [P05 becoming tearful] are you okay? PO5: Yeah. I: Are they troublesome at the minute? PO5: Yeah, that's why I'm… I: Okay. And are you okay carrying on? PO5: Yeah. Reference 2 - 1.16% Coverage PO5: I did struggle a lot because I was in a secure unit, and that was pretty hell, pretty hell. Made me very kind of like, I won't use the word paranoid, but they were out to get me, not help, and kind of putting things in my head, saying that they weren't going to help. Which doesn't help because you do think anyway that they're not there to help you anyway, so the voices don't help with that anyway.	More therapy, more activity workers to do activities on wards. Even on acute wards, I think the same. I've been on so many acute wards as well in Manchester, Darlington and Middlesbrough, all over the place. Because when I lived in [town] they never used to always have beds, so I got taken all over the place. They should have more activities and stuff, so you're not just sat watching TV all day. Reference 8 - 0.54% Coverage I: What's the difference between that and your experiences of being in service? PO5: The professionals? They don't understand. I: So the hearing voices group understand, but the professionals don't? PO5: Professionals don't, no. Because they haven't experienced it. Reference 9 - 0.14% Coverage I: And did staff talk to you about any of that? PO5: Not really, no.	that it comes out as a blah because I don't talk about them usually because it's so difficult. That's the hard bit. **Being critical of voices** PO5: I have words with [voice] a lot. I: Okay. And so would it be typical for you to say something back to [voice], or describe her as a bitch? PO5: That was a kind of friendly bitch now, rather than a… I: Horrible? PO5: Yeah. I: Okay. And would she be alright with you saying those things? PO5: Probably not. **Distancing self from voices** I: So some people have described they prefer to have a relationship where they're at a distance from their voices, so they've got this more arm's length distance. PO5: I'd love to be able to do that, to

	I: Okay. Does that go back to the "they win" comment that you said before? PO5: Yeah, definitely. Reference 3 - 0.91% Coverage I: Okay. And are they telling you things about the practitioner? PO5: They would say things about them. I've written…I got in a lot of trouble, I wrote lists about different practitioners, about what they're like and things like this, because of what the voices have said about different practitioners before. I got in a lot of trouble, but it's voices and what they said and stuff, and I'd written things down about different healthcare assistants and stuff. **Hurting self for relief from voices** PO5: It was very much kind of a double thing with the hurting myself, because I would hurt myself to do as they said, but also when I hurt myself, they would go away because they got what they wanted. So it would yeah. It would just be so much easier to hurt myself and have that peace.			I: What would the voices do in that situation then, what would they say? PO5: Just that they're not helping you, don't listen to what they're saying, they're not trying to help you. Reference 3 - 0.49% Coverage I: So when you've been going to the hearing voices group for the past six years, how has that impacted on your relationship with your voices? PO5: They didn't like me going, because they don't like me doing anything that's helpful, never have done. Reference 4 - 0.87% Coverage PO5: My voices don't like know that any practitioner that it's not good, so… I: Your voices don't like any practitioner? PO5: No. I: Whether the practitioner's not going to help you or not, they don't like any practitioner?	**Experiencing MH services as uncaring** That you just don't want to go to A&E then when you've self-harmed. I've even considered buying stitch kits off the Internet to do the stitches myself, because I've just had such horrendous experiences in A&E for so long that I was just going to do my stitches myself. Reference 2 - 0.77% Coverage For three and a half years, you just sit there. And, I mean, they did do some activities and stuff, but day after day after day, it was just sat there with the telly on. And, I mean, I couldn't read because I can't read with my voices, so I struggled with that. And, I mean, now I still can't watch Loose Women because it just goes back to sitting in front of the telly in the secure unit and… Reference 3 - 0.53% Coverage PO5: Awful, absolutely awful. I think it is traumatic trauma as well from all of	kind of push them away. Reference 2 - 0.21% Coverage I: Okay. And what would that mean for you then if they were further away? PO5: Hopefully, they'd be quiet. **Voices interacting with emotions** Stress is a huge part with my voices. If I'm stressed, my voices will just get…they just seem to get…well they will get just a huge power surge. So I think if I keep my stress levels down, which I try to do, I know that that would keep my voices quieter. Reference 2 - 0.34% Coverage PO5: I'm very anxious, yeah. I: But your voices… PO5: Feed into it. I: Feed in. So when you say they feed in,

	I: So they would be…once you hurt yourself, they would be… PO5: Quiet. Reference 2 - 0.14% Coverage That peace when I cut myself, that would, and still is, like a drug. Reference 3 - 0.22% Coverage As soon as I hurt myself or do something that they want, it'll…this intensity will go back down to, say, zero. Reference 4 - 1.36% Coverage The stuff I've gone through in the past, and what I've been through, and the stuff that I've done because of these voices, and the kind of…the positions they've put me in, I've been on top of railway viaducts just to get some peace. And it's like the scariest situation I've ever been in my life, but my voices were silent when I was up there. I got dragged down but then I went up again, just to get that silence in my head. And it was, it was peaceful up there. And			PO5: Uh-hum. I: Okay. How do you know they don't like any practitioner? PO5: Because I get the barraging. I: Okay. So your voices react when the practitioner's there, is that right? PO5: Uh-hum Reference 5 - 0.49% Coverage I: I think you might have said this before, but I'll ask you again. So why do you think the voices are reacting in this way to practitioners? PO5: I think it's this struggle isn't it, that they worry that if they help, they will lose some power. Reference 6 - 0.87% Coverage Because you only have this kind of short meeting with the…like, say, you're seeing the psychologist and they're kind of like asking you what's going on, and you've got some…a voice, like, at you, and you're trying to say, and you get	the stuff and hospital stuff that's gone on as well. I: So you experienced trauma in the early part of your life anyway and then you had more trauma from… PO5: From being in hospital. **Practitioners not talking about voices** PO5: I think it's understanding as well. I: The practitioners understanding? PO5: Yeah. I: In what way? PO5: Just with voices I think it is as well. I: So they understand your voices more? PO5: Uh-hum, to talk to you about them.	what do you mean by that? PO5: They make it worse. Reference 3 - 0.54% Coverage I can understand why you'd be anxious then because you're not sure whether to trust people or not? Did you say trust before? Yeah. My voices can be quite…I struggle with public transport and stuff like that. My voices tell me that people have got bombs on transport. Reference 4 - 0.50% Coverage I: So do you notice yourself becoming more stressed then in certain situations? PO5: Yeah. I can't travel to new places, you know. So I can do places I've been before on my own, but I can't go to new places on my own without someone coming with me.

	I still crave to go up there, I still get cravings to go up there because I know that I'll get some peace in my head up there. And it's like constant craving to do these different things, just to get that peace in your head. Reference 5 - 0.66% Coverage I: But that means that the voices win when you do that. What does that leave you with after that event's happened then? PO5: After I've self-harmed or anything like that? I: Yeah. PO5: You get quiet from the voices but you're left with stitches, more scars, more feeling shit. It does, but you'd do anything just for that silence. Reference 6 - 0.40% Coverage I: And does that change how you relate to your voices the next time they come then or…? PO5: [Becomes tearful] I: Can I ask… PO5: Because it's worth it. I: For the peace? Yeah. PO5: Yeah.			everything muddled up and you can't…you're trying to talk. You try and say things and it all gets muddled up, you can't…it's like…it is, it's really hard to kind of say stuff and get…you get it all muddled up. Reference 7 - 0.41% Coverage Well, the psychiatrist wants it…it's very much…but yeah, when you're being asked questions and the voices are at you, it's hard not to get everything, you're trying to say everything and it all gets muddled up. Reference 8 - 0.38% Coverage PO5: Distant he calls me. XXX calls me distant. I: Who calls you distant? PO5: XXX, my fiancé. I: XXX, okay. What do you think that means then? PO5: When I'm struggling with my voices.		Reference 5 - 0.16% Coverage I: Okay. And would the voices respond to that? PO5: Yeah, the stress definitely. Reference 6 - 0.24% Coverage PO5: Yeah. I've got OCD as well, so that feeds into my stress and stuff. I: Okay. PO5: Yeah, making the voices worse. Reference 7 - 0.56% Coverage Try not to get too stressed about it. Ad helps a lot, he knows like what I'm stressing about. But sometimes he tells me that…it's locks and security, and trying to make myself safe, but he can tell me that the door's locked and I won't believe him. And the voices feed into that anyway. **Looking after voices**

	Reference 7 - 0.33% Coverage I: And what are your voices like in those situations? PO5: Because I've self-harmed, my stitches – my stitches – my voices are quiet while I'm getting treatment at A&E. Reference 8 - 0.95% Coverage all we did all day was just sit and watch the telly. And that's why you'd end up trying to find ways to hurt yourself, just to get that peace. And it's not easy to hurt yourself on a secure unit. But that's what you did because all you wanted to do was get that peace in your head, so you would try and hurt yourself because that's just…it was very, very –.what's the word – intense, very intense. In some ways, it was helping, it was containing you and keeping you safe and everything Reference 9 - 0.07% Coverage Maybe when I give in and self-harm.					P05: So I think it's definitely about kind of looking after myself and I think I've learnt how to, like, look after them. I: Look after your voices? PO5: Yeah. I: Okay. By? PO5: Keeping my stress levels down. Maybe listening more, which I was scared to do. Reference 2 - 0.24% Coverage years ago, I would never have listened, I would only listen to the bad parts, the you need to do this, you need to do that. Reference 3 - 0.58% Coverage I: And when you say looking after your voices, what do you mean by looking after your voices? PO5: Just giving them time to listen to them, whereas I think before, I would just ignore them and try to ignore them.

	Reference 10 - 0.77% Coverage PO5: Constant. Absolutely constant. I would do anything to kill myself in these times. I was walking along railway tracks, I was taking overdose after overdose. I was ligating really seriously, just doing anything to [inaudible 1:08:33]. So… I: And would that be to get the peace that you were talking about before then, from the voices? PO5: Yeah. And just to get away from my past. **Lacking agency with voices** I: When you ignore voices and the voices gain strength, what do you understand by…what it is that they're doing to gain strength, and how are they gaining strength? PO5: They have always had a hold on me, always. And I don't know, the things that they've made me do, it's like it would gather up the more that I kind of…they would go at me and go at me, and go at me and go at me, and go at me to the point where I couldn't take it any more. And then it would be too much. And then something					Whereas giving them time now is better than just completely ignoring them. **Trusting people is difficult** I don't trust people. I don't trust the world. But I think that comes from my trauma anyway and that's fed in by the voices. Reference 2 - 0.21% Coverage I: Yeah. Okay, so does that mean because of your trauma, you don't trust… PO5: I'm very anxious, yeah.

	would happen. And then it would go down again. So it was that kind of power that they would have. Reference 2 - 0.72% Coverage I: So are you saying that they demonstrate their strength to you by just going on and on, and on and on, telling you to do something? PO5: Yeah. I: And do they change how they tell you to do something? For example, do they become louder or more aggressive? PO5: Oh, yeah, yeah, yeah. But it's usually the same things and it has been the same things for years. Reference 3 - 1.15% Coverage I: And just hearing you say that reminds me of standing up to voices. PO5: I'd love to be able to do it. We talk about it in the [Hearing Voices] group a lot and there's a lot of people that can stand up to them and kind of like tell them what to do, and tell them to come back in half an hour, and stuff like this. It's just like the ultimate wish that					

	you'd be able to do it. But it's taken people years to be able to do it. And you kind of like practice it and think, oh, I'll try that and stuff, but I'd love to be able to do it and tell my voices to come back in half an hour. Reference 4 - 0.21% Coverage I don't think it's me standing up to them, I think it's my life now standing up to them. Does that make sense? Reference 5 - 1.40% Coverage Me, myself, I'm still that person I've always been, I've still got everything that's happened in the past, all that stuff, still a very, very, very weak person. Whereas the stuff that's going on at the moment is really, really good, really happy stuff, fiancé, getting married, volunteering and everything. And that's the stuff, that's the good stuff that's standing up against them voices but without that stuff, I wouldn't be able to stand up to my voices. So it's not me standing up to them voices, it's that stuff					

	standing up to them voices. If I didn't have that stuff, I would still be that person on a night going to hospital nearly every night, self-harming, getting stitches, because it was…so it isn't me. Reference 6 - 0.26% Coverage They vary, they can come and go, but it's their decision, not mine. So I'd love to be able to have that control of where they are. **Voices wanting to be acknowledged** Because if you just completely ignore them, they're getting strong. And they get angry					
P06	**Empowering self through action** but over time, especially when I was in [hospital], I did a lot of work on the voices, a lot of medication and mind works. Reference 2 - 0.46% Coverage So it was in the past and the past shouldn't hold any power over you. I'm a great believer in Buddhism and	**Dominating influence of medication** P06: I'm on the highest dose of antipsychotics that you can be on in England. I: What are you on? P06: Four hundred milligrams of Depixol once a week. **Being persuaded to take medication** The only thing practitioners are good at is giving me medication Reference 2 - 0.37% Coverage	**Making sense of voices** And came to see them as different parts of myself, like a split off parts of my personality, basically whenever I've had a tragedy in my life, my personality has split off at that point and it's become a voice. Reference 2 - 0.52% Coverage	**Voices don't like VH getting help** They don't believe happiness can last forever, like, when I met my wife, it was…I knew I was going to spend the rest of my life with her the very moment I saw her, but the voices were very, mm, you know, and it took them about a year and a half to come around to the fact that	**Practitioners failing to connect & understand** The only thing practitioners are good at is giving me medication, they've never helped with any of the…I went to a Mind course on mindfulness which I found very interesting, but that wasn't anything to do with practitioners, that was just Mind and that's about the only thing. I started doing CBT with somebody, but	**Feeling valued by practitioners** It was really helpful, it was someone that when I was struggling I could phone up and say, here you are, [CPN], I'm struggling and he'd say, well, what's the problem? And I'd tell him the problem and he'd say, well why don't you try this or why don't you try that or why don't

	Buddhism says the past has no power over you, so I worked on the fact that they were all part of my past, so they had no power over me. That’s what they were saying that they were, so I just believed them, because I had nothing...until I read a book, I can’t remember the name of the book now, but it was a book on voices and until I read that book, I had no idea **Setting limits** I used to have no control whatsoever, but now I can tell them to hush up for a while, when they’re there, which, like I say, they haven’t been for 11 weeks now, but when they were there, I used to just say, well, let me say my piece and then I’ll listen to what you’ve got to say and I’ve actually turned around to the doctor and said, listen, I need a couple of minutes on my own and I listen to what they’ve got to stay and if they’ve got anything interesting to say that I think the doctor will want to know, then I’ll tell him, but if they haven’t got anything interesting to say, I’ll say,	I: Do you talk to people about your voices or practitioners? P06: Occasionally. I: And what sort of questions do they ask? What things are they interested in? P06: Mostly medication. **Benefitting from medication** I: Okay. And what does that depot do for you and your voices then? P06: Just dampens my emotions, that’s all it does. I: Okay, so when you say dampen your emotions, just tell me a little bit about that. P06: It stops me getting so het up by the voices, like when they’re bum, bum, bum me, it doesn’t affect me so much. I: So you don’t get stressed by it. P06: No, I don’t get stressed by it and I don’t get…it’s just a chemical cosh isn’t it, that’s all Depixol is, it’s just a chemical cosh. **Importance of being involved in treatment decisions** Right now, I’m pretty much in control, Dr XXX has come to the conclusion that I probably know more about medication than he does. Reference 2 - 0.80% Coverage	Well the five year old told me that it was a child and I worked out myself it was, because of the way it acted, it was the same way as I used to act when I was that age and that’s, sort of, gave me the indication that the rest of them were part of my personality as well. Reference 3 - 0.35% Coverage Yeah, because they’re acting from the age that they’re at, it’s like the whole bogie man theory again, you know, if I go and see someone bigger than me, then it’s, like, the bogie man. **Identifying voices as part of self** Well knowing that they’re part of me means that whatever they’re thinking and whatever they’re saying is part of what I would say or think. Reference 2 - 0.36% Coverage So he’s naturally scared, so that part of me is scared, so I have to sooth that part of me then. I’ve got various ways of soothing,	she wasn’t going to leave me, you know. **Voices being disruptive** When I was in [secure hospital], the voices were very, don’t tell them we’re here, don’t tell them we’re here. Reference 2 - 0.45% Coverage I: Okay. What was your reason for not wanting people to know that you heard voices while you were there? P06: Well the voices didn’t want me to tell them that I heard voices, because that would have given them a reason to keep me in.	she left, so that went down the pan. Reference 2 - 0.49% Coverage I think I scare them, I truly think I scare them, because I’ve been through the hospital system, I’ve been through the high security system, I’ve been through the cat A prison system, I think they just think, well, keep him dosed up and he’ll be nice and calm. Reference 3 - 0.08% Coverage I don’t think most of them understand it. Reference 4 - 0.31% Coverage P06: In all my time in hospital services, only XXX [CPN] has ever done any work with me. I: Yeah, so that’s one person in 30 years of experience. P06: 30 years. **Practitioners not talking about voices** But the psychiatrist just put me on Depixol.	you go back to doing this, because this worked for you before? Reference 2 - 0.71% Coverage Because the thing about [CPN] is he actually listens and he knows what I’ve done before and he knows what’s worked before, so he knows what to advise me to do and sometimes you just need a reminder. Sometimes you don’t need a new technique, sometimes you just need remaining of the old ones that have worked before and he cared, that was the difference, he actually cared. **Concealing voices** even though I’d been through [secure hospital] and I’d been through the hospital services, I’d been through them without telling anyone that I heard voices, so nobody knew that I heard voices

	well thank you for your input, but there's nothing there for me to say and I'll go back to my conversation with the doctor. **Taking responsibility** I: So they were joyous that you'd done what they'd asked you to do and what did that leave you with then? P06: I thought I was a failure and then decided it was never going to happen again. Reference 2 - 1.19% Coverage P06: Well the guy hadn't done anything to me, he was literally walking through the park, you don't expect some radged to come attack you when you're walking through the park, you know, and I didn't really give him a chance, there was no opportunity for him, you know, it was just wham, bam, bam and I had to put myself in his position and I did, I came back home and I meditated and I sat down and I imagined myself walking through the park and then somebody jumping on me and attacking me and	Well, yeah, he was…he turned around the other day and said, I'm going to see if I can get you depot moved to fortnightly, I said, you won't be able to, he said, why not? I said 400 a week, a fortnight is the most you can give and he was, like, well I want to give you 800 a fortnight instead of 400 a week, I said, well, 400 is the most you can give, he said, I'm sure it's not and he looked it up in the BNF and went, oh. Reference 3 - 0.88% Coverage No, no, I went from Depixol injections to Clopixol injections with a view to going onto Clopixol tablets to be discharged from services, but I had a major breakdown with the Clopixol, it just wasn't working for me and I ended up in hospital and they said, right, what are you wanting to do? I says, well, put me back on Depixol, but put me on 400 a week instead of 400 a fortnight, because I need to stabilise out and they went, oh okay then and they put me on it.	I've got meditation, mindfulness, these little things. Reference 3 - 0.48% Coverage That's the main difference, I thought they were separate from me, I thought there was something else, I went through a whole range of things from Gods to Aliens to metaphorical beings to astral beings, I went through a whole range of things, you know. Reference 4 - 0.21% Coverage I think there's someone else that's much better for her than me. So, yeah, I think the voices feed off that. Reference 5 - 0.25% Coverage Well as soon as I realised they were separate parts of myself, I realised that I'd already lived that part of my life, I survived it. Reference 6 - 1.01% Coverage		Reference 2 - 0.42% Coverage I: Right. But do you let them know that you do hear voices? P06: What the practitioners now? I: Yeah. P06: Yeah. I: And yet they still don't talk to you about those voices. P06: No. [CPN] did a little bit.	Reference 2 - 0.43% Coverage So they were very closed off and I had to talk to the doctors as though they weren't there and that was very hard, because they were always giving input into what they wanted to say and it wasn't always what I wanted to say. Reference 3 - 0.50% Coverage P06: They had no reason to keep me in, because I was just there on a personality disorder and I was untreatable. I: Okay. P06: So there was no reason to keep me in, if they found out about the voices, then that would have given them a reason to keep me in. Reference 4 - 0.76% Coverage No, no, I'd been talking to different people in [secure

	how that would make me feel. I: Mm. P06: And it made me feel like shit, so I decided that it was never going to happen again. Reference 3 - 0.76% Coverage You know, and it's the same with your mind, the voices can be battling and battling and battling against you, but only you're going to go and do that thing. At the end of the day, it's my choice and it's always my choice, so I've got to decide whether or not to go out and do what they want for a peaceful mind or I've got to say, well, no, and it's got easier and easier over the years to say, no. Reference 4 - 1.11% Coverage Just little things like that or going swimming it's well it's going to be freezing, you know, and obviously I have to work on that now because I can see it, so I've started to inject positivity into my mind, so when it says, well, there'll be no milk, I'll be, like, well I can get soya milk, no problem,		I: Okay. And is it a better place to be with your mind or with your voices? P06: That's a hard question. There's been times when I've thought about asking the voices to come back, but I haven't, because I don't want to do that because my mind's so negative and I believe…I've come to believe that part of the voices being so negative is my mind being so negative, so maybe if I can inject some positivity into my mind, it'll inject some positivity into them. So, yeah, I suppose it's better being with my mind at the moment. Reference 7 - 0.54% Coverage I: So that sounds very polite and courteous in how you communicate with them. P06: Well, yeah, I've found shouting and screaming just makes them shout and scream back. I: Okay. So is there a bit of mutual respect there then? P06: Well, yeah, because they are part of myself. Reference 8 - 1.21% Coverage			hospital], different patients, like, secretly without telling them that I actually heard voices and I was, like, well what would happen if somebody heard voices, would that give them a reason to keep them in? And they were, like, oh yeah, yeah, yeah, because they'd have to give them treatment and medication and stuff like that and I was, like, oh right. Reference 5 - 0.82% Coverage And staff started to get suspicious, so they sent me to see the psychiatrist and the psychiatrist turned around and said, listen, you're hearing voices aren't you? And I was, like, no, no, no, he said, listen, we know you're hearing voices, you're responding to them, you're either hearing voices or you're winding everybody up and I didn't want anyone to

	you know, or the baths are going to be freezing, well, I'll just swim until I'm warm, you know, or you're going to miss the bus, well there'll be another one in 15 minutes, there's no hassle, you know. So I've started to inject positivity into my mind to try and flip it around. Reference 5 - 0.77% Coverage Well that's when I started working on them, like, properly working on them, you know, so I didn't work while I was in prison, you know how you have jobs while you're in prison, well I never had a job, I just told them, no. I didn't get any money, because I didn't work and I was left alone basically in a cell on my own to do my yoga and meditation, so I just started working on the voices from that point. Reference 6 - 1.12% Coverage P06: I was in a strip cell on suicide watch and this guy opened the cubby hole and turned around and says, hey, read this and he threw		I: So that love that you could then start to feel and recognise in your relationship with your wife, how did that then change the way you felt about yourself and, in turn, how you felt about your voices? P06: Well it showed me first of all that I was worth loving, which meant that the voices must be worth loving too, because they were part of me. So I, sort of, started to try and see them in a different way and try and give them love. Especially the five year old, I mean, the 10 year old, seven year old and the 14 year old are not really interested, you know, but the five year old really craves it. So, yeah, it helped a lot. **Linking voices with trauma** Well knowing that they're part of me means that whatever they're thinking and whatever they're saying is part of what I would say or think. So it's also something that I can challenge within myself, I can, say, for instance, when I'm walking down the street, the little one			think I was winding everybody up, because I wasn't. So I just admitted it. **Linking relating with voices & relating with people** I: So what is it about your wife and that relationship that you two have that's made that difference for you to have that different view about your voices? P06: I'd never felt love before, I thought I had, but it wasn't love, it was just lust. P06: Yeah, they started telling me to cook her meals and get her flowers and… I: Okay. So why were they changing, do you think? What helped that? P06: I think it was the stability of my wife, she's a very stable person. **Voices interacting with emotions** If I'm stressed they're stressed, if I'm happy they're worried.

	me a book called We’re All Doing Time by Bo Lozoff. I: Right. P06: And it’s all about yoga and meditation in prison, so I got in touch with the people that wrote it and I started writing to them and they sent me some more books on yoga, because there was no yoga in this book, it just explains it and they sent me a book on yoga and I thought, well, I’m in the strip cell, I might as well do it, so I just started doing it and it really relaxed me. Reference 7 - 1.27% Coverage P06: You have to do all the work yourself, because nobody can do it for you, people can guide you to what to do, but, like, what I was going starting the work for the next man and what the next man does, they do the work for the next man, so there’s got to be a variety of things that you can try out and you’ve got to do it yourself. I: Mm. P06: I think that’s the main point that people don’t get, people go the doctors, oh, I’m hearing voices, I’m hearing voices, what can you		doesn’t like men bigger than me, so it tells me to attack them and then I can think to myself, well, why am I thinking that? And then it’s because it’s a child that was abused by men that were bigger than him. Reference 2 - 0.80% Coverage So it was almost as though I was transferring myself back to them people when I did what they wanted me to do. So I was living that trauma again, whereas if I stayed where I was now and I acted the way I wanted to act now, that trauma was put to one side. First of all, I had to forgive the traumas, it was very important for me to forgive the traumas, because otherwise they just came up as flashbacks all the time and…			Reference 2 - 0.21% Coverage I: And when that happened, did the voices change how they spoke about her? P06: Yeah, they turned rather nice. Reference 3 - 0.47% Coverage Yeah, I was feeling very weak at the time, mentally weak, I hadn’t been doing my meditation, I hadn’t been doing my yoga, I hadn’t been doing my mindfulness, I was very mentally weak and they were just bump, bump, bump, bump, bump, bump, bump. Reference 4 - 0.27% Coverage I: Okay. How did your voices respond to that then? P06: Well they were relaxed too. I: So because you were relaxed they would be relaxed.

	do for me? Nothing. We can give you medication to knock you out, that's all they can do, if you want to work with the voices, you've got to do it yourself, because it's you and them. **Voice hearing is about power & control** And they stayed there for a month and then decided they didn't want me to do martial arts anymore, they wanted me to do yoga and meditation. So I said, well, stay quiet for another two month and I'll do that and so far they've stayed quiet. Reference 2 - 0.51% Coverage It's a bit of a struggle, it's a bit of a struggle, you've just got to decide in your own mind that you're not going to listen to them, it's, like, the Dalai Lama says that somebody can be right up in your face shouting and screaming, but only you make yourself angry. Reference 3 - 0.59% Coverage P06: They'd tell me what to say or I'd have three different voices telling me					**Relating more positively with voices** So I had to find out who they actually were, because until you find out who they are, you don't know how to deal with them. So I started questioning them and asking them things in meditation and mindfulness, I spent quite a lot of time just having them shout and yell and scream at me before they actually gave me an answer, but eventually they told me who they were and I've been able to deal with them a lot better since then. Reference 2 - 0.35% Coverage I: Yeah. So you said your voices haven't been around for a while. P06: No, 11 weeks. I: Yeah. So what's your life like without voices? P06: I'm quite lonely to tell the truth.

	three different things and I'd have to choose which one to say. I: I could imagine that being difficult. P06: Well, yeah, because it used to all get muddled up in my head and I didn't really know what I was saying at the end. Reference 4 - 0.32% Coverage P06: I did CBT while I was in [high secure hospital], but… I: What was it like there then? P06: I couldn't really understand it because the voices were all at me all the time. **Acting on what voices say** Yeah, the last time I conceded to the voices, I attacked somebody in the park. Reference 2 - 0.50% Coverage I: So if you think back to that event then, what were the voices like after the event, after you attacked the person? P06: Joyous, they were joyous.					Reference 3 - 0.38% Coverage I mean, I worked on my voices before I met my wife, but only very…only to get rid of them, it's only since I've met my wife that I've come around to the fact that maybe I should get along with them. Reference 4 - 0.47% Coverage And she opened me up to so many different ways of seeing things, that I had a new dynamic that I could work with the voices with, I didn't have to get rid of them anymore, I could accept them, I could be with them, I could nurture them, you know. **Looking after voices** There's lots of different ways, it's just soothing a five year old that wants to be soothed. Reference 2 - 1.05% Coverage

	I: What were they saying to make you think they were joyous then? P06: Well done, we knew you could do it. Reference 3 - 0.36% Coverage But, at the time, I used to do whatever they wanted me to do, so I used to just say it and it used to come out all garbled and the doctors thought I had all sorts of things wrong with me. **Having agency with voices** I tested them, I tested them. More recently when the voice of God came back about two years ago, three years ago, when I was with [CPN], I decided to test it and I told it that if it could create a banana I'd do whatever it wanted me to, all it had to do was create a banana and it wasn't going to go do anything wrong and it wasn't going to change the world, all it was going to do is give me a banana, obviously it couldn't do it and the voice disappeared. Reference 2 - 0.41% Coverage					Because I understand it's the five year old that's scared, it's a scared child and I have to look at it as in a scared child. So it's a bit like a kid being scared of the bogie man, you know, you have to check under the bed for them, you have to check the closet, you have leave the door open, leave the light on, you know, all them sort of things to sooth the child so that it doesn't think the bogie man is going to get them. So I've got to do all them things for my child inside myself so that it's soothed and it doesn't feel the need to attack. Reference 3 - 0.81% Coverage P06: Well with the seven year old, it's usually play a game, so we'll play word association games, takes his mind off what's going on, you know, with the 14 year old, he just

	And the fortune telling voice, I got a pack of cards and told it to tell me what the next card was, I give it six chances, so I give it a fair chance, it couldn't tell me what any of the cards were and it disappeared. Reference 3 - 1.06% Coverage Oh, it doesn't anymore. I go ahead and do whatever I want to do now, whereas before, when I thought they were something separate from myself, I was very closed off, in fact, I spent two years in a bed and breakfast, basically in my room just eating the breakfast then I didn't want to go out, getting things delivered off Amazon and things, because I didn't want to go out and I didn't want to associate with people. So I stayed very closed off, but now I have friends, I have family, I have people I go out with, I have places I go, I have people I see. Reference 4 - 0.49% Coverage I: So you've not heard them for 11 weeks?					wants to smoke, so I would smoke or my e-ciggy, as I've got now. I: So you find something for each of the voices to help what? What would it help? P06: It helps calm them down, bring them back to…I've got to remind them that I can protect them. Reference 4 - 0.80% Coverage P06: I've got to remind them that I'm quite capable of protecting them, so nothing is going to harm them, but sometimes, especially with the little five year old, I mean, when I say people bigger than me, I don't mean a little bit bigger than me, I mean massive, you know. I: Yeah. P06: And I've got to remind them that I can still protect him, I don't need to provide that I can protect him, I can still protect him.

	P06: No, I made a deal with them that's pretty much worked. I: What was your deal then? P06: Well first of all the one that's all martial arts, so I said, if you stay quiet for a month I'd go to martial arts Reference 5 - 0.25% Coverage since I've realised that they're separate parts of myself, I've took the power back, so they don't have any control over me anymore. Reference 6 - 0.38% Coverage I don't know really it was just by questioning them, everything they said was something I would have said 10 years ago or 20 years ago or 30 years ago, it wasn't what I'd say now or what I'd do now. **Voices wanting to be acknowledged** They like to push me a certain distance, but they don't like me to go past that and if there's anything that's going to make me go past that, then they start to panic, because that means jail and hospital and things					Reference 5 - 0.28% Coverage P06: I created this mind…this garden in my mind because for them so that they're all comfortable. I: Okay. P06: And I send the voices to the garden. Reference 6 - 0.73% Coverage Well, yeah, now when I want to talk to my voices, I go to the garden myself and I talk to my voices in the garden and I found that I have a much better conversation with them there, because they're not out and seeing everything and being scared and they're in this nice relaxing place with a nice pool and trees and tree house and all sorts of nice things there, nice little stream. Reference 7 - 0.26% Coverage

	like that and they really don’t like that.					He’s the one that talks to the voices the most while they’re in the garden, so he’s a very calming influence, so he keeps them calm for me. Reference 8 - 0.41% Coverage It doesn’t reassure them, but it…I think they’re coming around more to the fact now that she’s not going anywhere after eight years, you know, they still have their doubts, especially when we have arguments, but... Reference 9 - 0.56% Coverage Well I didn’t know how they were going to react, I didn’t know whether they were going to start taking advantage of me again and trying to control me again, but they didn’t, they, sort of, respected the fact that I was trying to give them love. I think that’s what was

						missing all them years. Reference 10 - 0.38% Coverage They voices are quite happy in the garden, they don’t want to come out, they really don’t want to come out. If I call them, they’re, like, oh, what do you want, you know, let me get back to the garden? Reference 11 - 0.56% Coverage I: Yeah. Do you think they would have something to say about your medication being changed? P06: Yes. If they were aware of it. I: Okay. If you can imagine what that will be, what do you think they would say? P06: They’d panic. I: Because… P06: Because it makes me more volatile.
P07	**Empowering self through action**	**Dominating influence of medication**	**Making sense of voices** No, it wasn’t anybody’s voice that I knew. In fact, if	**Being persecuted by voices**	**Practitioners failing to connect & understand**	**Being accepted & supported**

	It’s hard work. I think most of the situations for me arise with work at that particular instance because if I was at home, I’d probably just give up and let them witter on, and because for some bizarre reason I seem to have a strong work ethic and a desire to be a bit like the rest of the world, you just make yourself…there isn’t any other anything, you just…most of the time you just make yourself somehow **Disclosing voices reduces their power** And they knew about the voices, but I mean, I make light of them all the time, you know? My voice isn’t a problem today, you know, don’t worry about it sort of thing. Reference 2 - 0.26% Coverage I suppose I decided at some point that I would let bits of it out to certain people, and it wasn’t too many. Different people would know different amounts, I suppose. Reference 3 - 0.73% Coverage	I: And what might happen if you stopped taking the quetiapine? P07: Well, logically I don’t know what would happen because I won’t stop taking it ever, because I would fear the voices would come back. I mean, like anything, there’s no 100 per cent certainty that’s what would happen, but I believe they would, enough to take the quetiapine forever **Benefitting from medication** I: Okay, so the voice has been around but on the periphery, not as much, for about a year? P07: Yes. I: And how do you explain that? Why do you think it’s been so different in the last year? P07: 50 milligrams of quetiapine. Reference 2 - 0.23% Coverage within a couple of days of taking the quetiapine they weren’t there as much, and after a couple of weeks, they’d more or less disappeared. **Feeling worse from medication** I started thinking about killing myself because in 2002 I was depressed by a work situation and I couldn’t get over it, which I normally could do, and the GP gave me Prozac and it sent me mad as a box of frogs. Within 72 hours, I’d stopped eating and I	I’m honest, it probably sounded as much like I think my voice sounds as anything. It wasn’t anybody’s, you know, that I could give a name to. Reference 2 - 0.59% Coverage I: So what was it at the time then that you think how do I know that it’s a voice and not my thoughts? P07: I don’t know. I don’t remember the thinking, except that the experience was it wasn’t in my control. I: Right. P07: It just took over what was happening in my head. I: So are you saying that the experience of it felt different? P07: Yes. Reference 3 - 0.60% Coverage Yes, it was very clearly…you know, it’s a long time ago, I was concentrating on the television, trying to, and I couldn’t because this thing in my head stopped me and I kept turning the television up because I couldn’t hear properly and	it’s usually telling me that I want to die and I should kill myself and that’s what it does on a good day, when it’s just wittering in the background and not being too much of an arse. Reference 2 - 0.46% Coverage It’s telling me what I should go and do, so if I’m walking to work, it will say, oh, there’s a bus coming, walk out in front of it. If I’m walking over the river, it will be, oh, there’s a nice river down there, there’s some steps, why don’t you walk down there and get into the river? Reference 3 - 0.72% Coverage I remember a whole afternoon trip into the Dales with my mum and two brothers in September ’16, when they were all enjoying themselves and my voices were going, god, this is a really brilliant place to come in winter. You could just park your car up somewhere and you	I wanted to talk about killing myself endlessly and the subject was never mentioned and I thought I was being ignored Reference 2 - 0.41% Coverage Well, I don’t think…I’m not sure that I would ever have raised the subject with anybody apart from that first…you know, the initial conversations, but I just don’t think it was…my recollection is that it was never mentioned and I just wanted to talk about it. Reference 3 - 0.94% Coverage there was a male and female therapist in our group, and I said something in the group and I don’t know what it was, but the male therapist said that he didn’t think I got on with men very well, and I asked him his evidence. I said I disagreed and asked him his evidence, and he said the fact that I disagreed with him was evidence, and I didn’t quite know where to go with that because I just felt if I carried on arguing he was going to	I: Okay. Can you remember then in disclosing what was happening what people’s responses were and how they reacted? P07: I think largely their response was amazement that I was up and about and coming to work every day, and, you know, I think that was the response, I don’t recall any negative judgemental responses ever from anybody, really. **Talking about voices & problems is difficult** I really was suicidal and how do you go around telling people you want to kill yourself because that’s not fair to the rest of the world and I didn’t want people worrying about me, and it wasn’t their responsibility **Finding it difficult to relate with voices** And I’d like to think I wouldn’t have minded so much if

	my manager and a couple of other colleagues knew that I heard voices, that sometimes I really struggled, really, really struggled and that sometimes I needed to just walk away from the desk and just have five minutes in a quiet corner somewhere and swear at somebody, and of course I'd had some lengthy times off sick so I've been to occupational health, so therefore people knew what I'd told the occupational health doctors, and I suppose it was a gradual **Taking responsibility** Sometimes I might get a spell where it does it everyday for three or four days and I'm starting to think, okay, right, what am I going to do now if this comes back, who am I going to speak to, who am I going to tell, what action is likely to be taken, but I've never actually had to do anything about it, it's always disappeared. I'm terrified…well, I'm not as terrified as I was that it will come back, because it's been gone over a year now more or less so…	didn't eat for four months, basically, and I was walking around the house looking for something to cut my wrists with, and I just, from then until whenever, I thought of nothing but killing myself, day in and day out, basically. And I think the problem, to a certain extent, was because it was a typical presentation of…in the first instance, the doctor was saying that's the depression talking, keep taking the medication, and you can kind of understand that, but I mean, even back then, people knew you could have a bad reaction to Prozac. I think people really didn't quite believe what I was experiencing. Reference 2 - 0.17% Coverage I: And am I right in thinking you're attributing the suicidal thoughts to the Prozac? P07: 110 per cent. Reference 3 - 0.72% Coverage Yes, when I looked back, I'd certainly been depressed for six months and possibly a year before I took the Prozac and I've had spells of depression on and off all my life, and never had medication before, to be fair. But yes, it was absolute and utter…I took the medication, next day I stopped eating, I don't	edging closer to the television, and it just stopped me doing something that normally I enjoy doing. It's strange, it's not describable. Reference 4 - 0.25% Coverage I: Does it belong to anything that you can recall or does it connect to anything you've experienced before? P07: No, it's an absolute and utter alien. Reference 5 - 0.29% Coverage It isn't there anymore, mostly. It will have a little poodle around every now and again, and then it disappears again, like a balloon, you know? It's sort of there and it's gone, Reference 6 - 0.27% Coverage I've tried to think is that in a response to being stressed, being tired or being whatever, and it isn't, it just seems to poodle by whenever it, you know, feels the need.	could walk out there and you could just lay down and die, and would you like to take a flask of coffee with you and some biscuits for a last…? And that went on for the whole afternoon **Voices being disruptive** it would pick up on things that people said, so I could be having a sensible conversation with somebody about something and the voice would pick up on a word or a phrase and it would twist that into a way to kill myself. I had a conversation at work one day with someone about how atmospheric it was cycling to work along the river because at the time it had been foggy that morning, and I finished the conversation and I went back to my desk and thought it was fine, but by the time I was sat down at my desk, the voice had this horrendous chant about the river and about not going home tonight, about going down by the river and walking into the river and killing myself, and I'd been fine until I had that	think it even more, and that was when I decided I wasn't going to go anymore, because we clearly weren't going to get on, and I couldn't see the point. Reference 4 - 0.67% Coverage Don't talk to me about recovery unless we've an agreed definition of the word because to me, you know, if you went into hospital with a broken leg and you came out and you still needed crutches, you wouldn't be saying you'd recovered, would you? I haven't recovered when I'm hearing voices, I'm suicidal, and you're telling I'm leaving work but we follow the recovery strategy and you're recovered sufficiently…bog off. Reference 5 - 0.99% Coverage I had a strange conversation with someone from the crisis team one night who I'd been referred to because I was suicidal over that particular weekend, and I'd phoned	there had been something that happened that I could have related to in my life, you know? The NHS were very much, "well, obviously something happened in your childhood that has caused you to feel this way so you must have some talking therapy", which I didn't understand at all. Reference 2 - 0.38% Coverage There are times when it's very difficult and you probably have to walk away and listen to the voices for a bit and give them what they want for a bit and then come back and try and have another go or try and do something else for a bit. Reference 3 - 0.28% Coverage No, I think it was never a good relationship. I never accepted it at all. Yes, I suppose it depends

	Reference 2 - 0.44% Coverage there was a practical side of things, you know, I’m not clever enough to cope with the benefits system, you’ve got to work to keep… I mean, I was still paying my mortgage at the time on the house, I’d have lost the house, you know, if I hadn’t carried on working somehow. Reference 3 - 0.65% Coverage It’s hard work. I think most of the situations for me arise with work at that particular instance because if I was at home, I’d probably just give up and let them witter on, and because for some bizarre reason I seem to have a strong work ethic and a desire to be a bit like the rest of the world, you just make yourself…there isn’t any other anything, you just…most of the time you just make yourself somehow **Voice hearing is about power & control** It tended to shout back at me, and escalate the matter and then I’d shout back at it,	remember the next day, by the Thursday I came home from work and I just searched the house for something sharp enough to cut my wrists with. Reference 4 - 0.22% Coverage No, to me, the being suicidal came from the Prozac, the voices came from being suicidal, so that was, for me, all the time, that was it. Reference 5 - 0.24% Coverage It was soon after I started taking the Prozac because my depression didn’t get better and I was feeling suicidal, I was fairly swiftly referred to CMHT. Reference 6 - 0.25% Coverage I was all the time 100 per cent convinced that Prozac did something to my head that made me suicidal. All they needed was the right something to undo that. Reference 7 - 0.53% Coverage Unfortunately, I guess, because of being ill for so long and some other medications I’ve taken, it’s left me with other health problems and I take a fairly heavy medication load in terms of my mental health, so yes, you	Reference 7 - 0.10% Coverage I don’t know that I ever made…there was no sense to anything. Reference 8 - 0.35% Coverage But effectively what happened was by whenever we got to the year was up, I ended up in hospital and it was kind of that towards the end of that time when I was in a hospital that I started to interpret it as a voice. Reference 9 - 0.72% Coverage I: I’m jumping to conclusions here, please tell me if I’m wrong, does that mean then it didn’t make sense for you to have talking therapy because there wasn’t something to do with your past… P07: To talk about. No, there wasn’t anything to talk about. I: Okay, so for you the issue is because of some chemical reaction from the drug, it’s caused the voices, so to explore that through	conversation, but the river was mentioned and the voice has hooked into the word Reference 2 - 0.48% Coverage I: what is your experience of that voice in those interactions then? P07: That it gets in the way of my listening properly to what’s being said, and processing a response, and so I’m slower to do that, but can usually manage it in shortish spells and then need a bit of a break and then start again. Reference 3 - 0.20% Coverage It knocks your self-esteem, it makes you feel you’re wasting people’s time, that you’re misunderstood, that nobody believes you.	them up and I had a bizarre conversation about I don’t know what it was, no resemblance to me, so I asked the person if she knew why I’d been referred, and she said, no, she didn’t, but she’d go away and have a look, and she did that and she came back and she said, sorry, I still don’t know why you’ve been referred but that doesn’t matter, just go to bed, think positive, it’ll all be better in the morning. I don’t quite know who that helps and how Reference 6 - 0.15% Coverage I’ve been told that I did it to myself, that I’d obviously got something out of being so unwell They will check what I’ve done so far to try and get over whatever the problem is. They’ll say I’m doing all the right things, they might suggest a tweak to something, and sometimes the act of having that conversation will help get over the…because then I have to think about that conversation…	what your voice says, doesn’t it, whether you have a good relationship or not. **Being active and distracted is helpful** The voice can become less problematic if I have lots of other stuff that’s filling my head, and this isn’t 100 per cent because it can not work as well, but if you are doing two or three other things at once or you’re doing something that’s quite complicated Reference 2 - 0.45% Coverage I: Okay, so when you’re angry about something, it helps? How do you mean it helps? P07: I suppose because I’m usually so angry about something the NHS hasn’t done that it takes over my head and there’s no space for the voices because I’m so busy thinking how rubbish the NHS is.

