

EXPERIENCES OF STAFF WORKING WITH VOICE HEARERS IN ACUTE
MENTAL HEALTH:
AN INTERPRETATIVE PHENOMENOLOGICAL APPROACH

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

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ABSTRACT

Introduction: Staff in acute mental health settings work with voice hearers at times of crises, when experiencing high levels of distress. Research has demonstrated the importance of exploring the subjective experiences of voice hearing yet there has been little focus on staff experiences of working with voice hearers. The present study therefore sought to explore staff experiences of working with voice hearers in an acute mental health service.

Method: Eight staff members (three mental health nurses and five healthcare support workers) from one acute mental health hospital were interviewed about their experiences of working with voice hearers. These interviews were transcribed and analysed using Interpretative Phenomenological Analysis. Individual analyses were conducted for each participant before conducting a group analysis.

Results: Three master themes and seven super-ordinate themes were identified from the group analysis. Participants described ‘struggling to exercise control’ in their work with voice hearers, moving from positions of ‘powerlessness’ to ‘feeling powerful’. Participants experienced the ‘emotional impact of the work’ to different intensities, often going through an initial ‘startling phase’ and transitioning to feelings of ‘performance anxiety and self-doubt’. ‘Ways of managing feeling overwhelmed’ were described including going through a ‘process of making sense’, ‘forming relationships’ with voice hearers and feeling a ‘sense of duty and responsibility’.

Discussion: The present findings relate to power literature and previous research on empowerment and control in mental health services. A parallel process was identified between voice hearers and staff, both experiencing an initial ‘startling phase’ but transitioning to an ‘organisational phase’ where they make sense of their experiences. The research findings were also consistent with previous studies demonstrating staff anxiety around opening up conversations about the content of voices, highlighting staff training and support needs.

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ABBREVIATIONS

APA: American Psychological Association
CBT: Cognitive Behavioural Therapy
CBTp: Cognitive Behavioural Therapy for psychosis
CFT: Compassion Focussed Therapy
CRHT: Crisis Resolution Home Treatment
CSM: Clinical Service Manager
CTM: Clinical Team Manager
DSM: Diagnostic and Statistical Manual of Mental Disorders
EE: Expressed Emotion
HCP: Health Care Professional
HSW: Healthcare Support Worker
ICD: International Classification of Diseases
IPA: Interpretative Phenomenological Analysis
MHN: Mental Health Nurse
NHS: National Health Service
NICE: National Institute for Health and Care Excellence
OT: Occupational Therapist
PBCT: Person-Based Cognitive Therapy
PSI: Psychosocial Interventions
QRPSG: Qualitative Research Peer Support Group
RCT: Randomised Control Trial
R&D: Research and Development
WHO: World Health Organisation

INTRODUCTION

“My first book, in 1905, was on the psychology of dementia praecox [schizophrenia]. My aim was to show that delusions and hallucinations were not just specific symptoms of mental disease, but also had a human meaning”

Carl Jung, 1969.

The focus for this study is the experience of staff working with voice hearers at times of acute distress, when they require inpatient hospital care to support them in a crisis. This chapter will set the scene for the research by providing an understanding of voice hearing¹ and the likely voice hearing experiences of service users² for whom staff members are caring. The chapter will then consider these experiences in the context of acute mental health services and the role of frontline staff, notably mental health nurses (MHNs) and healthcare support workers (HSWs) who are the focus of this study.

Before thinking about the impact of voice hearing on mental health workers it is important to have a clear understanding of what is meant by this phenomenon.

Voice Hearing

Definition

Voice hearing is often used as a “*blanket term*”, which includes a variety of experiences ranging from “*hearing a clear voice coming from the external world when there is no one there...through to inaudible, soundless voices located within one’s own head, and experiences that are more ‘thought-like’ than voice like*” (McCarthy-Jones, 2012, p. 1).

In Western cultures, the experience of voice hearing is often defined as a symptom of ‘mental illness’ that is particularly associated with ‘schizophrenia’ or the broader concept of ‘psychosis’. The 18th-19th centuries saw the emergence of hospitalised treatment of ‘madness’ for what were considered to be ‘incurable diseases’ of the mind. The categorisation of ‘madness’ in the late 19thC saw the first use of the term “*dementia praecox*” (Kraepelin, 1893, as cited in Bentall, 2003, p.15) and

¹ The term ‘voice hearing’ will be used throughout this thesis rather than the term ‘auditory hallucination’. This is due to my understanding of this phenomenon as part of the continuum of human experience rather than being part of a ‘mental disorder’. Terms associated with a more medicalised model of voice hearing will be written in inverted commas.

² The term ‘service-user’ will be used to describe voice hearers who are accessing mental health services.

subsequently the term “*schizophrenia*” (Bleuler, 1911, as cited in Bentall, 2003, p.23), both of which emphasised a chronic, biological, and genetically explained disease. Kraepelin’s ‘dementia praecox’ was however criticised due to poor evidence that it was a separate disease entity, as multiple subgroups of ‘dementia praecox’ had emerged by 1913 (Boyle, 2002).

In more recent years, the notion of voice hearing as a ‘symptom’ specific to ‘schizophrenia’ or ‘psychosis’ has been contested, as voice hearing experiences are also considered to be associated with other ‘mental disorders’, such as ‘bipolar disorder’ and ‘borderline personality disorder’ (Bentall, 2009). However, the reality or truth of voice hearing experiences for other ‘mental disorders’ is sometimes questioned, with terms such as ‘pseudo-voices’ or ‘pseudo-hallucinations’ being used, particularly for people who have received a diagnosis of ‘borderline personality disorder’ (McCarthy-Jones, 2012). Berrios and Dening (1996) suggest that the term ‘pseudo-hallucinations’ is used when people’s experiences do not neatly fit into the confines of psychiatric diagnostic criteria, rather than reflecting a qualitatively different voice hearing experience.

Diagnostic classification

Bleuler’s notion of ‘schizophrenia’ remains dominant in the mental health system today. The experience of voice hearing continues to be listed as a core ‘symptom’ in the recently revised Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, American Psychiatric Association (APA), 2013). The criterion has however changed, as ‘schizophrenia’ can no longer be diagnosed from the experience of only one ‘positive symptom’ i.e. voice hearing or unusual beliefs (Shinn et al., 2013). Despite this, a recent review has shown that “98%” of people who received a diagnosis of ‘schizophrenia’ under DSM-IV criteria continue to be diagnosed with this ‘condition’ under DSM-5 (Tandon et al., 2013, p.330).

The International Classification of Diseases (ICD-10, World Health Organisation (WHO), 1992) is the most widely used classification system for ‘mental disorders’ in the UK. Under this classification system voice hearing experiences are defined as “*hallucinatory voices giving a running commentary on the patient’s behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body*” (WHO, 1992, p.78).

In ICD-10, these ‘hallucinatory voices’ are categorised as ‘positive symptoms’ of ‘schizophrenia/psychosis’ and also listed under diagnostic criteria for ‘bipolar affective disorder-mania with psychotic symptoms’ (WHO, 1992, p. 96). Prior to 1980, this classification system looked very different with an emphasis on “*the role of*

experience” rather than biological symptoms, as it was based on the “*psychoanalytic ideas of the time*” (American Psychological Association (APA), 2009, p.63). However, DSM pioneered the descriptive symptoms checklist approach to diagnosis, which became increasingly popular and was subsequently adopted by the WHO (APA, 2009).

It is clear that under these diagnostic frameworks, there are many examples of voice hearing as a ‘symptom’ of a ‘mental disorder’, which is rooted in a biological understanding of the experience. However, this is merely one perspective of this phenomenon. The following section will present a summary of the different perspectives of the aetiology of voice hearing and estimated prevalence rates.

Aetiology

There is a long history of voice hearing and it has not always been considered a sign of ‘mental illness’. Early reports of voice hearing were often thought to be indicative of closeness to God and understood as privileged occurrences (e.g. the experiences of biblical figures such as Moses and Joan of Arc). This view is still present in many agricultural societies, where a distinction is made between voices heard from revered deities and those from evil entities (Hoffman, 2012). Despite this, in industrialised societies, voice hearing is primarily associated with ‘madness’ and is treated as a ‘mental disorder’ (Leudar & Thomas, 2000).

This perspective is based on the biological view of voice hearing whereby neuroleptic medications (antipsychotic drugs) are often used as first line treatment (National Institute for Health and Care Excellence (NICE), 2003; 2009). The main biological explanation for voice hearing is the dopamine hypothesis (Carlsson & Lindquist, 1963, as cited in Seeman, 2007). This hypothesis asserts that ‘schizophrenia/psychosis’ develops due to over activity in the dopamine system of the brain. More recent theory development has suggested that ‘positive symptoms’ like voice hearing, are caused by over activity of dopamine D2 receptors in the mesolimbic pathway, therefore typical antipsychotics act to block the D2 receptors (Reynolds, 2004). However, there is mixed evidence for the validity of the dopamine hypothesis. Some research has suggested a reduction in ‘positive symptoms’ following neuroleptic treatment (Karow & Naber, 2002), though others have shown that many individuals continue to hear voices despite taking neuroleptic medication (Leudar & Thomas, 2000). This has exposed the need to explore other understandings and approaches to voice hearing experiences such as psychological models.

Psychological understandings and approaches to voice hearing

One of the first psychological understandings of voice hearing came from psychodynamic theory. Freud (1924) claimed that voices emerged due to the disintegration of the ego. It was thought that the voice was a part of the self that could not be accepted by the voice hearer, therefore the voice was heard as a separate entity, representing repressed desires and a need to fully integrate the self (Jardim et al., 2011). Under this framework, psychological therapy aimed to reintegrate the self, eliminating the need for separate voice entities.

Voice hearing has also been understood in terms of trauma (Read et al., 2005). It has been suggested that voices often have multiple meanings, which correspond to traumatic experiences (Manning & Stickley, 2009). Voice hearing has therefore been understood as an expression of unspoken difficulties from the past, which need to be processed and “*confronted*” by the voice hearer (Karlsson, 2008, p.372). Within this area of research voice hearing has been viewed as a dissociative response to extreme stress (Moskowitz & Corstens, 2007). This perspective is aligned to Freud’s understanding as it advocates that therapeutic work focuses on unresolved experiences, which allows the voice hearer to be “*(re) integrated into a previously fractured sense of self*” (Longden et al., 2012, p. 62).

Studies have shown a significant relationship between voice hearers’ experiences of traumatic life events, such as childhood sexual abuse, and negative beliefs about their voices (Andrew et al., 2008). Daalman et al. (2012) found that though voice hearers with no psychiatric diagnosis (‘non-clinical’ group) and voice hearers who had received a psychiatric diagnosis (‘clinical’ group), experienced more “*sexual and emotional abuse*” than those who did not hear voices (‘control’ group), no particular childhood trauma correlated with positive or negative voice hearing experiences or level of distress (p. 2475). The researchers did however find a theme of “*danger*” with ‘non-clinical’ group participants hearing words of reassurance and encouragement at times of threat, e.g. “*he will be okay, don’t worry*” or “*I will warn you if there’s danger*”, while participants with a ‘clinical diagnosis’ reported hearing threats e.g. “*that man is going to kill you*” or “*you do not deserve to live*” (Daalman et al., 2012, p. 2481).

These findings link to the cognitive model of voice hearing. This model stipulates that the voice hearers’ appraisals and beliefs influence their responses to their voice/s in terms of emotional and behavioural reactions (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994). It has been found that when voices are perceived as powerful and authoritative they lead to fear and distress (Birchwood & Chadwick, 1997) and when voices are viewed as persecutory in nature they evoke “*avoidance, anger and*

despair” (Birchwood & Chadwick, 1997, p. 1346). Cognitive behavioural therapy (CBT) approaches have been developed which aim to modify the appraisals and beliefs of the voice hearer to negotiate the relationship that they have with their voices (e.g. through person-based cognitive therapy; PBCT; Chadwick, 2006).

Over time, the cognitive models of voice hearing have begun to acknowledge the importance of the relationship between a voice hearer and their voices. There are considerations of how this relationship may parallel social relationships (e.g. social rank theory; Byrne et al., 2006) and the importance of acknowledging the voice hearer and voice relationship as a real relationship, (e.g. through Voice Relating; Sorrell et al., 2010) and Corstens et al’s Talking with Voices technique, adapted from Voice Dialogue (Stone & Stone, 1993).

Voice hearing has also been understood in relation to attachment theory. An attachment is the bond between two individuals whereby one person experiences security and safety from the other at times of threat (Bowlby, 1982). Attachments are developed in early parent-child relationships and create an internal working model that guides a person’s style of relating to others (Bowlby, 1982; Golding, 2008). A recent study by Berry et al. (2012) found a significant relationship between adult attachment anxiety and the perceived severity and distress of voices. Rejecting or critical voices were also associated with attachment avoidance (i.e. cutting off emotional responses and maintaining psychological distance; Golding, 2008). This suggests that understanding the relationship between voice and voice hearer in the context of attachment styles may be important when working with voice hearers.

Another understanding of voice hearing is to consider it as part of a continuum of human experience (Bentall, 2003). This stance asserts that voice hearing exists on a spectrum, and is experienced by people in the general population as well as people who have received a diagnostic label such as ‘schizophrenia/psychosis’. It is suggested that 10-15% of the general population have heard a voice on at least one occasion (Slade & Bentall, 1988). A more recent survey of 121 mental health workers, found that 16% of the workers experienced voice hearing as measured by the Psychotic Symptom Rating Scale (PSYRATS) and found a significant association between voice hearing experiences and anxiety, as measured by the Hospital Anxiety and Depression Scale (HADS). The authors suggest that these results support the evidence of voice hearing as part of the continuum of human experience as it was found in a non-clinical sample. However, the participants were mental health staff members who were working clinically with people who had received a diagnosis of ‘schizophrenia’, and therefore may have been more aware and open to the phenomenon of voice hearing and readily acknowledge these experiences more than the general population.

The difference between the voice hearing experiences reported by people in the general population and people accessing mental health services seems to be the frequency, intensity, beliefs about and level of distress caused by the voice/s (e.g. Beavan & Read, 2010; Vaughan & Fowler, 2004).

Voice hearing and associated distress

Vaughan and Fowler (2004) showed that level of distress from voice hearing experiences was positively associated with “*voice upperness*” (i.e. voices that were often insulting to the voice hearer and dominating), which would often result in the voice hearer distancing themselves from the voice, avoiding communication and treating them with suspicion (p. 143). This may result in voice hearers distancing themselves from their voices at times of distress and being reluctant to engage in conversations about the voices with others. This may also be reflective of the person’s interpersonal style in their social world (i.e. more distant and suspicious of others), which is consistent with findings by Birchwood and Chadwick (1997). However, distance was not found to be significantly related to emotional distress in Hayward (2003) - in contrast they found “*closeness*” to be associated with a lessening of distress, though the voices heard in that study seemed to have benevolent intent (p.378).

There is often a focus in the literature on negative and distressing voice hearing experiences however there are many accounts of positive experiences of voice hearing. For example, Jackson et al. (2011) interviewed twelve voice hearers who reported hearing positive voices. Eleven of the twelve voice hearers had spiritual beliefs connected to their understanding of their voices and these seemed to provide a sense of protection. They described “*diminishing fear and establishing control*” as a “*core process*” for the integration of voices into their lives (Jackson et al., 2011, p. 489). The authors highlighted the importance of developing personal meaningful narratives and actively engaging with the voices, as helpful steps towards developing positive voice relationships.