	and I never won an argument. Reference 2 - 0.64% Coverage I: But I’m getting the impression that actually sometimes even when you try and push yourself through and get on with that, you can’t? P07: Yes, it’s really hard and it might take a long time of being in an argument…well, not an argument but a competition between the voices and whatever you’re doing before you actually get rid of the voice, mostly, and you’re on what you’re doing, you know? Reference 3 - 0.34% Coverage If it’s really bad then it doesn’t work and I’m pacing up and down and banging my head against the wall and usually swearing about the NHS, to be honest, and saying I can’t do this anymore, get me out of here. **Hurting self for relief from voices** I think there would be times when it was less at the	know, quetiapine has fixed quite a lot but there’s still quite a lot of other stuff I’d prefer not to have. Reference 8 - 0.37% Coverage the pay-off is probably not getting the right medication for so long in some ways. I’ve got type two diabetes now because I can’t say directly because of medication but I think to a certain extent it’s partly because of some of that **Fearing enforced or involuntary treatment** P07: I was an inpatient at various times on and off, yes. I’ve been sectioned once and threatened with it on several occasions. I: Threatened with it? P07: If you don’t come in voluntarily for your own safety, we’ll section you. Reference 2 - 0.19% Coverage I: But if you said, no, you don’t want to go in? P07: They’d say, well, it’s for your own safety, we’ll section you. Reference 3 - 0.55% Coverage So by the time we’d get the bit where they’re having to	talking therapy didn’t make sense? P07: No, it didn’t. Reference 10 - 0.78% Coverage I’m just thinking about that now. I suppose actually…quieter, very much quieter… Maybe more sort of down there rather than here. I don’t know, they need to just pop in for a bit and I’ll tell you. Yes, that’s not something I’d thought about because there’s not been that experience while they’ve been constant about them being here or there or further away. So I don’t know, I don’t know, really, whether it is further away or just wrapped up in a duvet or something and very much quieter. **Living with voices** P07: I don’t really know, because I was, like, stupid woman. I’ve been told there’s no medication that would help. I: Help your voice? P07: Yes. Or me. And really just by learning to live with them.		Reference 2 - 0.45% Coverage being accurate and specific and listening and I don’t want to say arguing but explaining about what’s happening and why what they’ve suggested isn’t going to work, so I suppose that’s kind of another added something you concentrate on to this mix of whatever it is that I’m doing. Reference 3 - 0.56% Coverage Yes, and by talking to the right people on the phone, well, because I’m a pain and there are things you could say to me that would have me reaching down the phone and strangle you, so you don’t ever mention coping strategies. We can have a chat and then you can suggest something but coping strategies, no, listen to a CD, bog off. Recovery Star? No. Reference 4 - 0.76% Coverage I think it’s sometimes about the words they use because you can say the same thing	**Concealing voices** it took me all my time, energy physically and mentally to carry on looking and behaving as if I was okay, which is what I did all the way through being unwell. The vast majority of people who know me would never know that I heard voices. Reference 2 - 0.47% Coverage I think to start off with it was because I didn’t expect it to last so long and I thought it would go away so, you know, pretending everything was okay was fine, and then you get to a point where, well, you know, how am I going to go back six months and say I’ve been this unwell for six months, **Voices interacting with emotions** I: Okay. Does it feel the same as it used to be when you had the

	forefront of my thinking, but I had an odd coping strategy, I suppose, in that I used to decide on a date when I was going to kill myself and some date would pop into my head or the voice would suggest a date, like I don’t know, 15th March or whatever, and then I’d be thinking that’s fine, I’ve only got so many more weeks to go, it’s fine, that means I can cope because then I’m going to kill myself. I clearly never did, but yes… So that helped a bit, because the problem was there was no end to it, you know? There was no end to it, because I was being told there was nothing they could do. It was my problem, it was in my head, I had to learn to live with it. **Lacking agency with voices** And it might have been there for, I don’t know, seconds, a minute, before I realise and then I just say, okay, hi, nice to see you, cheerio, and that’s usually all there is to it, really. Sometimes I might get a spell where it does it everyday for three or four days and I’m starting to think, okay, right, what am I going to do now if this comes back, who am I going	threaten to section me to go in and I know it’s probably only going to be for three or four days and I’ve got to explain to people where I’m going and unpick whatever I’ve got on at home and work and stuff and go in and then come out again, it’s, like, it’s not really worth my effort. **Lacking involvement in treatment decisions** I: Well, what you were kind of intimating there with your hands as well is that not only was it six sessions but you don’t know whether you’re going to get another. P07: You don’t, no, so in actual fact, you don’t know when it’s going to end, but it gets extended so when the end does actually come, it’s a shock and you feel betrayed because, you know, there’s no clarity there about what actually is going to happen, and you also have to remember that I wasn’t thinking properly at the time either, you know? Everything was very strange. Reference 2 - 0.33% Coverage So we all ended up at the GP’s surgery and the social worker and I went in to see the GP and we had a chat and then they asked me to come out of the			in different ways and one way for one person is better than another way, but it’s about knowing the person as a person not a diagnosis or a whatever, it’s about accepting the person as they are with all their peculiarities and ways of looking at things, and talking to them like that, and as another human being as well, I don’t do being patronised. I don’t do being treated like an idiot. Reference 5 - 0.47% Coverage I think mostly because if I’m talking to a professional about my mental health stuff unless I’m really, really unwell, I’m focusing enough on the conversation about being accurate and precise and clear because that’s the only way I’m going to get help that they’re pretty much in the background. Reference 6 - 0.69% Coverage I want them to be able to treat people as individuals, as a proper intelligent sensible person and talk to them properly about	suicidal thoughts or does it feel different? P07: It’s the same in that it’s the same voice, it says the same things but it’s not as strong and invasive. It’s just more on the periphery of my awareness. Reference 2 - 0.19% Coverage It was clear. Sometimes it was quiet, sometimes it would be loud, and more intrusive depending on what it felt like, Reference 3 - 0.27% Coverage pacing the waiting area and getting so agitated by the voices and what they were saying that I didn’t know how much longer I’d be able to stay there without running out **Wanting to get rid of voices** It’s not a good relationship. I’ve never actually been

	to speak to, who am I going to tell, what action is likely to be taken, but I've never actually had to do anything about it, it's always disappeared. I'm terrified…well, I'm not as terrified as I was that it will come back, because it's been gone over a year now more or less so… **Voices wanting to be acknowledged** The voice can become less problematic if I have lots of other stuff that's filling my head, and this isn't 100 per cent because it can not work as well, but if you are doing two or three other things at once or you're doing something that's quite complicated and you can get over the bit where the voice is trying to stop you doing it, and you can get into whatever you're doing, you know, it's boxed into a little corner and it can't get out, but you've got to get over the voice not wanting you to have its attention taken away. Because one of the things they tell you sometimes to do with voices is you decide at what time of day you're going to give them attention, which is fine when they're not really	consulting room while they talked about me behind my back			diagnosis and symptoms and treatments and options, and properly engage with them about that kind of thing rather than just going, well, this is what you're going to get and, no, we don't do that and you can't have that because whatever, and then recording that in notes as we discussed, when you didn't. Reference 7 - 0.17% Coverage I would rather people were honest and truthful and if there isn't a fix at all, not just there isn't a fix **Experiencing MH services as uncaring** the problem was that just after I'd started, within the first two or three weeks, someone was asked, told, whatever, to leave the group because the therapist thought she'd benefitted as much as she could, and that happened, but after she'd gone, the rest of the group, both in the therapy group and in the free time, were quite personally rude about her	asked to describe it before. It's not a good relationship. No, if I could not have ever had it, that would have been my preference. Reference 2 - 0.40% Coverage I: And I guess then would you prefer then if staff could talk to you about rather than living with the voice, staff could talk to you about how to get rid of the voice? P07: Yes. I: Okay, right. P07: Yes, I never owned it as part of me. **Being able to trust is important** I suppose the obvious one is that my manager needs to know stuff, so that's one decision and fortunately they've always been the sort of manager you could speak to about stuff, and one of the other people I shared and spoke to about it was someone who

	bothering you because they quite like that because that means that, you know, this time, this time and this time, they’re going to get your attention so they like that, so that really didn’t help, and of course if they want your attention all the time they’re going to want your attention all the time. They’re not going to shut up just because you’re not giving them attention at ten o’clock in the morning. Reference 2 - 0.95% Coverage You just don’t have to give it that much attention, because it’s just having a quiet witter on in the corner. It probably isn’t…I think it’s probably worse when it’s telling me what to do. If it’s just wittering about, you know, you should kill yourself, you’re a waste of space, whatever, if it’s not that bad it does become a bit background noise, I suppose, to a certain extent, and it could be like that for quite a week or so, maybe, but it’s when it’s loud and you never know when it’s going to start up again or what it’s going to pick up on				and that was allowed to happen by the therapists, and I wasn’t strong enough to challenge it because I really felt it was inappropriate but I also thought that if I challenged it they might start on me. Reference 2 - 0.48% Coverage I: Because you said this a few times, kind of dissatisfaction or being angry about the NHS, what is it about the NHS …? P07: Yes, it’s usually about mental health services and how rubbish they are because they tell you fibs, they say ridiculous things Reference 3 - 0.96% Coverage I’ve been told I should be grateful I have a job, people who cared about me and a life, because not everybody with mental health problems has that, and I was totally forgotten about by the crisis team one weekend. Another weekend, not that one. And in the end, I phoned NHS 111 for one thing, and they said go over to A&E, so I did, and saw whoever was	managed me briefly for a while and then I went back to the other person, so that was kind of why she got into the loop, and then there was someone else who worked in the same team as me, who I got on with really well that I’d shared bits with her so basically it was kind of the three of those who would know the most. **Trusting people is difficult** that was another thing that kind of happened on and off was that someone would say you can have so many sessions of this, and then, oh, well, we aren’t quite there, you can have another so many, and then have a few more, and trusting people was hard because you think you’ve got four sessions and it ends, so like how much can I trust, you know, and you never know quite what’s going to happen and that was

	or you just know it's never going to go away.				on duty from the crisis team and she said "don't you realise A&E is a busy place?" And I did kind of complain quite strongly about that particular weekend, and met with the service manager and he admitted I'd not been offered a very good service. **Perceiving practitioners lack hope** I: So were you worried then that if people discovered you were hearing voices you would lose your employment? P07: At points, that was certainly what people wanted to happen, either my employer or the NHS, they thought it was better if I gave up work because it was too stressful. Reference 2 - 0.56% Coverage P07: From the NHS, I was told that. By my GP and my CPN. I: So what is that they said to you? P07: I think they basically suggested that I found going to work very stressful and that I should give it up. The response to which of course is it's not work	a difficult thing for me at various points, how much do you put into the arena with someone you're going to get six sessions with?

					that’s stressful, it’s having the voices that’s stressful. I’d rather you took those away. Reference 3 - 0.52% Coverage I: So staff have spoken to you about how to live with your voice? P07: Yes, and just tolerate how distressed it makes you feel. I: And how did you find that? P07: Horrible, just like you weren’t giving me any hope, and not only were you giving me no hope, but you were going to walk away and leave me with no hope. **Framing experiences according to professional interpretation** Because the talking therapy was usually about my childhood or something, which didn’t involve feeling suicidal, or it involved some kind of CBT type stuff, one of those stupid downward arrows, and I hate the Recovery Star with a vengeance, or any mention of the word recovery, actually. It’s about coming to terms with what’s the	

					matter with you, and probably I’m not phrasing that… CBT is about looking at what happens and what you do and your response and it didn’t fit, you know, not to that particular bit. You can see it in other areas of your life how you make a response that’s not appropriate, whatever, I forget stuff anyway, but it wasn’t right for me. And then they sent me to group therapy. That’s fun as well. Reference 2 - 0.92% Coverage I: Okay. So let me just make sure I’ve got this right, so you’re recognising looking back at the time, you really wanted someone to…practitioners, I mean…to ask you questions about these feelings of suicidal, yes? Because it helped you then get it out your head. P07: That’s what I hoped, looking back I hoped that’s what it would do. I: But that version, for want of a better way of putting it, of talking and asking questions was framed up more formally in a therapy of some sort and you talked	

					about CBT there which you said just didn't fit for you… P07: No Reference 3 - 0.56% Coverage I: Can you just tell me a little bit about that group therapy experience then? P07: I can't without being rude about the practitioners. It was strange. At the best of times, I'm not a particularly sociable person and if I'm in a group of people, I'd rather pick the group, so it was very alien to me to go into a group of people who I didn't know. Reference 4 - 0.39% Coverage P07: But you see, when they talk about recovery, you know, what does the average person in the street think of as recovery? You know, you think of getting better, don't you? I: But getting better to you isn't about living with? P07: No.	
P08	**Empowering self through action** No, they don't change, but I just pay less attention.	**Dominating influence of medication** I think back in the early days, they were unsure what to do.	**Making sense of voices** So I was quite naive, when it came to hearing voices, I didn't even know even,	**Being persecuted by voices** And my voice hearing experiences came on very	**Practitioners failing to connect & understand** And the whole experience with the staff, they didn't	**Being accepted and supported** And my husband gives me private time

	Reference 2 - 0.41% Coverage That’s why, when I go to work, so I'm not tuning in as much, because when you're in four walls, what do you with yourself – you listen. You could be listening to music, and you're more likely to listen to a voice that’s telling you, you're a heap of crap. That’s why I chose to go back to work. Reference 3 - 0.23% Coverage And then, before that, I used to not really speak to my voices, I just used to listen. But I found, when I started speaking back, that that was giving me some power. Reference 4 - 0.46% Coverage I think, through therapy, I realised, I had to have some sort of relationship, or some kind of function. There are some people who hear voices who are different to me, and will choose, not really to do anything. They can ignore their voices, but it's easier not to do anything	So it was a way of, what they thought was perhaps, was easing a situation, was it more comfortable for them if I was sort of sedated and in bed. I have to weigh that one up. And which, I was given diazepam constantly, I was on Clozaril at one point, so I was very sedated. Reference 2 - 0.11% Coverage And I think they were trying to chuck everything at it, to shut me up, literally. **Benefitting from medication** But now, and I don't know if it's the medication, but I can sleep through the night, and I'm not woken up. But I'm not overly sedated either, because I'm up for work, I get up at five o’clock in the morning. So the medication isn't over-sedating me. Reference 2 - 0.17% Coverage the confusion started to ease, and the more I started to relax, I started to become a bit more aware of my surroundings. Reference 3 - 0.25% Coverage I got very upset, I did get upset. And David actually took me back to the hospital, and they gave me some PRN, because I was in	that I was hearing voices. I just knew there was a man’s voice, but I didn’t know where it was coming from. Reference 2 - 0.35% Coverage I told the psychiatrist in the military hospital that I could hear a man’s voice, but I thought it was God. I'm quite religious. And my only explanation that it was God, and that I'd failed, and the voice was telling me all these things about myself. Reference 3 - 0.19% Coverage I still hear the one male voice, but I also hear other voices, which I didn’t realise could happen, that I would start to hear more voices. Reference 4 - 0.43% Coverage we started to visually hallucinate of a woman, seeing visions. I've never experienced that before, I've never had what they would call, a visual hallucination, as they	quickly. I was in full time work, I'd literally been at work on the Friday, left work, saw some friends, and I started hearing voices on the Sunday. Well, I heard one voice, a man’s voice, who was very derogatory, and said that basically I should get rid of myself, I should kill myself, and not be here. Reference 2 - 0.28% Coverage a second man’s voice came, but a younger man, who I didn’t recognise. And he was of the same vein, that basically, I wasn’t a very nice person, that I shouldn’t be in the world, and why was I in the world. Reference 3 - 0.10% Coverage Well they say I'm not worthy of it, I'm not worthy of help or respect. Reference 4 - 0.29% Coverage They want me to be alone, that was one of the big things they wanted, was for me to remain	explain anything to me, they just locked me up, basically. Didn’t talk to me Reference 2 - 0.11% Coverage It wasn’t helpful. The staff weren’t helping me, they were just locking me up. Reference 3 - 0.57% Coverage But I also started to hear a female voice, who was very critical of me, and would get me to change my appearance, and my clothes all the time. Which I found quite unsettling, because I couldn’t leave the house, ‘till I was dressed in the way they wanted me to dress. Which was probably, as the doctor once called me, inappropriate. But it was to do with the voice hearing experience, which I couldn’t communicate. Reference 4 - 0.25% Coverage There was an awful lot of fighting. Physically, as well as mentally. I felt, especially the consultant, was trying to break me, he	[to spend with voices]. Reference 2 - 0.37% Coverage My husband sends me a text every day telling me that I'm worthy of a life, and that will get me through, maybe half a day. And he’ll send me a text on the afternoon saying, you're still worthy of a life. It's the little things that add up, that can make things change. Reference 3 - 0.56% Coverage I honestly get to that point and I think, I can't do this anymore, there's no way I can live. But I find comfort in my two best friends, who have always encouraged me. I met them here at the university, we work together. Who have stood by me through thick and thin over these last few years. And believed in me

	with their lives. And that makes me feel really sad. Reference 5 - 0.52% Coverage But to me, it made perfect sense, but you know. And I kind of went along with it. As I say, it was easier to remain…it would have been…and even sometimes now, I think, would it have been easier to remain in the bubble. That’s what I describe it as, my alternative world. Would it have been easier to stay there, because I fought to get out of it. I fought for my life back. **Setting limits** And I try to say, you want me to do these things, but that’s not what I want, and I have to be quite firm, and I have to set boundaries for myself. Not just with them, but in my life, I've found that I've had to do that. I've had to change my whole life, because of them. Reference 2 - 0.15% Coverage And then I call time on them and say, right, I'm going to work, do not interrupt me, do not come shouting.	a bit of, not fighting, but just, quite hysterical. Reference 4 - 0.12% Coverage It doesn’t stop the voices, but it allows me to function, so I'm grateful for that. Reference 5 - 0.16% Coverage I've tried without medication, it failed, it didn’t work for me, for whatever reason, maybe I’m not strong enough. **Medication not helping voices** And I realised that all this medication was actually not stopping the issues that I had. **Fearing enforced or involuntary treatment** I was informal at this point. On saying I wanted to leave, they detained me under the Mental Health Act. I didn’t even understand what that meant, as it had never happened to me before. Reference 2 - 0.47% Coverage And basically, as I tried to leave, I said this isn't for me, thought I was rational, gave my explanation. They said, your mum’s gone, I said, it's alright, I'll get a taxi. They injected me	would term it. But I was seeing things that weren’t real, and weren’t there, and I started hearing another woman’s voice, and another man’s voice. Reference 5 - 0.31% Coverage I understand now that other people can't hear the voices that I hear, I used to think they could. So I'd wear a hat all the time, because I thought if I did that, I'd protect them from hearing what shit I was going through. Reference 6 - 0.40% Coverage PO8: When I'm in a better place, I can look back and think…not that I recognise the voices, but some of the connotations, some of the wording. When I was 12 years old I was in a, my French class, and a boy called me a c.u.n.t. I: Uh-huh. PO8: And I hear a man’s voice saying those words. Reference 7 - 0.67% Coverage	very alone. Me being in hospital, I was very alone. I had no family in there, had no friends in there, so I was alone. Reference 5 - 0.69% Coverage I: What do you think, then, because it seems to make sense that, if your voices want that, and they're happier when you're in that situation, then some of your earlier treatment experiences, where you did feel alone, and you weren’t being treated the way you would have liked to have been treated. I wonder whether that would have made the voices happier, but actually, you were saying, it made the voices worse. PO8: It made the voices worse, but they were happier that I was getting persecuted. **Voices being disruptive** Because the more they said I was wrong, the more it enforced the voices that I was hearing, that basically, yes they were right.	couldn’t cure me, but he was trying to break me. Reference 5 - 1.04% Coverage He wasn’t a very nice man. Well, I don't think he was very nice, he might have been nice to other people. But he constantly…I remember, he'd put me on some medication, and it made my legs really jittery, and I couldn’t sit still, they were very restless, my legs, so I had to keep walking around. He said, I can't talk to you while you're walking around, and just left, and I didn’t see him for another week, and I was on constant observation. And only the consultant could remove it. And he never came back, he just said, I can't talk to you while you're walking around. What he didn’t realise was, the medication he'd put me on had actually given me restless legs, which as you know, makes your legs jittery, and you kind of feel really uncomfortable. Reference 6 - 0.67% Coverage	that I can move forward. They've never doubted me. And that has given me the courage. Reference 4 - 0.07% Coverage My husband gave me courage, to keep pushing forward. Reference 5 - 0.30% Coverage And once I realised that I could cope a bit better than I was, when people started giving me ideas that I could cope, that things were going to get better, help me believe in me, that’s when things started to change. Reference 6 - 0.67% Coverage But it was about five days later, when he'd dared to do that, because if he'd have did it before, it might not have ended so well. I would have been frantic. But he took a risk, and he

	Taking responsibility I've realised now, it's how I deal, it's the situations I get myself into, how can I avoid certain situations, how can I make it better for myself, so my voice hearing experience isn't as bad as it was all those years ago. How can I do that, in a realistic way. Reference 2 - 0.06% Coverage Hearing voices doesn’t mean that you can't work Reference 3 - 0.44% Coverage But, voices can limit you, and I live a very simple life, I don't go out on an evening. I'll go to the cinema on an afternoon. Not a big drinker. Just all these little things that I've had to change, to accommodate, to keep, so I can go to work, so I can have a life. I can give my husband some sort of life. Reference 4 - 0.35% Coverage But I want to work, so I do what I would like to do, not sort of, what I want, but	with Acuphase. I didn’t know it was Acuphase, until much later on, which knocked me out for 12 hours. And that was deemed because I was so unwell. Reference 3 - 0.20% Coverage And they kept Acuphasing me, it wasn’t just a one, it seemed to be like a course. They felt it deemed necessary, because I didn’t want to be there. Reference 4 - 0.38% Coverage And when I look back on it now, I'd done nothing wrong, but I felt like I had. Which enforced the voice, because the voice was saying that I'd already failed, and that I was a failure. And basically, the voice had me right where it wanted me, away from everything I knew. Reference 5 - 0.48% Coverage He thought, his answer to my parents was, she's too much of a suicide risk, we’re sending her to a special hospital. I didn’t know what a specialist hospital was, I'd never been in one before. If that doesn’t work after six months, she's going to another hospital, which is a low secure, for two years. So I had that threat hanging over my head.	And I will never, I don't think I'll fully understand, but I understand more than I did. I understand, now, that I'm not mad, and I'm not a bad person either. The voices can say I'm bad, but I'm not bad, because I haven’t done anything wrong, I just became unwell through what people had done to me, in my earlier life. And that is, unfortunately, that is life, and that happens to people. But people don't realise how much damage they're actually doing to other people at the time. Reference 8 - 0.11% Coverage Maybe something’s changed within me. You have to find some peace inside yourself. Reference 9 - 0.13% Coverage It made them louder, but they were happier that…it's a bit like a self-fulfilling prophecy. Reference 10 - 0.15% Coverage	Reference 2 - 0.42% Coverage And they wondered why I got upset. And I used to think to myself, not only am I hearing voices, I'm hearing their voices, I'm hearing voices outside my head that I don't know where they're coming from. But they're humiliating me even more. And the voice said, they’re humiliating you. And they were. Reference 3 - 0.15% Coverage They had little respect for me, and my voices had no respect for me, so it just made them worse, you know. Reference 4 - 0.18% Coverage I: can you remember how your voices reacted to all those other treatment experiences? PO8: Badly. Really badly, it made it worse. Reference 5 - 0.60% Coverage	He was very, very hung up on the fact that I heard all these voices, yet I was doing nothing positive to resolve it, because I didn’t know what to do. And the only answers I had was that I needed to commit suicide, and that was all I knew, I didn’t know there was other options. So I was constantly, while I was in hospital that period of time, trying to find ways to get out of life, which frustrated him. So he sent me away, that was his answer. He couldn’t deal with it anymore. Reference 7 - 0.48% Coverage I spent six months in the secure unit. And the most embarrassing part I ever had, was that doctor coming back to meet with my consultant, who was treating me in the secure unit, and we had arranged a plan of what was gonna happen next, for me. And they were arguing over what should happen, in front of me, which I just think is deplorable. Reference 8 - 0.30% Coverage	said that to Doctor Gary, I played Libby some music from her mum’s funeral, and she's actually said now that she knows her mum is dead. She just doesn’t like the voices telling her that her mum doesn’t love her, because that’s a really hurtful thing to say to anybody, you know, when it's not true. Reference 7 - 0.75% Coverage And he thought it was best that I went back, because I was gonna spend the night at home, and he said, I think it's best you just go back for tonight, just let them give you something to help you sleep more, and see how you're feeling in the morning. Because, you know, it's not because he didn’t want me at home, he said, but you can come home tomorrow, I'll pick you up at, like, nine o’clock, after you’ve

	what I would like to do. So I try to remain in work, because that's part of me that exists, that's me that is choosing, I'm making a choice, that that's what I want to do. Reference 5 - 0.25% Coverage And yeah, I've had different jobs, all cleaning jobs, but people will say, oh, you're only a cleaner, but it's work. I'm choosing to clean, I'm not asking anyone else to do it for me. Reference 6 - 0.56% Coverage I was watching the seasons change, I was thinking about people at home, I was thinking about my parents. My parents were foremost in my mind, my mum was still alive, then. And I thought, is this what I really want in life. Again, I had to make a choice. It's about choices, some of it. You can be guided, but at the end of the day, it's ultimately down to you. If you don't want it, you won't change. Reference 7 - 0.08% Coverage	Reference 6 - 0.28% Coverage you need to take this, you need to take that, put me on a community treatment order, which as you know, is quite, if you don't take your treatment, you're whisked back to hospital within minutes, literally. **Importance of being involved in treatment decisions** And I responded to that. I think my responses were different. Instead of getting hands on, and pushed down, and told I couldn't do this, and couldn't do that, the staff encouraged me to do things. They started to ask what I actually liked to do. Reference 2 - 0.89% Coverage So, [partner] called the doctor. The doctor came out, we talked, I said, I have seen my mum, and kind of, you're involved in this now. And he said, I think you need some help, [name of participant], and I broke down, and I said, maybe I do, but I don't know if I can face a hospital. He said, hospital is the right answer, right now. They needed to alter my meds, and they needed to calm me. I did need to be calmed, because [partner] was going to work the next day, and he couldn't take the time off. He said, let's just	Sometimes they move further away, or sometimes they'll shout really loud, and it'll take me by surprise. Reference 11 - 0.82% Coverage I started to hear voices, and I just, I had no rational explanation, I'd look for explanations all over the place. None of them fitted. But my therapist explained, because I went to a Catholic school, that, basically, my religion led me to believe that it could be God, because I felt as though I'd failed life. And that basically, because of my religious background – my mum was a staunch Catholic – that was my explanation. Which to me, seemed very rational. But it stems back, again, from my childhood. Church every Sunday, confirmation, school, why wouldn't I use God as an explanation. Reference 12 - 0.51% Coverage Probably with the lead up to the wedding, you know, nerves, worrying, is it all	And they got louder. Laughed at me, they used to laugh at me a lot, the voices, but not a nice laugh, just a, we're taking the piss laugh. And I used to find that really awful. But I found the nursing staff were so rude, wouldn't acknowledge me as a person, that it made the voice hearing experience much worse. Because they were reiterating everything that I was hearing, you know, and actually acting it out. And I could see that. Reference 6 - 0.43% Coverage And the girls who bullied me, it wasn't physical, it was just emotional, I kind of had to walk away from that. And you get that throughout your life, and it's hard, because then the voices will come back, and remind you that perhaps you aren't the person you thought you were. But staff sometimes reinforce that. Reference 7 - 0.18% Coverage	And I was scared, I was scared shitless. But they just said I was angry. Yeah, I was angry at the situation, but I was scared as well, and the staff couldn't cope with that, they couldn't understand that I was scared. Reference 9 - 0.46% Coverage And the staff, when I came back, their attitude was like, oh she's back, what's she gonna be up to. It wasn't because I was up to anything, didn't they realise the power of the voice, which I've always said, it's much more than people release. And they couldn't understand that, they were just like, they treated me with contempt. Reference 10 - 0.20% Coverage Well, because I was on, before I got sent away, I was on constant obs for seven weeks, on an acute unit, but they didn't talk to me, they'd just sit. Reference 11 - 0.21% Coverage	had your tablets, and we can go do something, and you can stay at home that night, but tonight, you're too upset, he said. **Feeling valued by practitioners** He told me the voices wouldn't go away, but there could be explanations as to why I was hearing them, what brought it on, what started it, what was keeping it going. It wasn't just all about pills with him, it was about "let's see". Reference 2 - 0.39% Coverage And we started talking about difficult things, we started talking about my past, what could have led up to it. And after about three months of seeing the therapist, I started to trust him. Because he made me realise that I wasn't mad, and that was a biggy, that

	I held my hands up and said, perhaps I need a bit of help. Reference 8 - 0.13% Coverage So, now, I feel as though I've taken some control of my mental health, and how I want it to be. Reference 9 - 0.31% Coverage Things have changed for the better, for myself, but I feel as though I've done some work as well. I don't want to give all the credit to the doctors, because I worked hard at trying to get, fix myself, and understanding myself. **Voice hearing is about power & control** Because I was embroiled with them, it's about being embroiled. Reference 2 - 0.05% Coverage They go quiet. If I answer back… Reference 3 - 0.11% Coverage	take you to hospital, to…I said, don't be injecting me, and doing all these forceful things to me. And then he realised how terrified I was. Reference 3 - 0.22% Coverage And I said, he said, you just, you need a bit of space, you're getting married in two weeks. I was discharged on the Tuesday, I got married on the Saturday. Reference 4 - 0.06% Coverage Well I felt there was an end to the beginning Reference 5 - 0.35% Coverage Because I got to hospital, and then two days later, had what they call these formulation meetings now that they hold. And I was involved in my care, we discussed medication, discussed that I needed some sleep, because I hadn't been sleeping very well. Reference 6 - 0.43% Coverage And they let me talk about things, and they let me explore things. There was a psychologist there in the meeting, and she did come and see me, and spoke to me for about an hour. I could discuss medication freely, I said	going to be okay. I'd never been abroad in years, and we were going to Rome. It was a tenuous time, because I always wanted to go to Rome, obviously I wanted to go to the Vatican, because I thought, if anywhere, my mum's gonna be at the Vatican, because that's the closest I get to God. **Feeling physical presence of voices** My husband always walks on the left hand side of me, because I hear the voices on the right hand side. So I still can have the contact, I can still hear them, so he'll walk on the left side. Reference 2 - 0.18% Coverage Because when I first started hearing the man's voice, I used to look over my right shoulder, because I thought, who the hell's that. **Linking voices with trauma** A lot of trauma, that I realised I'd had a lot of traumatic hospital experiences, within services. Which could have led to more voices coming.	Well, the voices used to say things like, you know, be negative towards me, even while we were talking, while I was speaking to him. Reference 8 - 0.37% Coverage No. They don't like me to have friends, I have very limited friends. I have two good friends, best friends, and they both work here. They don't like my husband sometimes, they make me shout at him, which isn't a very nice thing for me to do. But it's frustration. Reference 9 - 0.60% Coverage That I was getting nasty treatment, I wasn't gonna be helped, I was just gonna get, sort of, verbal, physical, it sounds awful using the word, abuse, but that's basically what it was. And that's what I was gonna receive, and they were quite happy with that. It made them louder, but they revelled in it. That, if I wasn't gonna kill myself,	And when I got upset, they couldn't understand why I was upset, and shouting. Because I think that's just, it was just typical of them, no respect for me. Reference 12 - 0.44% Coverage I think people realise that people who hear voices aren't deaf, aren't stupid, and are certainly not thick. But the staff treat you as though you are the lowest of the low. As soon as they find out you're hearing voices, you're wiped off the face of the earth. And the stigma, even from mental health staff, is awful. Reference 13 - 0.42% Coverage You know, I'd had nurses, when they used to sweep my room, come and say, I'd say, can you sweep my room I want to go to bed – we're having a cup of tea first. It's patient centred care – I don't think so. So they'd sit there having their cup of tea, and not really wanting to engage with the patients.	was one of the biggest Reference 3 - 0.24% Coverage Because he wasn't calling the police on me, he was letting me talk about suicide. I think they call it, positive risk taking. But he wasn't a threat to me, and I trusted him. Reference 4 - 0.66% Coverage At first, I couldn't put it together, but my therapist started to talk to me about school, about, could I have heard these words before. Was it possible that somebody had said these words to me, and it was possible, and it is possible, and it did happen. But I couldn't acknowledge it, because maybe it was too painful, and I didn't want to. So it was easier to be mad. But I'm not mad. And I don't want to be mad. I will always

	Sometimes they will, though, you can't control that, that’s just their nature. Reference 4 - 0.12% Coverage And that’s made it a little bit tricky, but I've managed it. I've managed it alright. Reference 5 - 0.28% Coverage I suppose, obviously, there's been times when I haven’t been able to work, because I couldn’t string a sentence together without a voice interrupting me. But that was because I didn’t know how to cope. Reference 6 - 0.12% Coverage Because it is about power, voice hearing is about power, and control, for me, anyway. **Acting on what voices say** And tried to take my own life, because I thought, that was what they wanted Reference 2 - 0.13% Coverage	there was medications that I didn’t want them to put me on, I didn’t want massive cages. Reference 7 - 0.33% Coverage And they let me plan my own leave, with their guidance, but they let…and they invited my husband to the meeting, so he could be involved, too, so he could talk to them and explain what it was like being at home when all this was happening. Reference 8 - 0.64% Coverage PO8: They gave me some sedatives, not a lot, something to help me sleep, and try and unravel the chaos in my mind. They increased my anti-psychotic, which I wasn’t too happy about, but… I: Were you in agreement? PO8: I agreed, yeah. But I just don't think pills are always the answer. But I needed to get over the confusion, I needed to get to my wedding, and the honeymoon that we had booked. So I was kind of like, okay, I was on the Abilify injections. Reference 9 - 0.20% Coverage And then the next day I went home, and I stayed the evening. And then we planned my	I'd had a difficult childhood, sort of from an early age. And I was also severely bulled at school. Reference 2 - 0.36% Coverage I: And that led to you identifying that you had early trauma in your life, but also, there was traumatic treatment experiences. PO8: Yes. I: And is that trauma that explains to you why you hear voices now? PO8: I think it is, I think it is trauma based. Reference 3 - 0.75% Coverage That boy in my French class, probably never even realised what he was saying, probably didn’t even understand the connotations. But it resonated with me, and it stuck with me, and later on in life, it came back to bite me. And now I have to listen to a man’s voice who calls me that word, which I find utterly disgusting. It's not language I would ever use, I would never call anybody it, and it would	somebody was gonna kill me, because I was like an animal. And that’s an awful way to be. Reference 10 - 0.23% Coverage Hard. They don't like it, because I'm functioning, even with them. So I can be at work and I'll still hear them. That can be hard, because it's another challenge. Reference 11 - 0.30% Coverage Especially if you're doing something they don't like, or you're trying to interact with somebody. That can be hard. I found the induction hard, because I had to interact with new people, and the voices have come in. Reference 12 - 0.25% Coverage I: Yeah. And, while we've been talking, have your voices been around? PO8: Yeah. I: And have they been commenting?	Reference 14 - 0.18% Coverage But not all nurses still, some aren’t like that, and will take the power, which I think is unfair, for someone who hears voices. **Experiencing MH services as uncaring** So I was taken to a military hospital, which was the closest to my parents, and stayed there for four days. But while I was there, a psychiatrist came and decided that I needed to be moved to a psychiatric ward, which I'd not experienced, as an adult. So I was scared. I arrived there, staff scared me, I was on one to one observations. Reference 2 - 0.39% Coverage And my mum had to leave me, obviously, because I was gonna be remaining there for a period of time, and I was very scared. I was scared of the staff, I was scared of the patients. In general, the whole experience was very, very scary, and I told the staff that I wanted to leave.	hear voices, but it doesn’t mean you're mad. Reference 5 - 0.32% Coverage I: So that sounds like you had a chance, there, to kind of explore your own history. PO8: I did, I was given a space and time to talk, instead of being injected, talked down to, belittled, or made to feel that I was the wrong one. Reference 6 - 0.93% Coverage He was very calm. He, we used to meet weekly, and he used to be very open, and very, he used to let me lead the way. So if it was too much, I could say, I can't do this anymore, I need to talk about something different. And at each of the session for about quarter of an hour, we'd talk about maybe a film I was gonna see, or what I

	And my parents found me, after I'd overdosed, quite a large overdose, unconscious in my bedroom. Reference 3 - 0.37% Coverage But I also started to hear a female voice, who was very critical of me, and would get me to change my appearance, and my clothes all the time. Which I found quite unsettling, because I couldn't leave the house, 'till I was dressed in the way they wanted me to dress. **Having agency with voices** I just said, lay off me, I've had enough, I'm not listening for the next, you know, I'm not gonna listen for quite a while. And the man's voice came back and said, you will listen to us, you bitch. And I said, I'm not going to. And for at least two minutes, he went silent, but that two minutes was respite for me. Reference 2 - 1.13% Coverage So I've learned different ways to look at it. When a voice, or the women say I'm evil, or the men say I'm evil,	discharge, which I was involved in. And it went quite smoothly. Reference 10 - 0.62% Coverage And that I can have a say in what medications that I'd rather not have, due to horrible side-effects, weight gain predominately being one of them, because I'm not comfortable being grossly overweight. And also, my mum had diabetes, so I would be at risk, I had to think of my health. And she now includes me in my treatment. There are times when she thinks perhaps I need a little bit more, but she's not forcing it on me, she's giving me the choices. Reference 11 - 0.13% Coverage But at the moment, I'm on the bare minimum, which is my choice, and she supports me in that. **Lacking involvement in treatment decisions** And he, basically, his answers were, you need to take some medication. The medication wasn't explained to me, the staff didn't sit me down, or explain it to me. It was just written up for me, and I was expected to take it, which I didn't, until they put me on depots.	never enter my vocabulary, and I'd never heard that word before but I knew it was very rude. I was 12 years old, you don't call someone that. Reference 4 - 0.38% Coverage And the girls who bullied me, it wasn't physical, it was just emotional, I kind of had to walk away from that. And you get that throughout your life, and it's hard, because then the voices will come back, and remind you that perhaps you aren't the person you thought you were. Reference 5 - 0.33% Coverage Which is why I changed my job. Because I was bullied in the workplace at the university, so it set off the trauma, that I'd had as a, in my teenage years, it was all being replayed out. I couldn't go through that again, I had to change tack. Reference 6 - 0.40% Coverage They go quiet. If I answer back…because when you're	PO8: Yeah, they told me to shut up, because I'm boring. Reference 13 - 0.12% Coverage They're unhappy with me right now, because they feel that I'm spilling secrets on them.	Reference 3 - 0.02% Coverage I was petrified. Reference 4 - 0.34% Coverage A lot of trauma, that I realised I'd had a lot of traumatic hospital experiences, within services. Which could have led to more voices coming. I'd had a difficult childhood, sort of from an early age. And I was also severely bulled at school. Reference 5 - 0.52% Coverage I felt like nothing was ever gonna resolve. And I was just in and out of hospital, because I couldn't, they kept me in hospital for so long, that I didn't know where my life was going. There was no talk about recovery, there was no talk about therapy, there was no talk about going back to work, there was nothing. It was just, there was nothing, and the staff didn't help.	was gonna do. Because I was living in a women's project. What I wanted to do with my life, which direction I wanted it to go. Something on a positive note that I could identify with. So he changed tack, to end the session on a positive note, but had given me three quarters of an hour to basically talk all about the shit I'd been through. Reference 7 - 0.19% Coverage And made me realise that there was an explanation. And that was painful. Because for many years, I couldn't acknowledge the pain I felt. Reference 8 - 0.25% Coverage they spent time with me, and tried to understand me. And realised that I was terrified, that I wasn't this angry woman that they were portraying me as, that

	through therapy, we looked at what evil, what my perception of evil actually was, and worked down to zero, and realised that, possibly, you know, it was quite true that I wasn’t actually evil. We all do bad things, we've all done things that we probably regret, but it doesn’t mean we’re evil. Evils are people who murder people. I'm not saying they hear voices and murder people, but people who just cold-bloodedly murder somebody, to me, that’s evil, that’s not a nice thing to do. But I haven’t actually done that, so it's come down, so I must be not so as bad as I think. And we did that type of therapy, evidence based – where’s the evidence that you’ve done this. There actually wasn’t any. Reference 3 - 0.59% Coverage So if you give them a bit of time, then, you know, my voice will say to me on a daily basis, oh go and kill yourself. Now, if I went to A&E every time the voice said, go and kill yourself, I'd be there 24/7, kind of thing. So I kind of think, okay, it's not a very nice thing to say,	Reference 2 - 0.11% Coverage The doctor deemed that I was too much of a suicide risk, and got me sent away. Reference 3 - 0.45% Coverage And the doctor from home said basically, that she's my patient, and she's coming back to the hospital. So I walked out, 'cause I thought, I can't bear to hear you argue over me. And there was a social worker there from [local town], she was about as much use as a chocolate fireguard, and just sided with them, with the doctor. Reference 4 - 0.18% Coverage They said that I might hurt myself with the bra strap. But they put it in the office drawer, which I think is really inappropriate. Reference 5 - 0.38% Coverage And I wasn’t being forced to take diazepam, because they had me on that four times a day, as well as other meds. And they used to say, it's time for your diazepam, [name of participant], and I used to say, do I have to take it. But it was written up for	bullied in life, you don't answer back, and you don't tell anybody. You keep it to yourself, you're fearful of what the bullies will do, will it make it worse if I go and tell my mum, or my dad, or a teacher. So you don't answer back. Reference 7 - 0.22% Coverage I'll always hear negative voices, I don't think they're gonna change into happy ones, because that’s the nature of the way they are, because of the trauma. **Living with voices** Yeah, it's me who changes. The voices will keep saying the awful things they say, and I kind of, I've realised now that I kind of have to live with that. Because they're not gonna change, they're not gonna be happy, they're not gonna tell me jokes, they're not gonna make me laugh. Their barrage of abuse is something I've learned to live with Reference 2 - 0.08% Coverage		Reference 6 - 0.17% Coverage I'd spent a little bit of time in seclusion when I first got there, because it was all alien to me, and I was terrified. Reference 7 - 0.43% Coverage Then I went back to the unit, spent another six months sectioned…I did a full year in hospital. So it was, I got plenty of leave, because I had to settle back into my flat, but they put me in supported housing, they didn’t think I could cope on my own. But they weren’t giving me the tools to, to change that. Reference 8 - 0.17% Coverage Being in hospital made it worse. The negativity that came from the staff, just reinforced the negativity I heard in my head. Reference 9 - 0.23% Coverage There are some forward thinking nurses who are coming through, but there's	I was actually terrified. Reference 9 - 0.84% Coverage There was only one nurse, and he actually left nursing to go and be a surfer, but he was very kind, and he talked to me. He'd ask me about the voices. And we’re talking 2006, so it wasn’t so much recovery focused, but he'd actually say to me, what can you hear. Because I'd go off into a little trance, because I was hearing. Or, what could I see. He talked to me like a human being. But he actually left nursing because he was disillusioned with the treatment that people were receiving. Very good nurse, just, nobody was on the same hymn sheet as him. So he was about the only person who spoke to me. Reference 10 - 0.54% Coverage

	and I've heard you, but I'm not gonna do it today. And I kind of try to pull it off, to the point where the voice becomes a little bit less. Reference 4 - 0.28% Coverage Of course there's days when I think, god, I really don't want to get up this morning, I don't think I can face it with these, with them shouting at me. But you push forward, you have to push forward. Reference 5 - 0.33% Coverage I: And as that was happening, and you were noticing this different way of being treated, did you notice anything about how you were then, in turn, relating to your voices? Did that change? PO8: Yeah, I started to stand up for myself. Reference 6 - 0.43% Coverage I started to take a bit of control back. Because I was out of control. Not in that way of, when people say, out of control. I mean, I was letting them run it, I was	me, so I had to take it, it wasn't PRN. Reference 6 - 0.30% Coverage I hadn't been outside for, I don't know how many weeks. Apart from the little courtyard, I'd never been in the grounds. I'd come in, in a secure ambulance, just literally brought in the back door, and there I was. Reference 7 - 0.60% Coverage And I remember two staff coming in and they said, [name of participant], you've got some time out, you've got 15 minutes, with two of us, in the grounds, how are you gonna use that. You run away, you're not gonna see daylight for, I don't know how long. You stick with us, you can have a walk, you can have a cigarette, you can go out again tomorrow. I had to make a choice, again. One, I didn't know [city], where the hell was I gonna run to.	But voices will remain, for good or bad, voices will remain.		some old school who still go for the hands on, injection approach, that's the cure for anybody. Reference 10 - 0.34% Coverage But in treatment, I wasn't given that very often, it wasn't until much later on. I fell ill in the '90s, it wasn't, well, how it is now. It was only when I went to the secure unit that things started to change, it was the wake-up call I needed. Reference 11 - 0.06% Coverage I can only describe it as a nightmare. **Perceiving practitioners lack hope** one doctor said to me, you'll never work, you'll never have a relationship, you won't finish your degree, you won't do any of these things.	I've got a very nice CPN now, whos very forward thinking. And I have a nice consultant who, yes, she gives me my prescription and I take it, but it's not all about pills now, she does talk to me. She just doesn't write a prescription and say, there you go, she actually sits and has a conversation with me. And supports me being in full time work, which is a big difference. And my CPN does. Reference 11 - 1.07% Coverage He wasn't just sweeping me under the carpet. He wasn't just saying, oh it's Libby, she hears voices, don't worry about her, forget about her, she's just one of our dead-end patients, basically. Treated me like a person, with feelings. Like, what music I liked, he would let me put my CDs on, and

	letting them run the show, and I wasn't doing anything about it, I was taking a very passive role. But then I started to stand up for myself **Voices wanting to be acknowledged** sometimes, ignoring them can make them even more feisty. Because they're not getting your attention.					he would sit and listen, and say, oh I quite like this. And I would say to him, is there something that you like that I've got in my collection. Because, obviously, he sat with me for an hour, and it could be quite boring, if someone's just in bed. He'd say, oh I quite like that. And I found I could get on with him. Not in a weird level, but in a level of, he actually had a little bit of respect for me, and realised how distressed I was, without taking the mick out of me. Reference 12 - 0.64% Coverage Well, the voices used to say things like, you know, be negative towards me, even while we were talking, while I was speaking to him. But it was just the kindness in his voice, and I know it sounds really daft, that somebody's kind

						voice, but he was very calm. And it kind of calmed me, and the calmer I got, the less I wanted to listen to the voices, yeah. His calmness was rubbing off on me, so I wasn’t as, like, shouty and aagh, and I can't cope with this. Reference 13 - 0.28% Coverage He said, it'll make you relax a little bit, and I would say, I feel more relaxed now, are you sure it's necessary. Because all he did was spoke to me like a real human being, I think that’s what it was. Reference 14 - 1.04% Coverage He said to me, it's okay to talk to voices, it's okay to have a conversation. He said, what you’ve got to recognise is, you can't do it in public. Privacy of your own home, you can do what you want, but in public, people will

						notice you're unusual, you're a little bit different, it draws attention to yourself. If they're really bad, go on your mobile phone, pretend you're having an argument with somebody, if it's got to that point. So he started giving me, I suppose, coping skills on how to not appear weird in public. So, if they were bad in public, I'd get on my phone, and people would think, oh she's giving someone a bit of a bollocking on the phone. They didn’t realise that there was nobody on the end of the phone. But that helped me. Reference 15 - 0.52% Coverage I think I learned that to understand that it was a power thing, from my therapist. And he said, at the moment, when I first started seeing him, he said, your voices have all the power in the world, and you're

						letting them. Not in a nasty way, but he said, you're letting them run your life. And he said, it's not about taking control, it's about the power balance between them. Reference 16 - 0.82% Coverage P08: But my therapist said, why can't you answer a voice back, and I'd say, because I'm terrified of them. They said, but try it, so we did it in therapy. So like, okay, the voice is speaking, and he used to talk to my voices through me. I: So a bit of voice dialogue. PO8: Voice dialogue, yeah. He'd say, I want you to answer the voice back and tell them that you’ve had enough of listening, what’s the worse they can do, and I said, they'll get louder. He said, only for a short time, and then they'll realise that it's not fun

						anymore, and they'll back off. And it actually worked. Reference 17 - 0.06% Coverage But they started to help me believe in myself. Reference 18 - 0.35% Coverage I like to draw, I like art, I've got some artwork in Manchester that I've done, it's up on the wall. I don't know if it's still there, somebody’s probably torn it down. But I did that, and painted a picture of them, and they put it up, and that was mine. Reference 19 - 0.52% Coverage They used to take me to the gym, there was a gym on the ward, and one of the guys would come, even if he was on a late, and take me for an hour. Because we weren’t getting much

						experience, because we weren’t allowed out. But he would come and spend time, he'd say, how’s today been, and if I'd been reasonable, then I could go to the gym. And I used to look forward to that. Reference 20 - 0.21% Coverage I was treated with respect, and a human being, I wasn’t just treated as someone who hears voices, and is no good. I was treated with a bit more compassion. Reference 21 - 0.21% Coverage I think he had quite a lot of respect for my husband, and what he was trying to do, and understanding that while he was at work, he needed me to be safe Reference 22 - 0.44% Coverage I think my CPN, whos very nice, and I will

						justify that, he is very nice. I only see him once a month, for an hour, but he said, you've been in crisis a bit for the last two years, he said, since losing your mum, it's been turbulent. He said, but we'll get there, and he's positive, and hopeful. He's never let me down. Reference 23 - 0.05% Coverage I found a consultant who would listen. Reference 24 - 1.47% Coverage P08: Some of the nurses are very good. I just remember an incident where I was curled up on the floor because I felt it was the safest place for me to be, and one nurse, who was actually, they did some teaching here, was actually one of the students. I: Okay, yeah, right. PO8: She got, came down and sat on the

						floor with me. So she came down to the level I was at, and talked to me until I felt able that I could uncurl myself, and sit back in a chair. She didn’t threaten me, she didn’t tell me to stop being stupid. She realised I was in distress, and that was my safety, my position of safety, because of the battering I was taking from the voices, I just wanted to curl up in a ball, because I didn’t want to be there. I didn’t want to be alive, but I didn’t want to end it, so the safety position was to curl up in a ball. And she came down and sat on the floor, and talked to me like a human being. And gave me that time, until I could uncurl myself, and with her help, get sat back on the bed. And I realised, then, that she probably did actually care.

						Talking about voices & problems is difficult And I didn’t want to talk to the doctor, because I found him very patronising. **Finding it difficult to relate with voices** I don't think I'll ever get any respect from my voices. And that’s sometimes quite hard to deal with. Reference 2 - 0.37% Coverage I: And with your voices, how do you describe your relationship with them? PO8: Sometimes, it's very volatile. Sometimes I get very angry, in private. I: When you say, volatile, what do you mean by that? PO8: Sometimes I swear at them. But I do it in private. **Being active and distracted is helpful** But I hear the voices when I'm at work, and that’s difficult. But I

						clean even harder. And the physical exertion, you're worn out, so you don't have all that time to give. I don't have that time and energy to give them, because I'm really physically tired. **Concealing voices** I didn’t tell anyone I was hearing voices. Reference 2 - 0.07% Coverage Still hearing the man’s voice, didn’t tell anybody Reference 3 - 0.48% Coverage I didn’t want to tell them I was hearing voices. And I’m not really sure why. At first, I didn’t want to tell anybody, it was like my own thing. Because the man’s voice said, you tell anybody, we’re gonna kill you. So I went, well if I keep it to myself, I'll just get rid of myself, and then nobody will ever

						know I was hearing voices. Reference 4 - 0.39% Coverage I: And do you speak out loud to them? PO8: I speak out loud to them. I: But when you're in a private area. PO8: When I'm in a private area, because I realise that shouting in the street just led to me getting arrested, and picked up. Or people notice that you're different. Reference 5 - 0.17% Coverage And my colleagues seem to be okay with me, they don't know, I haven't told them, because I don't know them well enough. **Distancing self from voices** And I suppose, you choose to ignore, that's when I don't have as much of a relationship with them.

						Linking relating with voices & relating with people I don't think I'll ever get any respect from my voices. And that’s sometimes quite hard to deal with. And to realise that sometimes staff in the wards don't really have much respect for you, reiterates everything you think and feel. Reference 2 - 0.46% Coverage PO8: It's complex. I: But it also sounds quite holistic, that you, in changing how you have to relate with your voices, you’ve had to change how you… PO8: How I live. I: …relate with other people, and get on with life. Would that be fair to say? PO8: That’s true, yeah. It is true. It's hard. **Voices interacting with emotions** I: In those situations then, when you say,

						actually your voices became worse, what does that then do for you, how does that affect you? PO8: It just makes you want to get out of life even faster. Reference 2 - 0.29% Coverage PO8: The pain that comes with hearing voices is immense…sorry, if I get upset. I: That’s okay. PO8: But the pain of hearing voices, and knowing that these voices think so little of you, is very painful. Reference 3 - 0.28% Coverage I used to be very volatile, because I was so angry, that I was hearing voices, and there was nothing I could do about it. It was the shock, the shock factor, which got me, because it happened so quickly.

						Reference 4 - 0.64% Coverage Well, the voices used to say things like, you know, be negative towards me, even while we were talking, while I was speaking to him. But it was just the kindness in his voice, and I know it sounds really daft, that somebody’s kind voice, but he was very calm. And it kind of calmed me, and the calmer I got, the less I wanted to listen to the voices, yeah. His calmness was rubbing off on me, so I wasn’t as, like, shouty and aagh, and I can't cope with this. Reference 5 - 0.14% Coverage And that affected the voice as well, because I calmed, so I wasn’t listening as much, the calmer I got. Reference 6 - 0.65% Coverage

						But I've found that when I'm very down, my voices will be louder. When I'm in a better place, it's a bit like choosing to ignore them. If I feel happier, I'm not listening as much. I do get really down, and I accept, and I will accept, that I have problems with my mood. But who isn't gonna be sick from hearing, they're not very nice, all the time. But if I get into a better place, where I'm functioning, doing things that I want to do, then I'm not listening as much. Reference 7 - 0.09% Coverage What’s happening…my environment is very much a trigger for them. Reference 8 - 0.59% Coverage He doesn’t like it when his wife’s in hospital, and he's got to come and visit, and

						leave me there. And then, that builds up the ante, because the voices are like, oh he's leaving you, you're left here by yourself, we're gonna antagonise you, you're gonna be up at four o'clock in the morning, 'cause we're gonna wake you up. There's no one for you to talk to, and the staff don't want you up at four o'clock in the morning. Reference 9 - 0.10% Coverage When you're physically tired, sometimes, you can hear the voices more. Reference 10 - 0.22% Coverage But you hear the voices more, but you're so physically tired, that you're not tuning in, 'cause you're tired, you want to go to bed, you just want to go to sleep. Reference 11 - 0.50% Coverage

						But I admit it, I say, the last two years have been hell, because my mum was my world. And her not being in my world, the voices turned round and said, your mum doesn’t love you. That’s the cruellest thing that anybody could say to me. Because they were playing on me. And I've really struggled the last year, but I'm still here, and things are changing again. Reference 12 - 0.24% Coverage It's difficult. Because obviously, I was getting married last year. I wanted my mum so much at the wedding, that two weeks before my wedding, I was admitted to hospital. Reference 13 - 0.86% Coverage Because I thought I saw my mum, I thought she was in

						the house, and nobody could persuade me otherwise. But that’s because, when I rationalise it, and when I look back, I wanted her to be there. I wanted my mum back. She isn't coming back, but I still wanted to see her again. And what you’d give for that last minute with someone, that you can't have, is the worst pain ever. But I know that she's with God, and she's with her mum and dad, and her sisters, and she's fine. But to not have her at the wedding, was awful, because she was the biggest piece. I wanted to see her, and I thought I did see her, but I didn’t. Reference 14 - 0.22% Coverage And the voice said to me, she doesn’t want to be found, and she didn’t love you. So, all that was going through my head.

						When I know my mum loved me very much. Reference 15 - 0.18% Coverage They were quite loud, saying, don't believe. Because I got very upset, and the voice started to laugh at me, because I was so upset. **Relating more positively with voices** I: So what’s the difference, then, for you personally, between, someone who chooses to engage, and get to know, and have a relationship with their voice, and someone who chooses not to do that, and keeps the voice quite distant? PO8: You can only do that for so long, I think. I tried to keep the voices at a distance, I tried to ignore, but they have an impact on all of your life. So if you're gonna try and get on with your life…I

						always remember saying to one doctor, I just want my life back. Maybe not to how it was, but I needed some sort of life. And if that means that I try to have a relationship with my voices, then so be it. **Looking after voices** If I need to go and speak to voices, I'll just go up to the bedroom, have a little bit of a rant, not loudly, we've got neighbours. But I can go and have some private time, and then I'll come back downstairs, and we'll have some tea. Because they say I'm not worthy of the food, so mealtimes can become an issue. So, not a big eater anyway, but mealtimes are an issue for us, so we have to accommodate them. Everything me and my husband do, we accommodate the voices first. And that sounds awful, that

						we’re putting them first, but it gives us a life. And you have to accommodate, you have to co-exist. Reference 2 - 0.17% Coverage I do early on a morning, because I'm going to work, so I have half an hour before I go to work, where I let them bombard me. Reference 3 - 0.39% Coverage Yeah, thank you voices, we know you're a bit angry right now, but you will feel happier, once we can talk in private, voices, and we can work it out. But they're alright, they're not…they're just saying things about me. Which I'm kind of used to, so it doesn’t deflect from anything. **Being able to trust is important** And they asked me what things I liked,

						and then started to trust me with little things, like, I could have one CD an hour. If I broke that CD and hurt myself, I wasn't gonna get another one, not for several weeks, anyway. So they trusted me, we built up trust, and that's what was different. Reference 2 - 0.04% Coverage So it was all about trust.
P09	**Empowering self through action** And then through therapy we did several things; we contacted the police, we contacted the church, a vicar came out to see me, called XXX, and then the safe wellbeing lady from the church, from the Cath…from the Methodist church, she came out to see me. Reference 2 - 1.76% Coverage After more therapy we decided to contact…well XXX [therapist] did it all for me, we contacted the church	**Dominating influence of medication** I can just remember starting to hear voices and I was acting a bit strange. XXX, my wife, noticed. And we were in the other room and then I told my wife that I was hearing voices. And I went down to see the doctor and he gave me some of antidepressants, Prozac Reference 2 - 0.33% Coverage I can't remember that much of [dominant voice]l in the hospital because they gave me a lot of medication. They put me on the Amisulpride, the Quetiapine, the	**Making sense of voices** I'd say he's probably in his 50s, and he's a reverend, and he's called XXX. Reference 2 - 0.54% Coverage I always hear…like now I always hear like mumbling voices, which I explained to my therapist it sounded like a congregation of like women, but I could never understand what they were saying. It was always as if it was like muffled and I was too far away to hear what they say, but I hear the muffles all the time.	**Being persecuted by voices** He tells me that I deserved what happened when I was young, I was bad, I was a bad child and I deserved what happened and that no one would believe me, and stuff like that when he first came up. Reference 2 - 0.74% Coverage Yeah, he still shows me the bad images of what Mr Robert Shaw did, and then obviously he thinks it's funny, he laughs and	**Practitioners not talking about voices** I: And when you were in hospital can you remember whether staff spoke to you about your voices, or whether you were able to tell somebody about the voices? P09: No, I didn't talk to the staff any time about my voices.	**Being accepted & supported** Yeah, after a while, you know, she gave me videos to watch on YouTube from a woman who heard voices. Now she's a psychologist. I can't remember her name now. Reference 2 - 0.49% Coverage It was how he was like a lawyer and he acted for people who were sexually abused, and that, in the

	and XXX came out, a vicar, because I couldn’t look at people in dog collars. And then obviously, what, on the telly with all the cases what came up, you know, the sexual abuse of footballers and Jimmy Savile, and all like that, that used to make me bad as well. So, we contacted XXX and he came out and spoke to me, written things down, and he went back and seen the…like the child bit of the church and she came out and took a statement, and that. He's deceased now. I think he died about nine year ago, ten year ago. So, we contacted the police, the CID, and they took all my details, but obviously since there's been nothing to pursue because he's deceased. If he wasn’t deceased then, you know, he said he would have been struck off and there would have been an investigation, but obviously with him being deceased there's nothing they can really do now, apart from log it as like a crime, you know, when I was young. Reference 3 - 0.09% Coverage	Fluoxetine, and I couldn't remember that much Reference 3 - 0.22% Coverage I: So, in hospital they were giving you meds to try and suppress your feelings? P09: Yeah. I: Did they do that? P09: No. Reference 4 - 0.60% Coverage I: Why do you think practitioners have put you on medication then? P09: I think…I don't know. I mean obviously I think they hear people with mental health problems, and that, then you're diagnosed with schizophrenia, and I think it's just…I don't know if it's like a rule book, or whatever, just go down and think, oh, we’ll put him on medication **Benefitting from medication** I don’t feel as low as what I did before. So, I feel like the Fluoxetine working. **Coming off medication without support** I: So, how much improvement have you had when trying to come off the meds?	Reference 3 - 0.57% Coverage P09: He dresses like a reverend, long black cloak, a hood, you know, like a monk but black. So, I could only ever see usually his bottom bit of his face, stubble, like that. I: And how tall? P09: Oh, I'd probably say…he was quite tall, I would have probably said maybe 6 foot. He was quite a tall person, yeah, he wasn't small. Reference 4 - 0.32% Coverage Yeah, I can walk through him, he disappears. So, I know where before I used to always think he was real, where now I know that it's…you know, it's in my head, it's in my mind. So, yeah. Reference 5 - 0.55% Coverage No, I realise now that…where before I always thought [voice] was real and I used to hide from him, where now I know that it's not, it's just…it's in	thinks it's funny. He says, you know, that’s what happens to bad boys, and it's what I deserved, I was a naughty child, no one would believe me. But I know that people do believe me now. So, he…the things what he says I think he knows that I don’t believe him now but he still says it, he still says it, so. Reference 3 - 0.31% Coverage Well before he used to always laugh, and that, and he always used to show me the bad images of the abuse and laugh, and I used to always act on it and get really distressed about it. Reference 4 - 0.83% Coverage I: Can you remember if [voice] was around at that time? P09: Yeah, [voice] was laughing. I: He was laughing? P09: [voice] was laughing. I can remember it clearly. Yeah, [voice] was laughing. He thought it was very funny and he		Catholic church. You know, I watched that film. That was a good film to watch. You know, so just all different tools to try and help me and to understand it and to start accepting it. **Feeling valued by practitioners** I: So, what's helped you come to that view then…whereas once you thought he was real now you know he's not real? P09: Just through therapy with [therapist], with [her] coming. It's like going just to [MH unit] I had therapy for about…it must have been about a year, a year and a half Reference 2 - 0.40% Coverage when I first had my therapy it was mainly around about my voices, and stuff, hearing it, and then when I couldn’t cope with certain aspects I went back to therapy and we concentrated

	just to get me out and to get my mind on other things Reference 4 - 0.49% Coverage Well it's made me self-believe a lot more, you know what I mean, I suppose, and then just becoming like a survivor, you know what I mean, where I'm not putting my head in the sand and thinking about it all the time and thinking negative about it. I think more positive about it now. Reference 5 - 0.61% Coverage So, I'm starting to do a lot more things now. Like today…you know, like today I get the bus. I can get the bus myself now. Where like nine months ago what it was like the last four years, I couldn't do anything like that. I couldn't be on my own. I can start being a bit more independent now. I work a couple of hours on a Sunday at the charity shop Reference 6 - 0.22% Coverage I go and talk to people who've hurt themselves, or I	P09: To be honest I don't know. No one's ever spoke to me about it. **Medication not helping voices** I: And what do the meds do for voices then? P09: I can honestly say that they didn't do nothing for me, they didn't do nothing. No, they didn't stop the voices. They didn't help in… I: Did they change the voices? P09: No. Reference 2 - 0.50% Coverage there's a chance that the voices could get slightly worse, or more increased, you know what I mean, where I don't…but my feeling is that I don't think the voices will get worse, or increased, because I honestly don't think that the medication is helping with the voices or with the images. Reference 3 - 0.10% Coverage But I honestly don't think the medication's done anything. **Feeling worse from medication** I need to see the GP now to see about reducing my medication a little bit because I've got to try and look for employment soon but I need my medication dose	my mind, it's in my head, you know, seeing him, and that. He's not real. I know he's not real, I know he's not real, but obviously it's just what I see and what I hear. Reference 6 - 0.30% Coverage but now I understand that it's not real, it's in…you know, it's my head, it's in my mind, you know what I mean? But I accept now so I don't do things now, I don't hurt myself. Reference 7 - 0.38% Coverage Yes, I know he's not real, so I know that he's just like in my imagination sort of thing, but, you know, my head plays tricks on me when I see him, and stuff like that, but I'm not…I wouldn't say I'm scared of him now. Reference 8 - 1.19% Coverage I used to sort out a lot…I used to disassociate a lot and go back to the abuse, back to being small, back to being little [participant's	was showing me the abuse, and that. And he showed me the night before, the abuse, and that's the times when I was scared and distressed and acted on it and he said that I…you know, I should just kill myself, I shouldn't be here, and stuff like that. Reference 5 - 0.23% Coverage I can remember distinctly that, you know, he…he was like somebody like…he'd like won something, he'd like gained something probably. Reference 6 - 0.27% Coverage Like even before when…like when XXX came, the vicar, he said, you know, he won't believe me, he'll laugh at me, he won't believe me because he's a vicar Reference 7 - 0.63% Coverage You know, did all sorts and hurt myself and…you know, and the believing		on my childhood trauma what it all started with. Reference 3 - 0.49% Coverage Like what [therapist] always said, it's like you've got like a filing cabinet in your brain and you file things away and sometimes you file them that far away it doesn't come up until a certain point. Then a drawer opens, everything comes out, you know, and that's how it all happened. Reference 4 - 0.23% Coverage With therapy I think it was the start of my journey, starting to talk to…you know, when I started opening up and started to say things Reference 5 - 0.28% Coverage She did some of that on me. I have a safe place at the farm where I go if

	go to meetings with doctors, and that, because it's like expert by experience Reference 7 - 0.20% Coverage I can start back up on the football, because I liked the football, it was always something for me to look forward to Reference 8 - 0.31% Coverage I definitely think I'll be able to help other people, you know, and understand other people and tell them my problems, and that. You know, I tell people now, I'm not embarrassed. **Voice hearing is about power & control** It's not a very good relationship, no, but I've managed…with my therapy I've managed to keep it under control now and managed to, I suppose, not listen to him and act on what he says, where before I did. Reference 2 - 0.24% Coverage	down a little bit on a night because it makes me drowsy Reference 2 - 0.33% Coverage I've stopped the Amisulpride. I came…because I was on one in the morning, one in the night, and I've stopped that because that wasn't making me feel very good. I'd put on a lot of weight. Reference 3 - 0.45% Coverage But the Quetiapine, it…you know, I try and take it about five/six o'clock, because I used to take it about seven/eight o'clock before and then on a morning I was just sleeping, I was just drowsy. My wife couldn't do anything. I couldn't do anything on a morning. Reference 4 - 0.39% Coverage So, I take that a bit earlier now and it's not as bad, but some days are worse than others. Some nights my wife says like I slur my words and she knows that, you know what I mean, that the tablets have kicked in, and stuff. Reference 5 - 0.55% Coverage it was worse when I was on the Amisulpride. That was really bad for me. I was just…it	name], and the abuse. That's why I hear muffled voices all the time now, but I don't know what they're saying, but they don't hurt me, they don't…I can't say they say anything negative because I can't really hear what they're saying, but they're not like I'm scared of them, if you know what I mean? I: Aha. P09: You know, but on the other hand I…they're not trying to help me either. So, I don't really know what they are. But [therapist] said that could be associated with the congregation of a church, you know what I mean, all linked back to the abuse, and stuff. Reference 9 - 0.76% Coverage P09: [voice] was always visiting when I was with [therapist]. I: Always? P09: Always, yeah, he used to always come when I was with [therapist], apart from the last couple he never appeared, and like [therapist] just said that, you know, how strange it is now where I accept things,	that I wouldn't be believed, you know, and that it was my fault. Nobody would believe me. You know, my dad wouldn't believe me, the police wouldn't believe me years ago, and you know what I mean? And now the church wouldn't believe me, and the therapist wouldn't believe me at the start, but… Reference 8 - 0.42% Coverage I: What did he say when you started to say, I'll listen to you? P09: Just laughed, and he said, you know, he said, you know, you will listen to me, you will do as I say, which I did because I was scared, but I can remember them times clearly. Reference 9 - 0.34% Coverage He tells me that, you know what I mean, that I was a stupid boy, I was a bad boy, I was a dirty boy, no one would believe me, I should hurt myself,		anything's bothering me. She told me to go there and, you know, nobody can hurt me there. Reference 6 - 0.30% Coverage So, I think from the start of the therapy things just started to get a little bit better with me understanding the voices, how they're associated, and how I control them now. Reference 7 - 0.48% Coverage I think when you had your therapist, and that, and you trusted her, and that, you know, you can open up more, and stuff, you know what I mean? I mean obviously I opened up to my wife, but it was nice to talk to somebody actually who could tell me things to do and trying to help **Importance of being believed**

	Well before I couldn't accept it and the images, and that, were like so distressing for me I just couldn't manage it, just couldn't cope. Reference 3 - 0.31% Coverage Where before I used to always listen to him and act on him and when I was with Steph I used to just zone out and just listen to [voice] and just see the images what he would show me. Reference 4 - 0.28% Coverage Just…because he knew he had the power to. He knew that, you know what I mean, that I wasn't at that point yet where I could accept it and get across my hurdles. Reference 5 - 0.43% Coverage I: How would you describe that power? P09: Like a couple of year ago or…no, three/four year ago it was really strong. He was like he could do things…well show me things and sort of that I would think that he's…the worst thing, the biggest thing	just…the…I just…it just numbed your feelings. I didn't……I went through a bad time with my wife where…I can't say I didn't want to but it was just that I couldn't show no affection, or anything. It just numbed me, totally numbed me. Reference 6 - 0.36% Coverage yeah, I put a lot of weight on, yeah. I'm trying to lose weight now like but it was just the medication. I said before, you know, would…I would put weight on with the medication, especially the Amisulpride. Reference 7 - 0.51% Coverage I've been on medication for like four…over four years now. I've been on the Amisulpride. I was taking quite a high dose of them on a morning, on a night. It just suppressed everything. It never helped things, just made me feel…I can't even say like zoned out, it just made me feel like empty Reference 8 - 0.56% Coverage I used to just zone out, I used to disassociate all the time. Kids used to come round for Sunday dinner and my grandkids and I just couldn't be with them. I used to just sit in here on my	and that, now and I know that he's not real and he can't hurt me that sometimes he doesn't come when we're having therapy because he knows that I'm not going to listen to him. Reference 10 - 0.30% Coverage Yeah, where I was turning the point of where I was accepting it, of being abused and accepting, not listening to [voice] and knowing that he's not real, that he can't hurt me. Reference 11 - 0.72% Coverage I: What difference has it made to you then to try and make some sense of all of this, or does it matter whether you can make these connections and…? P09: Oh, it matters to me that I can make the connections, yeah, but I know that years ago I had this breakdown and obviously he came out my brain, and that's when [voice] manifested, and that, and I can make the link to [voice] and [name of abuser], and stuff like that.	especially when I'm in the shed doing the washing. Reference 10 - 0.05% Coverage He wants me to hurt myself. Reference 11 - 0.49% Coverage I: Can you remember what [voice] would do when that would happen and if you cut yourself and your…that release of pressure, seeing your blood? P09: He used to laugh, he used to…like he used to always tell me to go down, cut here, but I was always too scared, I couldn't, I couldn't. like positive things to him and…you know what I mean, but he always used to get round me by showing me the abuse, showing me images in front of my eyes, showing me the images of Mr XXX abusing me because he knew that's what hurt me. He knew that what got to me and that's why I couldn't accept		and scared of not being believed. Then obviously when I spoke to XXX and he was almost in tears and he believed me, and then the lady came out and she thanked me for, you know, reporting it, and stuff, then I realised that, you know, people will believe me. Reference 2 - 0.42% Coverage I couldn't even tell my mum and dad because I was scared of not being believed because, you know, somebody in the church, you know, he was like in a good with standing in the community, and that. So, I was just scared of not being believed. Reference 3 - 0.35% Coverage I: And so, what was it like to be believed? P09: Oh, a big weight off my shoulders, and that, to be believed, and that, and that's

	Acting on what voices say I used to act on it, obviously I used to cut myself and, you know what I mean, do things and act on what he said Reference 2 - 0.17% Coverage Where before I was scared of him. You know, I used to hurt myself and…all the time and, you know? Reference 3 - 0.11% Coverage before he was always there and I used to do things and hurt myself Reference 4 - 0.59% Coverage I used to hide from him, I used to just do things. I used to…you know, I used to…when I was driving before when I started the medication I used to drive to mass railway stations to look at the train tracks and…you know what I mean, and stuff like that. You know, things what Samuel told me to do, hurt myself all the time, always hurt myself	own, just not with it, you know what I mean? Part of it…you know, a lot of it was Samuel, and that lot. I think it was the medication, **Medication suppressing emotions** I can't really say I really got any treatment in hospital. It was more medication, more like medication to numb me to…you know what I mean, not…I can't say to keep me quiet but just to numb me, maybe to suppress the feelings. **Wanting to reduce or stop medication** now I'm on the Quetiapine now on a night, and I am trying to get that reduced now. Reference 2 - 0.09% Coverage I want to try and reduce the dose of the Quetiapine now Reference 3 - 0.21% Coverage so when they refer to the GP they'll have all my records. So, I need to speak to the GP and they will start reducing my dose Reference 4 - 0.14% Coverage Yeah, I want to reduce the dose because I want to get my driving licence back.	**Feeling physical presence of voices** P09: He dresses like a reverend, long black cloak, a hood, you know, like a monk but black. So, I could only ever see usually his bottom bit of his face, stubble, like that. I: And how tall? P09: Oh, I'd probably say…he was quite tall, I would have probably said maybe 6 foot. He was quite a tall person, yeah, he wasn't small. Reference 2 - 0.14% Coverage I: And how close would he tend to be? P09: It could be different distances. Reference 3 - 0.36% Coverage When I've been driving the van I seen him in the passenger seat. I see him sometimes when I'm sat on the couch. He can be the other side of the room. If I'm down the farm he could be in the…on the field. **Linking voices with trauma**	**Voices don't like VH getting help** I: And how does [voice] respond to you doing these things now? P09: Well he's still says certain things. He still says I'm bad and that I…you know, I should hurt myself and kill myself and do different things, you know what I mean, walk in the road, and stuff like that Reference 2 - 0.76% Coverage I: Did you get an impression of what Sam thought about staff trying to help you? P09: He didn't like it when I used to go down to see Steph. He used to…when my first sessions are…I can't remember a lot. I think Steph told me like, you know, over the last couple of months, you know, when I first went into the room I used to have to move the chairs around and turn ones round so if Samuel sat there I couldn't see him, you know what I mean?		how I started to progress and become more positive, and stuff, you know? Reference 4 - 0.36% Coverage if somebody said something they'd be believed, a child would be believed, and that. You know, now, you know, things would happen. Where years ago there was just nothing you could do, nothing you could say. Reference 5 - 0.39% Coverage I was scared of contacting the police in case I wasn't believed, and I was scared of contacting the church in case they tried to make me out to be lying, or, you know, and…or they tried to protect him because he was a reverend Reference 6 - 0.81% Coverage

	Feeling threatened by voices I: Okay. So, you might…if he's asked you or told you to do something you might do it but you'd put some measure on it, what you would do? P09: Yeah. But now, you know, he tells me quite a lot to hurt myself, and stuff, you know? **Having agency with voices** with my therapy I've managed to keep it under control now and managed to, I suppose, not listen to him and act on what he says, where before I did. Reference 2 - 0.25% Coverage But I've learnt from therapy now, you know, they…where before it used to distress me and worry me, but now I can walk up to him, walk through him. Reference 3 - 0.33% Coverage Yeah, and it doesn't bother me as much now because I know that he can't hurt me, where previously I always thought that he could hurt me. He used to tell me to do	Reference 5 - 0.29% Coverage But I want to just still try and come off that medication, you know what I mean, because when I…it was worse when I was on the Amisulpride. That was really bad for me. Reference 6 - 0.47% Coverage I'm only on 300 grams, or 300 whatever it is, mg of Quetiapine. So, Steph said they'll probably reduce it slightly, reduce it once, then leave it a couple of weeks, and then they'll reduce it a bit more, because I want to come off them, I don't want to be on the medication. Reference 7 - 0.72% Coverage I: What effect do you think it will have on [voice]? P09: I don't know. That's why I've got to do it slow. I: Right. P09: I don't know, I don't know, I don't know. I think when it gets reduced I'll just see how things go and see if there's any difference in the voices, ie, you know, in the negativity in the voices of [voice]. But I'm at a better place now where I know where I can cope a lot more with [voice]	Because when I was like seven or eight year old I was like sexually abused by the local vicar in [town] where we used to live Reference 2 - 0.21% Coverage it started just small things and then it progressed into the worst things, into things what he used to do to me, bad things. Reference 3 - 0.16% Coverage It just…the main thing of what I had before is just not being…being embarrassed, feeling dirty, Reference 4 - 0.41% Coverage But in the '70s, you know, it happened probably about '77/'78, there was nothing that I could do, there was nothing I could say to no one because there was that much of it going on but who could I…who could a small, little child talk to? Reference 5 - 0.45% Coverage	Reference 3 - 0.44% Coverage I: So, why do you think [voice] came along all those times before? P09: I think it was because obviously I didn't accept it and I was scared of not being believed and he just kept on coming up and saying negative things and making me just feel like crap Reference 4 - 0.78% Coverage So, the power was there that he could get rid of [other voice] because [other voice] was trying to help. Well I can't say [other voice] was really trying to help me. He was being nice to me, you know what I mean, but what I came to a conclusion was that I wouldn't say [other voice] was too weak but [other voice] was not as powerful. He couldn't challenge [dominant voice]. [Dominant voice], you know, could just dismiss him. his voice was always the biggest, you know, and the		I'd seen XXX from the church and [he] believed me and told me how brave and strong I was and courageous for doing all this and trying to move forward with it. And then the lady came out from the church and she was very nice and she'd like comfort me by saying that if Mr XXX was still alive then the first thing he would have done, he would have been stuck off, he would have been suspended with a full investigation and they would have informed the police. **Talking about voices & problems is difficult** P09: took me about four/five sessions to start opening up about the abuse and talking about it, and there're still bits I can't say about it, you know, like the worst part what you could do where…you know, like I could say like he hurt me but I couldn't tell Steph exactly

	things and I used to do things. Reference 4 - 0.32% Coverage Yeah, I can walk through him, he disappears. So, I know where before I used to always think he was real, where now I know that it's…you know, it's in my head, it's in my mind. So, yeah. Reference 5 - 0.08% Coverage Yeah, and he can't do nothing, he can't hurt me. Reference 6 - 0.92% Coverage Well he's still says certain things. He still says I'm bad and that I…you know, I should hurt myself and kill myself and do different things, you know what I mean, walk in the road, and stuff like that, and… But where before I used to act on it, obviously I used to cut myself and, you know what I mean, do things and act on what he said, you know what I mean, but now I understand that it's not real, it's in…you know, it's my	**Fearing enforced or involuntary treatment** I went to the doctors and I seen somebody from services and the next day they came and then they sectioned me on Section 2 the following day and then I just…I had to get the ambulance to Roseberry Park. Reference 2 - 1.08% Coverage there were about five people. They came in and they just talked to me, and stuff, but then obviously I had a jumper on and they told me to take my jumper off and I'd cut all my arms open, and stuff. And then they told me to go into the other room, because my sons came up, you know, my two sons came up, and my wife was here, and obviously they must have had a talk, or whatever. And then they brought me back in and, I don't know, they just tell me, but they just said, you know, they would section me under Section 2 of the Mental Health Act and told me that I couldn't leave the house and that I had to wait for an ambulance **Lacking involvement in treatment decisions** I: Were you involved in agreeing how to take those meds, or…? P09: No. I: They just gave it to you?	So, he was…well I didn't know he was a reverend but he was just a…to me he was just a vicar, but, you know, he was called Mr XXX, he was the abuser, but then we found out that he was a reverend and that's associated with [dominant voice], who I see now. Reference 6 - 0.16% Coverage Yeah, he takes me back. It's not that…he's not Mr XXX but he feeds off Mr XXX. Reference 7 - 0.50% Coverage after a week or two we mainly pinpointed the abuse, how it happened, what happened, arranged different like…we always arranged different like 1 to 5, the abuse, where 1 was where he was just touching me, and then 2, 3, 4, 5 where it got worse and worse and worse and worse, he did things to me Reference 8 - 0.29% Coverage	strongest, and the scariest. **Voices being disruptive** I: In those discussions, because I can imagine they were very difficult discussions, but I can also imagine actually feeling believed and accepted would be powerful for you, can you recall typically what Samuel would be like when you were having these discussions? P09: Oh, [dominant voice] was always there, he always piped up and he always said that I won't be believed and that I'm a bad boy, I'm a bad person, you know, I mean for trying to get him into trouble, and stuff, you know what I mean? Reference 2 - 0.17% Coverage Just hurt myself and I shouldn't be here, I should be dead, and I'm useless, and I'm bad, I'm dirty.		what he did and, you know, I was just saying what I just couldn't say, and I still… I: So, you couldn't…? P09: …yeah, I still can't say the words now, you know what I mean? Even to the police I couldn't tell them the words. They had to probe for it and then he had to say it, what he did, and then I need to say, yes, you know what I mean? **Finding it difficult to relate with voices** I: Okay. And how would you describe your relationship with [voice]? P09: Not very good. It was bad like four years ago. He was always very active and telling me to do things all the time. **Relating more positively with voices** I had…at one stage I had two or three, yeah. I had one called XXX, and he was a voice that tried to help me. He was a

	head, it's in my mind, you know what I mean? But I accept now so I don't do things now, I don't hurt myself. Reference 7 - 0.97% Coverage Well before he used to always laugh, and that, and he always used to show me the bad images of the abuse and laugh, and I used to always act on it and get really distressed about it. Now…but now I think it's part of me, it's the acceptance of I know what…I know it happened and, you know, I am believed, and it doesn't make me upset as much now, and stuff. So, he still says things but I just ignore it and then after a short while he'll go away. Where before he was always there and I used to do things and hurt myself, and stuff, you know, and stuff. So, yeah. Reference 8 - 0.90% Coverage where before I used to do what he says and listen to him all the time, and he used to be a lot more active and I used to hear him a lot	P09: They gave me it, yeah Reference 2 - 0.26% Coverage It was just medication what they prescribed for me. You know, they said, you know, the Quetiapine and the Amisulpride, it was just what they gave me.	But obviously that was the link to reverend, you know, [voice], you know, the way he dressed and I couldn't look at dog collars and I couldn't look at vicars on the telly			voice that tried to help me. He was a nice voice. Reference 2 - 0.14% Coverage And then I had another voice called XXX. She was another voice trying to help me

	more. Where now I don't hear him as much, but I still hear him every day and, you know, I mean maybe six/seven/eight times a day, but it's not as active, it's not as…it just doesn't upset me as much now, it doesn’t upset me as much now. I accept, you know, the abuse took place and there was nothing I could do about it. Where before it was just…you know, I just didn’t know what to do. Reference 9 - 0.42% Coverage after I went past them hurdles I just accept it a lot more now and, you know, when I hear Samuel or see Samuel it doesn’t bother me as much because I'm not going to go and hurt myself now, I'm not going to do anything what he says for me to do Reference 10 - 0.61% Coverage And then since I seen [voice], and stuff, and the woman, and then we phoned the police, and that, Samuel still says things, he still, you know, tells me to hurt myself and that I'm bad,					

	you know what I mean, and stuff like that, but I just don’t…I don’t accept it, I don’t listen to him now. Where before I used to listen to him all the time and act on him. Reference 11 - 0.22% Coverage I don’t accept what he says, I don’t listen to what he says, I don’t act on it, you know what I mean, because I know it's wrong. Reference 12 - 0.99% Coverage to me the main bit of my therapy and the main bit of getting to a better point was accepting things, accepting [voice], that he might never go away, accepting him, accepting that he can't hurt me, things what he says aren't true, people do believe me, and I have…you know, I went over certain hurdles, ie the church and police, and, you know what I mean, it's all proving to Samuel that when he talks to me that, you know, I'm not going to listen. I mean I've got to listen because I can't notice him, but I'm not going to act on him I mean,					

	I'm not going to act on what he says. Reference 13 - 0.45% Coverage I: What do you think [voice] will think about you helping other people? P09: I don't know what he'll be like when I go to [hospital], if I ever go there, you know what I mean, I don't know, but I can control [voice] now, where before I couldn't control him **Hurting self for relief from voices** And I started cutting my arms open, and that, in [hospital], which I got told off for because they said it was dangerous because obviously if anybody else is worse than me and they get the knife, you know what I mean, they'd kill themselves. Reference 2 - 0.37% Coverage when I used to cut myself it used to just be like a release, a release of pressure, a release of, you know, seeing the blood, just a release. It made me feel better, even					

	though I know it wasn't good, it wasn't nice **Lacking agency with voices** It was very hard. I couldn't really challenge him. I was too scared to challenge him years ago. I was too scared to do anything, to say anything to him, Reference 2 - 0.70% Coverage P09: Then [therapist] tried to do things like what Eleanor did on hers, tell them, the voice…telling [voice] in a nice way that I listen…you know, I hear what you're saying but I'm not going to listen to it at the minute, I'll listen to him at six o'clock at night, I'll sit down with him. But he never… I: Okay. P09: Yeah, but it never worked. I: Right, okay. P09: No, [voice] was just there all the time. **Power relations between voices** But I only had [voice] for probably a month or two and then [dominant voice] hurt him and showed me like images of him dead.					