Overview of evidence for psychological intervention with voice hearers

The National Institute of Health and Care Excellence (NICE) guidance on the ‘treatment’ of acute episodes of ‘psychosis or schizophrenia’ (NICE, 2003; 2009) recommended that all service-users be offered cognitive behavioural therapy (CBT),

including those accessing inpatient services. This guidance also recommended family interventions for all families in contact with people with ‘psychosis or schizophrenia’.

CBT involves the service-user and therapist jointly discovering the links between thoughts, feelings, behaviours and physical sensations, which maintain psychological distress (Beck, 1995). CBT for ‘psychosis’ (CBTp) usually focuses on the person’s beliefs about their unusual experiences (e.g. Chadwick et al., 1996) and therapy aims to support the person to “*develop more rational cognitive perspectives about symptoms*” and develop coping strategies (Dickerson & Lehman, 2012, p.218). Specific CBT interventions for hearing voices tend to focus on reducing the intensity and frequency of the voice hearing experiences.

There are a number of randomised control trials (RCTs) that have examined the effectiveness of CBTp. Wykes et al. (2008) conducted a meta-analysis of 34 RCTs and found a significant effect size for ‘target symptoms’. Consistent with previous meta-analyses, CBTp was found to have significant effects for ‘positive symptoms’, including voice hearing. However, the evidence for the benefit of CBTp for people who are experiencing an acute episode is limited (Dixon et al., 2010), as many service-users are not considered appropriate for therapy when in acute distress or dropout from therapy during a crisis period (e.g. Startup et al., 2004). The evidence for the effectiveness of CBTp, as recommended by NICE, is based on the outcomes of RCTs, which are considered to be robust as they aim to control for confounding variables. However, RCTs are criticised for the strict criteria for participant inclusion in the trials, which has implications for the clinical applicability of the findings.

Other psychological approaches for ‘psychosis and schizophrenia’ have been empirically examined but not to the extent of CBTp. Approaches include metacognitive therapy (e.g. Moritz et al., 2010), mindfulness therapy (Abba et al., 2008) and narrative therapy (e.g. Lysaker & Lysaker, 2008). The narrative approach is linked to Romme and Escher’s (2000) work of making sense of voice hearing experiences through people’s life histories. Narrative approaches to ‘psychosis’ therefore focus on building a coherent personal life story, which aims to help the voice hearer reintegrate a previously fragmented sense of self (Lysaker & Lysaker, 2008).

Epidemiology

A review of prevalence rates of voice hearing in the general population, which detailed seventeen surveys from nine countries, reported rates from “0.6% to 84%” (Beavan et al., 2011, p. 286). Rate variations were attributed to differences in sex, ethnic background, and environment (Beavan et al., 2011). The variation of prevalence rates

across the surveys suggests the importance of cultural factors and the subjectivity of meaning when understanding voice hearing experiences (Beavan & Read, 2010; Geekie & Read, 2009). The prevalence of voice hearing for individuals with a diagnosis of ‘schizophrenia/psychosis’ is estimated between 50% and 75% (Landmark et al., 1990; Wing et al., 1974). The higher top estimate in the general population supports the idea that voice hearing “*cannot automatically be attributed to psychopathology*” (Beavan et al., 2011 p. 288).

Summary

The voice hearing literature detailed so far has shown that there are many understandings of the phenomenon, including biological, psychological, spiritual, and can be understood as part of the continuum of human experience. This is by no means an exhaustive list as the meaning of a voice is so subjective to the person who is hearing it. There appears to be a theme suggesting that there is something about the level of distress caused by the voices that requires some voice hearers to come into contact with acute mental health services.

The next section introduces the topic of acute mental health care, the roles of MHNs and HSWs within this context and their work with voice hearers.

Acute Mental Health Care

Within the literature many terms are used interchangeably in reference to staff members working in acute mental health care. Usually a distinction is made between ‘qualified’ and ‘unqualified’ ward staff. For consistency, the term MHN will be used in reference to ‘qualified’ nursing staff, and the term HSW for ‘unqualified’ staff. The term ‘health care professional’ (HCP) will be used when literature is representative of all staff across disciplines.

History of nursing in acute mental health

Prior to the 18th century, mental health difficulties were often associated with poverty and criminality, and people with such difficulties were socially marginalised (Fagin, 2007). Many relied on Christian charity in accordance with the 1601 Poor Law, which stipulated the responsibility of local parishes to offer relief to those in need, often through the provision of almshouses (Higginbotham, 2012).

These provisions funded the development of small ‘houses of correction’ and ‘private madhouses’ before the creation of the ‘lunatic asylums’ (Scull, 1979). The first recorded asylum in Europe was Bethlem Royal Hospital, London, established in the early 15th century. Later, the Lunacy Act (1845) instructed the building of asylums across all counties in the UK. Large institutions developed, often located in rural areas, due to the growing number of “*incurable disease processes*”, such as “*chronic psychoses*” (Fagin, 2007, p.12). There were reports, however, of the poor conditions of the asylums, with people living in squalor and treated mainly through restraint e.g. use of leg-locks or straitjackets.

At this time, the emerging role of the MHN was to attend to the physical and environmental needs of people within the asylum. Indeed, the original name for a MHN was an ‘attendant’ (O’Carroll & Park, 2007). The priority of the ‘attendant’ was to keep the ‘patient’ and ward environment, often referred to as the ‘sick room’, clean and comfortable, with important consideration to the dietary, sleep and medication needs of those in their care (Bailey, 1908).

The first known training programme for MHNs was in 1854; lectures were held at the Royal Edinburgh Asylum, a ‘lunatic attendants’ handbook’ was developed and hospital-based training increased (O’Carroll & Park, 2007). In more recent years nursing training has changed from hospital-based training to taught courses in higher education establishments (United Kingdom Central Council, 1986).

Within mental health nursing training, experiences such as voice hearing are often understood as ‘hallucinations’, which occur due to changes in a person’s brain structure. Interestingly, in early psychiatry, ‘hallucinations’ were not in themselves considered to be problematic. Rather, it was the interpretation of these experiences as “*real*” which was seen as problematic and indicative of the need for “*treatment*” (Bailey, 1908, p. 262).

In 1930, the Mental Treatment Act came into force, which changed the name from ‘asylum’ to ‘mental health hospital’. In 1948, with the development of the National Health Service (NHS), the improvement of mental health hospitals began. However, their poor reputations were increasing with growing reports of overcrowding, limited resources, and inhumane treatments, such as lobotomies and solitary confinement (Fagin, 2007).

Enoch Powell, in 1961, gave his notable ‘water tower’ speech condemning the conditions of the asylums and calling for their closure. This saw the start of the de-institutionalisation process and a move towards ‘care in the community’ (Department of Health and Social Security, 1975). In practice, this resulted in people with mental health difficulties being supported at home or in small residential units. The acute inpatient

services that remained had a focus on short-term admissions designed to get individuals through a crisis period. Inpatient wards were placed alongside general hospitals in towns and cities, instead of the countryside settings of the large asylums, as mental health difficulties were considered to be “*just another medical problem*” (Hardcastle, 2007, p. 15).

During the process of de-institutionalisation many MHNs had to make the transition from working in a ward environment to a community setting. As such, further training opportunities became available to support their changing role in the community. This was the beginning of the role of ‘nurse as therapist’, with emphasis on using behavioural interventions, such as token economy (O’Carroll & Park, 2007). The implication of such behavioural techniques was that people could *learn* to behave differently, and the location of the mental health ‘problem’ in the person rather than a focus on systemic factors.

Psychosocial Interventions (PSI)

Behavioural and educational interventions for people with long-term mental health difficulties, often termed in the literature as ‘psychiatric rehabilitation’, began to grow (Anthony & Lieberman, 1986). The stress-vulnerability model (Zubin & Spring, 1977) heavily influenced this process. The model proposed that biological, psychological, and social factors impacted on an individual’s vulnerability for the development and maintenance of mental health difficulties. This represented a shift in the understanding of mental health difficulties from a purely biological perspective to an interaction of Biopsychosocial factors. This led to a rise in the use of rehabilitation interventions such as social learning (Paul & Lentx, 1977) and psychoeducation (Anderson et al., 1986).

Goering and Stylianos (1988) suggested that these rehabilitation strategies were effective due to the combination of a skills based approach and the development of a trusting, “*helping relationship*” between the service-user and the MHN (p.272). This *helping relationship* suggests passivity on the part of the service user, whereby they are given skills by the MHN, rather than being engaged in a collaborative therapeutic relationship, involved in developing a narrative about beliefs, appraisals and so on. Goering and Stylianos (1988) related their work to previous research, which had highlighted the importance of relationship building and a structured approach when working therapeutically with people with ‘psychosis’ (Rogers et al., 1976).

Over the past three to four decades, the use of PSI as these strategies became known in mental health services, has increased. The use of PSI to help people with

‘psychosis’ was seemingly developed in response to the growing evidence that psychological and social factors both contribute to its onset and maintenance. PSI training in this area initially targeted community MHNs in their delivery of family interventions (Brooker et al., 1992) due to a more emerging research linking high expressed emotion of close family members (EE; Brown & Rutter, 1966) with a higher risk of relapse (Barrowclough & Tarrier, 1984). PSI studies in community mental health services have shown a reduction in relapse and hospital re-admission rates at 9-18 month follow-up in comparison to standard care (Pekkala & Merinder, 2002).

NICE guidelines (2003; 2009) highlight the importance of psychological and social approaches for ‘psychosis’ throughout its course, particularly advising the use of CBT, art psychotherapy and family interventions during an ‘acute phase’ which warrants a service level intervention, i.e. admission to an acute inpatient ward.

There has been growing evidence for the use of PSI with service-users accessing acute mental health services. Studies have shown that such interventions improve the wellbeing of service-users whilst in hospital and potentially reduce length of stay (McCann & Bowers, 2005). Research suggests that improved service-user outcome is due to the collaborative nature of PSI, empowering service-users to have greater control over their care, and increasing confidence in their ability to manage their experiences of ‘psychosis’ (O’Neill et al., 2008). Interestingly, this research has shown a parallel process whereby MHNs have reported that PSI training has made them feel more “*competent*” and “*confident*” in their work (O’Neill et al., 2008, p. 585).

There are limitations and barriers to the use of PSI in acute mental health care settings. A recent study has examined the opportunities and barriers to implementing PSI across a number of acute mental health wards in London, UK (Mathers, 2012). A Grounded Theory approach was used to analyse the interviews of twenty MHNs who were in receipt of the same PSI training. Four core categories emerged from the data. Firstly, “*the nature of acute settings*”, which included lack of time to implement PSI, unpredictable length of stay, referrals to more specialised psychological/ psychotherapy services, and MHNs feeling that they lacked autonomy (Mathers, 2012, p.49). The second category identified was “*how supportive/discouraging have managers been?*” with MHNs reporting that they received managerial support to attend the PSI training, but subsequently were not provided with the time to use PSI with service-users on the ward (Mathers, 2012, p.50). A third category was “*how supportive have other members of staff (peers) been?*” which had mixed responses, with the engagement of service-users in PSI sometimes perceived by peers as “*time-off*” from usual ward responsibilities (Mathers, 2012, pp.50-51). A fourth category was “*supervision issues*” with most MHNs desiring an opportunity for group supervision and some wanting this

to be a compulsory part of their job role (Mathers, 2012, p.51). The findings of this study were consistent with previous research, which has suggested the low priority of therapeutic interventions on acute wards (Clarke & Flanagan, 2003) compared with the greater emphasis on crisis management and physical health monitoring (Bowers et al., 2005).

Studies have shown that the necessary conditions for the successful implementation of PSI to acute inpatient settings are “*effective leadership and management*” and “*sufficient and stable staffing of the ward*” (McCann & Bowers, 2005, p.218). However, these conditions are not easily met within the context of an unpredictable and hectic acute mental health ward where staff members are continually responding to crises.

PSI also emphasises the ‘doing role’ for nurses, i.e. having structured time with service-users to carry out a specific intervention as part of their ‘treatment’. As the time pressured ward environment does not always allow for these types of interventions, staff may be left feeling incapable and incompetent, unable to intervene at the level they want and have been trained to do.

Alternative approaches to nursing

Most nursing practices focus on ways of ‘fixing’ or ‘dealing’ with a problem however Parse’s (1992) nursing theory moved away from the ‘doing role’, emphasising the role of ‘being with patients’. Parse’s (1992) model of nursing is known as ‘the human becoming theory’. It presents an alternative approach to the biological or Biopsychosocial approach of other nursing theories. It places the service-user’s own perspective on *quality of life* at the forefront of nursing practice (Parse, 1992). Within this theory, the aim of the nurse is to ‘be with’ the person, with a focus on the lived experience, rather than trying to ‘fix’ problems (Current Nursing, 2011).

A nurse working according to Parse’s theory is therefore not problem focused, trying to offer advice and solutions (Parse, 1992). The focus for the nurse is on ways to help the person understand the subjective meaning of their experiences, rather than trying interventions to implement any behaviour changes (Parse, 1995). This represented a cultural and political shift away from behavioural interventions, such as token economy, and towards service user empowerment and involvement, in line with a ‘partnership model’ of healthcare (Hogg, 1999).

Martin (2000) reflected on Parse’s work and likened this approach to that practiced in hearing voices groups. The author highlighted the groups’ focus on having “*true presence*”; “*being with*” rather than “*doing for*”, which was consistent with

Parse's approach (Martin, 2000, p. 137). Martin (2000) commented, *"nurses should concern themselves less with the complexities of developing precise diagnoses and more with creating an environment that empowers service-users"* (p.140).

It therefore seems that there are additional pressures for nursing staff to move away from their original training in 'doing roles' to 'being with' service-users, facilitating personal meaning making. This shift could potentially cause anxiety in staff, moving out of their area of competency and capability, presenting a new challenge for MHNs. This is interesting in light of the recent Francis Report (2013), which stated *"training and continuing professional development for nurses should apply at all levels, from student to director, and commissioning arrangements should reflect the need for healthcare services to be delivered by those who are suitably trained"*(p.76). This recommendation highlights the need for continued post qualification training for nurses to ensure that high quality care is being provided by suitably qualified, trained and competent workers. Training in 'being with' service-users, facilitating the personal meaning making of voice hearing experiences may be one such need for staff working in acute mental health services.

Role of the healthcare support worker

The need for nurses has always outweighed the supply, therefore 'unqualified' nursing staff have formed a great part in the healthcare workforce (Dingwall et al., 1988). The 'unqualified' staff were often known as 'nurses' aides', however the term HSWs is now used to distinguish them from qualified nurses. Authors have highlighted the fact that HSWs have lacked the training opportunities needed for working in healthcare (Edwards, 1997). This has become increasingly apparent, as *"we are moving down a road where the unqualified are being asked to do the jobs previously done by qualified staff"* (Harding-Price, 2011, p.516). Many concerned authors are calling for *"regulations, role clarity and validated education and training"* for HSWs (McKenna et al., 2004, p. 452).

The Francis Report (2013) corroborated these concerns and recommendations were made for the role of HSWs. These included a process of registration, a code of conduct, and education and training standards designed to ensure that there is a national standard, which is authorised and reviewed by the Nursing and Midwifery Council. However, it may be important for HSWs working in acute mental health services to have specific training to meet the needs of their client group, which includes working with unusual experiences like voice hearing.