	I: Right. And so, [voice] disappeared then? P09:Yeah, he disappeared. Reference 2 - 0.37% Coverage P09:..and then she [voice] disappeared.[Dominant voice] was too strong. I: So, did [dominant voice] make her disappear as well? P09: Yes. He didn't…I don't think he killed her though, but he made her disappear. He was too strong for her. Reference 3 - 0.37% Coverage I: Okay. So, [dominant voice] sounds like he's been the dominant voice… P09: Yeah. I: and he's got rid of the two other ones? P09: Yes, he's the one who showed me images and pictures and I see him, and that, yeah. Reference 4 - 0.50% Coverage obviously when I used to see [voice] when I first started, he killed [voice] and what he used to do. I know it might sound daft but I used to see [dominant voice] and					

	around his belt…around his waist he'd got a belt with hooks on and he had [voice's] head on a hook and he used to show me that all the time. Reference 5 - 0.58% Coverage I: Why do you think [dominant voice] did kill [other voice]? P09: I think he was…I think way back then, like, you know, three/four year ago, I think it was like a power to make me scared so that I would listen to him, which… I: So, to demonstrate that? P09: Yeah, which I did. You know, anything…I did everything what he said, you know what I mean?					
P10	**Empowering self through action** I: Managing as best you could to kind of keep on doing what you were doing. P10: Yeah, absolutely. Because I had to keep doing my job because I've got a family at home, I'm a single parent, you know, I've got two kids to bring up, I've got to keep a roof over their head. So I've got to do something, so, you know, couldn't survive on benefits	**Dominating influence of medication** And I spoke to a CPN who…I think she understood but the next thing I knew, I was on all sorts of medication. Reference 2 - 0.53% Coverage we'll get rid of these voices for you, and they'd give me all this medication. And I'd go back to see the psychiatrist after three months, I'm still hearing the voices. Oh, we'll up the	**Making sense of voices** I wasn't feeling anything because my voices seemed to have taken over. As far as I was concerned, they were helping me get through my job, my career, which was a nurse. You can't get emotionally involved…you have to, but when you're nursing patients who you know are going to die in your arms. I was on an HIV and Aids ward, that's why I'm saying	**Being persecuted by voices** I: So at the time when you were in that hospital bed back in the late '90s and you first heard your voice, was it a good voice experience then? P10: No. No, they were damning. You shouldn't be here, what you doing here, you can get up and walk, there's nothing wrong with you, and all this bullshit, despite the	**Practitioners failing to connect & understanding** I would go into an appointment 40 minutes late and he'd just be ready to write another prescription out, not…he didn't want to interact with me at all, he wasn't interested in me as a person. He wanted just to get me out of the room. Reference 2 - 0.27% Coverage	**Being accepted & supported** But I started going to that group and that was for complex needs, and that's where the recovery started. And I actually engaged with them because, well, for certain reasons, but I could engage with the complex needs service. I could recognise in there the

	with a mortgage, so I had to do a job. Reference 2 - 0.42% Coverage if they do come, I don't expect them, you know, if I'm not tired, I'm maybe sitting at home on my own watching TV. It's usually nothing, it's usually, you know, okay, I might have to think about, oh, hang on, am I anxious about something, what's happened today, and reflect on it. **Grounding oneself** Well, I use mentalisation, mindfulness, any grounding technique really. I also write a lot that helps. I write quite a bit of poetry, that type of thing. **Taking responsibility** I was there basically on my own, obviously I had my team but, you know, there was nobody else sort of rushing round the ward, no doctors, do this, do that. It was, you know, I did my job and that was it. And that's really how I coped, yeah, focused on the job, the job, and that's it, you know. Don't focus on me because I'm unimportant, you know,	medication. And they used to up the dose. And after maybe a year, then they'd say, oh, we'll change your medication. And then there'd be a little dose, up, up, up Reference 3 - 0.14% Coverage And so that was it really, they just went along with that and they just medicated me after that. Reference 4 - 0.29% Coverage I: And it sounds like your treatment then was predominantly just medication? P10: It was medication, absolutely, yeah. I: And then you said… P10: And I wasn't offered anything else either. Reference 5 - 0.22% Coverage I thought they would stop the voices because the psychiatrist…the man in the white coat told me those tablets would work. He lied, simple as that. Reference 6 - 0.47% Coverage because they gave me the medication, which didn't work. If the medication don't work, don't give, it. What's the point,	that. There was nothing, you feel helpless, and to cover it up. My take on my voices is that they…my wonderful brain created them to save me from feeling emotionally distressed. I'm not saying I didn't get upset, which I did, but I wasn't, oh my God, oh my God, you know, it stopped that. And I think the voices…I'd created my voices to protect myself. Reference 2 - 0.58% Coverage And this one voice I heard, and I only heard it a couple of times, and that was a child of about two or three, screaming, and it didn't stop screaming. And I still don't know where that one came from. Because the others I could link to several emotions and, yeah…but that child still sticks and I don't know where it comes from, it's just a child screaming, crying, you know, really weird. Reference 3 - 0.35% Coverage On reflection, they thought they were helping me by	fact I had two major operations. They brought my children in twice because they thought I was going to die. You know, it was just one of those things that I thought they'll go, obviously I'd been stressed and, you know, it was stressful obviously. Reference 2 - 0.26% Coverage There were three voices that were always around me, talking to me, telling me how useless I was and if I did this and did that, then this would happen, so therefore do that. Reference 3 - 0.41% Coverage So I had one always what I called…I called him Mr Angry, because he was always angry at me, I'd always done something wrong for him. It was always, you know, I never…what did you do that for. He was always very abusive to me, outright abusive, you know, there's no hiding it.	Due to the stupid psychiatrist, I can't describe them any other way. He wasn't interested in me, he wasn't interested in my voices, he wanted me out that room as quick as he could. Reference 3 - 0.93% Coverage I: So what was her reaction to you sharing that with her? P10: Well, the first thing was, do you think they're going to go away? Well, no, they've been here a year. But nobody, even she didn't ask me about my voices as such. They kept going on about they're not real and nobody else can see them. Yeah, I know that, I'm fully compos mentis about my voices, but I just don't know why I'm getting them. And they said, oh, well, it's this, it's that, it's anxiety and it's that. I said, but why are they there all the time? And that's the bit I couldn't understand, I can't be anxious all the time or stressed all the time.	people I was meeting within that service, within that group, I could recognise traits and I'm thinking, that sounds familiar. And I could recognise stories and I'd think, that happened to me. And I could recognise what people…well, that's what happened to me. And I had that sense of actually, these people know what I'm talking about. Although I don't think anybody else in that group heard voices, they could understand the emotional state of shutting down and coping. That's what they recognised, that emotional shutdown, that I'm okay, yeah, I don't need anything. Yeah, that sort of attitude. Reference 2 - 0.53% Coverage And when I actually got into the therapy itself, and I spoke about my voices, and the first thing somebody said to me

	I've got 26 patients who are poorly and need my care. And that's what I'd focus on, and focusing on the job would help me get through. Reference 2 - 0.25% Coverage I needed rid of these voices. I'd been out of work, well, I'd been off sick from work for nearly five months, and I'd got to do something, I needed to get back to work. Reference 3 - 1.27% Coverage On the Monday morning, because I left the community on the Friday, on the Monday morning I was so fucking angry, you've kicked me out of the community. The fact that I knew I was leaving that day, the day I went in, I knew exactly what day I was leaving. And I reasoned with that, rationaled myself, heard the voices and all that, everything came back powerful. And then I sat down and thought about it. Well, actually they didn't kick you out, you were leaving, you had an effective leaving, you completed the work you wanted to do. Did	it's a waste of money and it's a waste of that person's time and health. And I think it's something practitioners should think about when they're just willy-nilly handing out medication, you know. **Medication not helping voices** And then after a few weeks they'd realise actually that medication's not working either. Reference 2 - 0.40% Coverage The only medication I must say that did sort of help a little bit was Clozapine. But they had to stop giving me that because…they did tests every three weeks or something, blood tests or something, and it came up and they couldn't give it to me anymore, it became red. Reference 3 - 0.48% Coverage P10: And after that, they put me on Depixol. Nasty, nasty drug. Nasty drug. I: Because of the side-effects? P10: Side-effects, the addictive quality of them. Yeah, the side-effects. And they weren't effective, they didn't do the job anyway, they didn't do what it said on the tin, they did not get rid of the voices. Reference 4 - 0.14% Coverage	shutting down emotions. They thought they were helping me because they helped me function in my job as a nurse, and I wasn't, you know, heaving out all over the place about voices. Reference 4 - 0.43% Coverage Well, I didn't know they were being useful at the time because I didn't know they were suppressing my emotions, I didn't know that's what they were doing. It's only when I came off them I could do that on reflection. And now I'm feeling rather than hearing, that's the way I look at it now. Reference 5 - 0.08% Coverage I think my brain created my voices to protect me. Reference 6 - 0.48% Coverage I: What was is that helped you make sense of your voices? P10: Looking at my emotions and the strength of my emotions, and	Reference 4 - 0.51% Coverage I had another voice, the only female voice, and she was always what I called my logical voice. Okay, let me think about this, if you do XYZ, you know very well that's going to happen, so why don't you do this. It's all negative but in that logical, negative way. So all those negative things, that's perfectly logical, thank you very much. Reference 5 - 0.66% Coverage Another voice I had, again it was a man, and again he would discuss people around me with me. Oh, look at him, don't trust him, he's…you know, oh gosh…oh, look at that one over there, they're quite funny, I wonder where they've come from, you know, and this sort of thing. And particularly if I'd touched somebody, what have you touched them for, you don't know where they've been, they might give you something, and all this sort of thing.	Reference 4 - 0.58% Coverage In physical health, right, we go and see a doctor, I've got a broken arm. Right, put a splint on it. Go to a mental health worker and say, I hear voices, completely different. They haven't got a splint to put on it because they don't know where it comes from. They don't know what is going on in here, exactly what's going on…I don't know what's going on in your head, haven't got a clue. Reference 5 - 0.45% Coverage What they need is help to discover what the voices are doing, you know, what their function is. And I think that's what a lot of practitioners are missing. Because they never asked me about the function of my voices or what I thought the function was. They never asked me even what the voices said. Reference 6 - 0.64% Coverage	was, we want to know about your emotions. Well, don't you want to hear about…? No, what's the emotion linked to that, attached to that? What's the story of your voices? And I suddenly began to understand what they were talking about. Reference 3 - 0.16% Coverage And the support of…once I'd got into the community, the therapeutic committee, the support of the members. Reference 4 - 0.31% Coverage 24 hour a day support. I could phone them up, my voices are back, I need help, what's happening, you know, I'm in therapy today. And they were there because they knew me in therapy and they would tell me.

	you complete the work you wanted…? And basically, I spent six months consolidating what I'd done in there, thinking, reflecting, working out other bits and pieces. And that work still carries on, I don't think you don't stop growing as an emotional being, you know, you just carry on. And that's what I try and do. Reference 4 - 0.33% Coverage Nobody else can hear these, these are mine. These are mine and I'm ready to own them. And I think that's the difference from that when I want to get rid of them, now I will take ownership and say, right, this is my issue. Reference 5 - 0.66% Coverage P10: And I work differently. From that different perspective, that means, okay, they're my voices, therefore it's up to me to find out what's going on for me, because nobody else knows what's going on for me, do they? I: That ownership of your voices is a key thing.	They just used to keep saying, you're wasting your time, and that was their main thing really. Reference 5 - 0.08% Coverage voice-hearing, medication…the medication wasn't working. Reference 6 - 0.81% Coverage helped set up a group in [city] of voice-hearers. And when we opened it up, there was all professors and God knows what else at that voice-hearing, a pharmacist there saying how much the medication worked and all the rest of it. So I got on after this pharmacist and the first thing I said was, the drugs don't work, don't take them. And all the service users there went, yes. They recognised what I was saying. So it's the function of the voices and what they're saying to focus on, not the inappropriate coping mechanism which is voices. **Feeling worse from medication** But by this time, obviously I'm addicted to the damn stuff. Depixol, why do they give that drug out? I'm sorry, it's just…I was like an old woman at 30 years old, I was shaking, I couldn't walk, I was shuffling. I had Parkinson's, there's no two	actually somebody saying to me, no emotion is wrong. An emotion is an emotion, if you feel it, you feel it. You can't change that. Somebody said that to me, you know, you're right, it don't matter. Reference 7 - 0.17% Coverage if I get the voices, they're telling me something, it's tell me something, I'm stressed about something usually. Reference 8 - 0.19% Coverage I don't do anything, ignore them, you know, because I know they're not real. I think my perceptions of them changed, you know. Reference 9 - 0.24% Coverage And once you've broken that down, then you've got the story. And once you've got a story, you've got a feeling. And once you get a feeling, you can't get voices. Reference 10 - 0.35% Coverage	Reference 6 - 0.34% Coverage Yeah, they used to say, you can't even do that properly can you, you stupid cow. That was always the response I got. You can't even do that right, how useless are you. So, you know, that sort of…always derogatory in some way Reference 7 - 0.10% Coverage Very quietly they'd be saying, slag, bitch, slag, bitch sort of thing. **Voices being disruptive** I: were they commenting on what was going on around you at that time? P10: Yeah. Obviously, I was in a side room, and whenever a nurse came in, they would comment. You know, they were there and I knew they were there, but they were constant. When I…after about a year, they became almost my constant companion, you know, they were always sitting on my shoulders, they'd make comment on	I: Why do you think practitioners have not been able to see it that way and struggled to do that? P10: Because they don't believe in the voices, I'm assuming. I don't know, I'm not a practitioner, I'm not professionally trained in that way. I don't know, I'm assuming they think they're not real, which I guess they're not but they are to that person, and that's the bit they're missing and they're very real to that person. Reference 7 - 0.23% Coverage P10: Yeah. And being ignored, that is…it's one of the worst things. I: Being ignored? P10: Being ignored, absolutely. Being dismissed almost. Yeah. **Experiencing MH services as uncaring** I: What were your voices like when you were in that situation? P10: On and off. Because again, as I said earlier, you got into there, I know it's improved a lot in the system, but they just locked you up. Now what? Now	Reference 5 - 0.26% Coverage It's 24 hour a day support. And I know it sounds ridiculous but I knew for 18 months, I had…I could phone up, pick the phone up and phone up somebody for support, 24 hours a day. Reference 6 - 0.79% Coverage Eating, cooking, eating, everything you did as a community. So everybody could see what you were doing, same as you could see what everybody else was doing. And that support, did you know you do so and so. and so and so on certain things. It may be something you've not realised but all those little things, you put them all together and suddenly you feel they're connected. Yeah. And that emotional connection, it stays because you've

	P10: I think so, yeah. Yes, but also knowing that there isn't anybody else speaks to me, this is brain…me, I've created them for some reason, my brain has created voices. Reference 6 - 0.38% Coverage I: So how do you actually get to own your own voices then? P10: By owning your emotions I think is the answer and realising that nobody else can get inside your brain and mess in there, you know, nobody's got the right to do that, apart from anything else. **Voice hearing is about power & control** And of course, the more I'd push them, the more they'd push back. Reference 2 - 0.57% Coverage And, of course, once they'd got enough strength, they would full force, you know, full force about how useless I was, oh, you can't possibly do that, I don't know what you think you're doing there, you know. Anything, you	ways about that. And that was just due to Reference 2 - 0.31% Coverage Side-effects, the addictive quality of them. Yeah, the side-effects. And they weren't effective, they didn't do the job anyway, they didn't do what it said on the tin, they did not get rid of the voices. Reference 3 - 0.31% Coverage that medication, it couldn't have got worse, I'm sure it couldn't have been, it felt like my head was going to blow up. Yeah, it felt like electric shocks coming out of my head, it was horrible. But yeah. **Medication suppressing emotions** Yeah, I had vacant spaces apparently, I can't remember them, but people said I did have vacant where I couldn't…I just wasn't engaging, I didn't…I was just vacant. That's the best way to describe it. And that was in the community but they supported me in that to keep off the medication and engage with my emotions, rather than… Reference 2 - 0.56% Coverage	I think the voices tell a story, anybody's voice will tell a story, some type of story. And hopefully, people, practitioners, professionals will listen to that. Listen to that distress as well, because there is distress in voices. Reference 11 - 0.79% Coverage Because the brain's so…if we don't…nobody knows what goes on in there, nobody knows. They know we use ten per cent of the brain, what's the rest of it used for? I know what mine's used for, do you? So who's better, you or me? I know that my brain has created my voices and that's all I…they've created my voices for me. And the way I look and reflect on it is, they were created by me to protect me from what I thought I needed protection from, which was my emotions, my extreme emotions, which you've just experienced, can happen Reference 12 - 0.21% Coverage	what I was doing, what I was seeing, what I was saying, the people I interacted with, and what their thoughts on what I should do. Reference 2 - 0.50% Coverage I: what were your voices like during those times of talking about voices with staff, with CPNs? P10: They were quiet. They would wait until afterwards. Or before they would give me a hard time because they knew I was going to reveal something which they didn't want me to reveal. And then afterwards, they'd give me a real tough time. Reference 3 - 0.32% Coverage I: So before those conversations that you had with CPNs, your voices would give you a hard time before that? P10: Sometimes, yeah. I: Because they were worried that you might reveal something? P10: Absolutely.	what? What are you…I actually asked somebody once, you've locked me up, why, what are you doing with me, I've been locked up now for, what, four weeks I think it was at the time, you know, you've not changed anything? Reference 2 - 0.25% Coverage Because I'd realised by then on this lock-up that they weren't doing anything for me, and I mean the service. The mental health service, as a whole, had done fuck all. **Perceiving practitioners lack hope** I had CPN after CPN but it was…because they couldn't tolerate me. They couldn't tolerate me because I was hearing voices, because I was self-harming as well. So it was very hard for them to tolerate my behaviour, as such. **Practitioners not talking about voices** So I had no way out with these voices almost, you know, nobody wanted to talk to me about my voices, nobody, and they didn't	shared something intense and real, which a lot of people didn't think my voices were, you know. Reference 7 - 0.37% Coverage I could make very strong relationships because, I mean, you are with these people a lot of the time, you're learning the deepest, darkest secrets of other people and you're sharing your deepest, darkest secrets. And there's something else you may know. **Feeling valued by practitioners** And through working and being theraped, I regulated the emotions Reference 2 - 0.59% Coverage It was more, obviously, I was being theraped at the same time, and that involves a lot of…I mean, 18 months therapy is a long time,

	know. Or they'd comment on what I'd done during the day, and that was terrible because there was nothing you could do because it's gone, you know what I mean. Reference 3 - 0.27% Coverage I: And it sounds like though, from what you were saying there, that to some degree you had power yourself to at least manage them? P10: At times, yes, when it wasn't too stressed. Reference 4 - 0.16% Coverage Because at the time of hearing voices, it was just chaos, I can't explain, it was chaotic, my life was chaotic **Feeling threatened by voices** I was too scared to try and engage with my voices. They were scary people, my voices, they were scary. I didn't want to engage with somebody scary. Reference 2 - 0.19% Coverage	I: What was the purpose of you coming off the medication then? P10: So I could do the therapy. I: Did the medication affect you being able to do the therapy? P10: Yes, because it suppressed the emotions. Any psychiatric drug will suppress emotions, that's what they're designed to do. And obviously, when you're doing therapy, you need to feel so you can understand. Reference 3 - 0.14% Coverage And that's because I've come off the medication because the medication was stopping all that. **Wanting to reduce or stop medication** Yeah, when I first started, when I came off the medication, I probably did come off the medication right away because I told the psychiatrist to stick them where the sun don't shine. So probably not the best way and I wouldn't advise that to anybody because that wasn't nice. Reference 2 - 0.16% Coverage Certainly when I come off that medication, it was like a thunderclap in my head all the time, it was horrible.	It's normal. So, you know, and that's the thing that I've accepted that my emotions are normal and everybody has them, everybody's got them. **Linking voices with trauma** it was a very vague memory, and I think the voices were playing on that vague memory. And it was only sort of when I started to feel rather than hear the voices that I began to remember bits, I had little flashbacks, little flashbacks. I'd had sort of flashbacks when I got divorced, which was in the '90s which is when this all started, I started getting flashbacks but I wasn't too certain….So I had flashbacks, I'd got this voice-hearing, you know, it was all sort of entwined, complex. Complex. Reference 2 - 0.32% Coverage And I'm still remembering bits and pieces, it just comes to me, you know. But yeah, I can remember his face, I can remember the place, you know, and all this sort of thing, and	Reference 4 - 0.41% Coverage I: They wouldn't do that during the conversation? P10: Very quietly they'd be saying, slag, bitch, slag, bitch sort of thing. I: Okay. So they would comment but it was quieter? P10: Yeah, just telling me what they thought about me telling somebody else about them. Reference 5 - 0.47% Coverage I: And then they would give you a hard time after? P10: Oh, definitely, yeah. They would…what the fuck did you do that for, are you stupid? They're going to think you're fucking bonkers, they'll lock you up forever. All this sort of thing I'd be getting and, you know, reinforcing what I thought would happen Reference 6 - 0.43% Coverage I: And what do you think…so if the voices were giving you a hard	want to talk to…you know, yeah, nobody else hears those voices, are they real? Well, I know they're not real, nobody else hears them, but I'm still hearing them, they're real to me. And nobody seemed to understand that Reference 2 - 0.08% Coverage Nobody really interacted with me about my voices. Reference 3 - 0.36% Coverage And the voices were very…they were always treated, all, well, the majority of mental health staff, as secondary to my self-harming, which used to be fairly annoying anyway because the voices were actually more annoying than the self-harm for me. Reference 4 - 0.38% Coverage So yes, the voices were involved but actually, you know, we don't want to talk about your voices, we want to talk about you, what's going on for you. And that's the bit I didn't understand	drama therapy, art therapy, music therapy, CBT sessions in small groups, playing games. I know it sounds stupid, playing games. We played games and we still play games now, because one of our supervision things is we play games, because it's a different place to be. Reference 3 - 0.56% Coverage Describing the voices, what they were saying, why I think they were saying them, you know. And that's horrible, you know, why do they call you a slag, why do they tell you you're useless? You know, you're telling everybody your worst sort of deepest, darkest secrets. But it helps and that's…you've got to have the therapy because otherwise you won't get to the root problem.

	They can be very powerful, yeah. They're scary. Well, that's my perception. I was terrified of them. They were scary people, yeah. **Having agency with voices** Whereas now, the way I've conquered that, without medication I add, is that I now allow emotions in. And that's hard. When you've been practiced at keeping them shut down, contained, you know, you're okay, I'm okay, you're okay. That's hard work. Whereas allowing emotions to be there all the time, which is the way people should be, but I struggle with that, I really struggle with it. But I know if I get upset, stressed, anxious, that's going to let the voice back. And now, so that's noise medication, if I get the voices, I think, oh, hang on, what's going on for me. And I have to think then. Reference 2 - 0.49% Coverage P10: I got in touch with my feelings. I: What happened to the voices then? P10: Just decreased and decreased. Over the 18	Reference 3 - 0.20% Coverage When I came off the psychiatric medication, my memory's come back, not all of it, but I can certainly remember what had happened to me. **Fearing enforced or involuntary treatment** P10: Prolific self-harm, yeah. I: And they took you into hospital? P10: Yeah. I: Was that under the Mental Health Act then? P10: Yeah, I was sectioned. **Importance of being involved in treatment decisions** So by that time, my CPN was very good and she knew about therapeutic communities, she'd worked in one of the young offenders I think it was, I don't know where. Anyway, she knew a bit. And they'd just opened the new therapeutic communities, well, it wasn't even open. Go to this group, she said. She said, the last thing I'll ever tell you to do, she said, but I'll really advise you to go to this group. I said, I'm on lock-up, I can't. She said, they will let you go to that group. I thought, oh alright then. I thought, great, half a day out, magic. Reference 2 - 0.39% Coverage	you think that must be real, it was real. Reference 3 - 0.33% Coverage with me it was all derogatory, but there's also a victim there of history. Slag, whore. Of course I'm a whore, you know, I had sex when I was 12 years old, of course I'm a fucking whore. Yeah, you see that, it's all logical.	time because you might reveal something, what was it that you might have revealed? P10: Abuse. I mean, I'd never talked about abuse from childhood because I didn't really acknowledge it. I didn't acknowledge it, I didn't Reference 7 - 0.35% Coverage I: …but your voices were worried that you would reveal? P10: Yeah. Well, you know, oh, don't mention that, no. I: So am I right in thinking then that your voices didn't want you to talk about what happened in the past? P10: No.	because the voices were the bits giving me the problem, I thought. Reference 5 - 0.22% Coverage So, you know, what happened when I was hearing the voices was, no, people wouldn't engage with the voices with me, so I wouldn't do it on my own. Reference 6 - 0.49% Coverage I: So what do the practitioners do then? P10: Exactly. Perhaps talk about what the voices are talking about. Now, that's an interesting one I've discovered, because if you listen to the voices, they will tell you a story. And I think that's the bit that practitioners miss, the story of the voices, what they are saying. Reference 7 - 0.60% Coverage I: So what role can practitioners play in helping? P10: They could be supportive in…for me it was chaos, right, in there, and I	**Importance of being believed** someone in therapy said to me, you talk with forked tongue. I said, you're calling me a fucking liar now, don't call me a liar. He said, well, I've never heard your voices. I said, because they're my voices, not yours. And, of course, that night I was really stressed. Reference 2 - 0.11% Coverage It's that disbelief, being told they don't exist, all the time constantly. Reference 3 - 0.37% Coverage I: Did you say it was something about being believed? P10: Absolutely, yeah. I: People believed that you heard voices now? P10: Yeah, and they engaged with me at that level. And that's the big difference. Yeah, I think that's what it is.

	months I was in therapy, it got less and less. Eventually at nine months somebody said to me, we haven't heard about your voices, tell us about your voices. I said, well I don't hear them anymore. Reference 3 - 0.58% Coverage Again, like last night, I got here, I couldn't find my hotel and I was going round [city] getting really stressed. And the voices, yeah, you're a bleeding nuisance, you know, shut up. Oh it is there you know. And I was tired, I'd worked all day. Reason why, you know. But no. No, if I get the voices, they're telling me something, it's tell me something, I'm stressed about something usually. Reference 4 - 0.75% Coverage I: So what do you do when your voices do comment on times like that then? P10: I don't do anything, ignore them, you know, because I know they're not real. I think my perceptions of them changed, you know. And also, if they do come, I don't expect them, you	And also, the other difference was this was something I wanted to do, not something I'd been told to do. Big difference. When you're being told by so-called professionals to do this, do that, go there, take this, you get fed up with that, you get pretty fed up. Reference 3 - 0.08% Coverage It was purely my decision and that's the difference. **Lacking involvement in treatment decisions** And I wasn't offered anything else either. I mean, I can remember seeing a bloke once, I've got no idea who he was, what his title was. And he said, oh, there's a group of voice-hearers. I ain't doing that, not a chance, mate. I've got enough thanks, I've got seven of my own, I don't want anybody else's. So I never engaged, because then I didn't know what it was about. Nobody explained it, you know. It was to go to this group, take this tablet, go there, and we're going to lock you up there, we're going to put you in there, you're going to go there, we're going to do this, we're going to do that to you. We're going to tell you this, we're going to do that, go there. 20			had very little memory of that as a child, very little. But sort of digging deep and finding that would have been helpful, not just giving you medication. Do you know why? Even questioning what the voices were saying might have helped. But nobody ever did, you know. Reference 8 - 0.25% Coverage Yeah, they acknowledged I was hearing, that was it, they didn't, well, what are they saying, how many have you got? Nobody ever asked me and I didn't really talk about it **Framing experiences according to professional interpretation** No. I mean, she made suggestions like, you know, write down what they say. Well, I can't write fast enough, it'll slow the voices down but it didn't work because I was trying to keep up with the voices like this. Several coping strategies they gave me. One of them, oh, yeah, go for a walk, have a hot bath. I don't want a fucking hot bath.	Reference 4 - 0.28% Coverage They're real to me. I mean, I hear them. I hear them, alright. I'm not pretending I hear them, I hear them. That's the bit they didn't believe. That's the bit I felt they didn't believe. **Talking about voices & problems is difficult** I: Okay. And did you want to talk about what happened in the past? P10: Not particularly because I couldn't really remember it. **Concealing voices** Anyway, then the next time I spoke about my voices, it must have been about a year later, because I'd been hearing them intermittently and I didn't know quite what to make of it. I didn't know, I really just didn't know what was going on.

	know, if I'm not tired, I'm maybe sitting at home on my own watching TV. It's usually nothing, it's usually, you know, okay, I might have to think about, oh, hang on, am I anxious about something, what's happened today, and reflect on it. Reference 5 - 0.14% Coverage What they need is help to discover what the voices are doing, you know, what their function is. Reference 6 - 0.19% Coverage So it's the function of the voices and what they're saying to focus on, not the inappropriate coping mechanism which is voices. Reference 7 - 0.21% Coverage I don't know. I don't think so because I tend to ignore them now. But nonsense, you know, what I do is challenge them rather than accept them. **Hurting self fro relief from voices**	years of being told what to do by somebody else who doesn't know what's inside my head, it's very frustrating, very frustrating. Reference 2 - 0.75% Coverage Oh, we're going to change your medication. No, you're not. She said, yes, we are. I said, no, you're not. And I saw the psychiatrist, he said, we want you to take medication. I said, no, I don't want to take it. He said, you've got to. I said, why? He said, because it'll make you feel better. I said, like the other tablets you've given me, I said, they've made me feel better? He said, but they worked. I said, no, you know what you can do with your tablets, stick them where the sun don't shine. Reference 3 - 0.12% Coverage I: was that your decision that you'd be on medication? P10: No. No, absolutely not. Reference 4 - 0.27% Coverage The doctor prescribed them and I took them. Because that's his job, right. He prescribed the medication, I took it. I went to him and said it's not working, so he upped the dose. Reference 5 - 0.35% Coverage			Reference 2 - 0.69% Coverage P10: They said I was schizophrenic, which I knew wasn't right. I: They said you were back in the day? P10: Yeah, that's the label I had, but it didn't fit. It didn't fit. I didn't have that…I've heard schizophrenics about sort of the numb feeling after a voice-hearing episode, you know, almost sort of transient episodes. I never had any of that, they were just there, you know. And also, I know from working in…now diagnosis of PD, personality disorder, Reference 3 - 0.21% Coverage Labels are meaningless to me. The only thing a label is good for is getting appropriate therapy. Yeah, or getting the appropriate treatment.	Reference 2 - 0.55% Coverage I: Okay. And looking back now then, was there a particular reason why you hadn't disclosed hearing voices to anybody? P10: Trust. If you're getting rebuffed like that psychiatrist, you aren't going to trust anyone in the services, you know. I was…I felt ignored, I felt insignificant and unimportant. And yeah, it was…and I almost…I felt angry actually as well. **Distancing self from voices** They would go at me, they were horrible to me, and I didn't want them anymore. And I would try not to engage with them, because I just think that would have encouraged them. I don't know if I'm right or wrong, I don't know because I've never tried it, I didn't want to.

	with self-harming, it just became too stressful to cope, the stress for me sometimes was just so much, so high, the only way to take that weight off my shoulders was to…I mean, I was overdosing, that was my modus operandi. And it was just like…and all the voices went, just…I self-harmed, everything went. Reference 2 - 0.23% Coverage it was like a weight being lifted. All the voices stopped, because obviously I was half-dead. But, of course, then after a while, they'd come back again. Reference 3 - 0.33% Coverage I: So when you self-harmed, actually that led to the voices temporarily stopping? P10: Absolutely. Yeah, that's why I did it. It gives you…and it's not just relief from the voices, it was everything. Everything. Yeah. Reference 4 - 1.08% Coverage	I: You didn't have any other options? P10: No, I wasn't offered therapy, I wasn't offered psychotherapy, I wasn't offered nothing. In fact, that particular psychiatrist couldn't give a toss whether I was there or not, to be fair.				Reference 2 - 0.33% Coverage I: And you had quite a distance from them, I guess from that, that you wanted rid of them, you wanted to push them away? P10: Yeah, that's right, yeah. And of course, the more I'd push them, the more they'd push back. Reference 3 - 0.40% Coverage P10: I found the voices, the relationships I had with them were, I wouldn't say better, but basically didn't need to be. Does that make sense? I: Mm. P10: I didn't need a relationship because they weren't there that often and they weren't so bloody annoying basically. Reference 4 - 1.09% Coverage And I didn't engage with the voices, I noted what they were

	P10: They were quiet. They would wait until afterwards. Or before they would give me a hard time because they knew I was going to reveal something which they didn't want me to reveal. And then afterwards, they'd give me a real tough time. And that was…it was…yeah, it was hard. But I didn't have any other escape because after disclosing something like that, self-harm would have looked, I don't know, it wouldn't have solved the problem, and I knew that, yeah? I: Mm. P10: Whereas other times when I self-harmed to get rid of the voices, that was what I did it for, for that relief, take that weight off my shoulders, yeah. But self-harm wouldn't have done it in those cases because it was a different type of abuse. Reference 5 - 0.25% Coverage And then every now and again, the emotions would go whoosh and to cope with that I would self-harm, because the voices were helping me protect my emotional being.					saying and then talked about…and I talked about those as feelings to the community. And they would either say, oh, where have you got that from, you're not stupid, or what's going on, you know? And they would query those. The feelings of rejection, the feelings of self-hatred, the feelings of not being good enough. Whose yardstick was I using? That's a good point, you know, because I'm never going to measure up to anybody else's yardstick. Use your own. Oh yeah, oh yeah. And sometimes I'd think, oh, why didn't I think of that before? But all these little things people just chipped in, and it sort of chips away, you start thinking about actually, yeah, oh yeah. **Linking relating with voices & relating with people** And listening to what my voices were saying

						and relating it to people that I was meeting in those groups, I could get into a relationship with real people, which I've never really done before. Reference 2 - 0.58% Coverage Because I've always been one of these people who would get engaged with some…you know, engage with somebody in conversation, become friends with people even, and then I would disappear. And they probably wouldn't even notice I'd gone. You know, I did it in school, I did it in my first job as a chemist, and I've done it since then obviously when I retired from nursing, I just disappeared. Reference 3 - 0.28% Coverage Very stressed, yeah. As I say, crowded places, like I wouldn't

						go to Trafalgar Square on New Year's Eve, and that sort of thing, I don't go into crowded pubs. You know, I do avoid crowds. Reference 4 - 1.88% Coverage And I recognised through going through the therapy, talking about emotions, talking about your relationships, I began to realise that actually I don't have really strong relationships with anybody really, you know, because I'm always wary. And I always realised that I'm…you know, I realised that about my emotional self, how…what was it somebody said to me once, you've got lots of personality, which is true and I tend to exaggerate that and that helps me. I exaggerate parts of my personality that I want to exaggerate. For example, my odd behaviour sometimes.

						Yes, I will talk to anybody, I'll talk to strangers in the hotel, you know, and I would engage in a conversation with them. Eccentric I think is the word. I do exaggerate that because I was very eccentric as a young adult and I lost that when I got married, I became all straight, yes, you've got to do this, it's got to be put in the box, you know. Whereas now I'm more, yeah, whatever happens sometimes, you know, I don't really care. And, you know, it's that sort of change of attitude I think and that shift in my emotional being, and concentrating on the bits of my personality…paranoia, I'm very paranoid, scored very high on paranoia. So I try and sort of hide that by being a bit eccentric. **Voices interacting with emotions** Yeah. And also, very, very…when I was very, very stressed, I

						would get visual hallucinations as well. Reference 2 - 0.97% Coverage since I've been theraped I've realised that the voices…I created my voices to protect my emotional self from my emotions. Because they can be overpowering, you know, when you think about, I don't know, anything when you get emotional, you can get…it's like a volcano, that's all I can… You don't feel anything and then suddenly you feel this, oh, what's going to happen. And suddenly, whoosh and all this comes out, all this shit, this emotion, you know, whether that be vitriolic or crying, whatever it is, it all comes whooshing out like that. And you can't stop it, you can't stop it. But the voices were keeping it…keep down, keep down, keep down.

						Reference 3 - 0.78% Coverage I now allow emotions in. And that's hard. When you've been practiced at keeping them shut down, contained, you know, you're okay, I'm okay, you're okay. That's hard work. Whereas allowing emotions to be there all the time, which is the way people should be, but I struggle with that, I really struggle with it. But I know if I get upset, stressed, anxious, that's going to let the voice back. And now, so that's noise medication, if I get the voices, I think, oh, hang on, what's going on for me. And I have to think then Reference 4 - 0.21% Coverage I was working, yeah. Which obviously, made me stressed even more, which I didn't realise at the time, because I was a senior staff nurse.

						Reference 5 - 0.16% Coverage Even now, if there's crowds, I can't cope, the voices come and I've got to get out of here, it's too much. Reference 6 - 0.21% Coverage And then occasionally, when the voice did intrude too much, then obviously I would have to go off sick, which is why I've retired from the NHS. Reference 7 - 0.45% Coverage I: What was that like trying to keep them at bay and continue focusing? P10: It's stressful, which obviously made the voices more powerful because they're being fuelled by the stress, by that emotion that I'm not blurbing out, I'm not getting rid of that emotion, so it's all going into my voices.

						Reference 8 - 0.34% Coverage I: So some people I've spoken to actually have talked about how powerful the voices felt. P10: They can be very powerful, yeah. They're scary. Well, that's my perception. I was terrified of them. They were scary people, yeah. Reference 9 - 0.42% Coverage Certainly, I recognise now, looking back on reflection, my voices were always there when the stress was heightened for…it could be a minor reason, I don't know, you know, my daughter leaving school, anything. And they would…yeah, they would go for me full time, real hard, you know. Reference 10 - 0.36% Coverage

						And as my emotions have grown, my voices have gone. They've faded, that's more the word. I very occasionally get them now, but if I do it's because I'm emotionless, which is very easy to get into, particularly when you do this sort of work. Reference 11 - 0.14% Coverage I shut down and my voices helped me do that. That's the way I look at it now on reflection Reference 12 - 0.31% Coverage Very, very occasionally. Again, like last night, I got here, I couldn't find my hotel and I was going round York getting really stressed. And the voices, yeah, you're a bleeding nuisance, you know, shut up. Reference 13 - 0.25% Coverage

						Yeah, because there's too much going on, there's too much stimulation basically, that's why they'll be…too much noise, too much sight, sound, it's too…whoa, it's overload. **Wanting to get rid of voices** I: Did you have any thoughts as to what might have been useful in you sharing to your CPN that you heard voices? P10: Well, I thought she might be able to help me get rid of them, to start with, you know, I just wanted rid of them because they were annoying apart from anything else, you can't…it's difficult to work when you've got somebody on your shoulder talking to you all the time. Reference 2 - 0.60% Coverage People have asked me this before, and I would always say I wasn't in a

						relationship with my voices. But I must have been because they were mine. And I'd just think I just wanted rid, and that's the only really relationship I had. They would go at me, they were horrible to me, and I didn't want them anymore. And I would try not to engage with them, because I just think that would have encouraged them. **Relating more positively with voices** And I suddenly began to understand what they were talking about. And listening to what my voices were saying and relating it to people that I was meeting in those groups, I could get into a relationship with real people, which I've never really done before. Reference 2 - 0.13% Coverage the relationship with my voices changed, as my relationship

						within the therapy changed. Reference 3 - 0.18% Coverage it used to be a constant battle. I've got to the stage now where actually I'm not that worried about them if they're there. **Perceiving voices are a guide** On reflection, they thought they were helping me by shutting down emotions. They thought they were helping me because they helped me function in my job as a nurse, and I wasn't, you know, heaving out all over the place about voices. **Being able to trust is important** Well, I've got a very good CPN is the answer to that, who I could trust. And I said, you know, I think I might be hearing voices maybe you can't hear. And we

						used to open that discussion.
P11	**Voice hearing is about power & control** They want to try, if I’m going to like, say I get an idea to do something they’ll sometimes try to change it, try to divert, to like trying to change what I do, to change my opinion, trying to put ideas into my head to do stuff. Reference 2 - 0.24% Coverage I used to…and like I always used to think that I’m predictable like, patterns and my voices can predict what I do. Reference 3 - 0.52% Coverage Like sometimes I’ll go to the shop or I’ll walk down the street or I’ll go make a drink or something and then they’ll like, they’ll pick…they’ll dissect everything I do. Like they’ll look into why I do it and what I do and why I do it sort of thing. Reference 4 - 0.27% Coverage	**Dominating influence of medication** In hospital, the way they mainly treat is, mainly with medication. So when I first went to [inpatient ward] I was on quite a lot of medication. Reference 2 - 0.48% Coverage Yes, so it was just mainly medication and like you…they’d have conversations but like they wouldn’t do much activities in [inpatient ward]. They did like art and, they did like art and…like choirs and I wasn’t into that sort of stuff. Reference 3 - 0.45% Coverage I: What would you prefer? If you did have that choice what would your preference be? P11: I know they do depot, do you know, when you go like once every…I think it’s once every three months you go for an injection. Reference 4 - 0.24% Coverage I: So has anyone ever offered you a different type of treatment, like talking therapy or…? P11: Not really no.	**Making sense of voices** so like the voices, sometimes it’s one person and they’ll say it’s only me. But then I get other voices saying no, it’s me as well. So like one voice says it’s only me and then another voice will come in and say, no, there’s loads, like there’s multiple people in my head, like well multiple voices. So I don’t know if it’s one person trying other voices on, if you get what I mean? Reference 2 - 0.32% Coverage So sometimes I don’t know if it’s my fault or my voices putting ideas into my head. So I don’t know if it’s my decision or my voices saying go and do this. Reference 3 - 0.72% Coverage And sometimes they tell, like they told me if we sound sad it’s ‘cos we’re mad and if we’re mad we’re actually sad. So it’s like it’s opposites and then if they’re shouting, if it	**Being persecuted by voices** Usually it’s like, usually it’s like they’ll take digs at me and stuff like that. Reference 2 - 0.48% Coverage I feel nervous when I go in for a shower because like my voices are there and I can’t get a shower like in peace because the voices like laugh at me and stuff. Because I’ve put a bit of weight on since being in hospital and that. **Voices don’t like VH getting help** I: How do your…that’s interesting, how do your voices respond to that then when you try and help people? P11: Well they call me, one thing they do is they call me a fool. Like they say I’m a fool and they say like a fool is only supposed to help himself, or help, I don’t know how it works but they say, oh a fool what likes to help.	**Experiencing MH services as uncaring** Not like, like when I was in [inpatient unit] all you could do all day was sit there and I’d sit there for 12 hours talking to my voices. Reference 2 - 0.85% Coverage I: Okay. Right, so…what do you remember of your experience of being at [inpatient unit]? P11: Well to be, like, wake up in the morning at like say half nine, ten, have breakfast, sit there until…well that’s all it is, you’re sat there. And when you’re not sat there you have, say you go for dinner and then you’ll be sat there again. So it’s literally just sat about doing nothing, talking to my voices 24/7. Reference 3 - 0.64% Coverage Definitely, I was just sat there daydreaming, yeah. Literally just sit there daydreaming and…one of the patients called XXX, he	**Being accepted and supported** But here mainly like you socialise with people who, here you socialise with people who’ve got mental health. Like everyone’s got all different types of things here and we used to just go day-by-day. **Feeling valued by practitioners** There has been a…like there was a guy called XXX, an Indian guy and he used to do quizzes and that. And I didn’t really do the quizzes but I used to talk to him and yeah, a really nice guy. Reference 2 - 0.18% Coverage Yeah, there was a few different members of staff at [inpatient unit] who we used to talk to. Reference 3 - 1.24% Coverage

	Yeah, sometimes it’s a bit like that yeah. And sometimes I feel like they know, my voices know what I’m gonna do before I do it. Reference 5 - 0.82% Coverage Like they say, well we’re years ahead of you, we know everything you’re going to do; and it’s like we’re years ahead and like, like we all have a path don’t we in life, a destiny sort of thing and they say like you can’t change anything, it’s dried. But yeah, in that way I feel power, I feel like they’re powerful because I feel like they are smarter than me and they know a lot more than me. Reference 6 - 0.36% Coverage Yeah, but I don’t know if they’ll…I can’t trust them because I don’t know if they’ll tell the truth or if they’ll just tell me what I want to hear or they’ll lie to me…so… Reference 7 - 0.46% Coverage	**Being persuaded to take medication** XXX from the outreach team come to see me and she brought some drugs with her, some like medication and her and her colleague were sat in the living room at my Dad’s house trying to get me to take these medication but I was adamant not to take them. Reference 2 - 0.74% Coverage They were literally sat there for like 10 – 20 minutes looking at me, saying take the drugs. And I was like no, and it got to the point where I was just sat there not saying a word and these two doctors were sat on the sofa just looking at me saying, take them. And it got to the point where no one was speaking. They were just sat there staring at me. Reference 3 - 0.37% Coverage I remember when they were talking to me about taking them meds, I kept thinking that I was just going to vanish; once I’d taken the tablet I kept thinking I was going to vanish. **Benefitting from medication** I feel like I don’t react as much. Reference 2 - 0.72% Coverage	sounds like they’re shouting they’re actually whispering and if they’re shouting it will sound like whispering, so it’s like opposites. It’s a bit weird, a lot weird. Reference 4 - 0.74% Coverage I’ve been walking down the street before where I’ve like passed someone in the street and then their voice comes into my head but that, I don’t know if it’s my voice, if it’s one voice like messing me around. Like I went into the shop and come back and sit down, come back and sitting on here and for about an hour I could hear him talking to me in my head. Reference 5 - 0.72% Coverage I’m not sure. I always think that my voices are like, do you know when you sleep and it’s your subconscious……I always feel like they’re with my subconscious, the voices. I feel like when I go to sleep, it’s like you go to sleep and your subconscious wakes up. And I feel like that’s	That’s one thing they say to me. **Voices being disruptive** like sometimes I get, sometimes I get bad thoughts about people. I don’t know if it’s my thoughts or my voices thoughts but like there was a woman at [inpatient unit], big, a bit overweight girl but she was really nice and that and they kept, I kept calling her fatty in my head, so it was like…And it kept going on for ages and after we, like XXX, who was Indian, it happened to him now, calling him names, like racial names in my head. And there was a bald guy called XXX, and I kept calling him, I kept calling him bald-headed ‘c’ word and then I walked to the shop with him and I kept saying it in my head so I told him. I says, I says, I keep calling you a bald-headed ‘c’…a bald-headed cunt in my head. He says, oh don’t worry about it. Reference 2 - 0.75% Coverage	said to me, why don’t you do owt? All you do is sit there. I was like, what else can I do? I was like, everyone else just sits there as well; there was literally nothing to do. **Practitioners not talking about voices** For a mental hospital they didn’t talk about it that much. Reference 2 - 0.34% Coverage I: So you sound surprised that you didn’t talk an awful lot about voices? P11: Yeah, sometimes I’d like love to, well sometimes once I start talking I don’t stop.	P11: It was, we wouldn’t…I wouldn’t really talk about mental health. Well sometimes, like I have dreams about space and stuff and like aliens and I have weird dreams like about like other things to do with the world and that. I: Yeah. P11: So sometimes I’d tell them the dreams that I had or they’d tell me how their day’s been and how the weekend’s been and just normal conversations. I: Yeah. And were they helpful? P11: Yeah, I wouldn’t always, it wouldn’t always be about mental health. We’d talk about normal things and that. And yeah, we would have good conversations with people. Reference 4 - 0.92% Coverage To be fair like, sometimes it would be staff talking to me,