Working with voice hearers in acute mental health

The de-institutionalisation process saw a significant reduction in acute mental health beds, and ‘treating’ people in an inpatient environment was considered as a ‘last resort’ (Department of Health, 2005). Lengths of admissions also declined, with average lengths of stay in acute inpatient hospitals lasting 1-5 weeks instead of months and years historically recorded (McCrone & Lorusso, 1999). These reductions have impacted on the profile of people accessing acute inpatient services, with many service-users being readmitted (i.e. ‘the revolving door patient’; Lloyd-Evans et al., 2010) and increased compulsory admissions under the Mental Health Act (Wall et al., 1999). This has led to a ‘disturbing environment’ in acute mental health wards, as people are experiencing such high levels of distress (Lloyd-Evans et al., 2010).

The current picture of acute mental health services shows that staff members work with service users at times of “*severe crises*” (Hoffman, 2012, p.20), many of whom have been diagnosed with ‘psychosis’ and are hearing distressing voices (Csipke et al., 2014). Research has shown that around 60% of voice hearers who are admitted to mental health hospitals continue to hear voices during their stay and post-discharge (Falloon & Talbot, 1981).

Duggins (2007) shared his experience of working as a junior doctor on an acute inpatient ward. He described the pressure to sedate service-users rather than to speak with them about their distress. This approach has also been suggested in accounts of doctors working in community settings. McCabe et al. (2002) carried out a conversational analysis through video recordings of consultations between thirty-two service-users (diagnosed with ‘schizophrenia’ or ‘schizoaffective disorder’) and seven of their psychiatrists, from two outpatient clinics in London. Results showed that service-users tried to engage their psychiatrists in a discussion about the content of their ‘psychotic’ experiences, but psychiatrists often “*hesitated and avoided answering the patients’ questions... smiled or laughed in response to the patients’ assessments of and questions about their symptoms*” (McCabe et al., 2002, p.1150). The authors hypothesised that the results indicated a potential unwillingness to engage with, and anxiety about, the topic of voice hearing on the part of psychiatrists.

Research has continued to demonstrate this disparity between the views of staff and service-users regarding engagement in conversations specifically about voice hearing experiences. Coffey and Hewitt’s (2008) article aptly titled, ‘You don’t talk about the voices’, discusses how mental health nursing training does not advocate the exploration of the content of voices with service-users (p.1591). This may be due to the continued dominance of the biological model in nursing training in which voice hearing

is understood as a ‘symptom’ of ‘mental illness’ rather than a meaningful experience (e.g. Gagg, 2002). The article reports MHNs concerns about opening up discussions about voices as “*it might make them worse*” and their “*lack of confidence*” in talking with service-users about the “*meaning of their voices*” (Coffey & Hewitt, 2008, p. 1598). Furthermore, in a recent investigation of mental health staff attitudes towards service users in acute mental health settings, views were divided for the statement, ‘Talking to patients about hallucinations and delusions makes the experience more real and personal’ (Tyson, 2013, p.383). The author hypothesised that those who disagreed with this statement considered that “*talking about hallucinations and delusions might reinforce these beliefs*” (Tyson, 2013, p. 384).

However, there are increasing examples of studies, which show that MHNs are opening up more discussions about voice hearing experiences. For example, Bowers et al. (2009) interviewed twenty-eight MHNs who were considered to be experts in working with people with ‘psychosis’. The aim of the study was to identify the skills and methods used by MHNs when working with people with ‘psychosis’ in acute distress, with a particular focus on skills that were not formally taught through mental health nursing training. The analysis resulted in seven core themes, the largest theme being “*talking about symptoms*” with twenty-four participants highlighting the importance of “*hearing and respecting the experience*” (Bowers et al., 2009, p.35). The MHNs used both structured questionnaires and more exploratory conversations to gain greater understanding of what the voice hearer was experiencing. Examples were given, such as a voice representing the loss of a loved one. The authors hypothesised that when MHNs do not listen to these experiences but instead encourage repression of the voices it may actually increase the voice hearers’ “*sense of difference, exclusion, loneliness and stigmatisation, thereby making depressions or even suicide more likely*” (Bowers et al., 2009, p.7).

Research has shown that voice hearers have many differing explanations for voices including biomedical, spiritual, supernatural, and specific personal circumstances such as abortion (Jones & Coffey, 2011). Recently there has been an example of staff adopting a narrative approach with their work with voice hearers to explore these personal explanatory frameworks (Place et al., 2011). The authors used this narrative approach with twenty-five voice hearers on an acute inpatient ward over an 18-month period, involving five members of ward staff (MHNs and HSWs). The authors developed a narrative tool based on the ‘Maastricht interview’ (Romme & Escher, 2000), which helped the voice hearer build up a narrative of their voice hearing experiences. This was done on a one to one basis lasting between one and three hours, often over many sessions. The role of the staff member was described as a “*supportive*

journalist” or *“ghost writer”*, with the voice hearer controlling the process (Place et al., 2011, p.839). The authors described a number of advantages of the narrative tool for staff including reducing staff anxiety of working with voice hearers, as the tool provided a model to structure their work. They also highlighted its use in building a therapeutic relationship. They further discussed the importance of *“access to supervision”* when doing this work (Place et al., 2011, p. 841). Therefore, emerging literature seems to suggest that staff are actively exploring the meaning behind voice hearing experiences within acute mental health services. The two examples discussed above highlighted the use of interview tools to facilitate talking about voices, as they provide structure and containment around a topic that may elicit feelings of anxiety.

Why talk about the content of voices?

So far, the literature has shown conflicting views, with some research advocating talking about the content of voices and others highlighting staff concerns regarding opening up those types of conversations. Service-users have also presented a mixed picture, sharing different perspectives on what works for them when hearing negative voices. For example, Jepson (2012) described hearing negative voices with content such as *“insulting”* comments and instructions to *“kill”* himself, which he described as an ongoing *“struggle”*(p.483). When experiencing these types of voices he commented that he does not *“like to talk”* about them and rather refocuses on an activity or attempts to *“ignore them”* (Jepson, 2012, p. 483).

It is recognised that it can be difficult for voice hearers to talk openly about their experiences, which may create distance in their social relationships (Mawson et al., 2011). This distancing seems to occur due to fear of others not understanding the experience of hearing voices, a form of coping to avoid uncomfortable social situations, but also wanting to shield others from any stress and worry (Mawson et al., 2011).

A study by Coffey et al. (2004) gained the views of twenty-two service-users about the responses to their voice hearing experiences from their community mental health nurse. The questionnaire looked at medication, the content and meaning of voices, ways of coping and therapeutic interventions. The results showed that voice hearers did not want their experiences to be dismissed or ignored but wished to be *“reminded of real things or ...presented with reality-based challenges”*(Coffey et al., 2004, p. 442). They did however, highlight that they wanted space to explore the content of their voices and their meaning, which they expected their community MHN to facilitate. This may suggest that voice hearers feel more comfortable talking to their mental health worker

about the content of their voices, than other people in their social world, whom they may want to protect and shield (Mawson et al., 2011).

A larger scale national multimedia study by Beavan and Read (2010) assessed voice content and associated distress for the voice hearer and contact with mental health services. One hundred and fifty-four participants answered the Hearing Voices Questionnaire and fifty of those respondents agreed to participate in a follow-up semi-structured interview about their experiences. The study findings showed that a quarter of the voice hearers reported negative or unhelpful voice content, which was found to be significantly associated with negative emotional response. The types of negative voices were critical comments about the voice hearer and instructions to harm them or others, which was similar to Jepson's (2012) account. Voice content was found to be the "*strongest predictor of contact with mental health services*" (Beavan & Read, 2010, p. 201).

So it seems that there is increasing evidence to support the idea of talking about the content of voices due to the association of distressing voice content and voice hearers needing the care and support of acute mental health services. The importance of allowing voice hearers to make sense of their experiences when under the care of mental health services was highlighted by a recent service user account of time on an acute ward. The service-user explained that they had a background in neuroscience and therefore understood their voice hearing experiences through this framework, seeing them as "*meaningless -the result of random but coordinated activity in the brain*" (Hawkes, 2012, p. 1109). However, the service user described how this explanation did not match their experiences when in acute distress commenting, "*My voices are no senseless firings inside my head. I can hear them clear as day. They have meaning*" (Hawkes, 2012, p. 1109). This suggests the importance of continuing to facilitate meaning making of voice hearing experiences as previously held explanations may not fit with the experiences of service-users when in acute distress.

Summary

This section has shown the changing landscape of acute mental health services, moving from large scale 'asylums' to smaller scale mental health hospitals, with an emphasis on short-term interventions to manage crisis periods. This means that acute mental health staff members are left caring for service users in moments of extreme distress, when they cannot be safely supported in the community. We have seen the introduction of PSI for people with 'psychosis', which seemed to have positive results in the community.

These interventions have been adapted for use in acute wards, but research suggests that staff are not afforded the time to use these interventions with service users and are often not well supported by colleagues or managers. This suggests that many staff are left feeling like they can not do a good enough job and cannot fulfill the ‘doing’ roles that they have been trained to do.

Research suggests that there are mixed views regarding talking specifically about voice content by both service users and staff. Some acute services have developed interview tools to help structure conversations about voices, which seems to have reduced staff anxiety about opening up these types of conversations. However, other research has demonstrated some of the fears around making things worse and staff lacking confidence.

There is increasing literature that advocates the notion of talking about the content of voices, particularly as research has evidenced the association between negative voice content and contact with mental health services. Therefore mental health workers are being encouraged to facilitate these conversations to help service users make sense of their voice hearing experiences in order to reduce their level of distress, therefore reducing the need for acute care.

As the improvement in individuals who are encouraged to talk about their voices becomes more apparent, increasing number of health professionals are beginning to understand that the key to understanding voices lies in the ‘content’ of the voices (Hearing Voices Network, 2014).

With the increasing pressure on staff to engage service users in work that explores the content of their voices, knowing from the above research that for some staff members this can cause feelings of anxiety and incompetence, the following section will consider the potential impact of this on staff.

Impact of Working in Acute Mental Health Care

Staff stress and burnout

Health care professionals (HCPs) across all NHS sectors have the highest sickness and absence rates in the UK, above any other occupational sector (Edwards & Burnard, 2003). A survey of HSWs and MHNs, working in adult psychiatric wards in England, identified an average sickness absence rate of 6.8% (Garcia et al., 2005). This exceeded the 5.4% national rate for sickness absence across all professions in mental health

services for the same year (The Health and Social Care Information Centre, 2005). The Standing Nursing and Midwifery Committee (1999) highlighted that nursing posts in particular were difficult to fill, highlighting difficulties in both recruitment and staff retention.

The closure of the large asylums in the 1980s-1990s saw a significant reduction in bed availability within acute inpatient wards. Subsequently, HCPs working in acute settings were left to care for and manage service-users with greater complexity of needs, with limited resources (Currid, 2009). This has led to feelings of apprehension and anxiety among staff members when entering acute inpatient wards (Travers, 2007). Acute settings are often considered to be the most “*undervalued*” sector of mental health services (Gournay, 2005, p.7). MHNs working in this area are often viewed by psychiatry as “*unspecialised*” and having a “*custodial role*” (Gournay, 2005, p.7). As such, many staff members do not have the level of training they need to meet the needs of the increasing complexity of the people accessing the service (Duffy et al., 2004). Hummelvoll and Severinsson (2001) suggested that MHNs might feel that they are offering a disservice to their service-users, as increased workloads combined with fewer resources mean that they cannot spend time with service-users to address individual needs. Some reflections on nursing training have highlighted the reduction in the time available to engage with service-users on a one to one basis post qualification for example, documentation of care planning is prioritised and time is not given to implement interventions with service-users (Sally, 2007). Indeed, research on therapeutic interaction among MHNs and service-users show that this is low in mental health services (Sullivan, 1998), with a greater amount of time being used for administrative and supervisory tasks than direct service-user care (Robinson, 1996b).

Interestingly, Bee et al., (2006) mapped nursing activity in three acute inpatient mental health hospitals. They found that 50% of nursing activity was direct service-user contact with the other half dedicated to “*ward administration*” (Bee et al., 2006, p.217). It was noted that much of the staff and service user contact was by ‘unqualified’ staff (i.e. HSWs) who reported greater work satisfaction than the MHNs, which was found to have “*a significant positive correlation*” with “*patient contact time*” (Bee et al., 2006, p.223). These findings supported previous acute inpatient research, which identified that MHNs often reported higher levels of “*workload stress*” than HSWs, and showed “*signs of high burnout in terms of emotional exhaustion*” (Jenkins & Elliot, 2004, p. 622). This suggests that stress and burnout may be more likely for MHNs who experience low job satisfaction and high workload stress (e.g. Sorgaard et al., 2010), as their service user contact is limited to administration of medication and containment tasks, such as observations.

A recent study examining service-users' perceptions of acute care and the uptake of therapeutic activities on inpatient wards identified that service-user and staff contact time (both for group activities and one-to-one sessions) averaged less than an hour a day (Csipke et al., 2014). Interestingly, service-users diagnosed with 'psychosis' reported less contact time with staff than those with other mental health problems, and reported taking part in fewer ward activities. Overall, the researchers concluded that in acute mental health hospitals, "*less time was spent participating in activities today than 50 years ago*" (Csipke et al., 2014, p. 665).

Berry et al. (2008) examined staff attachment styles in the context of interactions with service-users with 'psychosis'. MHNs and HSWs were asked to complete a measure, which assessed their levels of attachment anxiety and attachment avoidance. Attachment anxiety is associated with fear of rejection and abandonment by others, whilst attachment avoidance is linked to self-reliance and/or a fear of being dependent on others (Brennan et al., 1998). The study found that lower staff anxiety and avoidance related to more positive therapeutic relationships with service-users, which consequently led to better outcomes (Berry et al., 2008). The authors hypothesised that increasing levels of anxious or avoidant attachment styles might result in "*distortions in social perception*", which in turn might result in staff not understanding, and failing to respond to, service-users "*interpersonal needs*" (Berry et al., 2008, p. 356). Therefore, if staff members are increasingly feeling anxious about working with voice hearers because they do not feel confident or competent enough to open up discussions about the content of voices, then it is likely that staff will avoid, therefore reducing their stress levels.

Edwards and Burnard (2003) carried out a systematic review of stress among MHNs and the prevalence of stress management interventions. The review included seventy-seven papers, of which sixty-nine identified stressors for nurses. However, only eight papers demonstrated examples of how this knowledge was translated into stress management interventions that benefit nurses in their clinical practice. The main sources of stress included "*professional-self-doubt*", which linked to low self-esteem and high levels of emotional exhaustion, inadequate "*staffing levels*" and "*poor supervision*" (Edwards & Burnard, 2003, p.195).

Staff burnout and levels of expressed emotion (EE) were investigated in staff working in a male medium secure learning disability service for people with 'psychosis' (Dennis & Leach, 2007). High EE included criticism, hostility, and emotional over involvement. The study findings showed that high EE was more prevalent in male staff than female (41%: 8%) and was found to be higher in HSWs than MHNs (35%: 17%; Dennis & Leach, 2007, p.271). The researchers wondered whether the difference

between MHNs and HSWs was due to training needs, lack of support and supervision, or factors to do with the specific work role of a HSW. The results were consistent with previous findings that less trained staff members have higher EE and often present with more critical comments (Barrowclough et al., 2001; Van Humbeck & Van Audenhove, 2003).

A qualitative study using Interpretive Phenomenological Analysis (IPA) was conducted to explore the experiences of stress amongst eight MHNs working in acute mental health settings in London, UK (Currid, 2009). The research indicated three main themes of stressors experienced by the participants: firstly, “*pressures*”, such as bed shortages and under-resourcing of staff on the wards; secondly, “*violence and aggression*” (e.g. verbal and physical attacks on staff by service-users); and thirdly, the “*inability to switch off from work*” (Currid, 2009, pp.43-44). The latter linked to a broader theme of staff anxiety which was evidenced through the interview accounts detailing the “*fear of self-blame*” and “*blame from others*” if something bad happened at work (Currid, 2009, p.44). This finding was consistent with the “*professional self-blame*” identified in the Edwards and Burnard (2003) systematic review (p.195). The researcher recommended an increase in supervision and training for MHNs working in acute mental health settings, and advised further studies into the “*lived experiences*” of staff to increase the generalisability of these initial findings (Currid, 2009, p.46).

Understanding staff stress and anxiety

Research has suggested that over a quarter of all HCPs experience severe psychological difficulties in comparison to under a fifth of the general working population (Wall et al., 1997). Seecombe and Ball (1992) identified stress as a leading factor for many nurses leaving their occupations. Understanding staff stress might be useful when thinking about how staff members react to voice hearing, particularly considering what has already been discussed in the previous sections, including the increased pressures on staff working within acute mental health care coupled with the dilemmas faced when working with voice hearers in acute distress. .

The potential stress and anxiety felt by acute mental health staff members when working with voice hearers could be understood as a “*negative experience that is associated with threat, harm, or demand*” (Baum, 1990, p. 660). When voice hearers attempt to engage staff in conversations about their experiences it may be perceived as a stressful event. Stressful events are often characterised as those that are considered as beyond an individual’s capabilities and resources (Lazarus & Launier, 1978). Having “*a sense of mastery*”, which encapsulates the concept of controllability, and “*self-esteem*”

has been shown to reduce the impact of stressful events (Taylor & Stanton, 2007, p. 378). The above literature highlighted that nursing training does not include talking about voices, which may mean that they feel a lack of mastery in this area, and therefore lack confidence in engaging service users in conversation about the content of their voices.

Anxiety is also associated with a sense of uncontrollability and the fight/flight response to threat or perceived danger (Zinbarg & Barlow, 1996). Avoidance is often used to immediately increase controllability, and this reduces psychological distress in the short-term. However, avoidance is considered to have a maintaining role and can actually generate further anxiety and stress over time (Hammen, 1991; Holahan et al., 2005).

At times of stress, approach-orientated coping strategies have been linked to better psychological and physical wellbeing e.g. “*confronting emotional responses to a stressor*”, whereas avoidance coping strategies have been associated with an increase in psychological distress and exacerbated physical health difficulties (Taylor & Stanton, 2007, p.392).

The work of Menzies Lyth, particularly her paper on ‘Social Systems as a Defense Against Anxiety’ (1960) provides some useful insights into institutional anxiety. The paper is based on the study of a nursing service within a general hospital in London, UK, with particular consideration to the role of the student nurse. However, it holds many parallels to the role of HSWs and MHNs working within acute mental health services. Though the study is over fifty years old, the understanding of “*organisational defenses against anxiety*” is still being explored and researched in present times (e.g. Long, 2006, p. 279).

The study described how a nurse has to manage and tolerate the psychological distress of others, including “*patients*”, “*relatives*” and other “*colleagues*” (Menzies Lyth, 1960, p.441). This is described as “*projection*”, as others would project their own feelings of “*depression, anxiety, fear and disgust*” into the nurse to free themselves of psychological distress (Menzies Lyth, 1960, p. 442). Interestingly, it was noted in the study that people were often hospitalised not for the severity of their physical condition, but due to the stress caused by the condition for people at home.

Menzies Lyth described the use of social structured defence mechanisms (Jaques, 1955), which the nursing system uses in order to manage these anxieties. These included ‘splitting up the nurse/patient relationship’, which was based on the premise that the closer the relationship between the nurse and ‘patient’, the greater likelihood that the nurse would experience anxiety. To protect against this, ‘patient’ contact would be ‘split’ up by many ward tasks, which would often require restricted

access to a large number of ‘patients’, therefore preventing “*contact with the totality of any one patient and his or her illness*” (Menzies Lyth, 1960, p.444). The ward task list was further used to depersonalise and categorise the ‘patient’, again in order to reduce anxiety felt by any close relationship. For example, the study showed that ‘patients’ were referred to by bed numbers rather than name and everyone was treated identically i.e. all beds would be made the same and all ‘patients’ were washed in the morning, irrespective of individual needs and preferences. The ritual task list also served to reduce decision-making amongst the nurses, with checks and counterchecks in place to try and eliminate anxiety caused by responsibility of decision-making.

‘Detachment and denial of feelings’ was also found within operational policy, which encouraged “*detachment*” (Menzies Lyth, 1960, p. 445). Nurses were regularly moved to different wards and hospitals with a moment’s notice, an example of physical detachment which would teach the student nurses to be “*detached psychologically*” (Menzies Lyth, 1960, p.445). Distressed feelings were apparent in the student nurses but this was managed through repressive techniques, such as denying the feelings by having a “*stiff upper lip*” and “*pull yourself together*” attitude (Menzies Lyth, 1960, p.446).

Avoidance was also found, most notably the avoidance of change, as change was associated with the unknown and increased anxiety in the staff. At this time, hospitals were experiencing higher patient turnover with the establishment of the NHS which warranted greater flexibility of work tasks. However, the anxiety actually caused further “*rigidity*” to the system and “*ritual tasks*” (Menzies Lyth, 1960, p.451).

Overall, Menzies Lyth (1960) concludes that the social defence system helped staff to “*avoid conscious experience of anxiety, guilt, doubt and uncertainty*” by “*eliminating situations, events, tasks, activities and relationships that caused anxiety*” (p.452). Indeed, more recent literature has highlighted that nurses continue to recognise the issues raised in Menzies-Lyth’s paper, and some have described this as providing “*some relief that the seeming madness in their own systems has its own ‘method’*” (Long, 2006, p. 285).

If we considered this theory within acute mental health services, MHNs and HSWs may adopt a social defence system and employ avoidance and detachment techniques when service-users attempt to engage them in conversations about their voices. In doing so, this may increase alienation of the voice hearer leading to feelings of difference and belief in the concept of being ‘mentally ill’. This may also maintain the staff member’s beliefs that it is dangerous to talk about the content of voices. For example, if they avoid talking to the service-user about their voices, the service-user may become distressed due to alienation, which could be perceived by the staff member as a result of trying to talk about the voices. Indeed, avoidance by acute inpatient ward

staff has been associated with an increase in service-users' self-critical thoughts, e.g. *"I'm not worth finding out about"*, which maintains psychological distress, leading to poorer outcomes (Short, 2007, p.29).

Summary and rationale for present study

The literature has shown that over time there have been changes in how acute mental health services are structured, with more recent emphasis on short-term admissions in response to severe crises. During this time there have been shifts in the understanding of 'mental illnesses', particularly 'schizophrenia/psychosis' and the phenomenon of voice hearing. Historically voice hearing was considered to be indicative of closeness to God, which still remains the dominant discourse in some agricultural societies. In Western culture, voice hearing has mainly been associated with 'schizophrenia/psychosis' and has been treated as a part of a 'mental disorder'. More recently, there has been growing research into the subjective experiences of voice hearing and a call for greater psychological understandings of their origins. This has seen an increase in research demonstrating the importance of exploring voice hearers' experiences to ascertain the content and meaning of the voices. This has been particularly important due to the potential associations of voice hearing with past trauma, beliefs and appraisals, and attachment.

With the changes to acute mental health services, there has been a shift in the role of MHNs, from an 'attendant' of physical health needs to 'nurse as therapist', delivering behavioural and educational interventions. PSI has particularly grown, including CBT techniques and family work.

Despite the evidence-base for the use of PSI for 'psychosis', studies have shown a difference of opinions with regard to the importance of the exploration of voice hearing experiences by staff and service-users. So far, studies suggest that staff may feel apprehensive and anxious about the concept of talking about the voices, which seems to be linked to lack of confidence and increase in stress. Stress and burnout literature suggests that staff members in acute settings are working under increased pressure, with limited time and resources. Subsequently, staff may avoid engaging in conversations about the content of voices as a coping strategy if they perceive them to be stressful events.

The recommendations from the Francis Report (2013) have had implications for both MHNs and HSWs, as there is a move within services to ensure that there is compassionate care delivered by competent practitioners. This has seen extra guidelines and training recommendations for HSWs and an emphasis on continued professional

development for registered nurses to ensure they are developing competencies in the needed areas for their service. This may have implications for training needs of staff working with voice hearers in acute mental health care.

The literature suggests that voice hearers will have improved outcomes in acute services if staff members feel able to facilitate personal meaning making of the voice hearing experiences. It is therefore important to explore staff experiences of working with voice hearers; a psychological understanding of these experiences may inform staff training and support needs, thus improving service user care.

Research Questions

The broad aim of my thesis is to explore staff experiences of working with voice hearers in acute mental health settings. This includes examining the following questions:

- What are staff experiences of working with voice hearers?
 - How have staff members made meaning of these experiences?
 - How do staff members feel when service-users talk to them about the content of their voice/s?
 - What are staff members' relationships with voice hearers like?

METHOD

Design

Due to the exploratory nature of the research questions and the importance of gaining insight into the subjective experiences of the participants, a qualitative design was chosen. A homogenous self-selecting sample of eight staff members was recruited from one acute mental health service in the North of England. Each participant was interviewed using a semi-structured interview schedule. The interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA). The number of interviews was within the advised range for professional doctorate qualitative research using IPA (Smith et al., 2009).

Sample

To maintain homogeneity, I focused my research sample to an adult acute mental health setting only, excluding other adult mental health inpatient services such as forensic, psychiatric intensive care, continuing treatment and recovery and learning disability services.

I consulted with acute mental health ward managers regarding the feasibility of this research and I was advised to include HSWs and MHNs in my sample. The rationale for this is that both of these staff groups work most closely with service-users on a twenty-four hour rotation, and are therefore most likely to engage in one to one conversations with voice hearers on the wards.

All other staff groups were excluded from the study including medical staff, occupational therapists (OTs), art psychotherapists and clinical psychologists, as their roles involved less service-user contact. Non-clinical staff members, including ward administrators and housekeepers, were also excluded.

Research setting

The recruiting acute mental health hospital provided an inpatient service to adults between the ages of 18 – 65 years old. Service-users accessing the service had previously been assessed by the Crisis Resolution Home Treatment Team (CRHT) and required inpatient care, as they could not be safely supported in the community.

The hospital consisted of two female wards and two male wards, with a total of 90 inpatient beds. Each ward had a staff group consisting of HSWs, MHNs, an OT, a consultant psychiatrist and junior doctors. A clinical psychologist (or psychotherapist) from the local adult psychological therapy service attended the wards to facilitate staff reflective practice groups.

The service was supportive of staff working with voice hearers and previously supported the delivery of a two-day training course for ward staff (HSWs, MHNs and OTs) on using a narrative approach with people who hear voices. A nurse therapist and a mental health nurse with a background in this approach delivered the training. They adapted the Maastricht interview (Romme & Escher, 2000) for use within an inpatient setting. The interview tool helped staff co-construct a narrative of service-users' voice hearing experiences, which aimed to help the voice hearer make sense of their experiences. The trainers offered supervision to staff carrying out this work. The training also provided staff with an overview of models for understanding voice hearing experiences, including trauma and disassociation.

Recruitment procedure

The recruitment procedure involved a number of steps. I made contact with the local acute mental health clinical service manager (CSM) to discuss research feasibility. The CSM was supportive of the study and agreed to circulate research information to the acute inpatient clinical team managers (CTMs).

Following this, I was invited to attend a CTM meeting to discuss my research proposal. Feasibility, recruitment procedures and data collection were discussed. The CTMs advised on inclusion/exclusion criteria and suggested that they circulated the study advertising material through email to all HSWs and MHNs on their wards. I was advised to attend ward business meetings to further advertise the study if I struggled to recruit after initial advertising.

³Posters advertising the study were put up on notice boards in each ward staff room and circulated electronically by CTMs (Appendix II). My field supervisor advertised the study through the Trust-wide Communications email, which was circulated on two occasions (Appendix III). An OT based within the acute mental health service, who had experience of facilitating hearing voices groups, was interested in

³ The Trust logo has been removed from all study documents in the appendices to increase anonymity.

helping me with the research, and advertised and promoted the study directly to HSWs and MHNs on the wards.

I provided paper copies of the participant information sheet, along with opt-in slips and a freepost return envelope for each ward (Appendix IV). CTMs also circulated this information electronically through email to all HSWs and MHNs.

I also arranged alternative recruitment plans in case of recruitment difficulties in the local Trust. To minimise any delay in implementing alternative plans, I detailed three further Trusts as potential research sites on my ethics and NHS Research & Development (R&D) applications and had named local collaborators for the study in each service.

I did not face recruitment difficulties therefore the alternative recruitment plans were not employed. Two participants opted-in using the freepost envelope, one participant opted-in following initial interest raised with their line manager and subsequently having a verbal conversation with me, and the remaining participants opted-in by email. Research interviews were arranged, on average, within two to three weeks of initial contact.

Ethical Considerations

Participant and researcher wellbeing

Previous research suggests that the topic of voice hearing may elicit feelings of anxiety in staff members and those being interviewed could potentially interpret the current research as evaluative of their practice, potentially causing more anxiety. The purpose of the research was therefore clearly outlined in the participant information sheet with assurances of anonymity to dispel concerns regarding the possibility of evaluation. The information sheet provided my contact details and information about staff support services for the participant to access if affected by the interview topic area. At the end of each interview I also verbally checked the participant's wellbeing to ensure they felt able to leave the research setting and return to work or home. The interviews were held in meeting rooms on Trust premises to facilitate the timing of participants' interviews prior to or after their shift. This meant that lone working arrangements were not necessary and Trust staff members were present if support was required. No support was required, as participants did not become distressed during the interviews.

Consent

Informed consent was sought by providing the participants with an information sheet, which detailed an outline of the rationale for the research, what participation involved, including time commitment, topic area of the interview, potential sensitivity of the areas to be discussed and ways of ensuring confidentiality and anonymity. Participants were given a minimum of 24 hours to decide on whether or not they wanted to take part in the study.

At the start of the interview, following an opportunity to re-read the information sheet and ask any questions, participants were invited to sign a consent form (Appendix V). Two consent forms were completed, one for the participant to keep and one to be securely stored in the D.Clin.Psychol. administration office.

At the end of the interview, participants were asked to verbally re-consent to the interview data being used in the research. Participants were also reminded that they could withdraw from the study up to 72 hours following the interview. No participants withdrew their consent to participate in the research. Two participants, however, requested that specific information be removed from their interview transcript to maintain anonymity.

Confidentiality

At the start of the interview I re-iterated my position as a researcher and explained that everything discussed in the interview would be kept confidential. The participants were made aware of the two caveats to confidentiality; first, the use of anonymised extracts from the interviews in the final write up of the research and potential future publication, and second, if risk issues were raised during the course of the interview. No risk issues were raised during the interviews therefore confidentiality was maintained.