	Well not picking on me but, like I think they dissect, like psychology, like they dissect it, look into everything that I do and sometimes they like try to get on my nerves. Like and sometimes my thoughts are repetitive. Reference 8 - 0.10% Coverage I'll retaliate and like the voices will retaliate. Reference 9 - 0.60% Coverage Like sometimes I'll try to like get back at my voices and they are like, no, it's not going to work with us. Like they say it's far, like, I don't know like watching TV, they'll say oh…for everything I do they always say they're going to get me for something, like for stuff that I do. Reference 10 - 0.38% Coverage like, if I do something, they'll have like a retaliation for it. So sometimes I try to do stuff when they can't retaliate from it. But then they say that's not going to work with us.	Because it's like before I was in hospital I was staying at my Dad's house and I wasn't on medication and I used to take my shoes and socks off and go walking with no shoes and socks. And like I jumped through the canal thinking I was being followed by dogs and people. But now I, the voices tell us, like yeah, whatever and I don't react to it. Reference 3 - 0.26% Coverage Like before I was on the medication I'd be up and about looking out the window, thinking people were out to get me and stuff. Reference 4 - 0.11% Coverage The only thing I'm sure of, it stops me from reacting. Reference 5 - 0.11% Coverage like I'm happier and I don't react to the voices much Reference 6 - 0.82% Coverage Yeah, it does mainly make me feel, I dunno, I just don't react as much. I dunno, like I said, I sometimes get a big rush of fear through my body and that's probably when I react.	where they are with my subconscious. Reference 6 - 0.37% Coverage I was getting a bath a couple of week ago and they just kept, in my head they kept saying temperature over again; but I don't know if it's them saying it or if it's my thoughts. Reference 7 - 0.58% Coverage And then if I try to like, if I try to like, they call it crossroads, my voices. Like if like we come to a crossroads that's what they'll say; where I do something and they can't get me back for it. They call it crossroads but I dunno how to explain it. It's really complicated. Reference 8 - 0.49% Coverage I think they just want to hurt me and they want me to like, they're trying to like, trying to change what my thoughts are, like go and do this, or go and do that. They are trying to like	Like I started calling myself pig-headed cunt. Instead of calling him a big-headed cunt or whatever I called him, I started calling myself names. And I was going to tell XXX, I was going to tell, because I kept saying names about him and I was going to tell him but I didn't have the courage to tell him, because I felt really bad about calling him them names. Reference 3 - 0.54% Coverage I: whatever things you were talking about, can you remember whether your voices were present and around at that time? P11: Yeah, I think they were, yeah. Yeah. But it was, that probably, it was like, it was mainly me insulting people. I found that a lot.		like trying to get to know me and stuff and like with other patients they wouldn't talk about it that much. Because a lot of people, because a lot of people don't really want to talk about their mental health so, so it's like the members of staff would just like have normal conversations with you, rather than start asking you questions and stuff that you might not want to answer. Reference 5 - 0.34% Coverage I feel, I feel better from talking to people but I don't, I don't have to talk about my mental health. I can talk about anything and it will make me feel better. **Finding it difficult to relate with voices** Well we're not friends I know that; Reference 2 - 0.11% Coverage

	Reference 11 - 0.56% Coverage Well since I’ve came here to this house they’ve been a bit quieter, but then I think about like, I’m, say like for half an hour they’ll go quiet but then I’ll remember that like they’ve gone quiet and then they’ll start again. So it’s like on and off a lot of the time. Reference 12 - 0.26% Coverage But I feel like my voices hold a lot back. Like there’s a lot more they could say and I think that they’re holding back on me. Reference 13 - 0.54% Coverage I don’t know. It’s like they say intelligent people don’t reveal everything don’t they? You know, sort of thing, do you know what I mean? It’s like that. That they’re not going to reveal everything and they’ll, they’ve got like tricks up their sleeve and that. Reference 14 - 0.59% Coverage	Maybe I get a big rush of fear and I think, right, let’s go for a walk or let’s go do something but that’s like, I still get a rush of fear but I would just, won’t react, or maybe sometimes like adrenaline. **Medication not helping voices** I ain’t got a clue. I don’t think, it’s not for the voices, it’s for me isn’t it, but…so I don’t know. **Feeling worse from medication** I’ve lost a lot of confidence because I’ve put a lot of weight on and that bothers me. **Importance of being involved in treatment decisions** And obviously every day we make decisions about what we’re going to do. So I guess I’m in charge of my own recovery. Reference 2 - 0.20% Coverage They gave me a choice, here or [community place] and I chose here [community place] because I get along with people well here. **Lacking involvement in treatment decisions** I: And did you have a say in any of that or was it just… P11: No, no, I didn’t, no. If I could choose I’d go on a	disrupt it. Trying to disrupt what I want to do. Reference 9 - 0.18% Coverage And yeah, so I think they’re being quiet so I act normal, if you understand what I mean? Reference 10 - 0.30% Coverage Sometimes I just think of someone and a voice comes into my head but that’s what I think. I think it’s one person trying to put the voices on. Reference 11 - 1.28% Coverage Yeah. I think it’s all related to my subconscious and my like dreams. Like I think a lot, a lot of time like when I have voices and stuff I also think about life in general. So like, and like one thing I thought is, imagine a scale of one to a hundred and then like say you’ve got like half way, 50, so like someone could have like 50 per cent consciousness and like 50 per cent subconscious. And like some people have like ten			Yeah, we’re not friends, like they want to hurt me. Reference 3 - 0.60% Coverage And like usually it’s stuff that I do and like say, I don’t know, going into town or something…I don’t know. I don’t talk to them. They don’t talk to me, they’re just like…they pick on what I do. Or if I have a conversation it just goes back and forth and you don’t get anything out of it. Reference 4 - 1.29% Coverage But a lot of the time, like I feel…my voices say like I’ve said everything I’ve got to say because I’ve got my voice in my head like here and now, they say I’ve said everything that I have to say so anything I say to them is just repeating. It’s just repeating myself. So sometimes I’ll be like, I won’t be talking to

	Sometimes I don’t know if it’s my thoughts or my voices thoughts and then I get conflicting thoughts. Like I might be walking down a street and I come to a crossroads, and I’ll say go left…that’s just an example, but I’ll say, go left and they’ll go right and I won’t know what to do. Reference 15 - 0.27% Coverage I: Yeah. And do your voices listen, so are your voices listening in now to our conversation? P11: Yeah, a little bit, yeah. **Acting on what voices say** when I thought it was my idea I used to, I used to not go…like if it was my idea I didn’t do it but if it was their idea I found that I just went and did it. **Feeling threatened by voices** I feel like sometimes they want to hurt me. Reference 2 - 0.22% Coverage they say, it’s like they’re going to beat me up and	different drug because this drug makes me put on weight.	per cent consciousness and like 90 per cent subconscious. And that’s what I thought about myself. I thought I’ve got like ten per cent consciousness and like 90 per cent subconscious. Reference 12 - 0.70% Coverage I dunno, just, it’s like…it’s like meditating isn’t it? Sort of like meditating but I’d just sit there and zone out and see what I think, see what I see. But not always through my voices; I feel like they’re very good at hiding. Like I don’t know, I think they’re very good at not showing what they’re really up to if you see what I mean. **Feeling physical presence of voices** Like I’ve been walking down the street before and I’ve felt like they were behind me, like behind my shoulder. I’ve had that a few times when I feel like they’re behind, like over my shoulder. Reference 2 - 0.14% Coverage			the voices, I’ll just be thinking to myself and the voices will be, yeah, you’ve already said that, you’re just repeating yourself. Like that’s one of the conversations we have quite a lot. Where they say, you’ve said that. You’ve said all you’ve got to say, you’re just repeating yourself now. Reference 5 - 0.43% Coverage Well it’s, like I said I’ve got nothing new to say so everything I’ve, everything I’m gonna say I’ve already said to them, so it’s like nothing. It’s nothing new, no new conversation that hasn’t been said. Reference 6 - 0.80% Coverage Sometimes they say, or they’ll tell me something and they’ll way you weren’t listening. But like I wasn’t, I wasn’t avail…sometimes the

	stuff like that. Like they say a lot of stuff like that.		like I’ve felt them like quite close to me like behind me sometimes. Reference 3 - 0.34% Coverage well I don’t know if it’s like behind me or the back of my head or, I don’t know where but I’ve been walking down the street and it will be like someone’s behind me. Reference 4 - 0.28% Coverage Usually I just feel like they’re in my head, but I usually listen to music and then I feel like then they’re in the background a bit.			voices will be talking to me and then they’ll go like, like they’ll say, well we’ve just told you something but you weren’t listening but obviously, I listen to one voice and like they are saying there was another voice talking but I didn’t hear it. Reference 7 - 0.28% Coverage So yeah, like change, like sometimes they say they’ve tried telling me stuff but you don’t listen, sometimes they say stuff like that. Reference 8 - 0.24% Coverage Because I question, every day I question them? I was like, why are you being so quiet? And they won’t tell me why. Reference 9 - 0.09% Coverage But like I said I can’t really trust them.

						Being active and distracted is helpful But I think it's, when I keep busy; if I'm really busy one day it's not as bad but if I'm like a lot of time to myself where I can sit, like sit and think and they're more frequent. Reference 2 - 0.10% Coverage I like being busy because it keeps you occupied. Reference 3 - 0.64% Coverage Like sometimes we'd do tennis or football. We went on a long walk on Wednesday; we did like a four-mile walk up and down loads of hills. I was really exhausted. So we just do like activities; and if you ain't got anything to do just do housework and just clean up and stuff. So there's always something to do.

						Reference 4 - 0.43% Coverage I was at my Dad’s house and my voices were going off so that’s why I was walking down the street because when my voices got that bad I used to go walking. And I found when I walked they quietened down a bit **Voices interacting with emotions** Sometimes I feel, sometimes I feel I get a rush through my body of like fear or like anxiety or like adrenaline, so yeah. **Relating more positively with voices** Sometimes it’s nice to have the voices there, do you know, sometimes when you’re sat on your own not doing owt and a voice comes into your head. **Trusting people is difficult** I: Yeah. And so is that one of the reasons

							why you wouldn’t want to take those? P11: Yeah. And I just didn’t trust the doctors I think as well.
P12	**Voice hearing is about power & control** sometimes they’re a bit more disturbing, so I’ll be sort of swearing and stuff back to them and stuff. Reference 2 - 0.34% Coverage I: So let’s think of this in terms of whether they create distress for you. P12: Yeah, they do. They do create distress for me. **Lacking agency with voices** It’s just I can’t stop them, I’ve just got to sit through it, just got to get through it. Can’t stop them from being negative, I’ve just got to persevere. Reference 2 - 0.28% Coverage P12: Yeah, I’m waiting for it to die down. I: Okay. P12: Waiting for the negativeness to die down.	**Dominating influence of medication** I’m medicated on olanzapine to cope with what I suffer with properly as well. Reference 2 - 0.17% Coverage It could be a while, I could be on this medication for a while. Reference 3 - 0.15% Coverage I’ve been offered PRN when I’ve been a bit more stressed. Reference 4 - 0.28% Coverage I: So aside from the medication were you offered any other type of treatment? P12: No, not really. No. Reference 5 - 0.19% Coverage I don’t know, at this point in time I don’t really know, to be honest. Reference 6 - 0.21% Coverage	**Making sense of voices** I: So that it doesn’t even make sense? P12: Yeah, it doesn’t make sense. Yeah. So sometimes it can just be a lot of mumbo-jumbo and not even make sense. Reference 8 - 0.33% Coverage I thought I was actually chatting to people, do you know what I mean, I thought I was actually chatting to people at first. Reference 9 - 0.13% Coverage Yeah, I thought I was actually talking to people. **Feeling physical presence of voices** They can be distant, or they can be closer sometimes; can be distant or closer sometimes. **Living with voices**	**Being persecuted by voices** talking to each other or more like negative comments that are against me and stuff. Reference 2 - 0.19% Coverage It’ll be like commenting and swearing at me and stuff, calling me names. Reference 3 - 0.13% Coverage They’re a bit more louder when they’re disturbing. **Voices being disruptive** I: What do they do when you’re talking with someone like me then? P12: No, they’re just general conversation, still general conversation, just chatting away. I: Okay. So would they be still chatting away and even talking to you even while you and I are talking?	**Practitioners not talking about voices** I: Okay. So going beyond asking how your voices have been, do they have any other conversations about your voices, or…? P12: No. I: Okay. So they just ask are they all right? P12: Yeah. Yeah. **Framing experiences according to professional interpretation** I: Okay. And what do you understand about your voices? P12: My mental condition. My mental condition. I: Okay. So do you think then because you have a mental condition you therefore hear voices? P12: Yeah. Yes, it’s a part of my mental condition. Yeah. Reference 2 - 0.63% Coverage P12: It’s that it’s just something I suffer with, hearing voices; and then	**Being accepted and supported** P12: Yeah, I’ve spoken to other people. I go to a hearing-voices group on a Thursday. I: Ah, right. Okay. And what do you make of that? P12: People there…other people who suffer with similar experiences, it’s pretty good. Reference 2 - 0.45% Coverage Yeah, it’s good, it’s good to express them and find out what other people’s experiences are as well though, just the people who suffer with similar experiences to my own. Reference 3 - 0.40% Coverage

	Reference 3 - 0.44% Coverage I: And what would cause them just to die down then? P12: I don't know, they've always just seem to go back to normal, back to normal general conversation afterwards. Reference 4 - 0.34% Coverage Yeah, just still negative comments, just still negative comments, just continue; I just have to sit through it until it dies down. Reference 5 - 0.36% Coverage It gets like, it's like the general…it can be just mumbo-jumbo sometimes, you know what I mean, it's just like a lot of mumbo-jumbo talk. Reference 6 - 0.22% Coverage Sometimes they do, don't listen, just carry on chatting whatever they're chatting. Reference 7 - 0.38% Coverage	it's that I've been on medication a few times but I've stopped taking medication. Reference 7 - 0.25% Coverage I should, if I'm prescribed it by the general practitioners, this medication, I should take it. **Being persuaded to take medication** No, I'm told I need to be on it, by the doctor. **Benefitting from medication** It helps with how aggressive they are, and not, as well; and it subsides them a bit as well, helps subside them a bit. Reference 2 - 0.27% Coverage I think it helps, I think it has a…it helps a little; it doesn't help completely but it helps a little. Reference 3 - 0.16% Coverage It helps subside them a bit, they're a bit quieter some days. **Coming off medication without support** No, I just stopped overnight last time. **Medication not helping voices** It doesn't completely stop voices anyway, medication doesn't	Because I've suffered for a few years, so I've got used to it a bit now. Reference 2 - 0.30% Coverage I just get on with my life. Yeah, just get on with my life and, you know, and cope, cope with what I suffer with.	P12: Yeah. Yeah.	schizophrenia. So I just see it as like that it's just something I suffer with. I: Okay. So I guess you've been given a diagnosis of schizophrenia? P12: Yeah. Reference 3 - 0.35% Coverage I started off with psychosis and then I started hearing voices; I started hearing voices after I was first diagnosed with psychosis. Reference 4 - 0.39% Coverage They said that I was suffering from psychosis; and it started off with psychosis and then I was diagnosed with schizophrenia, and anxiety and stuff. Reference 5 - 0.25% Coverage getting a full diagnosis, getting a fuller diagnosis of what I suffer with was obviously helpful Reference 6 - 0.63% Coverage	P12: It helps. Yeah, it helps. I: In what way do you find it helps? P12: That just to get a picture of people who suffer with similar experiences. **Feeling valued by practitioners** I was able to make coffees, get sandwiches; I'd get my lunch made for me; I'd be able to play pool. Yeah. And I'd have staff there to support me. Reference 2 - 0.12% Coverage Yeah. Yeah, I talked about voices to nurses. Reference 3 - 0.20% Coverage They'd be asking me questions. Well, just asking me questions on the voices. Reference 4 - 0.16% Coverage

	P12: Chat to me. Yes, they'll talk to me. Yeah. I: And do you have any sense of influence over that then? P12: Not what I'm aware of. No. Reference 8 - 0.17% Coverage Yeah, just on and on. Yeah, it can be constant some days, yeah.	completely stop; it's just whether it helps you, if it helps or not, helps you or not to take a medication, it's just whether it helps you or not. **Wanting to reduce or stop medication** I just felt I didn't need to really take it any more. Reference 2 - 0.07% Coverage I chose to quit taking them. Reference 3 - 0.32% Coverage I'm not sure. I'm not sure. I guess if I was in the right situation and well enough I could, I could stop my medication. **Importance of being involved in treatment decisions** Yeah, I've been involved in the decisions made about my treatment. Reference 2 - 0.12% Coverage Yeah, I am asked if I want to take it as well Reference 3 - 0.21% Coverage They'd ask me if the medication's right for me, if it helps, or if it doesn't.			P12: Yeah, schizophrenia and stuff. Yeah. I: Okay. So what difference has that made to you then to receive that diagnosis? P12: Just helps me know a bit better what I suffer with really, helps me know basically what my diagnosis is. Reference 7 - 0.16% Coverage It's just paranoia and stuff, paranoia and voices, and… Yeah. Reference 8 - 0.18% Coverage Fine, that's just…it's their diagnosis, that's what they suffer with.	Well, because to get a better picture of what I suffer with. **Finding it difficult to relate with voices** I'm not very close to them. I'm not very close to the voices, no, it's just something I suffer with. **Distancing self from voices** It's safer for me, you know, safer and better for me to be there, instead of lumbering about the flat on my own. **Voices interacting with emotions** P12: Well, that's when they'll be calling me names and stressing me out. I: Okay. P12: And keeping me up at night, and that. Reference 2 - 0.47% Coverage P12: I don't know; if I'm more stressed I think they go a bit negative, when I'm more stressed. I: Okay.

		Reference 4 - 0.22% Coverage I told my care coordinator that I wasn't taken medication; I did, I did tell them. Reference 5 - 0.31% Coverage They were okay at the time, they were okay with me not taking medication at the time, and it was just fine with them. Reference 6 - 0.33% Coverage I'd have conversations and gradually quit. I'd have conversations with my care coordinators and stuff and just gradually quit. **Lacking involvement in treatment decisions** No, I'm told I need to be on it, by the doctor. Reference 2 - 0.58% Coverage P12: I have a care coordinator that checks in on me every few weeks. I: Okay. And this care plan then, what's in that? What does that mean? P12: I've not seen it recently, so I don't know what it is at the moment.				P12: I think it's more to do with when I'm more stressed and stuff. Reference 3 - 0.12% Coverage It happens more often when I'm more stressed. Reference 4 - 0.36% Coverage I: All right. So I'm wondering then is it possible then that your voices respond to how you're feeling? P12: Yeah, I think so. Yeah. Reference 5 - 0.25% Coverage I don't know, they're probably okay with it some days, and obviously when they're not stressing. Reference 6 - 0.16% Coverage when the voices are being negative I'll be a bit more stressed

						Reference 7 - 0.78% Coverage I: Yeah. So if they’re being disturbing or negative… P12: Yeah, or negative. Yeah. I:…that’s when they’re getting louder, swearing, being negative… P12: Yeah. I: …and calling you names and things. P12: Yeah. I: So when they’re like that you find it more… P12: Stressful. **Wanting to get rid of voices** I: What would you like to happen with your voices? P12: I’d like for them to go eventually, completely go. I: Yeah. P12: I’d like for them to stop, to be fair. Reference 2 - 0.59% Coverage I think some of them are happy having the voices, and some not. Some are happy with

						their voices, just getting on with their voices; some are not, some would like for them to stop. Some like me would like for them to stop. **Relating more positively with voices** I talk back to some of my voices sometimes, and, like generally chat back to them; Reference 2 - 0.19% Coverage Yeah, it’s okay, yeah, the relationship with one of the voices is okay. Reference 3 - 0.27% Coverage It’s just like general conversation, like general chatting away to each other and chatting away to me. Reference 4 - 0.24% Coverage my voices are mostly general conversation, chatting away to each other, chatting away to me.

						Reference 5 - 0.31% Coverage Yeah, I do. I do talk back to them, and I have asked them what they're doing and why are you doing it before and stuff. Reference 6 - 0.48% Coverage Me talking back to them, just me chatting away back. Sometimes I can be like having a conversation, you know, like to myself, I'd say… I mean like a bit of a conversation to myself.
P13	**Empowering self through action** I started to like do, get, do this research and like, not just research on line and everything like that, but research myself and understand myself Reference 2 - 0.57% Coverage I made it my mission to work out what was going on,	**Being persuaded to take medication** pushing like medication straight away Reference 2 - 0.27% Coverage And then I had like two years of them pressuring me to like go on medication, which I just instinctively knew wouldn't work out. Reference 3 - 1.20% Coverage	**Making sense of voices** I, quite a lot of the time it's more, it's like childhood, like school friends and people I've known for a long time saying that, just like almost like guiding me into like, not necessarily where I want to be, but more just helping me gain like a better perspective on life, and like how to like deal with things. And like quite often it's one, when	**Being persecuted by voices** Because like when it first started happening it was aimed a lot about death and me dying. Saying that like, me myself, I put a name to the negative voices as like the devil and his demons trying to like taunt me and that sort of thing. **Voices being disruptive**	**Practitioners failing to connect & understand** the first two years I was like on and off seeing people. Then when I was like seeing people from the [community] team like we'd just sit there and like almost like, she's obviously ask me how I'm doing and that sort of thing. And ask you if everything's okay. I'd just say like, yeah, they're all right here. And then like	**Being accepted & supported** if it wasn't for like probably my family ringing the services or whatever, then like might be a chance that I'd still have those delusional, delusions, and that sort of thing. So, yeah, like I don't think… I do think that most of it is just

	figure out why I'd been like given this gift, if you like, and just like yeah, just like working it out and how, and like how it could impact like society sort of thing for… And like, yeah, I just wanted to make sense of it. Reference 3 - 2.15% Coverage literally it was one video, just one video that I looked up when I, my mum first said the word psychosis, like later that night I'd like, I watched one video and it was a taped call it, psychosis or spiritual awakening and it just, it talked about like shamanism and that like just told me it was a gift, it told me that like everything we know about schizophrenia is probably, not wrong, but like going at it in the wrong way and just like it taught, like it, I just sort of learned to like, you know, to perceive it as like, no matter what it was, it's there to teach me something. So what lesson can I get from that? Yeah, plus like I've always been like really curious about almost everything that I encounter. So I've, it's made me like do a lot of work on it and just figure it out and I	Well it started off, there was like, oh what do you think about medication? And I said, well to be completely fair like I don't think I trust like the pharmaceutical industry. And I'd rather like, and I just remember saying, like at first I just remember saying, I'm certain my body will heal over time by itself. Or even, like my mind will heal over time by itself. I don't want drugs. Like I don't even take paracetamol sort of thing, I don't. I just don't. It's not that I don't trust it but I just, I know that there's like better ways with dealing with whatever's going on. Reference 4 - 0.25% Coverage And each time it was just like, right we think you should go on medication now. We think you should go on medication now. Reference 5 - 0.19% Coverage Because my family was like telling me to and they would just rather me be on the medication. **Medication not helping voices** when I started taking the medication like the voices was like… They almost disappeared, to be honest, which obviously is like the intent from the	it's like my friends talking it's quite, quite a lot of the time it's quite comical and, yeah. Reference 2 - 0.21% Coverage most of the time I can like, I can actually like recognise the voice, like the voice to like the face Reference 3 - 1.78% Coverage Well I was like, I was like smoking weed every day. I was working. And I don't remember the exact like time it started happening, but I know like roughly. But like I was just, like high at my house and like I started to like hear someone or something start to like tell me that like I needed, even happening when I was with my friends that like my friends, like they're using me, they're not my friend. They've bullied you for a long time. And loads of like quite negative things that at the time I didn't really, like I just completely ignored it and I was like, no, like you're not talking the truth sort of thing. But then like	only a few times where like I've been around people and I've like heard them say something to me. And even then it was only like probably them calling out bullshit on what they're saying. And they're saying oh like, you do know he's talking shit. Reference 2 - 0.21% Coverage I do remember like them saying, oh like, if they want to help you, this isn't right what they're doing. Reference 3 - 0.23% Coverage It was like, if they want to help you, that's not how to help you sort of thing. Like loads of things like that. Reference 4 - 0.13% Coverage it was just like the route that we take is the wrong approach Reference 5 - 0.41% Coverage	I'd never got to like talk, the conversation of like, let's work out why this is happening to you. Reference 2 - 0.38% Coverage It was more just, yeah, just like checking up on me and like not, it just, to me it just felt as if, like it wasn't help. Like it wasn't, almost like the system wasn't there to help. Reference 3 - 0.03% Coverage I hated them. Reference 4 - 0.08% Coverage I didn't want anything to do with them. Reference 5 - 0.55% Coverage as soon as like I got a rough understanding of like how they approached things and like what happened, I just, I didn't want, like I stopped, so I stopped going to see like the [community] team for like, after like literally three months or something like that	because of like my family's… Like my mum says she's proud of me now, like how well I've handled the past few years and she's stopped ringing the services. Reference 2 - 0.88% Coverage It's like freedom. Yeah, like to be honest, it doesn't make much difference like for them, sort of thing. But like for me it's just like, now I can, it's like now I've like, I've not won or anything like that, but now I've got the, now I've been societally accepted to like have this voices in my head guide me into my life. And like I don't feel like it's, I don't feel like society is telling me it's a bad thing anymore. **Feeling valued by practitioners** Just like the stuff that, like I just, that I need to do. And then like I talk about my, just

	think, I don't, I think my perception of it has changed from like when I first started to like hear it, up until like maybe the first year. Because I was like, I was fearing what I was hearing, whereas now like I fully embrace it, sort of thing. **Taking responsibility** in a way it's motivational but at the same time like in normal world terms, or societal terms like I'm not proactive but like with, but then at the same time I am because I spend hours and hours every day thinking of ways of like, and just theorising of like how can I achieve my purpose and help everyone? **Feeling threatened by voices** And I was hearing things like, oh we're going to come and kill you if you don't like stop doing your research and if you don't have this strong connection with all of the good, and like nature and everything like that. Reference 2 - 0.39% Coverage I was hearing things like taunting me saying that	medication. But I was still hearing things but it was, it was like less powerful. Reference 2 - 0.79% Coverage I: And do you remember how your voices reacted to that? P13: There was, no, mm, it wasn't even that long ago, but like I don't, I don't really know, to be honest. I would speculate that it was probably, it was like at least you've got what you wanted sort of thing. I: Mm. P13: Like leave those past few months behind. You tried it, it didn't work. Move forward, move on **Feeling worse from medication** I was like, doing nothing but sleep. I didn't even have time to think or do anything. I was, nothing but sleep. I didn't, the things that were coming into my head I didn't trust, like the thoughts. I didn't, I just felt like I didn't trust myself. I don't know if it's because like I had a negative perspective of medication in general, and it turned it into a negative thing Reference 2 - 0.90% Coverage I was literally sleeping for 20 hours a day. I just, I was having these really weird dreams that,	it, I was like, later I realised it was sort of like telling me the truth to me and like it was, it wasn't there to like to put me down about my friends and stuff, it was there to like help me turn my life around, essentially. Reference 4 - 1.38% Coverage I like to think of it as more like a bit of spiritual awakening and that like I've got like in the, like in like the Eastern part of the world, like the people who have like these hallucinations, they're like the top dog in the community sort of thing, because they can, like they've been like given a gift of like being able to communicate with like these higher beings sort of thing. And like I've chosen to like believe that's what my thing is. A, because it gives like a better view of it and makes, just gives me a bit more peace. And then, yeah, I think like doing that, it's stopped, it has almost stopped like the negativity like within myself sort of thing.	I: Okay. And can you remember your voices during these times when you were pressured into taking these medicines? P13: Yeah. It was always, you shouldn't trust that doctor, she's not a real doctor	Reference 6 - 0.63% Coverage I just felt as if like they should be explaining to me what's happening rather than like writing down my experiences and just like almost like putting it on the computer system for like whoever's to look at it to go, oh yeah, that guy is an absolute nut job. Now that's all like I felt that it was like. **Framing experiences according to professional interpretation** Well when they told me the diagnosis they did it like the guy said it like so slyly, like he just like slipped it in there, just like, oh like, he was the first few, like one, maybe like the third sentence or something. He was like, do you know you're paranoid schizophrenic? And I was like, I just went, yeah, I do, but like I was a bit, yeah. Reference 2 - 0.50% Coverage since I think of it as a gift and everything that I've learned on the subject, it's	like years, like my experiences through the week. If, on the whole, it's been a good week or if, on the whole, it's been a bad week. And then just sort of like, just have a bit of a general chat really at the same time. Reference 2 - 1.08% Coverage [CPN] would give me like, helped me figure out tips of what to think and what to say to myself when those situations arrive and trying to understand where it comes from. Because I, like I think it's like the devil, I just think it's the devil really. Like, yeah, just like the devil and his demons coming for me. And like Jane helped me just like, helps me like, just gives like reasons for and against that seem like the reasons why that seems plausible or not plausible and just like, it's almost like a counter argument.

	we've got a guy round the corner with a gun. I'm going to kill you. Why are you in my city? And like loads and loads of stuff like that. Reference 3 - 0.17% Coverage I was walking into town and they said they were going to come and kidnap my brother. Reference 4 - 0.41% Coverage I was walking around on my own, but every time I was, like the voices were saying like, oh that car that's going by is going to pull a gun out and shoot you. And like, you're going to get kidnapped. Reference 5 - 0.35% Coverage always when I go for a walk, like as I said, like I hear people telling that are going, that people are going to come and kill me and that, watch my back sort of thing. **Having agency with voices** the negative voices or whatever, they've been, that's what I was scared of	like almost, it was as if like… I remember one of them like my, it was as if my mind was in a cage and it was getting like electric, and there was like one of these like pole things, like one of them police batons, but it had like an electric thing on the end of it and like they were jabbing with it like frying my brain sort of thing. Reference 3 - 0.21% Coverage Which is a, on the whole I'd say is a bad thing because it's like my best friend spirit guide has gone. Reference 4 - 0.20% Coverage But I would just feel gutted. Like I wouldn't, I wouldn't, I don't think I'd be happy with myself. Reference 5 - 0.28% Coverage Just because like I don't have that connection with, with that thing that is so like, mind blowing that most people can't comprehend it. Reference 6 - 0.29% Coverage Not get rid because like, not get rid of, but like it wouldn't, like it would change and I just don't think that it would change for the good.	Reference 5 - 0.17% Coverage And yeah, I've got, I've got quite a good understanding of it all now, to be honest. Reference 6 - 1.22% Coverage there's two things in the entire universe. There's like yes and no, good and bad, positive and negative, male and female and like all that. And I think that like I've done a lot of like personal research into like what God is, because I believe that our entire nation has just lost faith with God. So I've tried to understand what, who he is and that sort of thing. And I believe that like he is, all of the love and good things that you hear. But then since there's like the yin and yang exists, the amount of, just as much good that there is, there's like this equal amount of bad. Reference 7 - 0.17% Coverage I was filled, like completely, with like what Christians call like the Holy Spirit.		a gift and it's like, it's a good thing. For me to get a label of something that is like seen and viewed so negatively, it really just bummed me out really. Reference 3 - 0.24% Coverage Yeah, it really negative. I was like, I was, I just remember being really like down and upset for about three days.	Reference 3 - 0.22% Coverage I've got, yeah, I've got good, like I say, I've got like a really good team helping me out now, to be honest. Reference 4 - 0.73% Coverage But then like as soon as like I met Jane she was like, you know, it's all right to hear voices. Like she's like, oh I've spoken to people who have said that, who have told me that they make them laugh every now and again and like it's not all a bad experience. I'm like, thank you, finally there's someone who's like...just be open and honest about it. **Voices interacting with emotions** Sometimes it can be quite nerve racking and a little bit scary, to be honest. Like the other night I had, like I had like a,

	for like two, I'd say two and a half years. It's not up until recently that I've like managed to find the willpower to say, no. Reference 2 - 0.13% Coverage I've definitely got the power over the voices, without a doubt. Reference 3 - 0.90% Coverage if I didn't then they would be telling me what to do rather, and like they're just not telling me what to do at all in any way, shape or form. Like not even once have, even if it's like oh I'll go to the shop and get a packet of biscuits or whatever, you know, like nothing. So I don't know. Like I do think I've got the power of like controlling them, in a way. Like I can't control what I hear, but I can control my perception of it. Reference 4 - 0.28% Coverage I'm not like as scared of hearing those than I used to be. It's stopped happening	Reference 7 - 0.29% Coverage I was just really flat. And I knew this. Like I knew this. I knew that I couldn't survive on the outside world like having this injection. **Wanting to reduce or stop medication** I knew straight away that like the medication was going to be a bad idea. Like I just knew. And that's why like I held it off for so long. Reference 2 - 0.74% Coverage a few weeks after the medication, after the injection like wore off sort of thing, so I felt back to my normal self and then the tablets came. I tried them and I realised that like, I preferred how I was in between having the injection and taking the tablets. I just preferred myself and it seemed to me like everyone else around me preferred that as well. Reference 3 - 0.38% Coverage I: Okay. And did you just come to an abrupt stop? How did that work? Or did you gradually come off, or…? P13: No, I did just stop. I: Okay.	Reference 8 - 0.39% Coverage But certainly like, with my connection with all these spiritual entities and that sort of thing, it makes me wonder if there is like ever going to be a time where I don't hear those things. Reference 9 - 0.22% Coverage Well I think that it's, there's like, see I think the voices are almost like a bridge to a greater power. Reference 10 - 0.30% Coverage And yeah, I just think like hearing the voices, it's more like a bridge way to not only like the highest self, but like the higher everything. Reference 11 - 0.39% Coverage I think having the voices communicate it's almost like, yeah, it's like a bridge way to like an ultimate supreme power really. It's everlasting, infinite, it's			essentially like a, what I would describe as like a demon talk to me. Reference 2 - 0.18% Coverage I remember when all this started I remember being like really depressed, like anxious. Reference 3 - 0.37% Coverage when that sort of stuff is happening it causes like a lot of fear like and that's the, I'd say that is like the worst part about being, about hearing voices and that sort of thing. **Relating more positively with voices** Because of like the experience I've had I've later then, I've later then realised that it has been guidance. Reference 2 - 1.34% Coverage

	as much by like, I don't know like 55, 60 percent.	P13: It wasn't a gradual thing. **Fearing enforced or involuntary treatment** the day I got there it was right, we're going to inject you and you don't have a say in it. Reference 2 - 0.18% Coverage Yeah, I think I had like five injections in like three months or something like that. Reference 3 - 0.69% Coverage I: When you say they injected you, was it enforced injection, or did you accept? P13: No, like I accepted it because like as soon as you're not given the choice I think it's best just to do what they say and then… I: Okay. So you were given a choice of either accepting the injection voluntarily… P13: Or it being forced, yeah. **Importance of being involved in treatment decisions** I spoke to [CPN] about it, and when she gave me, like my nurse, when she gave me the first injection like after I'd left hospital she didn't want to give me it. I don't know why, but she just felt uneasy about it. She didn't want to give me it. And then, which I thought was really	never going to go anywhere.			When it's like the ones that I can recognise, it's, like I've got like a good relationship with them. Like I do, like on like a night I can recall like laughing a few times. It was just like, at like what they're saying. Like if I'm, I don't know, like I can remember other times where I've been like watching Family Guy or something like that and then like they've like made a little joke and like a little remark about like a joke or part of the thing and I'm just like, just laughed and stuff. And then yeah, like my main relationship with them I would say that like, I'd say that to an extent but like it's quite a big extent at the same time. Reference 3 - 0.65% Coverage every day it was like, don't you dare freak out. I've got your back. I'm going to look after you

		nice. And then like I took it but then I didn't take it again. And then like she looked at more options with me Reference 2 - 0.28% Coverage I: And so how involved are you in making decisions about your treatment? P13: Now, it's like if I don't want to do it, we won't do it. Reference 3 - 0.91% Coverage I've got complete say in what I want to happen. Like the advice is there, like if I think it's a good, but if I, it's up to me to make the decision, they're like… I am really honest about it, like I will say, oh that sounds like a good idea, if it sounds like a good idea, you know. So yeah, I've got complete control in my care now whereas like when it first started, like I just, I didn't. Yeah, I felt like I was just getting trapped.				forever. Like, just as long as you keep me by your side, you're going to be all right. Like whatever happens in your relationships with your family, whatever, don't worry about a thing because I've got your back. **Perceiving voices are a guide** But I'd say that they're like my teacher in a way. Reference 2 - 0.47% Coverage growing up I've always wanted to be like, have like a bit of a guru sort of thing. Like figure in my life and like Karate Kid sort of thing. And like spiritually like I have got that. So I'm like, I'm really thankful for that. Reference 3 - 0.41% Coverage they were guiding me into what I should do. It was like, I'd gone to

							London in some like, I thought in a spiritual journey just to like understand why this city is so important to us, sort of thing. Reference 4 - 0.45% Coverage Higher purpose. Like I've always felt like, and yeah like, just like guidance for me to achieve this thing that, like I want to achieve so badly and it's there as like, yeah, it's like guiding through like my purpose.
P14	**Voice hearing is about power & control** I always think that he's, sort of got this power about him Reference 2 - 0.87% Coverage [voice] definitely doesn't like it. You know, the others, they don't really have an opinion. But [voice], you know, hates it. I think he just hates the fact that he wants to be the one in control, like he just, with anyone, sort of thing. Like, he's jealous of it, sort of	**Dominating influence of medication** I've asked the non-medical prescriber who I had, I've asked her quite a few times, to up my dosage of antidepressant. **Benefitting from medication** they seemed to help at first, like, they got me through that main stage where I wanted to die all the time. **Medication not helping voices** [Dominant voice] didn't like the idea of me starting it. Reference 2 - 0.32% Coverage	**Making sense of voices** I like to, how I like to imagine them, is that they're sort of like, in this sort of like black void, sort of thing. You know, I can't see them, but like, I like to imagine them that way. Reference 2 - 0.54% Coverage With [dominant voice], I like to imagine him with, like, chains all around him, just to like, keep him sort of secure. But with, like, [other voice] and the quiet	**Being persecuted by voices** He's the one that's like always there, he's like, he's, sort of, like my little own personal bully, I like to look on it. He's very angry, that's obvious. **Voices don't like VH getting help** he hates me going to therapy. And like, he just doesn't like me getting help. He likes to be in control, he doesn't want other people telling me things to, like, calm me	**Experiencing MH services as uncaring** I've always had a strong opinion about CAMHS, because when I was younger, my mum took me, well, took me to the doctor, and they referred me to CAMHS. And I went to CAMHS twice, and then they didn't get back in touch, so I was like, oh, so they're just going to sort of leave me. Reference 2 - 0.21% Coverage	**Feeling valued by practitioners** I was making progress with [dominant voice], about midway through therapy, I'd say. Reference 2 - 0.52% Coverage I think it's helped a lot, especially with my CPN. You know, it used to be where, she'd come out once every, now it's once every two weeks. But

	thing. Like, he wants to make the decisions, he wants to, I don't know, just be in control. **Feeling threatened by voices** I was scared that one of them was going to take over Reference 2 - 0.32% Coverage I was always sort of scared that [voice] would take over my body and, you know, do something, like, he would harm me, or to harm others. Reference 3 - 0.21% Coverage if I'm having a really bad day, there'll be moments where I'll sort of be scared of [voice] Reference 4 - 0.44% Coverage Even after, like, all the therapy that I've had, all the information given to me. It is, it's quite scary when, especially, because he tells me quite a lot, that he can take over. Reference 5 - 0.59% Coverage	I: Did you notice whether [dominant voice], or [other voice], or the quiet voice, change in any way, when you went onto the medication? P14: Not really. **Feeling worse from medication** I think at the beginning, they did. Over time, it has gotten worse, being on them. Reference 2 - 0.55% Coverage Especially with fluoxetine, they seem to not help with any sort of emotion. They seem to, like, block my emotion, or keep it one side, sort of thing, until it's like, right, like, there, and then I'm, like, overwhelmed by it. Reference 3 - 0.23% Coverage But over time, I just feel like I've, I don't know, they've, like, affected me in a weird way. Reference 4 - 0.43% Coverage But I think it wasn't, it's been like building up sort of, somewhere else, until it's like, so much of like a certain emotion, where it just hits me, and I sort of break down. **Wanting to reduce or stop medication**	voice, they've only got, like, say like [other voice], has only got a chain round her leg Reference 3 - 0.81% Coverage I've constructed the image where, like, the chains, and I have an idea of what they all look like. Because I have a conversation with [other voice], so I know [she's] got red hair. And I know that [dominant voice] is always wearing black. I don't know, the quiet voice is sort of like, always sat on the floor, like, sort of curled in a ball, sort of thing. Reference 4 - 0.55% Coverage Well I think, like all of them can move round if they want to. For me, I feel like I've just sort of like imagined that, like, they move round. I don't necessarily believe they can move around; I just like to think that way. Reference 5 - 0.50% Coverage	down, so like, I'm not affected by him. And he likes that control and power. So, yeah, he doesn't like me getting help. Reference 2 - 0.81% Coverage He definitely becomes more angry, when people try to ask me stuff about him, I suppose. He becomes more angrier when it's on him, he thinks he's like, I don't know what he thinks, to be honest. I'm guessing that he thinks that it's going to help me get rid of him. And that's not what I'm trying to do, I'm trying to help other people **Voices being disruptive** he's just, sort of contradicting everything that I've said, yeah, it's just like, oh stuff like, he doesn't believe you, he thinks you're stupid, you are stupid.	I've always felt, like, let down by them, like, I just don't think they've done enough	it's like, I don't know, it's like having people care, sort of helped. Reference 3 - 1.00% Coverage And the same with therapy, with my therapist. And sort of, I know if I've got any questions, or anything, I know that I could ask them. Or if I was worried about anything, I know that I could ask them. And they'd give, you know, like a logical answer…or logical, I don't know if that's the word. They'd, like, you know, they'd give me an answer to it. And, you know, they'd calm me down, and stuff like that. Reference 4 - 0.28% Coverage they'd chat with me, even on the phone. Or, they could come out, I know my CPN has, you know, took me out before. Reference 5 - 0.87% Coverage

	And that he can do things to me, or other people. So, say if I was like, already vulnerable, or having a bad day, it would be more scary to, like, listen to. But yeah, definitely in the past, I used to be quite terrified of him, to be honest. Reference 6 - 0.78% Coverage I'm scared that he takes over my body, and that, like, he's in control. And I'm not very worried about, like, what he'd do to me, I'm worried about, like, if he'd do stuff to others. Do you know, like, he could literally go on a rampage, and stabbing everybody? You know, that's just like the stuff that he says to me. Reference 7 - 0.39% Coverage Yeah, it's quite terrifying. It's like, erm, it's like claustrophobia, it's like, just all the walls shutting in on you, everything is sort of going dark, yeah. **Having agency with voices**	I don't know if I'm going to try and come off them, but I've definitely been thinking about coming off them. **Importance of being involved in treatment decisions** I think I said to my CPN one day, I was like, really depressed. Whereas, like, my depression was the main focus, not the voices, sort of thing. I just said, listen, can I try antidepressants. Reference 2 - 0.41% Coverage I like to think that I'm, you know, I'm very in control of my stuff. You know, I like to be organised, you know, I've got a folder full of all my mental health stuff. Reference 3 - 0.15% Coverage I normally make decisions, especially with my mental health	But say if like, I'm having a bad day, or my vulnerability is lower than normal, like the chains sort of get loose. And that's how I imagine, how [dominant voice] gets louder, instead of him just raising his voice more. Reference 6 - 0.70% Coverage I like to think that, like, the environment is being controlled around me. And like, the voices have been sent from, like, someone higher up, to, I don't know, like, torment me, or something. But it's very much like the Truman Show. So, it goes into, like, a bit of a conspiracy thing. Reference 7 - 0.40% Coverage I don't think that there's problems, you know, with hearing voices, and things, say if [dominant voice] wasn't a part of my voices, I'd happily live with the quiet voice and Roxy. Reference 8 - 0.56% Coverage			If they wanted to kind of join it up, really, it would be about the voices. It would be, random stuff, really, it would be like, oh what you doing at the weekend, or to take my mind off it. And then it would be, like, oh now that you've calmed down, like, do you want to talk about what happened. And it's normally like, oh yeah, [dominant voice] was annoying me, yeah. Reference 6 - 0.25% Coverage my therapist has asked me to, like, talk to them, especially when I'm, like, giving them more attention Reference 7 - 0.14% Coverage I can't thank them both enough, they've really helped me. **Being active and distracted is helpful**