Token of gratitude for participants

Participants were given a £10 book voucher as a token of gratitude for giving their time to participate in the research. The rationale for providing the voucher was that I would be recruiting staff members who do not have research time allocated as part of their job plan. Furthermore, the literature acknowledges that acute mental health workers are under increased pressures, working with greater complexity of need with limited resources. This was not made known at the recruitment phase so as not to coerce participation. The offer of a voucher was therefore made at the end of the interview. At

this point I reiterated the participant's right to withdraw from the study, without losing their token. All participants were offered a book voucher and everyone accepted.

Ethics and NHS R&D Applications

As the current research involved recruitment of staff members only, NHS ethical approval was not required. However, due to recruiting and interviewing staff members on NHS Trust premises, local NHS R&D approval was required. The study was approved by the University's Institute of Health Sciences' ethics committee on 10th June 2013 (approved with one amendment to the participant information sheet, see Appendix VI) and subsequently approved by NHS R&D on 11th June 2013 (Appendix VII).

Qualitative Methodological Approach

In the following section I will provide details of the qualitative methodological approach of Interpretative Phenomenological Analysis (IPA). This approach was chosen due to its focus on the subjective experiences of the participant's world, which was considered most appropriate for addressing the research questions of the current study.

Data collection

Different qualitative data collection methods were considered for the current study. First, an ethnographic approach was considered, which involves collecting data through participant observation, usually by spending time "*in the field*", living as part of a specific community (Griffin & Bengry-Howell, 2008, p.17). This approach is often associated with the social sciences, particularly social anthropology (e.g. Oakley, 1983). For the current study, this would have involved the researcher becoming part of the acute mental health wards, spending time with staff and service-users. This would have allowed me to observe staff interactions with voice hearers and get an overall sense of the context of the participants' world. However, becoming part of the day-to-day activity on the wards raised ethical considerations: first, I might observe, or over hear, confidential information regarding service-user care, and second, observational research notes might contain confidential service-user material. In discussions with the local NHS ethics committee coordinator, pursuing this approach would have required informed consent from all service-users and staff on the wards. In consideration of these issues participant observation was discounted.

Semi-structured interviews were considered as an alternative to participant observation. Semi-structured interviewing is a widely used data collection method, which often involves the researcher following an interview schedule, comprising a number of open-ended questions (Willig, 2008). The researcher is free to pursue novel ideas raised by the participant therefore the interview schedule is a loose guide to generate discussion. This flexibility is advantageous when exploring participants' lived experiences as it allows participants to talk in-depth about the topic, generating rich data (Reid et al., 2005). However, the interview schedule has its limitations as it is guided by the researcher's agenda, based on their beliefs and assumptions on the research phenomenon.

Individual semi-structured interviews were chosen as the most appropriate data collection method for a number of reasons. First, the one to one interview format would allow me to utilise my clinical skills, building rapport and alliance to facilitate in-depth

exploration of the topic. Second, I had recently used this method and was therefore familiar and confident using this method of data collection. Third, the commitment of staff to partake in one semi-structured interview was feasible in the time allowed off the ward. Finally, it was important to me for the interview process itself to empower staff to tell their story and talk about their subjective experiences of working with voice hearers, without judgement, which the semi-structured interview method would facilitate.

Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative research method based on the philosophical notion of ‘phenomenology’. Phenomenology is concerned with how the world is perceived through human experience (Willig, 2008). IPA recognises that the “*self and world are inseparable components of meaning*”, thus people often differ in their interpretations of the same event (Moustakas, 1994, p.28).

Within IPA there are two levels of interpretation, known as the ‘double hermeneutic’. Firstly, there is the participant’s interpretation of their experiences, and secondly the researcher’s interpretation of the participant’s experience (Smith et al., 2009). IPA acknowledges the potential impact of the researcher’s beliefs and assumptions on the research, highlighting the importance of reflexivity during the interpretative process (Larkin et al., 2006.) I used a research journal throughout the study to record my assumptions, judgments and decision-making. I also recorded my initial reflections following each research interview. Furthermore, I engaged in a reflexive interview with my academic supervisor during the analysis phase to explore my beliefs and assumptions, increasing the transparency of the research.

IPA is sometimes criticised for its reliance on the participants’ use of language to describe their experiences to the researcher, and indeed the assumption that language is the correct tool to capture experience. It has further been argued that IPA only describes experiences and neglects to consider explanations of the study phenomenon (Willig, 2008). Despite these criticisms, IPA appeared to be the most appropriate qualitative approach for the present research aim, because of the focus on subjective experiences.

Alternative approaches

Grounded Theory (Glaser & Strauss, 1967) was considered as an alternative approach to IPA. Grounded Theory facilitates the generation of theories from qualitative data with the purpose of developing an *explanatory framework* to understand the study

phenomenon (Willig, 2008). This approach involves coding the data and developing *categories*, which the researcher uses to inform further data collection until no new categories emerge (theoretical saturation). Grounded Theory was deemed less appropriate than IPA for the current study as I aimed to explore the experiences of staff members who work with voice hearers, rather than develop a theoretical framework for understanding the phenomenon of voice hearing.

Discourse Analysis was also considered as an approach. Willig (2008) describes two main versions of Discourse Analysis, ‘Discursive psychology’ and ‘Foucauldian discourse analysis’ (p.95). The former is concerned with how people use language, and the latter with what is constructed through language, both in the context of social interaction. As the current study was not primarily concerned with how voice hearing is constructed by staff members in acute mental health settings (though this may be revealed through the exploration of their experiences), or with the language used to describe this phenomenon, Discourse Analysis was discounted.

Interview Schedule

I developed an interview schedule with the help of my academic and field supervisors and guidance from IPA literature (e.g. Smith et al., 2009). I shared the interview schedule with members of the D.Clin.Psychol Qualitative Research Peer Support Group (QRPSG) to gain their advice and feedback. I further consulted with a MHN and HSW on my clinical placement about the interview questions. The interview schedule was used as a guide to elicit information about people’s experiences of working with voice hearers (Appendix VIII).

Brief demographic information was gained at the start of the interview to aid my assessment of the homogeneity of the sample and the development of a pen portrait of each participant (Appendix IX).

Interview Setting

Interviews were held in meeting/interview rooms on Trust premises at the participants’ place of work. Where possible the interviews were conducted off the ward to maintain confidentiality and to reduce the likelihood of disruptions.

Transcription

Interviews were transcribed verbatim, including pauses, hesitations and laughter. I transcribed two of the eight interviews in order to practise my transcribing skills and immerse myself in the data. The remainder of the interviews was transcribed by a transcriber based at the University of Leeds, who signed a confidentiality agreement (Appendix X). On receipt of each transcript, I listened to the audio recordings of each interview and checked the transcript for accuracy. This also served to immerse myself in the data.

Data analysis

The interview transcript data were analysed following the steps described by Smith et al. (2009). The recommended analysis process is outlined below:

Table 1. Stages of analysis.

Step	Title	Description
1	Reading and re-reading	Reading the interview transcript many times whilst listening to the interview audio. Recording recollections of interview experience, reflections and first impressions.
2	Initial noting	Initial exploratory comments noted including descriptions of content, use of language and conceptual comments. Notes made directly onto the transcript in the right margin.
3	Developing emergent themes	Analysing the exploratory comments to identify emergent themes. Focusing on discrete chunks of transcript whilst recalling learning from whole transcript. Producing a concise statement highlighting the important essence of a chunk of transcript. Emergent themes written in the left margin.
4	Searching for connections across emergent themes	Developing a map of how the themes relate to one another. Some emergent themes may be discarded but held in mind when approaching further transcripts. Some themes may cluster together under a super-ordinate theme. Print out the list of themes, or write them on cards, and physically move the themes around building a map. Graphically represent the emergent themes in a table with page and line numbers and key words to illustrate each theme.
5	Moving to the next case	Move to the next transcript and follow the steps outlined above. Repeat for all transcripts.
6	Looking for patterns across cases	Laying out the tables of themes for each transcript and looking across them for patterns and connections. Represented in a final table illustrating patterns across the group.

Each transcript was analysed using steps 1-4 outlined in Table 1. These steps were not followed in a linear process; it was more cyclical, moving between the steps when necessary. For my first analysis, I noticed that I moved between reading and re-reading and initial noting multiple times, listening to the audio on a number of occasions to help me with exploratory comments. My main stages of analysis involved:

- Multiple readings of the transcript whilst listening to the interview audio and making initial notes in the right margin. I used my initial reflections following each interview to help with initial coding and noted my reactions when re-listening to the interview.
- The initial coding was kept close to the participant's own language with more interpretative comments phrased as questions and underlined in the margin.
- I used cards to note the flow of each interview, to get a sense of the participant's overall 'story'.
- The initial coding was then viewed and emergent themes assigned and written in the left margin. Some were phrased tentatively as questions, to return to after emergent themes were assigned chronologically through the transcript.
- Emergent themes were then written on cards and physically moved around on a table/floor to cluster and discard as necessary.
- Emergent themes were moved in a variety of ways to create a final mapping, including super-ordinate themes, which seemed to reflect the participant's experience.
- I finally created a theme map, which detailed the super-ordinate themes, sub-themes and illustrative quotes.

For an example of the analysis process, including initial coding and emerging themes, please see interview extract in Appendix XI. An example of a participant theme map is provided in Appendix XII.

Following individual participant analysis, I conducted a group analysis to look for patterns across the sample. This involved the following steps:

- I printed each individual theme map and cut up each theme with illustrative quotes.
- I then clustered the themes across the eight participants and re-clustered until I was happy that each cluster represented the group experiences (see Appendix XIII for an example).

- I returned to the illustrative quotations to ensure that the corresponding themes captured the essence of experience. I employed the help of my academic supervisor and peers from the QRPSQ to assist with this process.
- Following this, I assigned master theme names, which captured the overarching essence of experience.
- The master themes, super-ordinate themes and subthemes were then written into a table, with frequency of themes across the participants.

Quality checks

Guidelines have evolved to ensure the quality of qualitative research. Examples of good practice include the provision of credibility checks, transparency of the research process and “*owning one’s perspective*” i.e. the importance of reflexivity (Elliott et al., 1999, p. 221). I took the following steps to ensure the quality of the current research:

- I detailed the methodological steps employed in the current research from assessing the feasibility of the study to data collection and analysis in order to be transparent about my research process.
- During data analysis, I brought extracts of transcripts to thesis meetings with my supervisors for them to provide credibility checks of my coding and themes.
- My academic supervisor viewed extracts of all interviews with accompanying codes and themes to ensure the credibility of my work.
- I enlisted the help of peers from the QRPSG to view extracts of initial coding and emergent themes for further credibility checks and to share analysis tips and advice.
- I had regular discussions with my supervisors about the emergent themes from both individual and group analyses to ensure they were grounded in the data.
- I asked participants at time of consent whether or not they would like to be contacted with themes from their interview. All participants agreed to be contacted by email and were invited to comment on the themes from their individual interview.
- The following results chapter will provide detailed transcript extracts to illustrate the themes to ensure transparency of the research findings.
- Finally, to own my perspective, I have kept a reflective journal throughout the research process and reflected on each interview at the time of data collection and data analysis.

Reflexivity

The beliefs, assumptions and experiences of the researcher are an integral part of the hermeneutic cycle in IPA. Reflexivity is important throughout the research process and has particular emphasis at the interpretative stages of analysis. I have therefore chosen to include my reflexive statement at this juncture before presenting the research findings.

Reflexive statement

I think it is important to state that I do not consider myself a voice hearer; although I have had one off experiences of hearing my name called when nobody was present.

I knew of voice hearing experiences first through spirituality and religion. I grew up within an Irish Catholic family, attended Catholic primary and secondary schools, was one of the first female altar servers at my church and the local parish and community featured heavily in my formative years. Through these experiences, I had heard of people hearing voices of guardian angels, often at significant moments in their lives, which were attributed to God and understood through a religious or spiritual framework. These voices were often not distressing, but carried hope and guidance for those that heard them. I found hearing of these experiences comforting and ‘magical’ and viewed them as positive experiences in people’s lives.

It was much later, whilst studying Psychology and Philosophy at undergraduate degree level, that I became aware that voice hearing was considered to be a sign of ‘mental health problems’. During my degree, voice hearing was taught as part of ‘abnormal psychology’ and listed as a ‘symptom’ of ‘schizophrenia’, often referred to as ‘auditory hallucinations’. This was incongruent with the existing framework I had to understand voice hearing, leaving me anxious and confused. I thought that there must be something qualitatively different about the voice hearing experiences of people I had been in contact with growing up and those with ‘mental health problems’.

After university I wanted to pursue work in mental health and obtained my first HSW role supporting forensic service-users in a community rehabilitation unit. The service-users had often received a diagnosis of ‘schizophrenia’ and most had experienced voice hearing in their lives. I noticed the level of distress of service-users hearing voices, which contrasted to my earlier experiences of this phenomenon. The MHN staff that I worked closely alongside would often tell me that service-users were ‘responding to voices’, which was part of their ‘mental illness’. Conversations were rarely opened up to understand the voices, rather they were understood as a sign of

mental health deterioration or a response to stressors in the service-user's life and not holding any meaning in themselves.

I conceded to this understanding at first, especially as a new worker in the mental health field looking for guidance from more experienced workers. It was much easier for me to distract people from their voices through daily activities however it was from engaging service-users in these activities that people would start to talk about their lives. It was through the process of spending time with service-users, and hearing their stories naturally, that I started to make connections to their voice hearing experiences. I felt pleased that their experiences had meaning, but I was saddened by the traumatic life stories of many of the voice hearers. From this point, hearing the subjective experiences of people's lives and understanding voice hearing as part of the continuum of human experience has become increasingly important to me.

Through this statement I acknowledge that as a white British female, who has grown up with Irish Catholic values and beliefs, I have pre-existing ideas about voice hearing experiences and the importance of listening to the narratives of people's lives. I am further aware of the influence of my previous job role as a HSW working alongside MHNs. This will likely impact on how I perceive the participants' stories.

Throughout the research process I have reflected on my beliefs and assumptions, particularly following each interview, and I have tried to keep the participant's world at the forefront, staying close to the words of the participants and employing the analysis credibility checks detailed above.

Reflexive interview

I engaged in a reflexive interview with my academic supervisor early on in the analysis phase of the research process. The aims of this was to increase transparency of the research and to help me become further self aware, providing me with an opportunity to consider my early experiences, beliefs and assumptions relating to the research topic area. The interview was audio recorded and transcribed (see Appendix XIV for an excerpt from the reflexive interview).

RESULTS

In order to present a coherent account of the participants' experiences, the findings from the analysis will be provided in a number of sections. First, brief demographic and work context information will be provided, followed by a pen portrait for each participant. This section will also detail my personal reflections relating to each interview. The findings of the group analysis will then be presented, followed by more detailed exploration of each theme with supporting interview quotations. The chapter will end with my reflections on the analysis to provide thoughts about my beliefs and assumptions that emerged through the analysis phase.

Participants

Demographic and contextual information

Eight staff members were interviewed about their experiences of working with voice hearers. Five HSWs and three MHNs were recruited from four wards within one acute mental health hospital. Four participants worked on male wards, three participants worked on female wards and one participant worked as a NHS bank worker across both male and female wards. The participants' age range was between twenty and fifty-five years old. Each participant was given a pseudonym.

At the start of each interview, participants provided brief contextual information about their current job role. Both HSWs and MHNs described working in 'Primary Nursing Teams', meaning that they worked as part of service-user care teams. They reported that they were usually allocated four to five service users per shift and were responsible for ensuring their care needs were met.

The HSWs described various roles and responsibilities including running group activities, escorting service users off the ward, observations, responding to attack alarms, providing cooking sessions and engaging service-users in one to one sessions. HSWs spoke about their ability to spend more time with service-users than the MHNs, as there are often fewer qualified staff per shift. The MHNs described similar roles to the HSWs; additionally, they administer medication, attend ward reviews, and complete care plan documentation.

The participants described using a number of strategies in their work with voice hearers. They reported offering "*comfort and reassurance*" and "*just being there*" during times of acute distress. Participants also described using person-centred

approaches i.e. empathising, listening, being congruent, and normalising voice hearing experiences.

As well as “*being there*” for voice hearers, the participants also spoke about their ‘doing role’, which included using strategies such as PSI and a CBT approach to identify triggers, relapse signatures and maintenance cycles. Some of the participants spoke about their use of a structured interview tool to build up a narrative around the voice hearing experiences of their service-users. This work was facilitated through setting aside specific one-to-one time with voice hearers, which was booked in the ward diary. One participant described how they were able to “*cocoon*” themselves away from the “*rush rush*” of the ward to facilitate the personal meaning making of hearing voices. The participants also described supporting voice hearers in finding coping strategies, such as distraction techniques, and many participants spoke about finding ways of challenging the voices. However, three participants spoke about empowering voice hearers to take more control and to negotiate their relationship with their voices, rather than challenge them.

Pen Portraits

Jamie

Jamie is a MHN who has been qualified for over four years and has worked in acute mental health services throughout this time. Jamie has experience of working with voice hearers as a student nurse and post qualification. Jamie has been involved with staff training on working with voice hearers.

When I arranged the research interview, Jamie asked whether any written work examples would be required. This left me wondering whether Jamie needed to have something tangible; a structure or framework in place to manage the interview situation, or whether Jamie wished to seek approval or validation for the work with voice hearers, potentially seeing the interview as an evaluative process.

Jamie was late arriving for the interview and was very apologetic. Jamie appeared to have rushed from the ward to the interview room appearing flushed and breathless on arrival. Jamie explained that the ward was short staffed, therefore struggled to leave at the end of the shift. I was very aware of not using up too much of Jamie’s time and feeling almost like I was a burden. I wondered whether this paralleled what service-users might feel when they see the nurses extremely busy on the ward.

During the interview, Jamie spoke more about the ward pressures, particularly as reduced staffing levels meant a reliance on NHS bank workers. Jamie explained to me

that this often placed extra demands on the regular qualified staff, as they would need to guide and instruct the temporary workers. Jamie also spoke of the bureaucracy and meeting targets side of the job, which was reducing the amount of one to one time that staff could spend with service-users. Jamie frequently laughed when talking about these pressures and difficulties with the wider mental health system. Humour seemed to be an important way for Jamie to cope with these challenges.

Jamie's need for structure and tangible interventions appeared throughout the interview when describing work with voice hearers. This often involved developing practical coping strategies, such as prompt cards, to help service-users challenge their voices.

This was my first interview, therefore I was aware of needing to ask open questions and follow the participant as a curious researcher, rather than conducting a clinical interview. Sometimes it seemed like I was spending too much time considering my questioning style and prompts rather than attending to Jamie's personal account. I remember feeling a sense of relief when emotions, such as fear, were shared. I thought that this must be a sign that I was accessing Jamie's experience of the world.

Alex

Alex has worked as a HSW for over two years. Half of that time has involved working on acute mental health wards. Through this work Alex has attended staff training on working with voice hearers.

I really warmed to Alex, as a lot of what was spoken about in the interview resonated with me, thinking back to my work as a HSW. I recognised the feelings that Alex shared, particularly the anxiety regarding not wanting to do or say the wrong thing and looking for guidance from more experienced workers. I had to work hard in the interview not to assume that I knew Alex's experiences in order to keep the questions open and to follow all lines of enquiry and thus be able to hear the account as fully as possible.

Alex was enthusiastic about working in mental health and seemed keen to know more about the different ways of working with voice hearers. I was aware that the language Alex used in the interview was aligned with a more medical understanding of 'psychosis' and voice hearing e.g. 'delusional beliefs', 'psychotic experiences', and 'responding'. I noticed that I felt tense and annoyed with Alex in those moments and sensitive to the medical language both during the interview and when listening back to the audio recording. I needed to be aware of my reactions and keep myself in the present moment, ensuring that I listened to Alex without judgement.

This was my second interview and it felt a little bit easier than the first. I was able to keep attending to Alex, rather than worrying about my next question. There was one question however that Alex struggled to understand. This was my question about understanding Alex's own reactions to things, which aimed to tap into how Alex was making sense of experience. After the interview, I discussed this in thesis supervision to help me consider alternative ways of phrasing the question.

Chris

Chris is a HSW who has worked with voice hearers for over four years and worked in acute mental health services for the last two years. Chris has not received any formal training on working with voice hearers but spoke of engaging in reflective forums with a ward psychologist, which incorporated theories about voice hearing.

Chris was bright, bubbly and enthusiastic about being involved with the study. However, at times during the interview it seemed like Chris was distant from me, maybe as a way of protection. This seemed to be at times when Chris had shared some vulnerabilities and experiences of working with people in acute distress, particularly relating to past trauma.

This type of work had led Chris to question people's motives for working in mental health, where people are exposed to hearing such distressing stories. I was really struck by this, as I became aware of my assumption that people work in this area for 'good' motives i.e. to help and support others, and that I neglected to consider some of the more challenging motivations and questions that the work might raise.

I was aware that at times during the interview it felt quite a struggle and I felt drained by the end of our time together. I wondered whether I was experiencing Chris' overwhelming feelings from the amount of emotional turmoil experienced in the work with voice hearers.

Morgan

Morgan has worked as a HSW in acute mental health services for over four years. Morgan has attended staff training on working with voice hearers and attended external talks and events on this topic. Morgan seemed passionate about working with voice hearers and had supported many service-users over the years to develop their own personal meaning of their experiences. However, Morgan had experienced a lot of disappointment and lack of support from colleagues with this work.

When arranging the research interview with Morgan, my initial impression was that Morgan was very assertive, was clear about availability for meeting times. Morgan's written communication was informal and chatty, therefore I was surprised that at interview Morgan seemed timid, guarded and quite detached at times. I found myself being distracted by this and I was left trying to work out what was going on in the room, rather than what was being said through the interview.

Morgan described some of the work with voice hearers, which included writing narrative accounts and using PSI. When Morgan spoke about work being '*good*' and things '*working really well*', it did not match the tone of Morgan's expression; it seemed incongruent. I wondered whether Morgan was feeling frustrated at the lack of support for the work with voice hearers, which is what I was feeling.

Sam

Sam is a MHN who has worked with voice hearers for the past two years. Half of this time has involved working in an acute mental health setting. Sam spoke of nursing training drawing on biological understandings of voice hearing and the importance of social supports. Sam has not received any further training specifically on working with voice hearers.

Sam was late arriving for the interview, and like the first participant, Sam was one of the only qualified staff working that day. In contrast to my first participant, Sam presented as relaxed, quite laid back, which seemed representative of the approach Sam adopted with service-users on the ward. Sam described using this relaxed, non-judgemental, and open approach with voice hearers to get to know them and build a therapeutic relationship. This was described as a process of moving from the superficial level i.e. informal conversations about a person's interests, to deeper conversations about important life experiences.

Through the interview it seemed that Sam had an expectation that the role of a MHN was difficult and may involve experiencing verbal and physical abuse. Sam spoke of managing this by '*splitting off*', putting it to the back of the mind, during the working day. At times during the interview, Sam could not remember some of the details of the experiences of working with voice hearers and it left me wondering whether this was due to the '*splitting off*'. There seemed to be a part of Sam that is kept detached, potentially as a way of coping and managing the difficult work context.

Robin

Robin has worked as a HSW for over two years on acute mental health wards. Robin has not received formal training on working with voice hearers but has accompanied service-users to inpatient hearing voices groups.

I warmed to Robin straight away. Robin's enthusiasm and passion to help others was apparent from the outset. Robin started talking to me about voice hearing work before I had chance to get through the participant information sheet and consent form.

I had positioned our seats in the interview room but Robin dragged another chair over and sat closer to me than where the chair was previously positioned. This seemed representative of Robin's general engagement and interactions with others, of wanting to connect and be with people.

I noticed through the interview that Robin required a lot of prompting to consider emotional reactions to the work being described. Robin spoke about sadness, finding the work rewarding but wanting greater support and further training on working with voice hearers. There was a strong sense of wanting to help people, not wanting to let people down and I wondered if Robin's enthusiasm for the research was also a way of helping others and not wanting to let me down.

During the interview, Robin often used 'we' and 'us' as if the ward staff held a shared identity. Robin spoke of how HSWs and MHNs protected service-users and each other, creating a picture of a safe and secure ward. I remember thinking that the context described by Robin sounded quite different to the experiences of the other participants.

Frankie

Frankie is a MHN who works in both acute inpatient and community mental health services. Though Frankie's main role is working as a community mental health nurse, Frankie has worked on acute mental health wards as a NHS bank worker for over two years. Frankie has attended training courses run by the Hearing Voices Network and attended talks and events about 'psychosis' and unusual beliefs.

Frankie presented as extremely passionate about working with voice hearers and spoke knowledgeably about psychological understandings of voice hearing, particularly links with past trauma.

The work context described by Frankie differed to the other seven participants as the work on the acute mental health wards involved covering shifts on an ad-hoc basis. Frankie described having different levels of conversation with voice hearers in an acute setting in comparison to the community. In the community context Frankie spoke of having more time to build up longer term therapeutic relationships with service-users.

In this context Frankie had been able to try out different initiatives with voice hearers, such as negotiating boundaries for the voices. However, in the acute ward context Frankie's role involved offering reassurance and comfort to voice hearers in extreme distress.

The work Frankie spoke about, particularly in the community context, resonated with me, as the work examples were more aligned to the work that I do with voice hearers. I needed to be aware of this and think carefully about how I gave equal voice and power to all of my participants and not allow my work experiences to cloud the analysis.

Drew

Drew is a HSW and has worked in this role for over four years, working with voice hearers at different points during this time. Drew has not received training in working with voice hearers but is interested in the area.

It seemed to take a lot of effort for Drew to think about examples and share work experiences with me. Interestingly, when we stopped the audio recording Drew was concerned about the struggle to express and communicate experiences. Drew commented that the process of engaging in the interview had facilitated thinking and reflection on the voice hearing work, which is not the norm for Drew. This matched what Drew described as hiding and 'pushing down' emotions, and not thinking about the impact of the work.

During the interview, Drew reflected on times working as a novice HSW and spoke about the anxiety around not really knowing what to say. There was also a strong sense of wanting to protect, help and make things feel better. Drew spoke of getting a good feeling inside when helping service-users overcome their distress. I wondered whether there was a similar good feeling when helping with this research.

All transcripts were analysed and a thematic map, representing my interpretation of each participants' experiences was created. As agreed at time of consent each participant was emailed a copy of his or her own thematic map.

Results of the Group Analysis

Overall, the group analysis yielded three levels of themes: master themes, super-ordinate themes, and subthemes. Three master themes were identified: *Struggling to exercise control*, *Emotional impact of the work* and *Ways of managing feeling overwhelmed*. The participants experienced these themes to different degrees along continua, with super-ordinate and subthemes representing the felt experience along each continuum. The master themes and super-ordinate themes are depicted in the thematic map below and Table 2 details the frequency of these themes and subthemes across the eight participants.

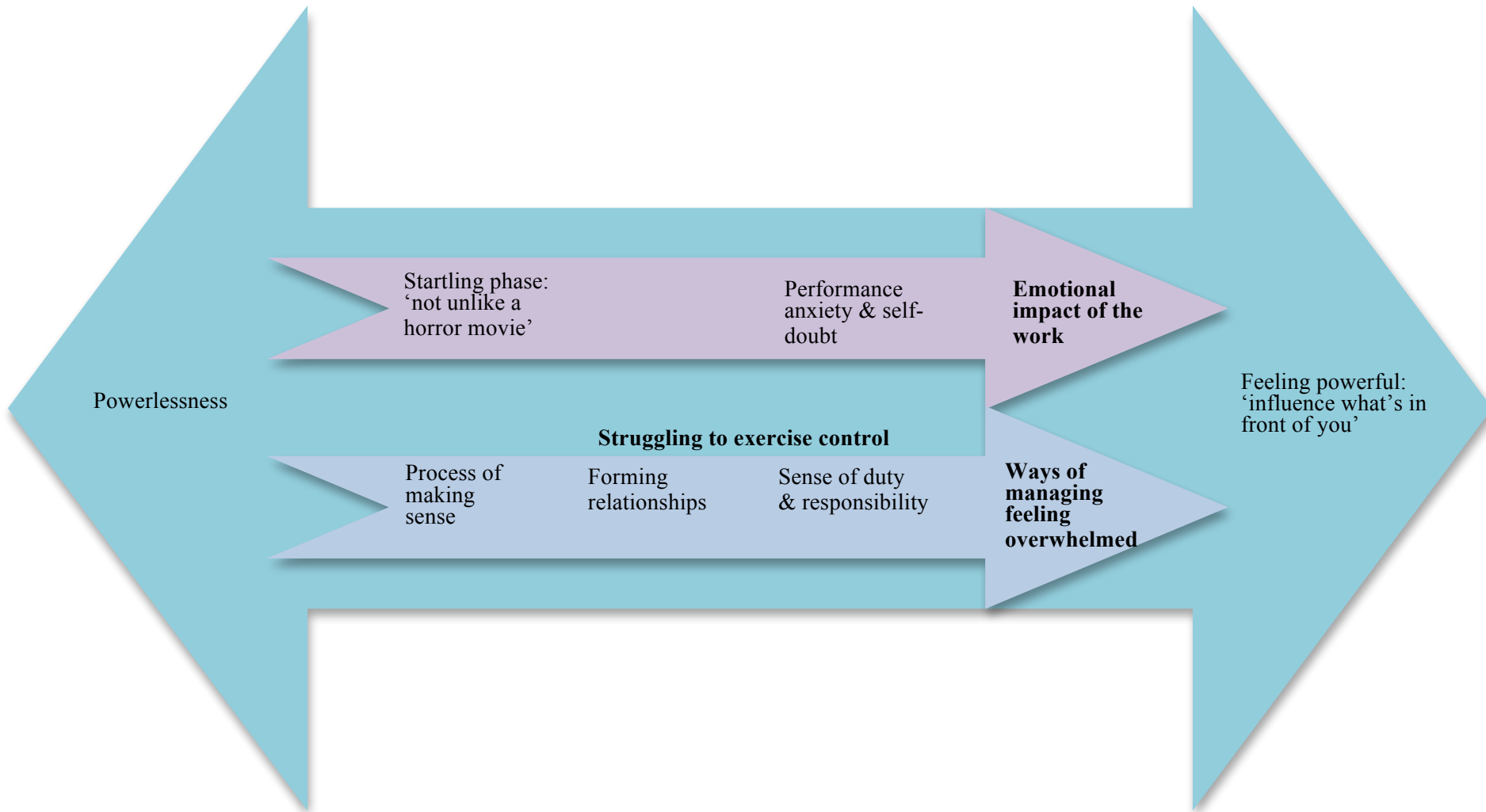


Figure 1. Thematic diagram representing themes from group analysis

Table 2. Frequency of themes across participants⁴

Themes			Participant							
Master Theme	Super-ordinate Theme	Subtheme	J	A	C	M	S	R	F	D
Struggling to exercise control	Powerlessness	Feeling trapped/ stuck				✓				✓
		Frustration	✓		✓	✓	✓		✓	
		Helplessness	✓	✓	✓	✓	✓	✓	✓	✓
	Feeling powerful: 'influence what's in front of you'	Good feeling inside	✓			✓	✓	✓	✓	✓
		Feeling confident and capable	✓	✓		✓	✓	✓	✓	✓
		Frustrated	✓			✓			✓	
Emotional impact of the work	Startling phase: 'not unlike a horror movie'	Shocked/ disturbed	✓		✓				✓	✓
		Fear	✓	✓	✓					✓
		Confusion/ uncertainty	✓	✓	✓	✓		✓	✓	✓
		Vicarious trauma			✓					
	Performance anxiety and self-doubt	What the hell is going on?	✓	✓	✓	✓	✓		✓	✓
		I don't know if I can do this		✓	✓		✓		✓	
		What do they think of me?	✓		✓	✓	✓	✓	✓	
		I might make things worse		✓	✓		✓	✓		✓
Ways of managing feeling overwhelmed	Process of making sense	Having something to hang it on to	✓	✓	✓	✓	✓	✓	✓	✓
		Independent discovery	✓		✓	✓	✓	✓	✓	
		Learning from others	✓	✓	✓	✓	✓	✓	✓	✓
	Forming relationships	Feeling close and connected	✓	✓	✓	✓	✓	✓	✓	✓
		Feeling disconnected and rejected	✓	✓	✓	✓	✓	✓	✓	✓
	Sense of duty and responsibility	Need to protect	✓	✓	✓	✓		✓		✓
		Feeling guilty when I've let them down			✓			✓		✓

⁴ ✓ = Subtheme present in participant account

Master Theme: Struggling to exercise control

The *Struggling to exercise control* master theme represented participants' sense of feeling controlled by an authoritative and powerful system. The master theme was split into two super-ordinate themes; *Powerlessness* and *Feeling powerful: 'influence what's in front of you'*. These themes related to the continuum of *control* within the system in which they worked.