	I: So where do you get the, the courage, the ability, to actually do that? P14: Erm, I've no idea, I wish I could answer that question. I think it was like, it definitely wasn’t a sort of thing where I just woke up one day and I was just like, oh I'm just going to take my hand off this door and let them in. It was like, sort of like a long process, to just ease them away, off them. Reference 2 - 0.36% Coverage With [voice], and the quieter voice, it's like, I know that I'm always in control. Like, I'm not really scared of, like, [voice], and the quieter voice. **Lacking agency with voices** just a bully that follows me around. Reference 2 - 0.63% Coverage he's trying to be more superior than me, or trying to be in control. So, you know, like, when he's, sort of like bullying me, I think that he wants to like, sort of, bring me down, to make me more vulnerable, to make		I'd like to think because he's a bully, that he must be hurting himself. So, maybe just having that conversation with him might be helpful, like it might calm him down for a bit. But I don't really know, I don't really understand. **Feeling physical presence of voices** I hear my voices, mainly, through my right side. Reference 2 - 0.59% Coverage P14: I like to, sort of, say, like, if I'm imagining them, [voice] is the closest, the quiet voice, who has a name, but like, it would sort of give away my name, so I won't say. I: Okay. P14: He's, like, next, and then [dominant voice] is furthest away. Reference 3 - 0.47% Coverage if I'm in a bad mood, or I'm like really low, just having a bad day, [dominant voice] would, like, walk closer, I like to imagine him. So, he would be louder. The quiet			my focus isn't really on him, my focus is on this conversation. But yeah, like, most of the stuff that he says, it's just like, white noise to me Reference 2 - 0.40% Coverage Say, if I'm in a worse state, it's definitely helpful to…no, I've still got this one…it's definitely helpful to talk about something else, just to take my mind off it **Being critical of voices** I know most of the things that he says is just made up. **Concealing voices** around the time when I believe I started hearing voices. But obviously, I didn’t go for that reason, I didn’t mention that reason to them **Distancing self from voices**

	me more scared to, like, try and take over. Reference 3 - 0.95% Coverage No, it makes things worse, to be honest. It's like one of them bad habits that I've got, where I try to do it, like, it makes things worse for me. Like, I just sort of like, it gives me time to overthink, to sort of spiral, to be like, even worse than, like, what I was already on. So, but it like, in a way, it makes things worse for me, but I feel like it makes things better for others. Reference 4 - 0.47% Coverage I could probably live with [voice], if he wasn't constantly there, like, shouting, or like, bullying me. Like, if he'd give me an hour break, at this point, every day, that would be like, amazing. Reference 5 - 0.46% Coverage there's definitely days where he is more in control than me, when I am, in a sort of worse state. Especially with		voice, and [voice], don't really move. **Identifying voices as part of self** The quiet voice, used to, like, I put the link there, and I relate, well I used to relate to the quiet voice how, just sort of like, being quiet. In my early teens, I used to be, like, very quiet, and not talk about anything, not talk about any of my problems with anyone. Just sort of like, shut down from the world. Reference 2 - 0.31% Coverage I used to relate to him quite a lot, and you know, there's still some days where I do. So, I like see him as, like, a mini-me. Reference 3 - 0.08% Coverage that's why I sort of relate to him Reference 4 - 0.43% Coverage my mum thought I was autistic when I was younger, because I had a lot of anger issues. Which			I'd always put my energy into blocking the voices out. **Linking relating with voices & relating with people** The first thing that I do is, I go to my bedroom, shut my door, sometimes I even barricade myself in. And I just, I lay on my bed, and I either try and go to sleep, or sometimes I'll just lay there. And that's, I think, really, it's like, when he's, sort of threatening to take over, and when I'm already having, like a bad day, it's like, I don't want to be, like, I don't want to, like, deal with him harming anyone. Because like, it's me, in a way, like it's my voice. So, yeah, I like to just like, stay away from people when that happens. **Voices interacting with emotions** I: Okay, yeah. So, can I ask you, then, what role do you think your emotion plays in

	my depression, if I have a depressive episode, then he's more in control. **Power relations between voices** [voice] goes quiet. There're times where, say, like, if I'm okay-ish, but you know, quite crappy, where [voice] will sort of like stick up for me. But when I'm, you know, spiralling worse and worse, she just goes quiet, and I think, in a way I prefer her to do that, because if she's sort of arguing with him, while he's having a go at me, it's like, I think she knows that it would be too much for me to, like, handle. So, yeah, them two just go quiet. Reference 2 - 0.72% Coverage So, say if I'm at a late stage one, just going onto stage two, [voice] will start arguing back with [more dominant voice], to try and like, stick up for me, sort of thing. But like, midway through stage two, she'd stop, because she knows it would be too much to handle for me, say if it was two voices instead of one		also relates to [dominant voice]. I believe that, like, all my anger is related to [dominant voice], in a way. **Linking voices with trauma** when I was in therapy, sort of, I can see links to how, especially a lot to my childhood. Reference 2 - 0.62% Coverage the link for me with [dominant voice] was, I was bullied quite, really, you know, quite badly, as a child. And, you know, like at home, and when I used to go outside, and at school. So, the link that I sort of created there is that, like, [dominant voice] has stemmed from bullying Reference 3 - 0.93% Coverage Because when I was bullied as a kid, I was very quiet, I didn't fight back for myself, I didn't thingy, so like, all this anger grew up inside of me. And it's always built up, until like, you know, a little thing would set me off. You know, like I'd go about storming about the house, probably smash			whether you see the voices being superior, if you like, or not? P14: Erm…it plays a big part in it, really. So, whereas today, it's like a normal day for me, I'm not good, not bad, I'm just like somewhere in the middle. I don't believe that [dominant voices] could take over, or don't believe that, like, anyone's in danger of him, including me. But if I'm having, say, a really bad day, then I'd probably, what I'd normally do is, I normally isolate myself. Reference 2 - 0.10% Coverage He normally gets worse when I'm spiralling. Reference 3 - 0.68% Coverage He just, he gets louder, and coming closer. You know, he threatens more to take over me, bullying

	Reference 3 - 0.74% Coverage So, she just, sort of like, let's me, you know, deal with it, and she just goes quiet. But yeah, she's definitely, well she's interactive with both of them, she's interactive with the quiet voice as well. I haven’t seen the quiet voice interact with other people. I've seen [more dominant voice] interact with [other voice], too. Reference 4 - 0.46% Coverage So, say if, like [dominant voice] is already angry, I think [other voice] knows that it's not going to help by, you know, telling him to stop, or arguing back with him, sort of thing, so yeah, she just goes quiet. **Voice wanting to be acknowledged** my therapist suggested that I should, instead of like blocking him out or trying to ignore him, that I should give him, like, a certain amount of time during the day, to sort of focus on it. Like, you know, listen to what he's got to say. And that seemed to help, like,		something. But I think that anger, now, definitely had led to the creation of [dominant voice].			me more, and he says worse things, he says he's going to do worse things. And like, you know, just all, it's all very, like, when I'm already overthinking, and got stuff in my mind Reference 4 - 0.55% Coverage I know that he's just trying to get to me, I know that he's, like, trying to affect me in a bad way, or trying to put me off. Say, if I was in a worse mood, I would probably, would have took ages to just understand a question **Wanting to get rid of voices** I think that he knows that, like, eventually, well I'm hoping anyway, I'm hoping that one day I'll wake up and they won't be there all the time. Reference 2 - 0.33% Coverage So, I think that he thinks that, like, I'm

	you know, calmed down a bit.					going to get rid of him one day, and, well really, that is the plan, that's what I am doing. **Relating more positively with voices** And then, the female voice, XXX, she's like, my own little best friend, really. She's like the supportive one, always, like, encouraging me to, you know, do better things, and like, improve myself, like, motivates me. And, you know, she's good to have a chat with. Reference 2 - 1.05% Coverage I think XXX relates to my best friend, a lot. She's like, my best friend sort of like saved me, in a way. Like, it was like, she, like, she sort of told me that, like, it was alright to feel how I was feeling, like, it's okay to have, like, problems, and it's alright, like, she sort of like, you know, helped me a lot. And,

						like, when I was about 14, maybe, 15 even, so that’s how I sort of see XXX, as, like, that one, my friend. Reference 3 - 1.36% Coverage And then, you know, when my therapist said, you know, maybe you should just try and like, not block him out, and like, give him some time. At first, it was like, but what if he jumps in, sort of thing. But like, as time went on, I was sort of like, giving him more, more sort of time, and like, more, like, I was more relaxed, to like, not blocking them out. So, like, now, like, I'm very rarely blocking them, sort of thing. I focus on other things, but I don't put, you know, all my energy into, as me and my therapist would say, like, keeping the door shut. Reference 4 - 0.13% Coverage

						XXX's very polite, and you know, respects my being. **Looking after voices** With the quieter voice, I would be worried, but not for the safety of others, for sort of like, the safety of him. Because the thing that I get from the quiet voice is that he's very, very depressed, and very low, in himself. **Perceiving voices are a guide** [voice] actually encourages me to go to therapy. Reference 2 - 0.26% Coverage It was [voice], who was like, sort of, was really helping me, like, sort of like encouraging me to go on them [medication].
P15	**Voice hearing is about power & control** I have to keep…to, like, stop them coming in, do you	**Dominating influence of medication** He wanted me to take…like, a really high dose of antipsychotic	**Making sense of voices** when they're in my head, they're more muffled, and then it's like a radio, do you	**Voices don't like VH getting help** Because they feed off it, sort of, and then it's like if	**Practitioners failing to connect & understanding** Dr XXX. Awful. He told me that he understood all	**Feeling valued by practitioners** I: And has there ever been a time when

	know, to make sure they don’t get in. Well, not to make sure that they don’t get in, to make sure that they don’t get out. Reference 2 - 0.84% Coverage Just try to not do what they’re saying all the time, because they tell me, they make me do OCD things like count numbers and stuff and it’s really debilitating and be frightened of certain colours and I have to try and fight it and not do it because whilst I’m fighting it, and not doing it, it’s okay but as soon as I stop fighting, and they get there, then it’s really hard. Reference 3 - 0.71% Coverage When I’m feeling better? They’re not as frequent. I can ignore them, they’ll be weaker. Not, you know, like they fade to…like you know far away? But not like they are in my head just going around and round, just fainter, more like when you’re being sucked…that sounds, like, weird, but like they’re being sucked away.	and they knock me out anyway, and then something else, then an antidepressant, then diazepam as well, and anyway my doctor wrote him a letter, because, why, what’s the point in getting drugged up like that, because it’s not going to get better from doing that, it’s not, is it? It’s just still going to be there when you stop taking all the drugs, so no, we didn’t really see eye to eye. Reference 2 - 0.71% Coverage I: Is it a lot? P15: Yes, because as well with antihistamines on top of that, because they’re supposed to make you…they don’t really knock me out, antihistamines, but the other day the pharmacist said to me I’m surprised you can lift your head off the pillow but that was to do with the antihistamines as well, not… **Coming off medication without support** But I don’t always do what I’m told with the medication, I try not to take it sometimes. Reference 2 - 0.10% Coverage I never take as much as they want me to take	know what I mean? It’s there and sometimes all of a sudden, they’ll say something and it’ll be clear, but when they’re out in the room, they’re like properly clear. **Feeling physical presence of voices** if they’re inside my head, that’s like all right because I know that they’re in my head and they’re coming from in my head, but then when I start to get sick, they come out, and they’re in the room and then that’s just awful, I start seeing things **Linking voices with trauma** I used to have two men who’ve done horrible things to me, I’ve still got them. Reference 2 - 0.18% Coverage Now I just have these two horrible men, these two men who’ve done bad things to me Reference 3 - 1.04% Coverage Because they always did worse and nobody could	I get better and people listen to me, they know that…well, I don’t know if they do know, they do know that they’ve done really bad things, I think, but they don’t want anybody else to know anything… They don’t want me to get better. Reference 2 - 1.10% Coverage I: And were your voices listening in to that conversation? P15: Yes. I: And they don’t have anything to say about it? P15: They wasn’t liking it. I: They didn’t like what we were talking about? P15: No, they didn’t like it, and they were retreating a bit. I: Did they? P15: Yes, they were scared, they didn’t like it. I: What were they scared of? P15: They were scared because you were properly listening and they didn’t like it. They really don’t like it. **Voices being disruptive** Yes, like laughing, I told you, you’ll not get rid of	about OCD because he’d written a leaflet, but he didn’t, he made it worse, he made it loads worse because how he said it, it was just basically…you know when you see on telly, and it’s basically just washing your hands and that’s it, and a fear of germs. Oh my god, it goes so much further than that, but his leaflet was basically that, so he made me feel more crazy Reference 2 - 0.78% Coverage I couldn’t speak and then he said I was rude, well, he made out I was rude because I couldn’t speak, like, I couldn’t speak to him. He said I refused to speak, so he stopped treating me. But I didn’t refuse to speak, I just couldn’t speak because he made it worse, he just made it loads worse and then he just wanted to properly drug me up. Reference 3 - 1.22% Coverage The only thing I don’t like is when they say, well, what do you want me to do?	your voices become less distressing for you because of something a practitioner might have done? P15: You know, like, when they listen, and you know that you’re going to get some help, like, [CPN] on the phone, this last time when I phoned up the crisis team, she was amazing and she stayed on the phone with me for two hours until somebody came to the house because a friend came around, and she promised me that I was going to get help, and she went I know you don’t like medication but we’re just going to put it up to get you through this crisis, and she did it that day, she was sorting it out on emails and stuff, and the doctor was phoning me up on the landline while she was sorting that out, so yes, really that helped me loads.

	Reference 4 - 0.71% Coverage if somebody else is there they wouldn't be able to do things, unless I was really poorly and I'd got so bad that I had no grip on reality, and if I try and be happy and do my best, they lose some of their power. They can't…do you know, and if I'm good, I try to be good and if I'm good, they lose their power as well. Reference 5 - 0.61% Coverage I: What do you conclude from that then, if anything? P15: What, from if I want to stop the medication, they become worse? I: Yes. P15: That they want to be in control and they're frightened of me being in control myself because they always want to be in control. **Acting on what voices say** It makes me feel worse because I've given in to it, but then I have to do it again and I just feel worse because no one wants to be near someone when they do things like that to themselves anyway.	Reference 3 - 1.38% Coverage I think I'll have to do it really slow because last time I did try and come off quetiapine and just stopped taking it and I was, like, crying every day at work and thought everyone was being really horrible to me and that many people couldn't have been really horrible to me, because they would all have got the sack if they were going to be that horrible to me, how I thought they were being horrible to me, but at the time it was real to me that everyone was being horrible to me. I think it was just because… Because when I went to the doctors about it, they whacked me straight back on the quetiapine and it stopped. **Medication not helping voices** they don't make them go away or anything like that, but it just muffles them **Feeling worse from medication** Just makes me sleep Reference 2 - 0.23% Coverage I: And what happens with your voices when all that's happening? P15: They really are quite powerful. Reference 3 - 0.31% Coverage	help me, when they were, like…one of them, I don't know…is he alive still, Tony Alan? Yes, one of them is far away and the other one is dead, but while he was alive, or…one was alive he just did really bad things to me and the other one, when I didn't have any…I was a little girl with the other one and nobody could help me, like my mum couldn't help me or anyone because my mum said basically she didn't believe me… Reference 4 - 0.44% Coverage one of the voices, the one that's dead who was really evil to me, like really evil to me, properly kicked me so hard he broke bones and things, he was schizophrenic and I don't want to be like that. Reference 5 - 1.07% Coverage Because that's what one of them, the one who's dead, he used to say he was my only friend in the world and nobody else cared about me, and he was bothered about me and he	us, how many years…the older one, how many years, it's been, like, 40 years, and no one believes you, so why are you getting rid of me now, because I've been there for 40 years, so I'm not going to go. Reference 2 - 1.20% Coverage I: So, does that mean then that while you're in an interaction with a practitioner, your voices would be responding to that interaction? P15: It depends, but yes, a lot of the time, yes, especially if they're not helping me, yes. If they're saying, oh, that's why I get so distraught because if they're saying, oh, well, we'll discharge you because this, that and the other, do you know, like, you've been smiling or whatever, they'll go, like, we're not going to go, because nobody's going to listen to you, they think you're stupid. Reference 3 - 0.52% Coverage	What plan do you want…? Because when I was first getting into treatment, you know, when you first get…you get in and out, don't you…when I first got taken in, I'm not at the stage where I…I don't know what to say, do you know? I don't know what to say, and then they say, well, I can't help you because we don't know what to say, we don't know what to do, you need telling sometimes when you're so far, you know, like you need someone to take charge because you can't… Reference 4 - 0.57% Coverage I went to [city] about the CBT thing, to this intensive therapy man, something intensive, I don't know what he was, but he said that I was too complex at the minute to have it and it would be too much for me because the OCD and everything was just too complex **Practitioners not talking about voices** Do you know what really upsets me? When they say, well, you function in	Reference 2 - 0.94% Coverage I: And does that mean the voices were less troublesome for you? P15: Yes, and they were really bad when I first phoned her up, I was really hysterical and I could even…because I can't make a drink or anything like that when they're bad because I might pour water on myself, and she even talked me through making a cup of tea and I could do that with her, and that's really amazing for when the voices are there, yes. Reference 3 - 0.30% Coverage They feel sorry for me. They're quite kind to me because they know when I get to the flushing down the toilet stage, I'm a bit unwell. **Finding it difficult to relate with voices** I hate them, I'm terrified of them. I'm

	Feeling threatened by voices once I start doing it one time, then I have to keep doing it and then I can't not do it because I think if I don't do it and then something bad happens, it will be even worse because I'll be even more frightened because I'll think I didn't do what they said and something really bad happened, Reference 2 - 0.26% Coverage It's just like standing there, just standing, threatening, like just standing there and looking threatening there. Reference 3 - 0.38% Coverage I just have to do it, because otherwise I will be too frightened of something harming my family or my children or me, anything, just whatever bad I don't want to happen. **Hurting self for relief from voices** It just gets too much. I just can't stop it, and my head feels like it's going to	I can't hardly stand up. When it's really bad, the dose that they put me on, oh my god, I just can't hardly…I'm like…I can't hardly speak. **Wanting to reduce or stop medication** I'm trying to get completely off antipsychotics, I don't really like to be taking them. Reference 2 - 0.40% Coverage I didn't really have anxiety attacks before and I went on it anyway so I think it's one of them, I don't like it because it makes me really fat, so I really don't want to be on it **Lacking involvement in treatment decisions** But I don't always do what I'm told with the medication, I try not to take it sometimes. Reference 2 - 0.53% Coverage I: So, you get a choice where they ask you what want to take and how much? P15: No, not really, so I don't really get a choice, no, they just say, oh, this and this, I can choose if I want lemon or tutti-frutti in the calcium tablets	had to hurt me because I needed knocking into line and deserved it, but he was the only person who cared about me, even though he…and then he used to dress me like a child, like put my scarf on and my gloves, like I was a little girl and just horrid, and I wasn't even allowed to go to the toilet by myself.	They get more obvious and they just say you're not going to get rid of us and nobody's going to listen to you, you know, so far, why do you think anybody's going to listen to you now? You know, like, nobody's going to listen to you.	society, and we've had this before, you've been in crisis and then the voices have gone, but it's between living and existing and, do you know, why should I have to put up with these voices? Do you know, although it's nobody's fault or anything, but why should I have to put up with these voices? Reference 2 - 1.33% Coverage I: So, the practitioners that you mentioned, have they ever asked you about voices and had conversations about the voices or…? P15: Not really. Just asking me if they've got worse, they don't really like to dwell on them, I don't think. I think they seem a bit…I think it might be difficult for them to talk about because it's quite a frightening thing, and it's disturbing, isn't it, to talk to… And it must be no different for a practitioner to be around someone who's mentally ill, it makes you feel disturbed sometimes, and it must be really hard probably to	really frightened of them, and it's like I'm always in the role of a child, you know, it's like I'm a child and I'm being punished and they always make it feel like it's my fault. It's like I'm never an adult with them. It's like I'm a child. **Being critical of voices** Like I said before, they're cowardly **Concealing voices** But she said, oh, well, you were smiley and pleasant when you saw me, but that's just I'm a people-pleaser, that's just what I'm like, I wouldn't…and I said did she want me to be impolite or something? So however sick I am, I can be polite and even if I'm falling completely to bits, I can be polite and nice. **Voices interacting with emotions**

	explode so it’s maybe just at that point doing things like counting and things like that, but then it gets worse and I have to harm myself, but at first…even the counting is awful, it’s like awful, but then it just gets so I have to do things. **Lacking agency with voices** I: So, the impression I have is when it gets to that point, that’s more distressing than when they are just in your head? P15: Oh yes, a lot more distressing. Loads more distressing, and that’s when I get frightened, that’s when I get really, really frightened Reference 2 - 0.30% Coverage I: Do you ever talk back to them? P15: No, in my head I do, like try and tell them to stop but I don’t talk back, I’m too scared. Reference 3 - 0.41% Coverage They just keep going and get worse and it feels like my head’s going to explode, and the more they know that I don’t like it, the more they				speak to people about voices. Reference 3 - 0.96% Coverage they don’t like to talk about voices, they really don’t, but the ones that I see at the hearing voices group, but that’s because that’s their interest and they’re really good, and [CPN] was really good on the phone, and Anna’s really good, I really like Anna, but she tries to veer the subject away from voices. It’s not very nice, is it? It’s not a nice… I don’t think even today in this day and age they like to talk about it. **Framing experiences according to professional interpretation** I: You just said something interesting, you said you have borderline personality…where’s that word come from? P15: Dr XXX. I: Okay, so he… P15: Diagnosed me. I: He told you that you have… P15: Borderline personality traits, yes.	but I get them when I’m tired or when I’m stressed, and when I’m trying to do stuff, you know, when I’m trying to face up to things and I get them after, do you know, like when I’m on my own Reference 2 - 0.63% Coverage I think because your brain’s not…when you’re tired, you don’t put your guard up and they can… It’s like any sort of poorliness, it gets worse when you’re tired and they can just get in there, they’ve got more…you’re weaker, you can’t fight back, and they’ve got more chance to get in. Reference 3 - 0.94% Coverage Just, say, if I got put on steroids and I got manic, because I get a bit manic with them, or if I had an argument with somebody because I

	do it. They don’t ever want me to get better. Reference 4 - 0.06% Coverage Yes, they always come back. Reference 5 - 1.03% Coverage I: I see, so when people are around you, the voices might not be as powerful but when you’re left on your own, they become more powerful? P15: Yes. I: Okay. And how do you explain that? Why do you think they’re more powerful when you’re on your own? P15: Because there’s nobody to…like, they’ve won and they’re right because nobody wants to be around me so they’re right, you know? Like they’re right that I’m stupid and stuff, you know? That’s why. Reference 6 - 0.37% Coverage They think that I’ll do what they want me to do eventually. And they think nobody will believe me or listen to me, because				I: In plain English, then, what does that mean? P15: I have risk-taking behaviour, I feel more upset than other people, do you know, like I really…now they call it, and I think it sounds worse what they call it now, emotionally unstable, don’t they? But that is what I am, emotionally unstable but I just think that sounds worse, but it’s not supposed to sound as bad, is it? But I think it sounds worse. Reference 2 - 1.66% Coverage P15: That schizophrenic one really upset me, but… I: Any particular reason why that and not the other one? P15: I think it sounds derogatory and like I want to hurt people and stuff. I don’t think… I think I understand the borderline personality traits but not the schizophrenic one because it’s not like it. I: So, that to you maybe represents something that’s more…severe or…? P15: I think one of the voices, the one that’s dead who was really evil to me, like really evil to me,	get really upset if I have arguments because I have borderline personality traits and I have arguments with people, it’s like it matters a lot to me and then they come back then and they say stuff, like, you’re just stupid and you’re always going to be like this and it is your fault.

	they've managed to keep things covered up. Reference 7 - 0.67% Coverage They just seem to go because they don't even…they just, like…what's the word? You know, in retreat…I'm trying to find the right…they retreat because they know that obviously somebody's listening to me and she properly did and she was going to get me help that day, so yes, that's…they just retreat.				properly kicked me so hard he broke bones and things, he was schizophrenic and I don't want to be like that. I: Okay, so when you hear that diagnosis, is that what you have in mind then, someone like that person? P15: Yes, someone like that.	

Appendix 6. Amendment to original Research Protocol

Study Protocol

FULL/LONG TITLE OF THE STUDY

Exploring the experiences of voice hearing during mental health treatment.

SHORT STUDY TITLE / ACRONYM

Voice hearing and treatment interactions.

PROTOCOL VERSION NUMBER AND DATE

VH-treatment interactions-Protocol.v.2 (revised protocol)

RESEARCH REFERENCE NUMBER

IRAS Number: 248530

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publically available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Funder:

Signature:

Date:
03.06.2019

Name (please print): Dr Michael Barber

Position: Contracts & Sponsorship Manager

Chief Investigator:

Date: 30.05.19

Signature:

Name: (please print): ROB ALLISON

LIST of CONTENTS

KEY STUDY CONTACTS

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STUDY SUMMARY

Study Title	Exploring the experiences of voice hearing during mental health treatment.
Short title	Voice hearing during treatment.
Study Design	Qualitative
Study Participants	People with experience voice hearing (auditory hallucinations) and mental health treatment.
Planned Size of Sample (if applicable)	15-20 participants (voice hearers) Two focus groups of 5-10 participants each (mental health inpatient practitioners)
Follow up duration (if applicable)	No follow up period
Planned Study Period	12 months
Research Question & Objectives	**Research question** How do people experience voice hearing during mental health treatment interactions with practitioners? **Objectives** 5. Understand how people who hear voices perceive their treatment interactions with practitioners. 6. Explore meaning people attribute to their voice hearing and how this is experienced during treatment interactions with practitioners. 7. Examine how people relate to their voices and practitioners during treatment interactions. 8. Develop theoretical explanation about voice hearing experiences during treatment interactions.

KEY WORDS: Voice hearing, treatment interactions.

STUDY PROTOCOL
Exploring the experiences of voice hearing during mental health treatment.

1 BACKGROUND

Evidence suggests that life experiences can influence voice hearing. For example, trauma is associated with the onset of voice hearing (e.g. McGrath et al, 2017; Read and Bentall, 2012) and human relationships can influence voice hearing experiences, i.e. how people relate to their voices can replicate their way of relating with other people (Birchwood et al, 2004). Conceptualising voice hearing within a relational framework is a recent area of inquiry (Corstens et al, 2012) and supports the notion that recovery can be achieved through treatment that focuses on improving relationships with voices.

The relationship between people who hear voices and practitioners is widely acknowledged as being central to effective mental health treatment. Professional standards for practitioners stipulate the importance of trusting and respectful relationships with patients to promote autonomy, empowerment and shared decision-making (Nursing & Midwifery Council, 2015, Royal College of Psychiatrist, 2014, National Collaborating Centre for Mental Health, 2012).

2 RATIONALE

How voice hearing is experienced in a context of treatment interactions, predicated on a relational framework with practitioners, is under-researched. Greater understanding is needed to understand whether an individual's relationship with their voices is influenced by interactions with healthcare practitioners. Through gaining this understanding this will inform education of healthcare practitioners to improve their support of people who hear voices and help practitioners avoid inadvertently contributing to a context in which voice hearing is triggered or exacerbated.

3 RESEARCH QUESTION & OBJECTIVES

3.1 Research question

How do people experience voice hearing during mental health treatment interactions with practitioners?

(Please note, the term 'treatment interaction' refers to any interaction with a practitioner within a treatment context (in any healthcare setting), e.g. an informal conversation, a discussion about treatment, discussion in a formal meeting of some sort, administering medication, etc.).

3.2 Objectives

5. Understand how people who hear voices perceive their treatment interactions with practitioners.
6. Explore meaning people attribute to their voice hearing and how this is experienced during treatment interactions with practitioners.
7. Examine how people relate to their voices and practitioners during treatment interactions.

8. Develop theoretical explanation about voice hearing experiences during treatment interactions.

4 STUDY DESIGN & METHODS of DATA COLLECTION AND DATA ANALYIS

This is a qualitative study informed by constructivist Grounded Theory methodology (Charmaz, 2014).

Information will be collected via in-depth semi-structured interviews. The CI will discus and obtain written consent from participants prior to interviewing and inform participants that interviews will be recorded on a digital recorder and stored as MP3 files. These will be transcribed onto a word document and transferred onto a qualitative computer software package (ATLAS.ti). Audio recordings will then be deleted. Interviews are expected to be for duration of approximately 60 minutes.

Interviews will focus on asking participants to recall their experiences of voice hearing during and following their treatment interactions with practitioners. A semi-structured interview guide will include initial questions informed by the 'Voice Dialogue / Talking with Voices' method (Corstens, Longden & May, 2012), the CI's clinical experience and from consultation with the Bradford Hearing Voices Group (see section 5).

However, the interview guide will act as an aide-memoir rather than script. Following theoretical sampling, interview questions will largely be constructed from participants' responses and, thus, evolve over the course of data collection. This will include 2 main themes with example questions underneath each theme.

<u>Experiences of voice hearing:</u>

1. Tell me a little bit about the voices you hear? (Prompts: how many do you hear? Are they positive/negative/neutral/dominant? Do they have names? Do they represent anything for you?).
2. Can you tell me more about how your voices communicate to you? (Prompts: are they commanding/advisory/commentary? How do they affect you? Do they have a visual presence? Where are your voices in relation to you? Does this ever change?).

<u>Experiences of treatment interactions:</u>

3. I am interested in hearing about your experiences of treatment. (Prompts: can you tell me about a time when you interacted with a practitioner during treatment and what happened? What were your perceptions of the practitioner during the interaction(s)? How did you interact with one another? What sense did you make of the interaction? How typical for you was this example of a treatment interaction?).
4. How did you experience your voices at that time? (Prompts: what did your voices say? How did your voices respond? Did your voices have anything to say about the interaction? Or about the practitioner? Where were your voices in relation to you? Did this change? How did your voices at that time compare to before and after the interaction? How did it compare to other treatment interactions?).

Qualitative data from the interviews will be recorded and then transcribed verbatim. Transcriptions will then be transferred onto a qualitative computer software package (NVivo) to manage and improve transparency of the data analysis process.

Data analysis will involve 3 stages of coding the interview data: initial, focused and theoretical. During initial coding, each transcript will be analysed line by line in order to select key words. During focused coding the most significant initial codes will be classified into categories. Theoretical coding will involve specifying possible relationships between these categories. Constant comparative analysis will be used to identify similarities and differences between codes and develop theoretical ideas.

After each interview and during coding the CI will complete memo writing of personal reflections and insights in order to develop ideas, record relationships between the codes and identify areas to explore in the development of categories and theory. Diagramming will also be used to make visual representations, or links, of relationships between categories.

To date, information has been collected from participants (voice hearers) via in-depth semi-structured interviews (please see VH-treatment interactions-Protocol.v.1, 20.04.18). Following data analysis and the theoretical sampling method of Grounded Theory, further data is needed from practitioners providing treatment for voice-hearing patients within clinical inpatient settings.

Focus groups are a well-established method of data collection, in which group interactions generate data consider as being closer to a more naturalistic environment and that can be less evident through individual interviews (Barbour, 2007). As such, it is a method that can help capture a sense of the culture within a treatment environment and the group dynamics between members of a clinical team.

Two focus groups of 5-10 participants will be scheduled as a method of collecting data from practitioners about their experiences of treating patients who hear voices. Each focus group will include clinical members of staff from a single clinical inpatient team, which will help provide an account of a team perspective and team culture.

The CI will discuss and obtain written consent from participants prior to each focus group and inform participants that the focus group will be recorded on a digital recorder and stored as MP3 files. These will be transcribed onto a word document and transferred onto a qualitative computer software package (NVivo) to manage and improve transparency of the data analysis process. Audio recordings will then be deleted. Focus groups are expected to be for duration of approximately 60-90 minutes.

Questions will focus on asking participants (practitioners) to recall their experiences of providing treatment and engaging with patients who hear voices. A question guide will act as an aide-memoir rather than script. Following theoretical sampling, interview questions are largely constructed from analysis of previous interview data and has therefore evolved over the course of data collection.

For practitioner participants this includes three main themes (with example questions underneath each theme).
Professional framework re voices
10. What do you understand about voice hearing and what informs this?
11. How does this inform your work with voice hearers?

Talking about voices

12. What sort of conversations do you have regarding voice hearing / what sort of words are used / who speaks first about voices / with colleagues and patients?
13. How confident are you in terms of talking about / working with voices?
14. What effect do you think your interactions have on voice hearers?

Decision making

15. What treatment choices are available for patients experiencing voice hearing (e.g. medication, talking, etc.)?
16. How involved are patients during treatment interactions?
17. How is decision making about treatment decided / who makes decisions?
18. Are there any circumstances where coercion is required (could include MHA)?

Data analysis will involve 3 stages of coding the interview data: initial, focused and theoretical. During initial coding, each transcript will be analysed line by line in order to select key words. During focused coding the most significant initial codes will be classified into categories. Theoretical coding will involve specifying possible relationships between these categories. Constant comparative analysis will be used to identify similarities and differences between codes and develop theoretical ideas.

After each focus group and during coding the CI will complete memo writing of personal reflections and insights in order to develop ideas, record relationships between the codes and identify areas to explore in the development of categories and theory. Diagramming will also be used to make visual representations, or links, of relationships between categories.

5 PATIENT AND PUBLIC INVOLVEMENT (PPI)

The Bradford Hearing Voices Group (HVG) advised on the development of this study. As part of the international Hearing Voices Network, HVGs are self-help groups for people who hear voices, providing a space for people to meet weekly and talk about their voice hearing experiences and exchange ideas for coping and gaining control over voices.

Prior to attending one of the Bradford HVG meetings, study documents (Flyer, Participant Information Leaflet, and Consent Form) were sent to the group facilitator and the CI subsequently met with the group for discussion. The HVG helped to shape the re-drafting of these documents and helped develop the initial interview questions.

The group provided invaluable advice regarding the use of language, how to support participants' potential distress during interviews and advice about participants' potential benefits from taking part in the study. All group members stated that they commonly refer to the terms 'voice hearer' and 'people who hear voices' (consistent with literature) but especially did not like terms such as 'schizophrenic', 'mental illness' or 'mental disorder'. As such, the terms 'voice hearers' and 'people who hear voices' are used here.

In terms of managing potential distress during interviews, group members suggested that an information leaflet before the interview would be helpful but, additionally, it would also be helpful for this to include some example questions to give participants some indication of what they might be asked. Further, group members were strongly of the view that they would not want a practitioner to be contacted should there be any concern relating to a participant's distress. All group members stated that this would be a breach of trust and lead to an unhelpful situation for them afterwards. Instead they were strongly of the opinion that each participant will be different and stressed the importance of asking the participant about who should be contacted should they need additional support. It was also suggested that participants could be encouraged to bring along with them a family member or friend to be available after the interview.

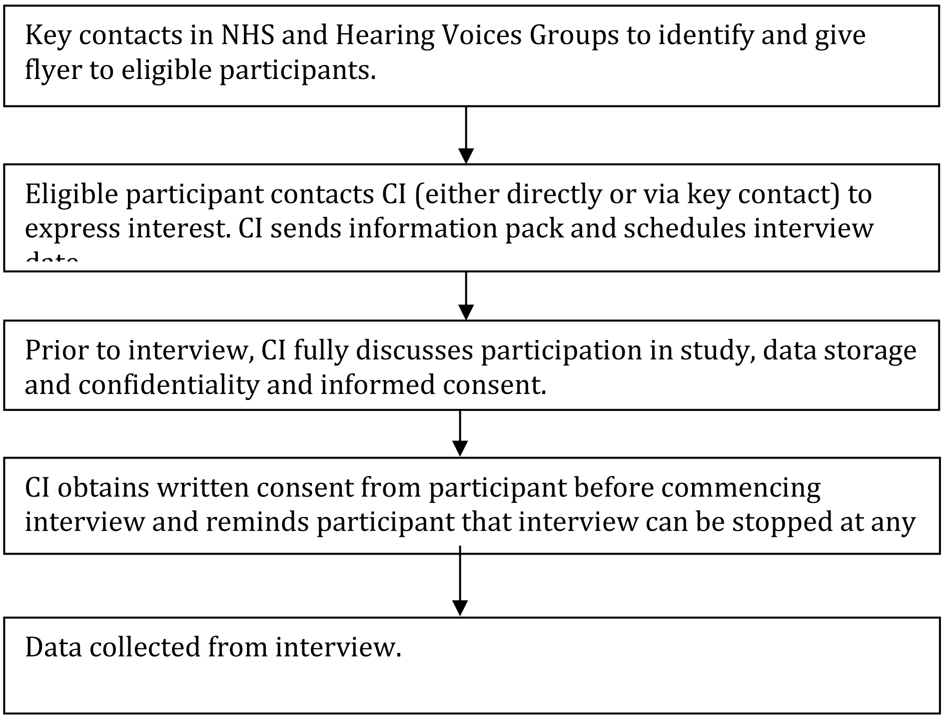
6 STUDY SETTING

People with experience of voice hearing (either currently or previously) and mental health treatment (including all health settings) will be invited to take part in an interview. Participants will be invited to meet either at the University of York or at participants' homes (or, if necessary, in the participant's hospital / clinical setting).

Team leads of clinical inpatient teams with experience providing treatment for people who hear voices, within a mental health inpatient setting, will be approached directly by the CI. The team lead will be asked, where appropriate, to invite practitioners from the clinical team to take part in a focus group. Participants will be invited to meet either at the University of York or in the hospital / clinical setting.

7 RECRUITMENT AND SAMPLING

The CI will approach key contacts within local NHS mental health services in the Tees Esk and Wear NHS (TEWV) Trust and in local Hearing Voices Groups to request they identify and give a flyer (Appendix 1) to potential participants meeting the eligibility criteria for the study. Figure 1 illustrates the process for identifying and recruiting participants.



Key contacts in NHS and Hearing Voices Groups to identify and give flyer to eligible participants.

Eligible participant contacts CI (either directly or via key contact) to express interest. CI sends information pack and schedules interview

Prior to interview, CI fully discusses participation in study, data storage and confidentiality and informed consent.

CI obtains written consent from participant before commencing interview and reminds participant that interview can be stopped at any

Data collected from interview.

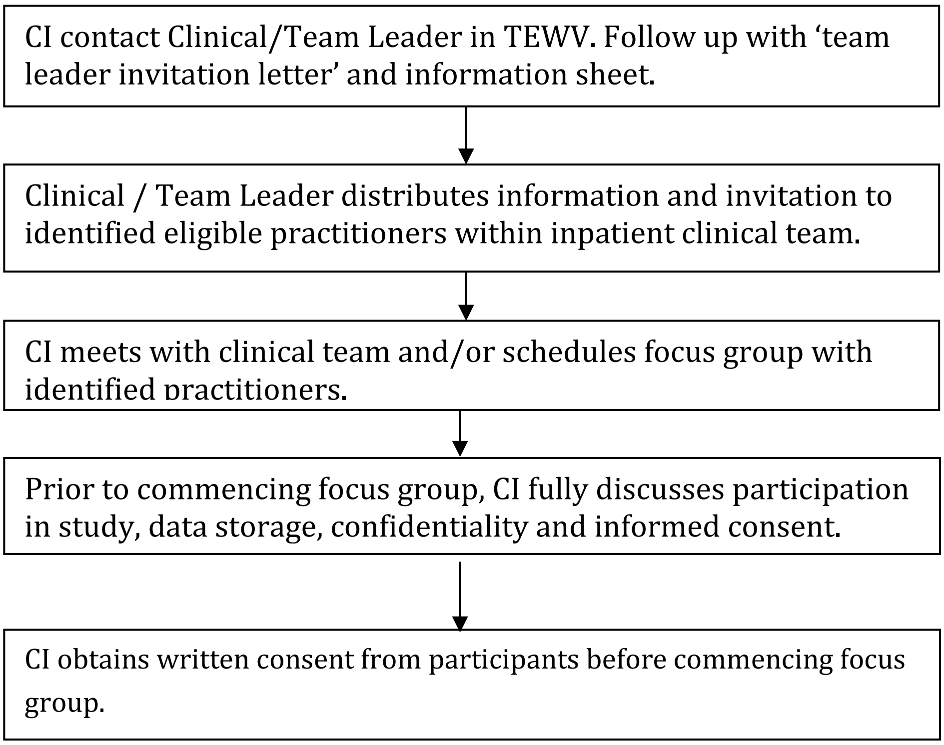
Figure 1 Process of participant recruitment and data collection

If interested in taking part in the study, eligible participants will be asked to inform the CI (either directly via the contact details on the flyer or indirectly through the key contact) to express their interest. The CI will send a research pack to the participant and schedule an interview date. This pack will include a cover letter (Appendix 2), a participant information leaflet (Appendix 3) and a consent form (Appendix 4). The CI will make it clear to participants that they can request further information or change their mind at any point and cancel the scheduled interview date.

Interviews will be face-to-face and take place in participants' homes, on University of York premises or, where necessary, on the participant's clinical premises.

Practitioner participants

The CI will directly contact the Clinical / Team Leader of a selected inpatient clinical team (within Tees Esk and Wear NHS (TEWV) Trust) to initiate discussion regarding the participation of inpatient clinical team members in a focus group discussion. The CI will follow this up by sending a 'team leader invitation letter' and accompanied study information sheet to the Clinical / Team Leader. The figure below illustrates the process for identifying and recruiting practitioners into a focus group.



CI contact Clinical/Team Leader in TEWV. Follow up with 'team leader invitation letter' and information sheet.

Clinical / Team Leader distributes information and invitation to identified eligible practitioners within inpatient clinical team.

CI meets with clinical team and/or schedules focus group with identified practitioners.

Prior to commencing focus group, CI fully discusses participation in study, data storage, confidentiality and informed consent.

CI obtains written consent from participants before commencing focus group.

Figure 2. Process of participant recruitment (practitioner) and data collection

7.1 Eligibility Criteria

7.1.1 Inclusion criteria

People will be approached to participate in this study if they meet all of the following criteria:

- Experienced voice hearing (either currently or previously), either self-defined or diagnosed by a responsible medical officer.

- Received mental health treatment (either currently or previously, including all health settings).
- Minimum age 18 years
- UK location
- English speaking.
- Agrees consent to participation.

7.1.2 Exclusion criteria

People will be excluded from this study if the following applies:

- Lacks mental capacity (determined by the Mental Capacity Act).

(Key contacts will not identify anyone clinically determined to be lacking capacity. For all other eligible participants, it will be assumed that each has capacity. Aligned with the Mental Capacity Act (2005), exceptions may occur where the CI has concerns during interview relating to a participant's retention and understanding of information and their subsequent communication of any decision).

7.1.3 Inclusion criteria (practitioner participant)

People will be approached to participate in this study if they meet all of the following criteria:

- Mental health practitioner
- Experience of an inpatient clinical setting in which treatment has been provided for patients who hear voices.
- Minimum age 18 years
- English speaking.
- Agrees consent to participation.

7.2 Sampling

Predetermining sample size prior to qualitative research is debated in literature, the essence of which is captured in a recent review as generally being one of a justification between pragmatic / practical considerations and methodological considerations (Sim et al, 2018). Whilst it is difficult to be precise about the sample size in advance of this study it is anticipated that a purposive sample of 15-20 participants will provide sufficient depth and breadth to address the research question.

Two focus groups will be scheduled, each including an anticipated 5-10 participants (practitioners). Focus groups will include members of a clinical inpatient team to help provide an account of a team culture and perspective.

Data collection and analysis will occur concurrently. It is anticipated that through this process of collecting and analysing data initial theoretical ideas will begin to emerge. This will influence the questions subsequent participants will be asked (see section 4) in order to follow up these theoretical ideas.

8 ETHICAL CONSIDERATIONS

8.1 Informed consent

As stated in section 7, participants will receive an information sheet prior to the scheduled interview date. Participants can also contact the CI for further discussion about the study.

Prior to the interview, the CI will discuss and answer questions participants might have about the study. Informed consent will be fully discussed and participants will be requested to provide written consent before commencing the focus group. The process for obtaining informed consent will be in accordance with Good Clinical Practice (GCP). Details of the study will be explained to participants using the participant information sheet and participants will have sufficient time to ask questions regarding their participation. This will include details about data recording, storage, confidentiality and the right to stop the focus group or withdraw their data. Participants will be asked to sign and date a consent form before taking part in a focus group. Participants will keep one copy of the consent form and the CI will keep a further copy.

Participants will be informed via the consent form that information they disclose is confidential accept in cases of potential harm to the participant and/or others. Participants will also be reminded of this at the beginning of the focus group. It is possible that information related to inappropriate treatment, which might be potentially harmful to participants/others, is disclosed during focus group discussion. Should this occur, the CI will discuss participants that this information might need to be reported to an appropriate clinical lead.

Undue influence. Emphasis on the voluntary nature of research interviewing will be given and participants will not receive any financial incentive to take part. However, travel costs will be fully reimbursed upon presentation of receipts so that participants do not endure any financial sacrifice in taking part.

Withdrawal. Participants will be informed that they can withdraw from the study at any time before or during the interview. They may also withdraw their interview data up to 7 days after the interview without providing any reason. Following this period, data will be used for the study.

8.2 Confidentiality

Participants will be issued a unique identification code, which will be used on study documents and electronic files. The CI will complete transcriptions. No identifiable information will be provided in any reports. Data will remain anonymous and confidential with the exception of any information suggesting serious risk to the participant or someone else (e.g. plans of harm). Should this occur, the appropriate course of action would be discussed with the CI’s supervisors and escalated where necessary.

8.3 Data storage and retention

Data management will be compliant with the current data protection legislation and in line with the University of York (UoY) Research Data Management Policy. The CI will be the data custodian and responsible for managing the data. Paper copies of consent forms and contact details will be stored in a locked filing cabinet within a locked room in the UoY, then scanned and hard copies will be shredded.

Electronic files will be stored on a UoY password-protected secure server. Consent forms will be scanned and stored in a separate file to other data. Audio recordings of interviews will be transferred securely to an electronic file until transcription is completed and then deleted. Only the CI and his study supervisors will have access to the original data. In accordance with the UoY Research Data Management Policy, study data will be stored securely on the UoY server for 10 years after the end of the study for audit purposes. Participants’ personal contact details will be destroyed once they have been sent a summary of the study findings, if they requested the summary, within three months of the study ending.