Powerlessness

The super-ordinate theme of *Powerlessness* captured the participants' experiences of feeling that they lacked power and control in their roles. For HSWs, this was often experienced as an inability to question the practice of qualified members of staff. For example, Morgan described feeling powerless to question due to being an "inexperienced HSW":

And so he'd [a voice hearer] spend a lot of time just sleeping in his room, like for days and then just before his depot was due, so it would be wearing off, he'd come out and ... be really loud and ...stuff but not really a problem but...usually... but then and then he'd get medicated again so you wouldn't see him for a few ... a week or so ... So... which didn't feel appropriate but when you're an inexperienced health support worker, you don't feel like you can question that kind of thing! (p. 10).

Powerlessness was also experienced by the MHNs. This was often described within the broader systemic context of working within a government organisation, for example, Jamie commented:

You can only work with what's in front of you, you've got that circle of control and I can influence what's in front of me, that's it, you know the rest of it is up to the government, people with money and it's way out of my league so (p. 37).

Two participants described *Feeling trapped/ stuck* by a dominant medical model system. This seemed to be compounded by the hierarchy of the professional groups with HSWs feeling unable to influence decision-making. For example, Drew commented:

Yes, yes ... everybody ... he [a voice hearer] was quite ... he was quite vocal about not wanting to go [to rehab services] and we were sort of like ... sort of stuck really ... no choice, this is what the doctors have decided (p.8).

All eight participants described a feeling of *Helplessness*. For some this was due to feeling unable to support voice-hearers, for example, Robin stated:

It's difficult really because... you want to try and support him but at the same time you can't really intervene (p.20).

For others *Helplessness* was felt because they could suggest interventions and support systems but did not know whether the voice hearer would follow this through:

So now we're getting her in touch with social groups and that kind of thing but whether she will do it or not is another thing. So yes, it does leave you feeling quite ... yeah, a bit unable to help (Alex, p.14).

As well as the feeling of *Helplessness*, there was a strong sense of *Frustration* shared by five of the participants. For some this included feeling frustrated at the stagnation and seeming lack of progress of voice hearers on the ward for example, Sam commented:

Um, I suppose it can get a bit frustrating really. I think, well we've been through this... like sometimes you can go through it 5, 6, 7 times with somebody ... "so we've been through this 5, 6, 7 times ... I'm here to help you but you've got to help yourself as well" so ... however much I... I'm just repeating the same stuff over and over to people (p.14).

For others there was *Frustration* that the mental health system let people down due to the lack of additional support services. For example, Jamie described the '*revolving door*':

Erm, but unfortunately again there's not enough sort of additional services for people to be referred on to. I guess that's why we get the revolving door, we sort of just sticky tape and off they go, then they stop taking their meds [medication] and come back [laughter] (p. 34).

Three participants also felt frustrated by others' attitudes and views on voice hearing experiences. This was particularly around the understanding of hearing voices as part of an 'illness', for example, Frankie stated:

It's more relating to other people's attitudes towards it [voice hearing] and thinking that is seen as an illness erm and I really really don't see it that way and it really frustrates me that that is kind of how it is erm that that's the status quo and people need medication to keep them well (p.28).

Feeling powerful: 'influence what's in front of you'

This super-ordinate theme described the ways that some participants had taken control and found ways to *influence*. For example, Jamie described influencing the practice of student nurses on the ward:

We have a lot of students and it's a good way to influence how they view things and obviously we provide them with the information and ...get them to work alongside you while you're doing one [completing a hearing voices interview tool] or get them to try one themselves. At the end of the day it's not rocket science, it is just asking people questions, building the relationship, where they feel comfortable to discuss that... erm so it may only be a little indent but hopefully wherever all these students go, or what have you, maybe they'll take that with them and it can then impact on other areas (p.53-54).

Participants also described influencing the voice hearers that they worked with, for example, Morgan commented:

It just felt like the contribution that you could make, you know, just make the difference that you can make to the people... that are there. You know what little difference you can make and try and counteract all the sort of negative stuff that the ...medical model and stuff (p.11).

When participants were *Feeling powerful* and able to influence, they described having a *Good feeling inside*, for example, Drew stated:

It's a good feeling if you can resolve ... like resolve that moment of distress, you can sort of resolve that or calm them down and do something to help

them, even if it's just playing a game of dominoes or a bad game of scrabble!
(p. 22).

Participants also described *Feeling confident and competent* when they were able to take control and influence the work of voice hearers. For example, Alex explained:

I just feel a bit more able in myself to maybe just suggest certain things (p.12).

Furthermore, Sam commented how seeing positive results increased a sense of confidence and competency:

And it helps boost your confidence as well, obviously as a newly qualified nurse, you go in ...well a bit like ... do I really know what I'm doing and then you see the results and you think, yes, actually I do know what I'm doing ... It just raises your confidence a bit (p. 9).

Despite moments of *Feeling powerful*, the participants also reported feeling *Frustrated*, particularly when colleagues or the wider service did not support voice hearing work. For example, Morgan stated:

I'd have times when I'd get really enthusiastic about something, try and implement something and then ... other people would ... but then sometimes it's too busy or ... for whatever reason, it just ... mainly it didn't have enough support from everyone else so then it doesn't happen and [I] get a bit sort of ...what's the word? Sort of jaded with everything and then ... then maybe go on some other course and feel ... try again and ... just keep happening like that really (p. 13).

Master Theme: Emotional impact of the work

The master theme *Emotional impact of the work* described the different feelings experienced by the participants when working with voice hearers in the context of an acute mental health ward. The master theme was divided into two super-ordinate themes; the *Startling phase: 'not unlike a horror movie'*, which relates to the participants' first experiences of working with voice hearers in acute distress, exposed to a part of human experience that was previously unknown to them, and *Performance*

anxiety and self-doubt, which relates to the prevailing sense of worry about working in an unpredictable, unsafe environment, which is confusing and leads them to question their own capabilities.

Startling phase: 'not unlike a horror movie'

Participants described feeling *Shocked/ disturbed* when entering this unknown world, observing such high levels of distress. For example, Frankie commented:

It was actually really disturbing [laughter] ... Erm...and she was really distressed with her voices, sort of like grabbing hold of her head, screaming ...erm, really distressed (p.6).

As well as the initial shock of seeing voice hearers in such turmoil, participants experienced *Fear* i.e. “*the blind panic fear of being caught in the headlights [laughter]*” (Jamie, p.47). One participant likened this to a “*horror movie*”:

Yes, just getting an awareness of what can go on ... it's quite scary really. But it's not unlike anything you could see in a horror movie, I guess it's just ... that it's real (Chris, p.14).

These initial experiences of feeling shocked, disturbed and fearful, when entering this unknown and ‘*horror*’ situation, seemed to lead to *confusion* and *uncertainty* about what was happening and how to communicate with voice hearers:

I didn't necessarily talk to her about them [the voices] because I didn't sort of know what to say, you know, say I'd just seen her really really distressed then the next day I see her sitting with a cup of tea and it almost feels like, what do you talk to somebody about? (Frankie, p.25).

Participants also described the *confusion* and *uncertainty* they felt due to the internal experience of hearing a voice, an unknown entity unless the voice hearer shares what they are hearing. For example, Alex commented:

Yeah not knowing what was going on really. Because you know, you can't ... you don't know what the voices are [saying], if they're not telling you what they're saying (p.5).

The participants experienced this *Startling phase* to different intensities, with one participant experiencing high levels of distress and experiences that seemed to suggest *vicarious trauma*:

[It] unnerved me, it stayed with me, like maybe was in the back of my [mind] ... like in my subconscious for a while, you know, a couple of weeks ... just ... where it might have maybe come up in [my] dreams ... I don't think it did. But that sort of thing where it can maybe come up in your dreams a bit because it's got down a bit deeper (Chris, p.12).

Once the initial shock and disturbance had subsided, the participants described further anxiety as they started to doubt their capabilities.

Performance anxiety and self-doubt

The second super-ordinate theme related to the feelings of *Performance anxiety and self-doubt* when working with voice hearers in this context, which was present in all eight accounts. Participants talked about their experiences of working directly with voice hearers, often in one to one situations either on the ward or on escorted leave. There was often anxiety about not knowing; *what the hell is going on?* For example, Jamie described feeling anxious whilst escorting a voice hearer on town leave:

Anyway I think it was when we landed in HMV and Michael Jackson started talking to him [the voice hearer] from the record shelf and he was talking back, bearing in mind that was my third month as a student and I had no healthcare experience prior so we sort of managed it by sort of shuffling him out and I was thinking, 'what the hell is going on?' (p.14).

The feeling of anxiety from working with such levels of distress and uncertainty led some participants to question whether they were able to do this type of job; *I don't know if I can do this*. For example, Chris stated:

I came into this job and I didn't realise, like I said, the first few weeks it was like, 'Jesus I don't know if I can do this'. I didn't know what I was getting into almost ... But like ... I remember being asked in the interview, 'do you know what an acute ward is?' And I did look it up for the interview but I couldn't remember what it was at the nurse and stuff and I don't think I really had an

idea ... you know ... the extremities, the different extremes of living and life experiences (p.15).

Furthermore, participants described feeling anxious about how they were perceived by colleagues; *what do they think of me?* For example, Sam described a concern about appearing as if “*you’re passing the buck*”:

What am I doing? What am I achieving here?” Don’t [know] what you’d call that. Well you think, “Is it helping you [a voice hearer] coming up to me and talking to me all the time, is it worth having a chat to somebody else, getting a different view point?” But then, I suppose it can look as if you’re passing the buck when ... you’re not, you’re just offering a different viewpoint but it depends on how it comes across to people (p. 14).

Participants also described feeling anxious that they *might make things worse*. For example, Alex commented:

You don’t want to do something wrong, you want to do the best for the patient, you don’t want to say the wrong thing because you don’t want to escalate something (p.11).

When participants were concerned about causing harm or making things worse, they described seeking reassurance from senior colleagues:

I think it was ... to do with ethics as well with the job really ... you didn’t want to do anything that wasn’t therapeutic ... and I said the rationale behind it is ... it’s a distraction technique, I didn’t read it anywhere I just thought of it, [and asked] ‘oh can I try this?’ (Robin, p.22).

The feelings of *Performance anxiety and self-doubt* seemed to link back to the feeling of *Helplessness*, and lack of control experienced by participants’ as they did not know what to do or say to lessen voice hearers’ distress:

How do you possibly reduce their distress or you know reduce their sort of intensity of their experience? (Frankie, p. 13).

Master Theme: Ways of managing feeling overwhelmed

The third master theme is *Ways of managing feeling overwhelmed*. This theme related to the ways in which the participants managed their emotional distress by re-focusing, shifting from the threat of emotional overwhelm to a more practical and rational problem addressing approach. The master theme is split into three super-ordinate themes that represent the main ways that participants described managing feeling overwhelmed; *Process of making sense*, *Forming relationships* and having a *Sense of duty and responsibility*.

Process of making sense

All eight participants described a *Process of making sense* of their experiences. They all sought a framework or model; *having something to hang it on*. This helped them make sense of voice hearing experiences and the distress that they were observing on the ward. Frameworks included a biological model, for example, Alex talked about stages and levels of illness:

I suppose you just realise everyone's ... everyone is in hospital so, everyone is at some stage of being unwell and to have someone react to something ... I don't know I suppose I just ... understand or accept that, yeah it's just like ... it could be at some level of their illness (p.10).

Sam explained that the biological and social understandings of voices were taught as part of nursing training:

At University we did ... training on ... obviously biological reasons maybe as to why people hear voices ... the ... social circumstances it can lead to people possibly hearing voices ... And just a bit about the conditions really (p. 2).

Three participants explicitly talked about a trauma model and Jamie referred to the importance of getting to the “*root cause*”:

... If you take your anti-psychotics, you'll be fine because that's not necessarily the case and that's certainly not looking at the root cause. We might manage the initial crisis but you know is it going to be whatever happened 10 or 15 years ago for that person, you know, whatever element of trauma they have experienced (p. 34-35).

Participants also described a *Process of making sense* through their past experiences, such as, observations in films and television, for example Chris commented:

I think I'd vaguely heard of people hearing voices, maybe in the movies or something before... (p. 3).

Further examples included previous care roles, such as caring for someone with dementia.

As well as finding a framework or model to *hang it on*, participants also described different processes of sense making, including a process of *Independent discovery*, for example, Frankie stated:

I don't like this idea that that's somebody's lot, you know, that's not to say that it's not that way erm but I kind of thought that if it isn't then I should be finding out about that. You know, to just to confirm for myself, if this is what it is for somebody who hears voices and that's going to be the way it is for them forever, okay, but at least let me find that out for myself, you know... (p.8).

All eight participants described some process of *learning from others*, often from senior colleagues, supervisors or trainers. For example, Jamie commented:

I guess it's trying to manage your time, picking out what really is important, which I guess you learn from your senior colleagues (p. 12).

Participants also described observing how other staff members interacted with voice hearers on the ward to learn ways of engagement. For example, Alex described:

... Watching other staff as well, how they kind of like worked with them [voice hearers]. Because I remember this one lady, I remember someone that I worked with, you know, she [member of staff] just... she just had a laugh with her [a voice hearer], even though she was still responding she was still like erm...[I] can't remember ... she obviously she had a name, but she didn't like being called that, she didn't think that that was her name. She thought her name was this random word! And I remember this member of staff, [name], she just like had a laugh with her about it almost. And ...yeah she'd just sit in the lounge and like, she'd still engage with her and then I just realised, 'oh yes... so there is other ways to do it (p.7).