Focus group data will be recorded on a digital audio recorder and stored as MP3 files. These will be transcribed and saved as a word document and transferred onto a qualitative computer software package (NVivo) to manage and improve transparency of the data analysis process. The audio recording will then be deleted. The MP3 files will be stored on the UoY centrally managed network and in the CIs personal filestore (p:drive), which is regularly and automatically backed up by IT services. The CI will use the Virtual Private Network (VPN) to connect to the personal filestore to work on/add to files when away from UoY. Research participants' responses will be stored in a locked cabinet within a locked office at UoY. Only the CI will have access to the cabinet.

The CI will also record memo writing throughout the study to document reflexive accounts during data collection and analysis. The CI will also record diagramming to help make conceptual links during stages of coding. These will be stored as described above. Interviews will be recorded on an encrypted passcode-protected Digital recorder (as described above). These recordings will be transferred and stored on the UoY centrally managed network, which is password protected, until transcribed and thereafter destroyed.

Participants will be anonymised and coded with an ID number. Direct quotations used in published work will anonymised and any information that might directly identify participants (e.g. identity of clinical setting) will also be anonymised.

8.4 Risks to participants and researcher

Risk to participants. There are no expected potential harms to participants in taking part in this study. Mental health practitioners regularly discuss clinical-related issues in group settings as part of routine practice. It is unlikely that participants will feel distressed during and following focus group conversations but, to anticipate this, participants will be reminded that their participation is voluntary and they can choose to decline to answer questions during the focus group and/or stop and withdraw from the focus group. Should this happen, participants will also be informed that they can withdraw their data from the study up to 7 days after the focus group.

It is possible that participants' voices might be present and active during interviews. This might be particularly evident when discussing personal issues related to participants or issues that voices might consider threatening, e.g. perceived attempts to get rid of the voices. The content of the voices might affect how participants engage during interviews. For example, voices can make derogatory comments to participants, be critical or even command the participant to do or abstain from doing things.

Therefore, it is important to consider the affect the voices might have on the participant during interviews. During interview, the CI will be alert to signs of distress from participants and will discontinue the interview if necessary. The CI will also check with participants before and during interviews whether they would like to continue with the interview. Should a participant remain distressed after the interview, the CI will discuss with the participant what contingency plans they might usually have and encourage they contact sources of support, e.g. family member, friend, GP, healthcare key worker, Crisis Line.

Taking part in the interviews may inconvenience participants. To mitigate this, participants will be offered a choice of times and location (e.g. UoY premises or clinical setting) for the focus group and any travel expenses will be reimbursed.

Potential harm to researcher. It is not anticipated that any harm will come to the CI during the interviews. But there is potential harm given that interviews may take place beyond UoY premises and possibly outside usual working hours. Therefore, all research will be in accordance with UoY Department of Health Sciences lone worker policy and, where necessary, a fieldwork risk assessment will be conducted prior to interviews.

Potential harm to researcher. It is not anticipated that any harm will come to the CI during the focus group. It is anticipated that Focus groups will take place in participants' clinical setting but this will need to be confirmed.

8.5 Potential benefits to participants

It is important that voices are accepted as real by the person hearing them and accepted as real by other people (Romme et al, 2009). As such, participants might find it beneficial to talk about their voice-related and treatment-related experiences, which might enable space for reflection and further validation about their experiences.

Aligned with national policy and professional literature, practitioners aim to improve their understanding of mental health distress, including voice hearing, in order to improve the treatment they can provide. As such, participants might find it beneficial to talk about their experiences relating to treating people who experience voice hearing, which might enable space for reflection and further validation about their experiences.

According to the Bradford HVG (see section 5), participants might also benefit from practitioners' contributing towards making positive differences to the treatment experiences for other people.

Table 1 Research timeframe

Activity	*Duration / possible calendar month (2018-2020)*
Approval from NHS Research Ethics Committee Develop data collection processes and materials	Aug / Sept 2018
Information to prospective participants	15 months (Oct 2018-Dec 2019)
Data collection	15 months (Oct 2018-Dec 2019)
Transcription	15 months (Oct 2018-Dec 2019)
Data analysis	16 months (Oct 2018-Jan 2020)
Write up and dissemination	4 months (Jan 2020-April 2020)

7.5 Indemnity

The University of York is the research sponsor and provides insurance and indemnity for research.

9 DISSEMINATION

Participants who wish to receive a summary of the findings, as indicated at the time of informed consent, will be sent an executive summary of the results. Papers will be submitted to peer-reviewed journals and presented at appropriate conferences and research seminars. Findings will also inform nursing curricula and educational workshops for healthcare practitioners.

10 REFERENCES

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11 APPENDICIES

Appendix 7. Team Leader Invitation Letter

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

UNIVERSITY of York
The Department of Health Sciences

Project title: Exploring the experiences of voice hearing during mental health treatment (IRAS number: 248530)

Researcher: Rob Allison

My name is Rob Allison and I am a mental health nurse and senior lecturer at the Department of Health Sciences, University of York. As part of my PhD I am investigating experiences of voice hearing and, regarding the above study, I have already interviewed a number of people about their experiences of voice hearing during treatment. However, it is important to also consider the perspectives of practitioners. I am therefore looking to organise a small focus group consisting of mental health inpatient practitioners from an inpatient clinical team in order to explore voice hearing from a perspective of a clinical team.

I would be grateful if you could discuss this invitation with your team. If agreeable, I would appreciate the opportunity to come and talk to the team about the study, perhaps during a team meeting. If possible, I would like to schedule a time to meet with members of the team interested in taking part in a focus group discussion. I expect the focus group will take approximately 60-90 minutes and take place in a setting most convenient for participants.

I enclose an information sheet that provides extra information about the study. I would be grateful if you could distribute this to any members of the clinical inpatient team you think may be eligible to participate.

Much appreciated

Rob Allison
Department of Health Sciences
Faculty of Science
Seebohm Rowntree Building
University of York, YO10 5DD
Tel: 01904 321689   Email: rob.allison@york.ac.uk

Appendix 8. Participant Information Leaflet

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

UNIVERSITY *of York*
The Department of Health Sciences

Practitioner Information Sheet

<u>Title of Study: Exploring the experiences of voice hearing during mental health treatment.</u>
IRAS number: 248530

My name is Rob Allison and I am a senior lecturer in the Department of Health Sciences, University of York. I am currently conducting a PhD research study investigating voice hearing.

You have received this information sheet from your Team Leader because they think you may be interested in taking part in a focus group consisting of members from your clinical team to discuss treatment experiences related to voice hearing.

Consequently, you are invited to take part in a focus group discussion that will contribute to the research study. But before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read through the following information carefully and, if you wish, please ask questions if anything you read is not clear or you would like more information.

What is the purpose of the study?

The purpose of this study is to collect information from practitioners about their experiences of treatment interactions with people who hear voices during mental health treatment. The term 'treatment interaction' refers to any interaction with a person who hears voices during treatment. For example, it may include an informal conversation or a discussion about treatment; or it may include a more formal discussion within a meeting or involve the administration of medication or other form of treatment.

Research evidence suggests that the relationships people have with their voices can be influenced by their relationships with other people. However, greater understanding is needed about people's experiences of voice hearing during treatment interactions with practitioners to inform and support approaches facilitating recovery.

Who is doing the study?

This study is part of a PhD project by Rob Allison at the University of York (rob.allison@york.ac.uk). Rob is the chief investigator and is a Registered Mental Health Nurse and Senior Lecturer (University of York), with experience of working with people who hear voices across a variety of clinical settings. The study is supervised by Dr Kate Flemming and Dr Lina Gega (both in the Department of Health Sciences, University of York) and funded by the University of York.

Why have I been invited?

Practitioners with clinical experience of providing treatment for people who hear voices are invited to take part. The study gives an opportunity for invaluable contributions from practitioners to discuss their experiences in a small focus group consisting of members of their clinical team. This is designed to enable shared experiences within a clinical team to contribute to an understanding of voice hearing.

Do I have to take part?

No, taking part is voluntary. It is entirely your choice whether or not you decide to take part in this study. If you have any questions about taking part you can talk to Rob Allison, chief investigator for this study (contact details at the end of this leaflet).

If you do decide to take part then, in addition to this information sheet, you will be asked to sign a consent form, which will be stored securely at the University of York. And if you do decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect you in anyway.

What will happen if I take part?

You will be asked to take part in a focus group discussion. This will be scheduled at a time and location most convenient for participants. The focus group is designed to enable you to provide information about your clinical experiences of treatment interactions with people who experience voice hearing.

The focus group will last for approximately 60-90 minutes and will be facilitated by the chief investigator (Rob Allison) and audio-recorded. This recording will then be transcribed word-for-word by a transcription service (1st Class Secretarial Services), which will then be stored on a secure computer at the University of York. The audio recording will then be deleted.

You may also be asked to take part in a follow up discussion in order to clarify or expand on information provided during the interview. Please note, however, that you can choose to decline a follow up discussion. All information collected from participants will be made anonymous by assigning a unique identification code to each participant, which will only be known to the chief investigator.

What will happen if I don't carry on with the study?

You can withdraw from the focus group at any point. You can also withdraw the information you provide to the study but you will need to do this within 7 days of the group interview. Please note that information after this 7-day period may have already been analysed and integrated with the rest of the study.

What are the possible benefits and risks in taking part?

The purpose of the study is to contribute to the broader knowledge base about voice hearing and mental health treatment. It is intended that this will lead to improvements in treatment experiences for people who hear voices. It is unlikely that you will experience any harm as a result of taking part in the focus group.

Who do I contact if I have a complaint?

If you have a concern about any aspect of the study, you should speak to the chief investigator (Rob Allison) who will do his best to answer your questions (see contact details at the end of this leaflet). If you remain unhappy and wish to complain formally you can contact:

Professor Tracy Lightfoot, Associate Pro-Vice Chancellor for Teaching, Learning and Students, Deputy Head of Department (Postgraduate) and Professor of Applied Health Research. Department of Health Sciences, University of York. Tel: 01904 321881. E-mail: tracy.lightfoot@york.ac.uk

Will information obtained in the study be kept confidential?

Yes. This study will be conducted in line with the current data protection legislation. All information collected about you during the course of the study will be kept strictly confidential and anonymous.

The interview will be audio-recorded, which will then be transcribed and stored on a secure computer. The audio-recording will then be deleted. Handwritten notes may also be recorded during the interview but these will not contain any personal details and will be secured in a locked filing cabinet until transferred to a secure computer at the University of York. The handwritten notes will then be securely destroyed. Direct quotations may be used in the completed study and future publications but these will be anonymised. All your contact details will be destroyed less than 3 months after the end of the study.

What will happen to the results of the study?

This study is part of a PhD project and will be academically assessed. Some of this work will be submitted for publication in a peer-reviewed journal, presented at conferences and also included in education materials to nursing students. Data collected from this study will be archived at the University of York on completion of the PhD. In line with University policy, information will be kept at the University for 10 years but this will not be identifiable to you. After this point, the data will be securely destroyed. You may also wish to receive a summary of the results of the study.

If you would like to take part in this study, ask further questions or have any concerns about the study then please contact:

Rob Allison, Chief Investigator and PhD Student, Department of Health Sciences, University of York, Heslington, York, YO10 5DD.

Tel: 01904321689

E-mail: rob.allison@york.ac.uk

Thank you for taking the time to read this information sheet

Data General Protection Regulation (DGPR) and Data Protection Act (2018)

The University of York is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of York will keep information about you, but which will not be identifiable to you, for 10 years after the study has finished. Identifiable information about you will be destroyed less than 3 months after the end of the study.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at https://www.york.ac.uk/about/departments/support-and-admin/information-services/information-policy/index/policy-on-the-publication-of-research.

When you agree to take part in a research study, the information about your health and care may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you or to affect your care. It will not be used to make decisions about future services available to you, such as insurance.

Tees, Esk and Wear Valleys NHS Foundation Trust may use your name, NHS number and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study.

Appendix 9. Practitioners focused codes and quotations

Quotations assigned to focused coding

	FOCUS GROUP 1	FOCUS GROUP 2	FOCUS GROUP 3
FEELING DISEMPOWERED	**Constrained by professional accountabilities** we can come from a position of acting from our duty of care and the position of balancing risk taking versus quality of life **Feeling pressure to treat** So I don't think we can always make the assumption that voice hearing is a negative thing and something that should be treated and taken away. But we've had some experiences of people who have believed in witchcraft and that kind of thing, and that's been part of what their belief system is. And we're saying no, you need to have this depot, because you're unwell I think being an acute service, there's always that underlying bit that whether or not we're as open-minded as we are, we often go in to treat things. And there's all those different questions that pop-up at some points. And it's do we just treat at that point, we're maybe taking away that voice hearing and part of that person's identity. For some people, yes, they're happy with that when they're leaving hospital and they're not hearing the voices anymore and they're going back to the life that they were able to lead before this experience. But then there's the	**Constrained by professional accountabilities** You have to tick the boxes, don't you? You've got to do that as part of your job. For you to be a bit more free in the things that you might advise and discuss. **Feeling pressure to treat** a lot of people have come via hospital to us, haven't they? Or multiple admissions. So you're almost doing all that stuff of where you're seeing people just because of that. **Power differential within MH services** PY11: That does likely come from the hierarchy of professions within mental health, doesn't it. PY10: Oh, yeah. PY10: We do go and try and influence it from our own formulation perspective. But I guess it feels like at times the power differential between us and the wards is…the difference is almost like they're the patient, they make the decisions. Whether that's discharge, stay in, medication, choices, are all there. Obviously we work with that, work with the clients and sometimes it's easier than others if we're in agreement. But when there's	**Constrained by professional accountabilities** So, we've got all those tensions and actually we've got to juggle those, and how do we manage it. So, for me it's about just being transparent about that all the time and being really certain that people know that that could be a tension, it can be a difficulty. if I feel there is a risk involved I am duty bound to alert services and offer appointments. And you risk saying that that the person won't open up to you and won't trust, but nine times out of ten they do. Because if you continue the engagement they see that you are trustworthy and nine times out of ten you're doing something positive with them. But there is a big balance in risk on being transparent. Sometimes our time is dictated by the tasks that we have to do: we have to do the depot, we have to do the assessment. Yeah, you have to do this, this or this. So, actually your time where you're looking at really proactive coping strategies for voices it just isn't there. And that's really, really frustrating because that's what we want to be doing. **Feeling helpless with treatment resistant people**

	other people that will talk about their experiences. Is that something about us as mental health professionals that we've got to treat something? Or is that something different?	disagreements that's when it's harder, isn't it. PY12: Oh yeah, definitely. PY10: And that's when it becomes conflictual and we don't…and the person always seems to get forgotten I think. PY12: But what you're saying then, so a client would feel those overarching power from the voices, sort of thing. And then we are feeling an overarching power from services? Is that what you meant? I: Well yeah, I guess what I'm reflecting back is that you've talked about this fear of what might happen if I don't do X, Y, Z. But you've also just before said the same thing for voice hearers. They're also thinking what might happen if I don't do… PY12: Yeah. **Providing disjointed treatment** So if you're in distress you go to hospital, but you're out as quick as you can be without getting you to a point… They're not places of safety. They're not asylums in the sense of the word of sanctuary. They're almost like a process and like we'll do this, we'll get you here, we'll get you on a depot and then you go out in the community and the Crisis Team can work with you. It's almost like you're insulating parts and just doing what's prescribed really, rather than actually really working with someone's distress.	I think when you work with an individual, it depends cognitively where they are, a lot of our clients are under the influence of drugs half the time so they can't take on board. The ones that you can work with and see where it's going and things reduce it's like one of those days when you go home and you think you've made a massive difference. And we all need days like that: when you see your clients are actually responding to something that you've done. I think it's recovery potential, isn't it; if they've got recovery potential the interventions you're more likely to see results quickly. People with longstanding diagnosis who are treatment resistant. We've all got, not so much in intervention, but in psychosis we all have people with treatment resistance psychosis. I cried last week because there's absolutely nothing, absolutely nothing I can do for this lady apart from go and visit once a week. It doesn't matter what I do it's not going to improve her quality of life. In fact we're just waiting for her to become unwell so she can either be put into a hospital or put into a care home. Some of the younger ones coming through are the same. I've got a lad on my caseload who is completely treatment resistant. He came through EIP at 14, so he had all the things they say you need, get the input in straightaway. And he is completely distressed and agitated all the time, and he's

		we do formulation meetings here. The ward will do a formulation meeting upon somebody's admission, and then you go to these meetings but they don't actually follow-on from what you're doing. It's like a fresh formulation. It's not a consistent piece of work. So when somebody goes in it's like a segregated piece of work that they'll do. PY12: We are involved in that though. I'm not sure I entirely agree with that because I think that's the purpose of us going, isn't it? Is to try and stop that gap. PY11: Yeah, I think it should be. But I don't think you ever see the ward pull up your last formulation and go right, okay, this is their formulation. I don't think you ever see them…you see it in the 117 aftercare meetings. All the people that are meant to be there are never there. There's never any social workers there. There's never any… The relevant people are never there. **Removing the shackles of professional accountabilities** PY10: But I also think that we're good at building relationships with people, aren't we? And being human with people. PY12: Yeah. PY10: I think that's the big difference, isn't it? We don't try and come across as professionals. We're want to be human and work on what they want to. So I think we can help people at times. And I think people have felt more relaxed to do it. And	24, and he's been on every different medication that you can be on, apart from clozapine. He's had so many different supports and resources and things put in place for him and nothing, nothing has helped. And this is a lad who is hearing voices all the time telling him to kill himself and his mum. And he just teeters between being recalled to hospital on his community treatment order and being at home and slightly less distressed, and there is nothing, absolutely nothing we can do. It depends on how he's feeling as to whether we can talk about his symptoms and what we can do about them, because if you push him too much, if I start trying to talk about coping strategies and stuff he just sits there and he just punches himself in the head. He gets himself so agitated he just sits there punching himself or looking for something to threaten me with because I'm talking about things that make him uncomfortable. And you feel absolutely helpless. There's nothing, nothing we can do. I think the big difference for me, my understanding between EIP and psychosis, is hope. I see loads of hope within EIP; I see loads of hope within the family units; I see loads of hope with the practitioners. I think that when someone's narrative is enduring and difficult then it's harder to hold onto that sometimes, and so that can sometimes get in the way of how effective an intervention may be because it's about the belief around that also.

		I think just try and be honest with people to be honest. I think that's the only thing I can ever…Because I always think what would I want, and I'd want honesty. And that's what I try to be. PY12: Well I wouldn't feel as responsible…no, not responsible. What's that word where you feel… Oh, I can't think what I'm saying. Accountable. I'm accountable for my PIN, my nursing and the procedures that I have to go through. So if it was a mate for example that I was talking to about hearing voices, I wouldn't feel that responsibility, that accountability as a mental health nurse. I would maybe… PY10: Yeah, the anxiety wouldn't be there as much, would it? The shit, I'm going to jail if… There's always that. PY11: It's all in your head, isn't it? I think am more free in comparison to you two, because you two are nurses and I'm a support worker. So I think the responsibility level isn't as much there that I have to push medications. **Trying alternative approaches is scary** PY10: Have you done the voice dialogue work? PY11: I have gone on the training… PY10: Yeah. Have you done a recent one? PY11: Yeah, I did with Rob. PY10: Yeah, but I know… PY11: Oh, I'm working with somebody on that. PY10: I remember the first time I did it I was scared shitless. No, I was. Because it was like what if I do this wrong? Do you	But I think from my experience – you can say whether this is wrong – we're talking about family workers in psychosis is that those models it feels harder to keep offering them and it feels like we've tried and everybody feels a bit like so where do you go. So, it's about how does the team get to hold onto that hope. when you talked about being treatment resistant what do you mean by treatment resistant? PM05: I think it's a term that's loosely used and it normally comes by the consultant or through the medics. It's a failed attempt to make a difference or reduction to their distress to any of the symptoms they've experienced using various numerous forms of medications PM06: I think it's the opposite of what you said because when you said about hope it's basically they haven't got hope, and they think we've got no hope because everything that we've offered or can offer or is available isn't going to make any difference. PM04: I think we do have hope though because that's why we keep offering things. PM06: Yeah, we have hope. But we haven't in terms of… PM05: Resources. PM06: We keep them open to work with them. But hope is different, isn't it. Like I was saying about my lady, my hope is that she deteriorates so she gets looked after. So, the

		know what I mean? Then you'll learn to know right and wrong because actually it's working out with someone, isn't it? But I remember being absolutely… PY11: I'm not actually engaging with their…I'm not at that stage. I'm just profiling, time lining and mapping it out really. So I'm at those stages. PY10: But I was honest with the person about it as well, I said I'm really nervous about this, because I hadn't done this stuff. But…and it was about getting it right for that person and stuff. But I remember being really scared. Don't tell anyone by the way. PY11: Yeah, there is a fear there, isn't there, that actually something you say or ask might trigger something really bad. Or you'll personalise it, that was me that did that. PY10: That awful mental health term, what if you open a can of worms? PY11: Yeah. I think that's the same as talking to any person. I would be very tentative about talking to any person about anything at first, because you're testing water and seeing what the response is and what the reactions are, aren't you? So naturally talking about voices, to me it's like another person, isn't it? So you're asking…you're very tentative and I feel like I'm walking on eggshells about it, I have to do it very slowly, very carefully. Like I would if it was a brand new client that I've met, do you know what I mean? So yeah, there is that	hope is there but it's just in terms of recovery it's a different recovery, isn't it? So, ten years down the line we now know what the symptoms are, we're struggling to find something to do with them, and he struggles with talking therapies, our treatments don't work **Feeling pressure to treat** Unfortunately sometimes when people have voices they're quite grandiose and they don't want them reduced. But it does have a negative impact on their quality of life and their family or carer concerned with them. But, once the trust is there and the engagement, people get the really negative, derogatory, paranoid, insulting voices, they really are quite willing to try and reduce them or get rid of them. PM02…So, it's about how we as a service also talk about what makes a difference. Sometimes people always want to see progress rather than stability or just no change. And that no change might still be full of risk, but it's not an increased risk. PM01: Or a deterioration. PM02: Or a deterioration. So, it's kind of how we make sense of it as professionals as well and what we want to see happen. And some of that is about our self-gratification as well about if we don't see any difference then what we are doing, rather than the differences that they're the same. In terms of what they say that we should be doing and the standards that we should be

		nervousness there because naturally there is when…well for me, when I'm meeting a new client there is. It's all…because you don't know them, you don't know, you don't know the voices, you don't know what their response might be that I'm talking about voices.	meeting. That's nowhere near what they want us to do. They want us to find all this stuff out within six months. We do our model lines assessment, we find all this out, we get some treatment into place and then all of our assessment should indicate that actually we've made a massive difference. And people don't work like that, do they? **Power differential within MH services** I think most treatments now, because they're non-medical, I think when I go out and see somebody I tell them what's on offer, if they'd like it and if they felt their voice hearing would respond to doing this. So, a lot is negotiated by me and the patient without any medical person being involved. And then coming back to the team, discussing it and seeing if there are any groups or anything that's relevant that could help this person. And then after that if things don't work then obviously it goes down the medical route and look at medication. But I try not to involve the doctor so it's just me and the patient. **Struggling with lack of resources or support** We haven't got any voice hearing groups Because at the moment we have no psychology We work with big caseloads. We've got 30 plus people on our caseload; some of them need to be seen weekly. So, the time that we can allocate for each person isn't always enough for us to be able to explore other

			things and other ways of managing their voices. But also I think a big thing as well is money, because again we've got no psychology at the moment. I'm petrified at the moment to do any trauma based work in case it triggers something because then there's no psychology to mop it up. [Agreement] So, they're there to back you up and if the patient needs a bit more in-depth work. So, I think that's quite scary for us at the minute as a service. I think we're under-resourced, but I know we're not talking about that, but it does impact and it massively impacts on how we do and what we do because we can only do some much in the time constraints that we've got. And is still astounds me that we're working in a field called psychosis which the most common symptom is voice hearing that we don't have the policy in place or a strategy or a group or a specialist or somebody within a psychosis team that deals with that. And when you were talking about the psychologist my take on it would be that the psychologist isn't actually just there for the people; it's there for the team, to hold onto that for the team and to hold on all that pressure of what can you do and caseloads. But the big problem I've only been with the psychosis team just over a year and we have no psychology, so you're carrying caseloads that you know would benefit from but we

			can’t offer them because we haven’t got the therapists in place. In all the time that I’ve worked in psychosis I can’t remember a time when we ever had a full-time psychologist. I don’t think that it was never felt to be a priority, it was just one of these things that we’ve just got used to working without one now, haven’t we? As frustrating as that is. I think it was, because I worked EIP, and it saddens me how well resourced they are, and they are well resourced and they had to be because it was a pilot study when it first started years ago, and obviously the ultimate aim was to keep people out of hospital. But then when I came on and saw how under-resourced we are and yet we’re working with the same clients. We get a lot of referrals but we haven’t got the resources. So, it’s a bit of a deterrent to get referred into the psychosis team because we can’t maintain the engagement and what they’ve done.
FEELING THE EFFECTS OF COERCION	**Difficulty of respecting VHs autonomy equally with professional accountability** And I don't think there's anything wrong with being honest with that person afterwards about acknowledging the distress you're causing them, and your feelings on that. But the reason that you're doing it I don't think there's anything wrong with… I mean we're not some massive corporate thing of we have to all toe the party line and say this. There's nothing with saying to somebody I don't like this situation,	**Difficulty of respecting VHs autonomy equally with professional accountability** And at the end of the day we do have a responsibility, like they do know that if we have got safeguarding concerns we'll have to act on it. If we do think there's a risk we'll have to act on it. And if we are worried about their mental state deteriorating or what their voices are saying, that might be really risky, they	**Difficulty of respecting VHs autonomy equally with professional accountability** So, we’re trying desperately to work with him at home and keep him there and increase his meds and work with him around his ability to cope. But ultimately you know in the back of your head that his voice is telling him to kill his mum, and he has a really bad relationship with his mum, and if he hurt her then everything that he’s telling us we’ve

	none of us like this situation, but this is why and what we're trying to achieve. **Feeling conflicted regarding coercion** I suppose if we're talking about things like enforced medication or where people do feel coerced, like we gave the example where people do feel coerced into taking tablets because the alternative is an injection. It can be quite damaging. And then I suppose then as well, given the CTO example for the long term, is that there can be quite damaged relationships for CMHT staff and things like that because that person feels like they've been lied to and they've not been honest. So I suppose you're damned if you do it and damned if you don't do it. Sometimes it feels like you're stuck between a rock and a hard place. And you often experience that yourself, don't you? That day that somebody's begging you not to give them their depot, and that practice inside of your head going but I know this is for the best interests of you right now. But then at the same time you come to nursing because you care. You come into this profession because you care about people. And that person's stood there and right now you're causing them the most amount of distress. And it is that horrible conflicting thing inside yourself. And you're thinking…what am I doing? But at the same time you know why you're doing it and it is, it's a really difficult position to be in yourself sometimes. But then you've always got to think it's that person there that's more than what you're feeling, that	know, don't they, that… So it's actually really a difficult relationship I think it's really difficult. I mean you can do what you can to get a relationship with somebody, like you were saying about getting a relationship in order for them to feel comfortable enough to talk to. But at the end of the day you are there as a professional and there are barriers right around you, even though you do your best to have that relationship. Especially when you as a care coordinator for example, have to talk about lots of other things that we have to talk about. Like the paperwork side of things, that clients might not want to be interested in, and the care planning and the…the more, I don't know… The business side of stuff. I think that is a big barrier. And I think sometimes you're almost better getting a relationship with someone who you're not a care coordinator for, because you don't have to do all that. And I think it is a massive barrier. you're almost saying if you're taking their decision away from them, that you're not trusting them. It is really difficult, don't get me wrong. I've been on both sides of it. And it's like…with successes and unfortunate things. So I feel like that's a tightrope that you're always walking, I think the other thing is when you perceive there might be a risk to others. I think I always struggle because that does	documented it and we've documented what we want to do about it, but ultimately people could turn around and say, but his voices were telling him to kill his mum and now he has and you didn't do anything about it, you didn't take him into hospital. But the relationship and his trust in services he's opening up and he's telling us so much more than he's ever told other people. So, it's really important to maintain that relationship, but you've constantly got in the back of mind risk and coroner's courts and what are we going to do if the worst thing happens. And when you have broken the trust all of us, well I can't speak for all of us, but a lot of us have lost that relationship with the patient: they go into hospital and they don't want anything to do with you. And it's even worse if the mother has told you; it causes conflict within the family as well. But it's a risk you've got to take as coordinators and it's a thing that we'd all have to do again. But it does, it can affect relationships. So, I think my tolerance of managing risk is fairly high compared to some people. And within the office you do hear stories of people worried about risk and looking for admission probably much earlier than I would. But then I also worried that maybe I get too complacent as well because I still carry it with me that I don't want people in hospital. it's our job to keep people safe, isn't it. And it's not just our patients; it's the wider public.

	person's feeling 100 times more. It's not an easy job. **Justifying coercion** there are times where yes, we do forcibly give medication to people who we think, as a team, would need medication at that point and you can't make an informed decision about it. And then I suppose to add to the bit about your rationale and things do feel uncomfortable, and how you get through that, you're looking at the long term for that person. Like this might be really uncomfortable for you now, and you're causing that individual a lot of distress now. But that individual is usually experiencing a lot of distress anyway, and you want to take that away. So while this might be a distressing moment which we're going to make as untraumatic as possible, you want that person to move forward and be as well as they can be I think a big thing in terms of that long term goal as well is that as a practitioner the thing that always goes in my mind when I'm stood in those situations and I'm torn myself is do you know what, the evidence states that, and I don't mean this by papers and all this kind of stuff, that the people that are going home and the ones that are going home well, and you getting that positive feedback about what's done, and there's some people who have been so, so poorly when they've come in, and they have eff'd and jeff'd at everybody that you ain't coming near me with any of this treatment. I don't want it. And they've got to the point where they're able to engage with those other bits of treatment, and engaged with treatment,	seem more in the public interest to me. To try and manage that as a professional. Because I think that's the difficult bit, how you manage that risk to others that you might have to assess. And that's really difficult. And just because they've got a mental health problem that doesn't mean that they're going to do it. Do you know what I mean? And I think that's the difficult bit. So it's about actually you can take that as a flippant comment. If they've got planned intent, then it becomes more difficult. I think that's the real hard thing to do, because it's almost like you have an interest, a public interest to do things. But it's difficult and scary at the same time for that person. And for the professional. PY10: Would you say that, even your best relationship with somebody, with a client or a person, whatever, that you can have an equal relationship? A fully equal collaborative co-productive relationship? PY11: If they're not on a CTO, yeah. If they're openly accessing it because they want to access it and they want to work on it… PY12: Probably not I'd say though. PY10: If I worked for MIND I think I could. If I worked for the NHS I don't think I can. I think there's lots of overarching aims that aren't in the client's interest, that are in the in the business of TEWV or the NHS' interest, about meeting their criteria, do you want to do [list of questions]. When	This lady didn’t want to be in hospital, but then she was having quite a lot of random hallucinations and she was very poorly. It took me five months to build that relationship with her and then she got admitted. And I was part of that because she wouldn’t let anyone else anywhere near her. And it’s taken me another five months now to try and build that relationship back up. But it’s got there and this lady is well, but it’s just a really slow process I think the only time we don’t involve the patient is when they don’t have capacity to be part of decisions made in terms of what’s going on for them. But we don’t…it’s difficult. And these are the things that we’re left with as professionals to… And also because we’re the caring role and we’re set up to believe that those are the right things to do. **Feeling conflicted regarding coercion** I’ve got a lad at the moment who’s got really bad mental hallucinations telling him to kill himself and his family, and he’s on a community treatment order, and he literally is balanced on the edge of recall to hospital constantly. And he doesn’t want to go in, and he’s never had a time when he hasn’t been recalled. As soon as his symptoms get this bad he’s recalled and he’s taken away from his family. And he finds the admission really, really distressing.

	having engagement with OT. And they've got to a point where they're going home and that quality of life has improved. And I think that's sometimes the bit that sits with me. Do you know what? Yeah, it might feel really uncomfortable talking to somebody right now who is really upset and quite traumatised in that moment, by this treatment option. But is this something that's going to benefit them in the long term? And I think if you can't all sit around the table and say yes, I genuinely right at this time think this is going to benefit someone in the long term, you shouldn't be doing it. **Mental Health Act enables coercion** the Mental Health Act feels like that decision then lies with you as the practitioner very much. there are times when you're talking through somebody's rights, and it's like you can be given medication whether or not you don't want that. But it's the Mental Health Act that's allowing to do that. Because if that wasn't there you couldn't forcibly give that medication to somebody. You could potentially end up with a lot of very poorly people who aren't getting well, if they're that acutely unwell. Because they're saying that's an informal patient, which an informal patient who's that unwell would not be informal. They'd be detained in this sort of environment because of the Mental Health Act being there.	would you ever ask that? When has it ever been applicable to… If they went actually I've got this list of questions, but it's like clustering, that's not in the client's interests. PY10: The idealist in me would say I think I could definitely have a 50/50 equal relationship with someone. But the pragmatist in me says how can that ever be possible in the current system? Because we've got the Mental Health Act. And not even human rights come into play when you're under the Mental Health Act. I think having just that potential power could be seen as people wanting to play ball a little bit with you. Because it's massive, it's huge, isn't it? I think you've always got that overarching power of the Mental Health Act potentially behind you. And you can't ever forget that. PY12: Even though you try your best… PY10: Yeah. Because of the conversations that you might be having to have. Because if it was a 50/50 relationship you would be weighing up their risk all the time, wouldn't you? You wouldn't be going… That's not a 50/50 relationship. You don't go with someone, do you, in your normal life and go oh, that's fine, they're not going to kill themselves today. You don't do it, do you? So I just think it's always there, isn't it? **Feeling conflicted regarding coercion**	You know your patient. and some of the coercion feels like there's real tension between knowing what's at risk for someone or what's at risk for their mental health, and what would that person want if they were in a different place. Like in, I don't know, five months' time would they look back and go, Elaine, you never did that for me, you never encouraged; my mind was in this state that I didn't want it to be. Versus that person is happy in the state of mind that they're in and you're forcing them to do something because you don't think. It's very difficult to know what you think someone wants. Often you're working on your own value base, on what you think is important for people's lives. You're thinking, well this is what I would like or this is what I would hope for. It's a bit of a minefield really, isn't it? So, people are put in a real kind of not win-win situation really. You've got to make really difficult decisions. **Justifying coercion** I've got a patient now who's in hospital and he disengaged from me because of the admission. But he turned around this week and he said, do you know what I did need to be in hospital, you were right, it was right for you to call that. And I had been around at the time of the Mental Health Act assessment, which had distressed him but he said, looking back you were there and I know that you're not going to take any shit from me and I know that you will act if you need to. So, sometimes that generates respect as well, doesn't it?

	Would that person have the choice to remain that unwell, and live through their life in that way? Is it causing distress for that person or is it causing distress for society? And they're questions that are asked many times over, aren't they? Can somebody quite happily live how we think they're very unwell? I've met some patients in inpatient units that have gone back out and they wouldn't necessarily in the eyes of everybody appear 100 per cent well. But yet they're going back to their house and there they're living quite happy lives. And they're maybe not taking medication, you chase them around three or four times a week to try and get them to take their medication. But they're causing nobody else any harm, causing no harm to themselves. But yet is somebody still saying so that person is on a CTO, so somebody is still going to keep going round and round. It's like a legal framework and it's kind of this idea, isn't it, if that legal framework didn't exist would we put another one… Would there be a different one? And we'd just call it something else. Because it's obviously come about in some way. Because I think we'd probably all agree that if someone is very, very distressed by voices, it's kind of heart-breaking, isn't it? You want to intervene. It seems cruel not to do something. And so if the Mental Health Act didn't exist would there be something else in the place? The Mental Health Act essentially allows coercion, essentially, doesn't it? Because how many people come onto the ward and they say	I just think with the medication stuff, I think the reviews of medication on where it's administered, you know, we work with a lot of people, experience sexual abuse, depot medication, usually in the rear. I don't think that's ever considered that much. **Mental Health Act enables coercion** PY12: But also you've got the CTOs and that. The amount of people who are on CTOs who hear voices or who don't hear voices. That's another massive barrier. PY11: They're not openly accessing our service, are they? They're not engaging with you because… PY10: That's power. PY11: …they want to. There's that power, isn't there? PY10: It's just total power, isn't it? PY11: So you've almost got this synthetic decent relationship with somebody that underneath it all is legally bound by do what we say basically. PY10: If you don't see us and you don't have your depot we're going to put you in hospital. PY11: Yeah. PY10: You can't get away from that. Yeah. I had a client who was on a CTO. Do you want to take the medication? No. But he'd end up going back to hospital which I thought was fine, we can work on the distress. But then they put him on a CTO, put him on a depot again and he'd go out. And he'd just like…and he's almost lost the	PM05: I think coercion is a two-way street. I think we are coerced by our staff and peers into doing stuff that we haven't got the time to do it. And we do coerce our patients; it's not documented how we got Joe Blogs and we coerced him into. It's down as gentle persuasion or encouragement or whatever. It's the transparent tool that sometimes has to be used, mainly the path of least resistance. [Agreement] That's what it is. We do it with kids and everything. PM03: And it's about the best interest of the patient, isn't it? PM05: Of course it is. And we do it with kids. And she does all sorts now: she's reengaged with her brother that she hadn't seen for 20 years; she's got a support worker that she goes all over. She went abroad three times last year on holiday. So, she has a fantastic quality of life. And it's because the only thing that works for her is a depot, a specific depot, and she's having that without breaks and she's got a much improved quality of life. But we had to go through that horrible coercive time to get her where we are now. I think coercion is a very powerful word that if it's said in a court of law it looks as though you're doing something very deceptive with the patient. And I will always justify my reasons because it's actually made a positive difference. So, I think coercion can work with voice hearing as long as you've got the person's permission to talk to their voice. Because it's a really powerful part of their

	I'll take my medication because I know I'll go home. **Softening coercive actions** We try to meet with people before that happens to say if we end up down that road what's your preferred scenario. Do you have a preferred position to be in? A preferred injection site? So we try to make it as…I'm trying to think of what I'm saying to say… And I think it is, it's having that transparency to be like this is the rationale and these are the discussions? Rather than going in there all guns blazing with the injection kind of thing. It's having that… I don't think I've ever walked into a situation where someone hasn't… Yes, there might be… the rapid tranquiliser is prepared outside the room but somebody's gone in and explained to that person this is the current situation. This is what we can see and this is what we're understanding of your experience. And giving that transparency at that point and then it might be that it moves onto that. I think that's what's important. And I think that's something that we do well. But other people might not agree but I think as a unit here we do, do well with that. I think we are good at giving people every opportunity before we go for meds. Because I think there's been plenty of situations where we've sat with patients, an hour, two hours plus, trying to have a conversation with them. Trying to have this discussion, and making sure we have exhausted every option before we go down that route.	will to do it. And he's just got…he just accepts treatment now. PY10: Well for example, if someone's not taking their depot, you might ask them…so we might ask them two or three times. And then if they're not doing it they might ask you to see the doctor instead of trying to persuade you to take the depot. I: So you're saying that's coercion? PY10: That sounds like coercion to me. It's not like someone goes do I want a flu jab, I go no, they're not going to go…not going to keep asking me, are they, and go and get a doctor out to come to see me, are they? PY11: Or where you tell them they have the right to refuse it in the community, and should you refuse it in the community we're going to… PY10: We could… PY11: …detain you and… PY10: …recall you under a CTO. PY11: That is coercive. I: So is it the repeated asking the same question? PY10: Absolutely. **Protecting relationships from detrimental effects of MHA** PY11: We do preserve relationships where possible, don't we? If we've got some really decent relationship with somebody… PY12: You'd keep that person… PY11: Yeah, you'd keep that staff member out of say a detention.	persona, so I think you should ask their permission. But if it's a depot and it's going to keep them… PM05: Keep them well. PM06: …it might increase but for a very short burst but the benefits far outweigh that. **Mental Health Act enables coercion** I think the main one is the CTO, isn't it? [Agreement] Because a lot of patients say to you, oh yeah, got me, I'll have to take my meds because I'm on CTO. We don't say to them if you don't take your medication you're going to be recalled to hospital. We say, that's a condition of your CTO One of our patients we had to recall seven times in one year under a CTO because she was refusing the treatment. And a couple of those occasions happened in public with police intervention. It was awful, it was really distressing. It had a massive impact on my relationship with that patient. **Protecting relationships from detrimental effects of MHA** So, our team we will offer, if there is a Mental Health Act assessment going on, if somebody is being admitted that the care coordinator, the designated nurse will take that step back and another coordinator might step in to be the face of that admission so that it doesn't impact on that relationship, so that we can still go and see that person in hospital, keep up that relationship and keep working on

	Struggling to distinguish between coercion and choice We were talking about this, this morning in that where does the line sometimes in mental health come between coercion and honesty? So like we were talking about in terms of CTO recalls. So we've had situations where people have come in who we know quite well, who have been on a CTO, they've refused their depot and they end up getting recalled because they've refused the depot in the community. And their care coordinator says oh, but they refused it and they have the right to refuse it, which is true, obviously. we've had this debate with CMHT staff, we're saying that they deserve to know that because of the CTO recall part of the parameters is that if they refuse the depot they're going to come back into hospital. That's just honesty. And they're like oh, but that's coercion. the consequence to that action is that yes, whilst you do have the right to refuse your depot, it could result in you being recalled into hospital. And it then allows that person to make an informed choice, because they can still refuse their depot at that point. It's the same with oral versus IM medication as well. Sometimes you have to say well, we need to medicate you, we're going to medicate you, and you've got a choice. It's have this oral medication or it's going to be an injection. And that feels very much like a threat. Like I'm going to jab you. And being honest and trying to give a choice, which of the two do you want to	**Softening coercive actions** It's almost like if you tell me about your voices, and it's gaining that trust back with them. And it doesn't mean you're going to end up in hospital. I've said this is… And I've read it out to people, because I'm like if I feel that you're at risk to yourself or others, then I might look at hospital. But what I do first is I talk to you about it. And help you make… And we discuss that together. PY12: Yeah, and then I think some people do think hmm, I'll give it a try then because you've asked me so many times and I maybe do trust your judgement, do you know what I mean? And maybe that sounds like that I really highly respect medication, or I think that that treatment works. Because I'm asking them over and over again…because I feel pressured to. Because of…yeah. PY10: Yet lots of people do still like it, don't they? They're not good off medication, go ask them again. And you get people nipping at you, don't you, it feels like sometimes.	them when they've had that discharge. And we've got that bit of continuity so they don't associate a named nurse with that admission and getting them into hospital. **Softening coercive actions** I think on the flipside though sometimes when people are being detained it's really distressing and it's really stressful, so actually it's a benefit you being there and seeing them through it. You try not to but sometimes if you're trying to get somebody to remain in the building, oh we're just going to get the doctor to see you now just for a little chat, while you're desperately in the background trying to arrange for the Mental Health Act assessment to go on, getting the social workers there, getting the second doctor in. Have another cup of tea, do you want to go for a ciggie. **Struggling to distinguish between coercion and choice** I've just done it today. I had a phone call with one of my patients and she was like, I'm not very well and I'm feeling a bit low and I'm down. I said, when I come to see you why don't we go for a coffee. I'm going to see her on Monday. Oh yeah, I feel brilliant now, I've got something to look forward to. It's not coercion, I will take her, I know that will lift her mood; I know that if she's got that to look forward to.

	take? But it does become a bit of a blurred line sometimes. because often people will go out on a CTO, because no, I don't want that medication. So then it's… Okay, so you're not going to engage with a treatment plan. So you're going to end up with a CTO which ultimately if you then say no, if you become unwell you're going to get brought back into hospital. And it's where does that lie I think without the Mental Health Act you would absolutely think it's coercion. But because that's there it's almost…it's giving people some choice within…a lack of choice.		
IMPOSING A PROFESSIONAL AGENDA	**Constructing voice hearing within a professional framework** And I suppose we're thinking about it from a mental health point of view, aren't we? But not everyone that hears voices, we've mentioned trauma, not everyone that hears voices had trauma. There'll be thousands of people, won't there, out there that are hearing voices and they've not had any trauma. And they don't have a psychiatric diagnosis. **Practitioner knows best** And I think it's experience as well of that presentation, just helping them understand what's going on with it as well, and just work out what's happening. they're not coming into hospital to completely get rid of the voices, because that might not happen.	**Constructing voice hearing within a professional framework** But I still think one of the problems for me is the intervention psychology service we've got. It's still predominantly…it is diagnosis led. So it's about you have to have a diagnosis of schizophrenia. **Practitioner knows best** PY11: But I think on the opposite side as that as well… PY12: Yeah. PY11: …enabling somebody to step up knowing that actually you hear about people being able to mask their experiences or whatever. PY10: Yeah, from the Mental Health Act assessment. PY11: I work with a really risky person who sings nothing but praise for his voices and actually helping him through the day,	**Constructing voice hearing within a professional framework** normally from observations it's me watching them be preoccupied and responding to something that's in their head. Obviously, my training, academia and books have validated lots of stuff, but most of my information comes from patient observation. For me one thing is to determine where the voices are coming from: are they inside the head, are they outside the head. Again, are they distressed, are they their own thoughts, can they see the link to the voices to social stresses that they've got going on at the moment. I think in EIP that's a little bit different because we're doing the initial assessment to someone, are they hearing voices, is it a true voice, is it their own thoughts, what's going

	it's about how we can educate the families as well as that individual when they come into hospital. And they'll hear these diagnoses being bandied around and instantly think that their child is going to go out and stab someone, or something like that. So it's educating them around that side of things as well. the practitioner knows best in that situation And there's people screaming bloody murder that they don't want this medication. But yet as a clinical team there's been a decision made that in the best interests of that person at that time, because they are incapacitated, and they're so unwell **Taking a team approach** If it's a forcible injection or something we have debriefs now with a team of people involved immediately after for them to reflect on that and talk about what's gone well and what could be better next time. And even if all of the practitioners around the table don't like it, it's a group decision at the end of the day.	making decisions, doing things. And I think the underlying thing is that he knows that if anything goes awry there's this powerhouse bus that'll whisk him into hospital.	on, do we believe it, is it valid. These are conversations that we do have: are they saying it for a reason; is there a secondary gain for doing this; what's actually going on for them. So, we do have some in-depth conversations. We use the CAMHS assessment when we're validating that with our psychologist, our advanced practitioner, going into quite deep discussions: was the patient distracted; were they responding to the voices; is there somebody that we can work with. So, we do have a lot of discussions around. It's a theory, I know there's been a conflict around it because I've heard different. When I was in early intervention it was if they're inside their head it tends to be trauma, disassociation, their own voices and they're more psychological routed and not a true, how you define true, and auditory hallucination. If it was outside it was a true hallucination. A lot of consultants still believe that. But it's very much trauma focused now so I think there are different opinions on true hallucinations and not true. I think it defines where the voices are coming from, like they say it defines what work you do with that person. So, if it's inside their head, like Elaine has just said, it could be trauma related, it could be their own thoughts, it could be related to stress. So, it depends what kind of psychoeducation you're going to do with that person. we don't necessarily call it voice hearing experience, we call it whatever people are

			calling it. The inside, outside part never really comes into my…because that's not necessarily…I find that's a much more professional narrative around things. But that kind of psychological trauma all that is very professional language in my experience, unless you're talking to a family that has got professionals in it, it doesn't really make sense I don't want to add to distress or agitation to my patients by talking about coping strategies for an illness that they don't believe they have. And again with hope and getting acceptance that yes, it is a mental health illness, at that moment at that time get them to get better from it and maybe just setting our goals together for that individual person, knowing that they might not ever be exactly the same as they used to be, but obviously this experience is going to impact them for the rest of their lives, whether that makes them stronger, whether that changes the route that they're on. And again just getting that understanding of somebody to me is massive, that somebody can accept where they are and start working together with us. you have formulations at six weeks and 12 weeks and that will think about the care package with the psychology. **Practitioner knows best**

			Unfortunately sometimes when people have voices they're quite grandiose and they don't want them reduced. PM02: Would that say to you that that was worth it? PM04: No. Well, she's never said it outright. PM02: But was it worth it to get through with her brother? Was it worth it to go on holiday? Was it worth it to do all those things? PM04: And all those things, yeah. PM02: Would you say, looking back I'm pleased you did that, or would she say, it's the payoff wasn't worth it, I'd rather not have gone on holiday and rather…? That's the difficulty. PM04: That's what they say but the depot, you make me have it, you make me have it, and I don't want it. PM02: It's really difficult because we're deciding what's best for people's lives, it is better to be in a relationship with your brother, it is better to go on holiday. **Taking a team approach** it's about collaborative working as well and working with other agencies because they might have some information on them, it might be Mind and they think well, they've done this and they've done that, or they've told us this. Although it's patient-centred care it's about reaching out to the family and to other professionals

			Anything or any new information about a patient or their symptoms comes through in the daily huddle. We have a huddle. So, you sort of talk through what you've done with the patient. You have one every day and you talk about the previous day, so you talk about what you've done with the patient and what your plan is. And they're quite invaluable because people go, well have you tried this and have you tried that. [Agreement] So, we are really good at team working, thinking about our teams, we are really good at team working, so I think that informs a lot of what we do.
NEGATIVE IMPACT OF MH SERVICES	**Disempowering effect of treatment for voice hearers** And sometimes we get a blend of some people maybe have been treated and aren't hearing them or aren't as much in their mind anymore as other side effects to that. And feeling more lonely, as if someone's not still there with you. People miss them, don't they? And people who we may have treated in the past, we do see people who will come and they'll say well actually now I don't want this treatment because I don't want that to go away. It serves a purpose and a comfort for them. And I think there's been sometimes, certainly in my experience of working in this sort of field, that that's potentially putting that person at risk as well. Because of those aspects of loneliness and that kind of thing. And we've had some people who have become very frightful at the point where we've treated	**Detrimental effect of coercion on voice hearing** PY11: I think it potentially feeds into suspicion, mistrust… PY10: Paranoia. PY11: Threat, paranoia. Yeah, absolutely. PY12: A negative, probably all negative things really. Yeah, because it's like when I've been with people and the voices do become more difficult when I'm with them potentially at times. I know there's a power threat there from the voices as well, from what I've read, but they can be difficult when you ask about them. When you ask to talk to the voices, the voice dialogue that I'm trying to do, because they do feel threatened, don't they? They voices themselves. And they can feel threatened…you can see sometimes that people are… Even if you're not asking	**Detrimental effect of coercion on voice hearing** If you do a CTO that's going to increase because their anxiety is going to increase. Anybody who is getting recalled to hospital their anxiety is going to increase. Well, they can turn around and say well, my voices said you were going to do that, you were going to make me go into hospital, and you have, haven't you, so they were right. So, then they might be more inclined to actually believe what the voices were saying because you've proved them right validating it. Yes, you have, and that's happened **Disempowering effect of treatment for voice hearers** And some patients will be fearful that actually we'll take the voices away in what we do within the treatments that we have.

	somebody for voice hearing and that aspect to life has gone. And it's a very risky period for that person because for them there's a sense of purpose gone as well, which is interesting. And I'm not saying that's for all people, but there has been some experiences where people have found that very detrimental. You can change someone's identity completely, can't you, with getting rid of that. And then offer a chance to talk about it afterwards. But it does take a lot of then rebuilding relationships after that. **Lack of treatment choice** at times we've attempted to start voice hearing groups within this service. And we've not really been able to, for one reason or another, get that going really. And I think sometimes the nature of an acute ward, there's always lots of stuff going on kind of thing, and it feels like sometimes we need to maybe prioritise a little bit more on those type of things. in terms of any direct work with the voice hearing kind of stuff, it doesn't necessarily happen in the acute environment. **Medicalising and medicating** Sometimes people attribute it to a mental illness like schizophrenia. some people will hear it as part of the diagnostic…it's schizophrenia and that's their understanding of it and they're maybe experiencing something that isn't within the social norm of hearing something that you and	about the voices, you can almost see that they're getting difficulty from the voices while you're there, can't you? I suppose in my experience it seems to be the negative. **Disempowering effect of treatment for voice hearers** I think actually what you're telling people is you can't cope with your voices, you can't cope with your stress. Let's give you some medication to stop you thinking and feeling. Yeah, to fix it and take it away. Rather than looking to understand it. it just causes problems for us, because then people ask for medication, rather than actually, let's talk about how can we deal with your distress now. PY11: This comes back to culture again, like you say, in your experience it's hugely negative, in my experience it is usually negative, I don't know about yourself? PY10: Mine is mixed. PY11: Mixed. It's mixed for me but predominantly it's negative things. **Medicalising and medicating** 90 per cent of them, 95 per cent of them are on an antipsychotic medication. PY11: And I think my work's informed I suppose from knowing the history of those hierarchies really and knowing how	**Lack of treatment choice** I always think that we're not very good at it, and I don't think the mental health services are good at it, that actually medication has always been top of the list of what we can…the intervention. When you come in I think it should be like…you should have a list. And you should have an explanation for each… PY12: A menu. PY10: … And actually what does medication do? What does CBT do? What does anxiety management do? What does relaxation do? This is when it'll be available and this is how often you'd have to… Why haven't we got that in the modern NHS? Because I think actually, that's perfect, isn't it, because the person gets to pick what they want. **Medicalising and medicating** Maybe when I first came into practice then I was much more tied into medical knowledge and medical understanding of voice hearing experiences. a lot of people have said to me they're frightened to tackle them because they think if they try and tackle them other than with anything apart from medication that it will make the voices worse and they'll attack them more. It can also be led by the patients where they are in their diagnosis. I was working with a girl, she got allocated to me last December and we're only just starting her stay in welfare because she's been so unwell and so

	I wouldn't be able to hear, but it's what they experience from it. when I started years ago it very much was a medical model and you gave people medication. That was the only option and there wasn't really anything else available. often there is a lot of medication focused We sometimes do like have peole who can't go outside because they think something bad's going to happen to them. So we do a bit of PRN medication and they'll say the voice hearing, I can't take that medication. So we'll look at the pros and cons of doing this and sort of work around it that way, don't we? we clearly need medication it's felt that they need some medication. And although, the voice hearing, the reason why we've gone with that treatment option is that the level of distress they're gaining from the voice hearing at the time, is at a point where it's felt that treatment is needed in terms of a medication. But yet you're stood there and you're like I'm now causing you distress through giving you treatment. So it's now distressing… **Voice hearing is stigmatised more than other MH problems** it's not just a hopeless case necessarily, and the person can still have a good quality of life. Because I think there's a lot of bad press obviously in the media and films, and a lot of	they've shoehorned themselves into position to be in power if you like, to make these decisions. And how they colluded with other organisations, pharmaceutical companies to… I: So are you're talking about this hierarchy of power… PY11: Yeah. So in the early 1900s psychiatry literally barged its way into the medical field as it were, set up its own governing body and became this thing that everybody thought right, well, they're professionals. But I also think there is that big collusion from big pharma. They have to prove that the medication works. When I think every test that they've done doesn't. Because if you look at it the people that are do it are handpicked. And also they're funding their own studies. So why would they… And also they don't have to publish a study that goes against the evidence of their medication not working. You only have to publish two positive studies. So out of 100, 98 are bad, you publish the 2 that are good, that medicine will come to market. Our doctors don't have enough time to be finding they're missing studies, don't have enough time to find that evidence, and are therefore prescribing medication that's not necessarily any good or effective. We see it time and time again. I don't think the mental health services are good at it, that actually medication has	medication focused that every intervention I've done has been around prevention from hospital and medication I think it's very dependent on the patient's level of insight and how motivated they are in terms of acknowledging what's going on and what they can do about it. I have patients on my caseload who have been in service 30, 40 years and they still don't have the insight to be able to work on their shared symptoms and their voices because they don't acknowledge that they're as a result of mental health problems, of schizophrenia, of psychosis; they don't acknowledge that at all. I guess in EIP my experience is that there are multiple interventions. Sometimes those interventions fight over who's the best and which ones work. I definitely see it as a dominant medical model I: You've mentioned several treatments. To be clear then what treatment choices are available for people in your experience anyway? PM05: Some sort of medication. And I suppose if you look at the lad I was talking about every single medication that he's been on hasn't worked, and he's been on everything possible apart from clozapine. PM03: Why has he not gone on clozapine? PM04: Because of his situation. He insists on staying at home, and mum is an alcoholic and she can't assist him to take his medication. He's not compliant with all the

	the public are quite ignorant, for want of a better word.	always been top of the list of what we can…the intervention. When you come in I think it should be like…you should have a list. And you should have an explanation for each… I: So when people are in and they're offered that, what happens if they don't want to be on the medication then? PY12: Well they're allowed not to be. But it'll always be talked about and it'll always be…I've got this at the moment, and it'll always be well, maybe one day… Maybe we can talk to them about medication again then. PY10: It's really coercive, isn't it? PY12: And every other ports of call, so they would get assessed elsewhere, say in the cells or wherever. And they would recommend that they take medication. PY11: I like that, I like the point that you always raise… PY10: Not treatment, medication, because it's not treatment. PY11: …is when somebody goes into hospital, is that not the perfect environment to try… I mean it's your point, isn't it? To try somebody off medication and actually see how they work in that therapeutic environment if you like. But that's not the case, is it? It's like right, in hospital, full whack of medication.	meds so he would need to be placed somewhere to make sure he was doing it safely. And like I say it's usually we get the doctors involved when we hit a glitch or there's a deterioration or when there's an improvement, medication wants to be reduced, it tends to be then when we get medical intervention. And then we see when they come into service they always get seen by a medic. But she is one of the people I work with who has the least insight into her condition. She absolutely does not believe she has a mental health problem at all. She doesn't need a depot. When we give the depot it hurts because that's her body rejecting it because she doesn't need it, because we're giving her something she doesn't need. So, that year she was really, really unwell. She was really distressed, she was really agitated, she was refusing a depot constantly. So, we had to recall her to hospital all those times in horrible circumstances to make sure she got her treatment. Five, six years down the line she doesn't even argue about having a depot, she accepts it. She doesn't like it but she accepts that actually she can live her life as much as she wants to live her life, as long as she lets me in once a month and she has her depot. **Medication traps people in MH services** But then there's the risk that the agency would have, they would be like you can

		PY12: And I still think it's frowned upon if they're not on meds. It is a bit frowned upon, and I feel like that's… I: By whom? PY12: Medics. PY11: Services, family members. PY10: The wards are very psychiatrist led, aren't they? They're very psychiatrist, medical model led on the wards. So we go in and they will go oh, they're not very well, let's jab them. And I hate that term, because I think it's awful. I think society will be on there as well. If somebody's got a diagnosis… The number of people have said I would've just loved to have chatted to someone, but they get medicated, don't they? And I think it's the same with depression. I think it's the same with anxiety, with all these things. You go to the GPs, have a tablet. Not like actually, if you want to speak about stuff. It is just a quick fix. **Medication traps people in MH services** PY10: I think it's a predominant theme of what keeps people in mental health services… I: Medication? PY10: Yeah. PY10: No, I think we do, but I'm just on about the predominant thing of what	never discharge them because the risk would be so high. **Voice hearing is stigmatised more than other MH problems** PM01: And within that there’s the sort of stigma of society, isn’t there, because voice hearing experiences isn’t accepted in society as something that is okay. But if you start talking about some professional people that have had voice hearing experiences people are like, oh really. And I think you were saying more people are talking about it now, aren’t they, so it’s coming out more now. But let’s be honest, there’s still loads of stigma around it. [Agreement] People say it’s really reduced, and I think it is reduced in lots of things, I think it’s really reduced in children’s mental health, I think it’s really reduced in depression and anxiety, but not necessarily in voice hearing experiences. I don’t see such a normality of people going, oh they’re experiencing voices, it’s just one of those…you know. Or people talking about, I can be a group of friends now that will talk about their anti-depression, so feeling anxious about something, people will talk about their depression. But voice hearing is not something that people suddenly will just talk about in the pub. PM04: I completely agree. [Agreement] PM06: It’s what’s put on the media as well, isn’t it? People don’t ever get some sort of psycho in a film or something that has depression, do you? It’s always somebody who hears voices has schizophrenia or has something like that.

		keeps people in mental health services, is medication. PY12: And I would probably think that hat's the first treatment that's offered. Exit strategies from services, because of the medications. Clozaril, you can't leave services, depot…you can't leave services. So you're working to a dead end a lot of the time with some of our clientele. PY10: Yeah. That's what I mean, there's got to be more options, haven't there? PY11: Absolutely. Voice hearing is stigmatised more than other MH problems	PM02: Something like talking in the town, it was going on a bit longer, we were talking about somebody who was hearing voices and they said, oh and their face changed, it went from a normal face to a totally different face. And I just felt like tapping them on the shoulder and saying, no, it didn't. That's why it's scaremongering, it's still out there, it still exists. I think that goes along with the media that's on it. It's okay in the media to be depressed or to be anxious, not many murders happen from that; but they do hear from voice hearing people command and hallucinations. So, it's a lot of scaremongering. there's much more of an understanding about why the world might be anxious or why the world might feel low or depressed; but not that actually those things can also contribute to why you might experience voices
NOT KNOWING HOW TO MEANINGFULLY ENGAGE WITH VOICE HEARING	**Concerned about colluding with voice hearing** Although we're trying to understand it, there's sometimes questions whether or not are we colluding with voice hearing And some people might dismiss that or question should they dismiss that? Because let's keep things in the reality and the here and now, and this is what's going on. And I think sometimes there's conversations about if you're maybe engaging with the fact that that voice hearing is there and that is	**Concerned about colluding with voice hearing** when I first came into working with people who hear voices, that there was a little bit by the professions, the older practitioners that would say we don't collaborate with the voices. We kind of ignore them. That was kind of it. And then luckily when I first came through, it was actually, you can engage with voice hearers. You can talk about the voicers. You're not collaborating with them. Colluding was the word that I got told about.	**Concerned about colluding with voice hearing** When I started my nurse training in '92 we didn't really talk about voices with patients. It was that culture, wasn't it, of you don't talk about the symptoms because you might make things worse. PM03: Don't challenge them. PM04: Yeah, and don't be seen to be colluding with them, because they say in nursing, that's not the right way to deal with them. So, in terms of professionals there has been a massive shift, but that hasn't hit other places at all.

	something that for that person is in reality at the moment. If you accept it into your reality are you colluding? And I think that's… Yeah, I think there's sometimes questions about that, about are we benefiting that person by engaging in that? **Dealing with the side effects of voices** But I think there's sometimes a bit of comfort in somebody that is actually listening and validating them, if you're listening to what they're saying about their voices, rather than dismissing it. It's not necessarily something that we might discuss in OT groups, but it's accepted that if that's what…if you are responding or talking to someone or hearing voices, then yeah, you can still engage in something else that's meaningful, and it's not a negative symptom. the voice hearing work is more once they've left hospital. And it's sign posting and there's a lot more signposting stuff rather than the stuff where we're just in hospital. It's very much getting through the acute phase in hospital, and the next bit comes once they've gone. Yeah, we deal with the side effects of the hearing the voices, don't we? So we'll work with the anxiety and doing graded exposure and CBT and stuff around that. Sometimes we get people hearing that they're an awful person, getting told all these horrible things. And I think sometimes it's just…I know people have said that it's nice just to get that reassurance that they're not.	You're not to collude with voices. They went don't listen to them, don't collude, ignore them. And I think you're still doing that damage with people now. **Dealing with the side effects of voices** I think the can of worms was actually about people's confidence to be able to deal with that, rather than opening it. Because I think that was… Because people for years wanted to talk about voices or deal with distress or deal with the difficulties, without actually how do you shut this down? And I think that was what people were taught, weren't they? About actually, medicate, shut them down, ignore them. And so that's where the idea of a can of worms came from I think. PY10: People can't deal with distress. They can't deal with somebody else's distress, that's what it is for me. We haven't got a tolerance for someone's distress. PY12: And then what does that say? It's about all emotional regulation stuff, that we can't deal with that. We're trying to stop your emotions, when actually we need to be teaching people more about how to manage their own distress and know that it's alright to be really sad and really happy or whatever. Or we'll give you some diazepam for that. **Historical attitudes discourage engaging with voice hearing**	**Dealing with the side effects of voices** when I'm talking to somebody with voice hearing I ask them when it happens, how often it happens, how much distress they get with it. Because, as we've said, some voice hearing they don't want to lose it. So, I look at the distress and times of day, so I get a baseline and then try and find out if there's a part of the day that it's more distressing or they're less able to distract from. And then usually there's a plan around that. And you've got to be cautious because some of them are command hallucinations, they're command voices. So, I try to reduce the stress So, rather than asking him and distressing him by what they were saying, because he would never tell me, and he'd say you know because they're actually talking to you because I can hear them, so he could hear the voices talking to me, but I would just say are they inside your head or outside. And then that would give me an aim to say, okay let's distract that. Whereas if they were inside his head I'd just leave them because he was quite happy with those voices. **Historical attitudes discourage engaging with voice hearing** I think people are much more open these days to what they were say 20 years ago when I first came into mental health, because there was more stigma then and people were more reluctant to talk about what they were experiencing.

	when they tell you what they've experiencing you can try and help them work through it a bit. Maybe saying well, you know, you're not an awful person. **Feeling anxious about speaking to people about their voices** sometimes people will maybe not go into too much about what a person's talking about, about their voice hearing or if they're maybe talking about what that voice is saying for them and that kind of thing. And I think they're some questions that you sometimes hear within the working environment, there are differences in how people will approach it and how people will possibly not…not voice dialogue with the voices and that kind of stuff because that's something different, that's a specialist kind of thing. I wonder if sometimes there's an anxiety about what’s there, or knowing how to speak to someone about their voices or what do you ask? And I suppose that can provoke an anxiety, and what people might do with that anxiety is then avoid it rather than ask some really awkward questions about it. I wonder if some of the collusion and things like that come from people who have been around for a long time, being told you're not to engage in the conversation about it. I need to just dismiss it and brush it under the carpet.	I think we're probably still a long way off from people feeling totally comfortable about it. But I think we're in a massively different position to where we were 20 years ago. **Struggling to get VH to disclose voices** PY12: And you have experiences, don't you? I did the other day where we were talking to someone about their mental health has deteriorated and I was open and honest about what my thoughts were on that. And then when I asked about voices they were…no, no. No voices there. And I felt it was because I was looking at it from a mental health point of view. So I'd got that…not that power, but do you know what I mean? It's what I can do with it when you're telling me now that… I: Do you think they were concealing the voices for those reasons? PY12: Yeah, because I had expressed concern about deterioration in mental health in all sorts of other different ways. And you try and do that, because people who have told people about voices in the past have been hospitalised, because of the perception.	But I think it’s definitely we’re more proactive in what we ask and what we want to find out than what we were in the past. Because in the past if someone said that then we’d just look at medication and hospital; we wouldn’t be looking at what we could do in the community really to try and help them cope with those voices. **Struggling to get VH to disclose voices** But I think though we do still have patients who are reluctant to talk about it because of what they fear that will lead to in terms of going into hospital. We’ll have patients who will say consistently, no I don’t hear voices; but everything else about what we observe about them and what the families report is voice hearing. So, you still have that element of people who won’t talk about the voices.

	we probably won't ask anybody in a group about hearing voices, because you think what's that going to uncover? In the middle of baking asking somebody about hearing voices **Historical attitudes discourage engaging with voice hearing** And I guess some of that has come from my professional training. And I can remember being trained when I first started to say to people it's not real, just ignore it. **Perceiving voices as too distressing to engage with** That's similar to in OT, if anybody was responding to voices or anything like that, it was seen that they maybe couldn't then attend the OT because it was going to be a stressful or a distressing time. Because it was seen as more of a negative symptom. it definitely was like that. It was…we can't see you, you're hearing voices, so you need to stay on the ward and be looked after the nurses and you can't come to the OT session today. **Struggling to get VH to disclose voices** if they say oh no, I don't hear anything and you're sat having a chat with them, and they're looking around the room, it's just like oh, what's going on? Why are you looking around? And things like that. Or if they give an answer that doesn't make sense, you can question it a bit more and maybe sometimes if you explore		

	things a bit more with people, they might divulge a little bit more.		
POSITIVELY ENGAGING WITH VOICE HEARING	**Being curious about voice hearing** there's nothing wrong with just being curious and having a conversation about it, without coming up with a solution. I think it's worst not to ask. I mean people can only say no, or not answer you. It's having that ability to be able to learn more about the person and if that person is experiencing voice hearing, then that's something to understand about that person. And it's part of that person's experience and their life at that current time. **Being transparent with voice hearers** I think the first time meeting a patient, doing an initial assessment, I kind of prefix the conversation that we have with I'm going to ask you a series of questions. If there's anything you don't want to answer or find too much or you can't respond to then you don't have to. So it gives a free space for people to talk about what they think is a problem or not if they don't want to. **Building a relationship is important** So if you haven't got a relationship with somebody you're not quite sure which ground you can cover or what might feel comfortable for that person to talk about I think it also depends on the rapport you've got with the person. Because you've got some people that are very much like a closed book.	**Being curious about voice hearing** I was just going to say about how perceptions have changed and the culture's changed from when I did my nurse training really. Like you say, Dave, every time we interacted with those voices, and I think we're very led now, aren't we, by the client and their experiences. They're interesting, we want to ask more questions. We don't feel as frightened about asking about them. So naturally breaking down those barriers. you don't have to collude, but you don't have to reject. You don't have to reject. You just have to open it up for what it is and start learning from there really. I think that's more helpful for me. as you get more experienced at doing it you get more confident over the years. It's alright to ask questions about people's voices. It's alright to ask them about if they've got a name, how old are they, do they come from the inside, do they come from the outside of your head. Or is there anywhere else they come from? And when you do the mapping of when they hear them from as well, you get more used to it, don't you? And you're like oh god, yeah. And it destigmatises it for you as well. **Being transparent with voice hearers** PY10: I think foremost…I guess the other thing is are you…because it's that thing,	**Being transparent with voice hearers** And it's about being transparent about that that's my role with them and I'm on a journey with them, but that I'm also within an agency that has professional responsibilities and that if there's something that falls outside of that that causes concern that I'm bound and I have to do that. It's about the transparency I think working with anyone about that you want to work with them for what they want to do, whether that be an individual, a family, whoever it is; but that you're also employed by an agency that has an expectation on you that generally comes from what society expects from us, which is that we will keep society within a safe place. Reference 2 - 0.19% Coverage we saw people right from the point of youth and first experiences, and I've always thought transparency was obviously best. **Building a relationship is important** But the big powerful tool is engagement, and I think once the client gets to trust you then they're more able and more willing to talk about those experiences. And because they're personal once the person has got the trust with me we develop a proactive joint care plan on how I'm going to support that person, being able to try and reduce the voices.

	But then we get people that come to us quite often and they know about the history and when they come to us we know it's patterns of behaviours and what's causing it. Because often we get people coming in at all different hours, and you've got a clerking doctor who's never met them before, and they're asking them all these questions. Whereas it might be more appropriate that it's somebody that knows them well, to talk to them about it and anything that, it might be a difficult time for them, is that's what brought them into hospital? Is that what they're experiencing? I think just getting that support and freedom to talk about it as well is massively important I think for people. I think that rapport is a big part of what we do here, and especially an acute service. You have to have that ability to build rapport quickly with someone. And I think that comes from the fact that if you are validating somebody **Offering a variety of treatment** But I think when we're talking about treatment options it's not always about medication. We do have quite a skilled MDT here. And I think we're not just looking at medication, but looking at input from psychology, looking at input from OT. Input from our physio and healthy living advising team. there's been people, hasn't there, that have come in, they've experienced voices, and we've offered a range of options of some medication.	are you speaking behind a client's back or are you… Because the clients I work with, I will say I'm…… PY12: I'm going discuss it, yeah. PY10: Yeah. Do you know what I mean? I'm clear with them that there are these processes that are here for me that helps me figure out working with you. And also I'll try and talk to you about what I'm talking about at times, about when I go to supervision, I'm going to go and ask them about this. Because I think it's that thing about that open transparency, that we're not hiding or colluding or making decisions about them without them being aware of what we are… I: So having that transparency about it, does that mean that you have…the kind of conversations you'll have with each other is similar to the conversations you'll have directly with the voice hearer? PY10: Absolutely. PY11: I'd certainly like to think so, yeah. PY10: I guess for me it's like you might be having those conversations with that person and these are all ongoing conversations over a period of time, aren't they? And so you're building up information and working with them. So it's never just you figure out something, is it? It's like you're almost feeding in all the time to what's going on. So it's not again we've had an epiphany, do you know what I mean? PY12: Yeah, that's right, because it might not be, it's just an idea, isn't it?	But, once the trust is there and the engagement, people get the really negative, derogatory, paranoid, insulting voices, they really are quite willing to try and reduce them or get rid of them. So, it's all based on engagement. I always tell people that we develop the relationship and we gain the trust PM04: And it helps your relationship as well because you believe what they're experiencing and they know that you believe that, and that helps, doesn't it? PM05: Yes. It's massive when a patient acknowledges that you really believe what they're experiencing. **Normalising voice hearing** actually this is normal, this does happen to people quite often, that's why there are teams developed around it, that's what we're here for. And getting them to understand that it's just another illness; it's something that you can recover from, something that you can get better. **Talking directly to voices** I've coerced with the voices and I've coerced with the patient and I've said to them, would it help if I told your voice to go away and talk to your voice. I won't tell you sometimes the terms I say. You've got to talk in a language with your patients that they use. I'm not saying you have to eff and blind. And I've got permission off the patient and I've spoken to the voice in a coercive manner and I've asked the patient if – a lot of the times it hasn't

	But then also an option of if you don't want to take the medication, we're not going to force that medication on you.	PY10: And also it's that contracting that you do. You might say do you want to speak about this? Or this is a theory about how we think about… So you might word it in a way that goes… Because some people find that because they're hearing voices it's protective in this way because…and the reasons why. That doesn't mean you can't have an equal relationship, does it? That means you will ask them something that necessarily they don't want. But being equal is being able to open it. You can say look, I've got to ask this, I've got to ask can we do this thing. Sometimes when you have a good relationship with people you go this is where I am, this is…I'm with you here now, this is the stress I'm potentially seeing, or the risks. I'm honest, I say this is where I feel, in my professional capacity, I have to do this. And I have been honest with people about that in the hope of preserving a relationship as well. That can get through difficulties. **Building a relationship is important** it's about knowing your relationship with that client, because I think that's really important. It's like that relationship is really key to working… Because if you haven't got the relationship it's really difficult to have conversations about people's voices. PY12: Oh my gosh, yeah. **Normalising voice hearing**	made a bit of difference, but a few times the patient has said the voice is listening to you and it doesn't want you to be here and it doesn't want you to talk to it. And I've said, but is it getting less. And they've said, yes they're going away. PM04: I have. PM05: Yeah. But I always ask their permission if I can, because sometimes they don't want anybody else talking to their voice. And I write down, patient said I can talk to their voice. PM04: I ask for the voice to actually allow us to have a conversation so that the voice won't be present while we're talking to the patient. I've done that. PM02: Asking the voice to be quiet? PM04: Yeah, can you come back in an hour and let us have our time, or sort of negotiated through the voice, Joe can't cope with you all day but he says you are welcome between six and eight tonight because he feels more equipped to deal with what you're saying at that time and things like that. PM02: And does that work? PM04: Yeah it can do. Not every time, but nothing works every time.

		I think it normalises it more, the fact that we're alright with it, we're alright talking about it. We're letting them be alright and talk about it. It's alright to be open. And not feeling like it's a shameful secret that you need to hide that you've got these voices, and that's a terrible, terrible thing. PY10: You know what I think really helps, is…I don't know about you, but appropriate thought disclosure? And not even appropriate, but thought disclosure with people. That we're normal and we have anxiety, we have rumination. I think I've done that with people, I don't know if you have. Because I think that really helps to normalise the relationship as much as you can, to go do you know? Sometimes I don't get a sleep on a night because I keep thinking about the same shit. I know I'll get better but I can't stop myself. I've had conversations with people about…because I think that's normal really. **Offering a variety of treatment** PM05: Yeah they did, a lot of people did, but it's all been pulled away. So, that's around medication, CBTp and online resources. PM01: With EIP you've got CBT… PM02: CBT, CBTp. PM01: You've got occupational therapy. PM02: EMDR, individual therapy, family work. PM01: Simon's team and family work. PM02: We've got CAT as well. PM01: Some CAT. And those depend on which psychotherapists are in the team, so	

		if there is someone that does CAT or EMDR then that would offered as a bit of a package. There’s carer support, family support. Occupational therapy which is different in each team so some teams offer quite a lot, like walking groups, gyms, there are support worker interventions, there’s the back to work intervention. PM06: IPS. PM01: IPS. PM06: Individual placement support workers. they’re given that menu, what’s on offer, what do they want to pick and choose from that. A lot of the time the care coordinator may guide and advise and say, well I think this might be useful for you, I’ve had experience of working with somebody who’s had this benefit from it, however you might have this come from it. **Talking directly to voices** PY10: Have you done the voice dialogue work? PY11: I have gone on the training… PY10: Yeah. Have you done a recent one? PY11: Yeah, I did with Rob. PY10: Yeah, but I know… PY11: Oh, I'm working with somebody on that. PY10: I remember the first time I did it I was scared shitless. No, I was. Because it was like what if I do this wrong? Do you know what I mean? Then you'll learn to know right and wrong because actually it's working out with someone, isn't it?	

		Trying to balance power I think you've got to give them enough space to work a lot of things out themselves as well, to come to their own conclusions. I was working with somebody recently and they dropped in there that actually their voices might be related to some anxiety. And I thought that was…they'd come to their own…So we explored that further and the potentials of that and what that meant and the reactions that causes them or the impacts that it might have on them. So yeah, I think it's important not to go in with the full, this is the right explanation, this is… I mean it is a lot of guesswork, isn't it? And it's important that they guess as much as we guess really. And it is a massive power difference you're having to overcome. Because they want to talk about substances, or particular things that they think might make it difficult. So you're having to undo all those difficult relationships that they've had in the past, aren't you, with maybe services or other people, and not being trusted. So you're almost like…it's alright. If you use drugs, fine. If you hear voices, fine. whose risk is it? Because is it to themselves? I know it's difficult. It's really difficult, and obviously I think I've been through some experiences with that. But whose risk is it? And if they've got capacity and they can prove that, it's like actually you can work on that person for them to	

		make their own positive risk decisions about it, don't you? But with the risk with the individual for themselves, if they've got capacity, I think that can be almost liberating for that person, not to take that control away from them. Yeah, it doesn't stop you being an equal person with them, does it? I think you're almost mimicking role model relationships, because I think a lot of people have relationship difficulties as well as voice difficulties. I think that honesty helps sometimes break down as much power differential as you can. But I don't think you ever get away from it.	
TRYING TO EMPOWER VOICE HEARERS	**Attributing voice hearing to trauma** I guess because when I talk to people about voice hearing it's often in relation to trauma. And hearing voices as a result of some trauma that somebody has experienced some people will hear it because of trauma, because of the trauma background. **Respecting individual experience** But also talking to patients about their experiences and what they attribute their voice hearing to. And it's about understanding what that person experiences from it. And that no matter where	**Attributing voice hearing to trauma** That we heavily link to some form of trauma. The CT MRI images of people who experience voice hearing are very closely linked to those people who have PTSD as well, aren't they? When you look at the brain scan images. I think most of the people I've worked with who have voice hearing have some type of trauma in their life. Whether that's sexual, physical, emotional. I think it's represented in something like, I think two to four per cent of the population, those that we know within mental health services.	**Alternative to biomedical approach to framing voices** But over time then I've kind of widened that and thought more psychologically about things, about different aspects of people's lives and what they're going through since training as a family therapist, then I'm more interested in more multiple narratives of how people make sense of voice hearing experiences and what that means to them. So, not getting tied so much into a truth about things or about a certainty and a knowledge. But kind of also remaining quite open about the fact that there are different ways of understanding it and that that's all okay really.

	the source, if source is the right word, or where the voice hearing is coming from, that for that person it's on that level of that's what they're experiencing at that time. And for me it shouldn't ever be dismissed or anything like that. Because if it's coming from an aspect of trauma or if it's coming because of somebody's mental state, to do with a diagnosis of schizophrenia or something like that, one isn't more valid than the other in terms of voice hearing. I suppose my experience of voice hearing is just what patients will tell you. And you can read all the books in the world but until somebody explains, one thing is very different to what somebody else might experience. I think voice hearing is very individualised. And I know we often try to understand it from that person's point of view. Which is why it's important to not dismiss any experiences that anybody has, where it's coming from. But those experiences, some people can see as quite positive, especially if it's engrained in some form of religious or spiritual belief. some people quite like hearing the voices. No, sometimes it's a positive experience. And it's an experience that they don't want taking away from them. So I don't think we can always make the assumption that voice hearing is a negative thing	because for me I don't think it's a diagnostic thing like schizophrenia. I don't believe in that label. I think it's a formulation…it's come as a result of people's trauma, it's a way of coping with life. And I think there's a lot of metaphor in voice hearing, for what people experience. And if they're paranoid or unsafe, it normally seeps down to something that's happened to them that's made them feel that way. And to cope these voices have come as a result of that, of almost helping keeping them safe. But I think that's a different perspective. Actually even though the voices might be negative, they're actually maybe helping keeping them safe. **Respecting individual experience** I suppose voice hearing for me is a phenomenon that certain individuals that I work with experience. That varies in type, either positive or negative voices. Usually a person or multiple people, that may or may not be connected to them in some way. PY10: And talking about learning from the person who hears voices. PY11: Yeah. PY10: We're not the experts in their voices, are we? So the people are the experts in themselves and actually it's helping feel	I guess I have a different position in I can work with the families, so I don't necessarily talk that much about voice hearing experiences as such, we've not named it as that; it's more about stresses and what's going on and what's more likely to create the stress And a shared agreement is that there's stress around or distress around, rather than there is a voice or there isn't a voice. I meet with people I don't even know if we start to differentiate between voice hearing experiences or hallucinations or thoughts that are not what other people might be thinking is happening. And a lot will be around making sense with the family about what that might be. Some people will talk about making some normalisation about that, but also just helping families' own stress about their understanding of what that person is going through or the fear of that or the stigma that's around that, and helping the family make sense of it in the best way that they feel they can. this is what different people would think, so a psychiatrist might say this, a psychologist might say that, what do you feel is with you most in your understanding. And then they'll go with, that makes sense to me I guess for me I learnt about never being married to the model. The model is just a model. All these are just ideas and we offer them out to people, and then they take up

	Because you've got to imagine how special someone would feel if they think that they've got this talking or some higher being is talking to them and giving them third person… I think it's important to understand the person's relationship to the voices So if you're potentially taking something away that's protecting for them, you know, what do they make of their experiences? Whereas I think since I've come here, definitely, in more of the acute setting I think people are maybe more, if that's what they're going through it's not always a negative thing. So you can still come to a group setting. **Trying to make sense of voice hearing** And I think sometimes a lot of experiences that some people have spoken to me about personally, there often can be something that's maybe have been born in reality at some point. And that's more of an exaggerated at the time that they're unwell We've talked about people who attribute it to trauma and attribute it to illness, but a lot of our service users won't attribute it to any of those things. And we'll be looking for an explanation to get people thinking that there's spirits, ghosts, god, the devil, aliens being communicated with through some other being. And I suppose it's for us then trying to make sense of why they've come to that conclusion and what that means to that person and how that affects them.	like they can understand themselves for me. PY10: Yeah, I think we get away from symptoms, don't we? None of us want to use the word symptoms, because I can't stand that. It's not a symptom, it's an experience of someone, isn't it? PY12: I don't think we do call them symptoms at all. PY10: No. PY12: We don't as a team. I think it's very much…yeah, factual about what they're… We might make links about it, about what that might mean, might we. PY10: And also people come to us at a stage where actually they're fairly sick of mental health services and the majority of them. PY12: Yeah. PY10: And they've told people about voices, they've told people about what's happened. It's like why am I telling you again? And you're like that's fine, I get it. And it's like I don't want to do this. So that's when you contract, you work out, and also I think we're really big on working out what a client wants too. And they might not want to do…they might just want to get housing benefit. And alright, let's work it out, let's get you settled, let's get you stable. And then see what they want to work at. I think that's the difference with our team, we're not going you hear voices, let's work on them.	what they think is helpful to them. And once I get married to the model and believe that that's the only thing and the right thing then I'm in danger then of cutting off everything else to the person. **Respecting individual experience** 47 years of experience of working with people with this diagnosis called psychosis, but actually not always psychosis, my information comes directly from the client. I think a lot of what people tell us informs us about what they're experiencing. It's catering to their needs, isn't it, and things that they experience, because everybody that comes into service they always have different experiences. So, it's trying to find something that suits them with the treatment, rather than just having one thing for everybody. I think like Claire said a lot of it is based on experience. It's like everything we do, it's patient led. So, like Elaine was saying there, some have negative voices, quite derogatory, and want rid of them. I've also got patients who like their voices, who find them a comfort. So, it's about getting the balance that's right for the patient. The thing in family work is that that is absolutely offered to everybody. That is not up to clinicians to ever decide; it's only up to families to decide. That was a strategy that

	There's cultural differences in how you interpret it as well, isn't there? So we see it as an illness over here, but other countries would find it odd and see it as a real positive thing.	PY10: I do talk about coming off properly though. Because I think the evidence base the Icarus Project, that document that they've done is really good. Speak to them about that, I said if you're going to do it, that's fine. But how do you it properly? How do you look after yourself? Because this does affect your brain. So you need to think how you come off it properly. So you can be safe with this, and you're not going to be rebounded into hospital potentially. So I do that with people because I think they need to have as much knowledge as we do. And I think that they always… And I think…I've never met anybody who said when I went onto antipsychotic medication everybody explained everything properly with them. I ask them that sometimes. When you were first on it how was it explained to you? And I've never met anyone who's gone oh yeah, they explained and they said oh, these side effects, and it might happen this way, weight again. It never happens. **Trying to make sense of voice hearing** It's culturally how we view voices. In different cultures that phenomenon, you might collude with…those cultures might collude with voices because they'll be seen as a different type of thing really. A higher being, presence, god, whatever they consider it as. And I think that changes how those cultures react to it. So you don't necessarily have to necessarily provide care for somebody or treatment from somebody in a different culture that perceive voices in a different way either…	came in when I came into post about three years ago because of the ideas that we would be the experts that know what people need, rather than they're the experts that will decide. **Trying to make sense of voice hearing** I think a lot of my understanding around voice hearing is it's integral to the person's experiences, what they might have gone through, what they might be currently going through. And I think quite often I find that the voices actually reflect that, whether the individual might be privy to that or not. Once you do a little bit further digging and get to know that individual and what they might have experienced that the voices they're having actually do make a great deal of sense in the context of that individual. And it's working together with that individual to get that shared understanding of these voices and what role they play in that person's life that actually it can be quite therapeutic to have that voice as a connection to somebody that they might have lost, what's happened in the past. But on the complete flipside of having this negative connection to something else that has happened in the past and working together to maybe try and reduce the voice and get a bit more understanding of the benefits of the other voice and how that can be managed as not to impact too greatly on their daily lives, so that is still an integral part of them.

		But also there are cultures are highly represented, aren't they? Ethnic minorities, highly represented in the voice hearing perspective, aren't they? And that's due to, kind of, the privilege of what they weren't born into, the lower strata of society, wasn't it? But I think that's quite relevant, isn't it? So you look at people who are black, Asian, they are more highly represented than white people when you look at the position. And that is due to the under privileged position that they come from, the lower strata. But they have raised stuff about Mauri and African cultures where the voice hearing is treated differently. PY10: But we'll link it to what's happening now, if the voices are more negative or positive or higher or lower intensity, won't we? We'll try and figure out is it linked to something that's gone on. Because we have might have informal formulations or formulations where we get…actually that sounds like it's linked to that person, what the voice is linked to. We'll use each other as sounding boards at times I guess, won't we? PY12: I think we do try to work it out, which might feel a bit wrong. Because obviously I suppose we're trying to make sense of it and trying to understand it. So therefore we can go back to the client to reflect our thoughts about that.	So, for me a lot about voice hearing experiences is about making a meaning for the whole family that they can go forward with that and make sense of it together. You're finding out as much information as you can about who they are; what they say; what they do; how they make you feel; how you cope with them. You're constantly asking questions, are they specific to certain times; certain voices will have different conversations. So, people will have at times multiple voices, some that will be running a commentary or being derogatory or being commands. And they'll have all these voices. Some people's voices will talk to each other, not just talk to them. There are so many different variables in terms of people's symptoms that you do have to get right in and find out and ask as many questions as you can, without causing any distress to the patient. And then you're sort of going into family and friends and the people around them and finding out what their interpretations are, because you might get so much information from the service user but then when you talk to his mum she'll be like, oh did he tell you about this voice or did he tell you that he shouts and he screams in the middle of the night because we can hear that his voices are worse at that time. So, you're literally going round and finding out as much information from as many people as you possibly can, and that gives you your big picture of what someone's symptoms are and also the level

			of risk that those symptoms pose to that person and to the people around them.

Abbreviations

CBT	Cognitive Behavioural Therapy
CBTp	Cognitive Behavioural Therapy for psychosis/voice hearing
CQC	Care Quality Commission
HVG	Hearing Voices Group
HVM	Hearing Voice Movement
HVN	Hearing Voices Network
MHA	Mental Health Act
NICE	National Institute for Health and Clinical Excellence
NSF-MH	National Service Framework for Mental Health

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