Forming relationships

This super-ordinate theme related to the relationships the participants had with voice hearers on the ward. The relationships fell along an attachment continuum with all participants reporting times of *Feeling close and connected*, providing the conditions necessary to make it possible for service-users to develop attachments with them. Trust was highlighted as important in the development of these relationships, for example, Morgan commented:

If you build... someone's got to trust you to start talking about those kind of things [voice hearing experiences] so then you build up this rapport with someone. And they remember that, if they come back in again, they'll ... they remember you as that person and ... instantly feel more ... safe around you and not as anxious (p.22).

Participants also described having a connection with voice hearers when they identified more with their experiences, indicating a humanising and de-alienating process that comes with being able to access empathy. For example, Chris commented:

I guess if they seem vulnerable, if they seem ... I don't know, unloved or ... unappreciated ... then yes ... I am like ... I identify with their feelings more I guess (long pause) (p. 16).

The participants described a process of building up a relationship with voice hearers; a process of getting to know each other, which ultimately led to *Feeling close and connected*. For example, Sam described moving from a superficial level to the “nitty-gritty”:

When I first start to form a relationship with any patient, I always try to keep it light hearted, I don't delve straight in with the 'nitty gritty', [asking voice hearers] “what's going on, what are you hearing?” [I] Let them get to know me a little bit, get to know them a little bit, personal, sort of enjoyment stuff and what they're like as people ... then that builds up to the 'nitty gritty' (p.17).

As well as developing *close and connected* relationships, five of the participants described times when they were *Feeling disconnected and rejected* in their relationships with voice hearers. For example, Frankie described being kept at “arm's length”:

I think it might take quite some time to build up that relationship as a health professional because, you know, he's [a voice hearer] had so many people involved in his care and ...the relationships might not have all been the same as they were on that unit but you know quite sort of arm's length, you give me my medication and I see the doctor once a week and that's it (p.26).

Voices were often described as a barrier to connection, for example, Alex commented:

She was quite, quite unwell actually in that if you did speak to her, she found... she was quite difficult to engage in conversation because I suppose her psychosis was quite ... what's the word? Quite strong, I suppose, at that moment (p.5).

Participants described *Feeling disconnected and rejected* when trying to open up conversations about the content of someone's voices. For example, Frankie reported:

I'm not sure if that was because they were again in an acute setting and quite a few of the people who would say, 'Oh, I hear voices because I have schizophrenia or because I'm bipolar' or something like that erm so they didn't necessarily seem like they wanted to discuss it in detail or people might just say, 'Oh yeah, they're awful, they say this and that'. Erm, but again, I suppose for them it's like, 'Why do you want to ask me about that? You know, it's horrible, it's there and that's it', and kind of shut you down almost (p.11-12).

Both Morgan and Chris described feeling disconnected in their relationships with voice hearers because they could not “reach them” or “get to them” while in acute distress.

For example, Chris stated:

I guess when you ... it's ... people that hear voices and they might be experiencing them really badly and.... they're just really ... loud, they experience them as loud and you notice that when you're trying to talk to them ... 'oh you're hearing voices?' and you try and engage them in some sort of distraction and ... coping strategies or something. And you can't quite get ... you can't quite get to them because they're in that stage where they can't ... I guess they need medication and it's difficult to help them then (p.21).

When participants felt *disconnected* from voice hearers, this seemed to increase the level of anxiety, confusion and uncertainty, which was described in the *Emotional impact of the work*. For example, Morgan commented:

It's just ... you feel much better knowing that someone will come to you if they're in distress. You don't have to kind of worry as much about them if they're ... you'll know ... if you know they're going to come to you if they're distressed then you kind of ... are less concerned about them than someone who you're not sure ... who you don't know and you don't know what's going on for them and they're ... no one has reached them yet, if you know what I mean? (p. 23).

Sense of duty and responsibility

This super-ordinate theme linked to the emotional experiences of the participants, such as fear, anxiety and confusion resulting from working in an unpredictable, potentially unsafe work context. There was a strong sense of *Needing to protect* the voice hearers, other service-users, colleagues and themselves. For example, Drew described being present on the ward to support colleagues “*just in case*”:

Yes you have to be on your guard and make sure that you can ... read the body language so ... and make sure that you don't ... that ... you're there to support your fellow workers. Even if it's just hovering in the background ... just by a doorway, a corridor, but just to be there, just in case. So that they know that they're ... supported as well (p.12).

Robin's account also highlighted the *Sense of duty and responsibility* to protect service-users and staff:

You know the staff in that area need somebody to come and assist them whether it's somebody that needs restraining, if they've got an issue so you're thinking of protecting other patients, protecting your staff ... your other members of staff, if they've been attacked ... so it's quite a big thing really (p.16).

Needing to protect was described by some participants as having a parental role, for example, Chris commented:

I just felt incredibly protective and mothering ... yes and I just didn't really want to leave her because she was constantly ... believing that people hated her (p. 22).

Participants spoke of *Feeling guilty* when they thought that they had *let them down* or thought that they had not been there enough, which was the impact of holding such responsibility for the protection and safety of others. For example, Robin stated:

It's difficult because when it's really busy, the ward, and you might not be able to give them all that time, you just keep an eye on them and it's like a case of well ... you do feel a bit guilty that you've let them down (p.26).

This participant also spoke of 'shoulds' and 'musts', absolute values that needed to be followed to fulfil this duty and responsibility, as it was "*more than a job*" (Robin, p. 13).

Summary of Results

Participants' experiences of working with voice hearers in acute mental health involved *struggling to exercise control*: a power continuum with participants feeling *powerless*; a sense of being controlled by an authoritative and powerful system; and *feeling powerful*; learning to negotiate power, finding ways to take control and '*influence what's in front of them*'. When powerless, participants described feeling trapped and helpless. When powerful, participants reported experiencing a *good feeling inside* and a sense of confidence and competency. In both positions the participants felt *frustrated*, either frustrated at the stagnation/ revolving door, or frustrated that the work they can do with voice hearers is not recognised or valued by others.

Participants described their first experiences of working with voice hearers in an acute ward environment; seeing people in extreme distress and exposed to a part of human experience that was previously unknown to them. When entering this unknown world the participants described feeling shocked and afraid, confused and anxious. The participants seemed to experience this *startling phase* to different intensities, with one participant experiencing high levels of distress and experiences that potentially indicated *vicarious trauma*.

Participants spoke about their experiences of working directly with voice hearers, often in one to one situations and *performance anxiety and self-doubt* seemed to

prevail across the accounts. There was an initial anxiety about entering this unknown and alien world, with participants feeling confused and questioning, '*what the hell is going on?*' This seemed to lead to further anxiety about whether they were able to do the job. There was also anxiety about how they might be perceived by others, fearing that they might be exposed as incompetent workers. Some participants felt anxious about opening up discussions about voices, as they feared that they '*might make things worse*'. This *performance anxiety and self-doubt* seemed to lead to a feeling of helplessness, as they did not know what to do or say to lessen the voice hearers' distress.

The participants used many strategies to manage feeling overwhelmed. They all sought a framework/ model to help them make sense of voice hearing experiences, which included a medical/biological model, trauma model and understanding through personal experiences. This process of making sense seemed to reduce participants' levels of anxiety and confusion triggered in the startling phase, but the reality of the distress and the unpredictable nature of the work meant that they remained '*on tenterhooks*'. Participants managed this through a *sense of duty and responsibility* to protect the voice hearer, other service-users, colleagues and themselves. However, participants spoke of *feeling guilty* when they thought that they had '*let them down*' or '*not been there enough*'.

Finally, the participants described their relationships with voice hearers, which fell along an attachment continuum. All participants experienced times of *feeling close and connected* in their relationships with voice hearers, however some participants experienced *feeling disconnected and rejected*; '*at arm's length*' with voices often seen as a barrier to connection.

Reflections on analysis

Through the analysis, I became more aware of my beliefs and assumptions about working with voice hearers. I came to realise that I had assumed that talking with voice hearers about the content of their voices and facilitating personal meaning making was good and positive and I had neglected to consider why people would want to hear such distressing stories. I reflected upon this in research supervision and considered the different motivations for people working in the helping profession, particularly supporting people who have often experienced trauma/ abuse. It helped me consider myself as a caring, helpful and compassionate worker but also someone who needs to offer help and support to others to feel like I have helped and made a difference, to get a sense of reward and pride in what I do.

It was also important to acknowledge that I found myself naturally warming to participants who spoke more psychologically about voice hearing experiences and participants whose work experience was similar to my own i.e. the HSWs. During analysis, I used mindfulness skills to keep me in the present moment, attending to the interview transcript and viewing the account in an open, compassionate and non-judgmental way. This helped me to give equal voice to each participant, ensuring that I interpreted each account fully and thoughtfully.

DISCUSSION

The aim of the present study was to explore staff experiences of working with voice hearers in an acute mental health setting. Data was collected through semi-structured interviews and analysed using IPA in order to answer the following research questions:

- What are staff experiences of working with voice hearers?
 - How have staff members made meaning of these experiences?
 - How do staff members feel when service-users talk to them about the content of their voice/s?
 - What are staff members' relationships with voice hearers like?

Three master themes and seven super-ordinate themes were elicited from the data. These findings will be examined in relation to the wider literature and linked back to the above research questions. The strengths and limitations of this study will be considered and suggestions will be made for future research. Clinical implications of the findings will be considered alongside recommendations for practice.

Main Research Findings

Struggling to exercise control

In the present study, the master theme of *Struggling to exercise control* offers insight into the main research question, 'what are staff experiences of working with voice hearers?' This master theme suggested that the experiences of acute mental health staff working with voice hearers fall along a power continuum. The participants experienced moments of feeling powerless, such as when they felt controlled by the wider mental health system, and moments of feeling powerful when they influenced the lives of voice hearers. This is consistent with power literature, for example, David Smail states:

Power, in fact, is the medium of our social existence, the dynamic which moves the apparatus of our relations with each other. We have to deal with aspects of power - the power others wield over us, the power we need to influence them...It is the power of others which either hurts or supports us, our own power which

enables us to establish an at least precarious perch from which to survey and deal with the world (Smail, 1995, p. 348).

The participants experienced both aspects of power described by Smail (1995); power wielded over them and finding their own power to influence others. This finding relates to previous research into the lived experiences of psychiatric nurses, which identified a main theme of “*The power of knowing*” (Pieranunzi, 1997, p.158). This power relates to an intuitive knowing established through the nurse-service-user therapeutic relationship. Power was described as shared within this relationship, rather than staff having “*power over*” service-users or “*controlling*” them in anyway (Pieranunzi, 1997, p. 159). Similarly, participants in the present study experienced power in a number of ways. They experienced the power of the dominant medical model mental health system in which they worked and its impact on the understanding and work practices with voice hearers. However, some participants also experienced power through influencing the lives of service users, for example, counteracting the medical model by facilitating personal meaning making of voices. This was done through a trusting therapeutic relationship like that in the previous study (Pieranunzi, 1997).

The present findings relate to broader literature on social power and social constructionism. Social constructionism asserts that there are no *absolute truths*; our knowledge is constructed through our interactions with the social world (Burr, 1995). Our understanding of the world is therefore created through the dominant discourses in our social context (Carr, 2000). One such dominant discourse highlighted by participants was the understanding of voice hearing experiences as a ‘mental disorder’. Literature suggests that dominant discourses maintain power by excluding competing discourses of those marginalised in society (Dallos & Draper, 2010). Throughout history, people with mental health difficulties have been marginalised and placed in positions of powerlessness (Fagin, 2007). Participants in the present study experienced moments of feeling powerful when they influenced the lives of service users, providing alternative narratives to the dominant medical narrative around voice hearing experiences. Part of their role was supporting voice hearers to talk about the meaning of their voices, including links to traumatic life experiences. This suggests that an important role for staff working within such a powerful, authoritative system, is to try and resist enacting the dominant medical model and allow less dominant narratives about hearing voices to be heard, valued and respected.

In the present study, frustration permeated both power positions, as participants experienced frustration when power was wielded over them, such as when the limited time they had to work with service users often resulted in the ‘revolving door’. This has been found in previous mental health literature, highlighting the continued pressures on

frontline staff to manage acute crises with a focus on short-term admissions, rather than time to attend to the therapeutic relationship and getting to the ‘root cause’ of psychological distress (e.g. Bowers et al., 2005; Currid, 2009; Scally, 2007). The participants also experienced frustration when they were able to influence others, for example, helping voice hearers understand their experiences, but it was not recognised or valued by colleagues. This supports previous research into the implementation of PSI across acute mental health wards, which identified lack of time to implement the strategies and lack of support from other members of staff, with PSI seen as having “*time off*” from usual ward responsibilities (Mathers, 2012, p.51). Participants in the Pieranunzi (1997) study also reported feelings of frustration when they felt powerless.

Previous literature on power and control in the context of acute mental health has often focused on staff control methods, such as the use of ‘control and restraint’ procedures (e.g. Duxbury, 2002; Southcott et al., 2002), rather than exploring the broader systemic power issues experienced by staff working in this environment. Historically, literature has focused on the inhumane control methods used, such as the use of leg-locks or straitjackets (Fagin, 2007). Research has also explored the use of the nurses’ holding power, section 5(4) of the Mental Health Act, (e.g. Ashmore, 1998).

Service-user literature often uses the term *empowerment* (e.g. staff enabling service users to be involved in all aspects of care planning; Lloyd, 2007). This has been a particular focus for the Tidal Model in acute mental health services, which is a model of person-centred care that aims to empower people with mental health problems (Barker, 2000). Research has shown positive results for service-users receiving Tidal Model care, with fewer formal admissions, violent incidents and less use of restraint (Fletcher & Stevenson, 2001). However, there is limited previous research into the *experience of control* from a staff perspective.

Recent research using a Grounded Theory approach to explore the experiences of young people with mental health difficulties produced a similar core category to the current research, “*I am Powerless*” (Marcus et al., 2012). The young people described feeling *overpowered* by their mental health difficulties, which was similar to the experiences of staff in the present study (Marcus et al., 2012). Participants felt overpowered by the mental health system in which they worked and also felt powerless at times to help voice hearers when experiencing acute distress. Previous research has suggested parallels between service users’ and MHNs’ experiences of “*powerlessness and their sense of being undervalued*” (Shanley, 2001, p.249). Such research has advocated for greater collaboration between MHNs and service users in order to have greater “*influence*” in the services in which they are based (Shanley, 2001, p. 249).

The current findings also indicate a parallel process between people experiencing psychosis who struggle to feel in control of their own awareness

(Davidson, 2003) and mental health staff who often feel out of control and helpless in their work with voice hearers. Psychological research into control has shown that people want to have a sense of control of their lives, and this leads to greater psychological wellbeing. This was demonstrated in the 1970s with control studies, for example, examining the experiences of people residing in nursing homes (Langer & Rodin, 1976). Residents on one floor of a nursing home were given houseplants to tend to and allowed to choose the time they participated in activities. Residents on another floor were also given houseplants but were told they would be looked after by staff. These residents were offered the same activities as the first group but at times stipulated by staff. The researchers found that the residents who had more control were more active and felt better than those who did not (Langer & Rodin, 1976). Similarly, in the present study when participants experienced greater control and power, influencing the lives of voice hearers, they described having a *good feeling inside* and feeling more *confident* in their work. In contrast, when they felt powerless and out of control they felt helpless and frustrated. As in the classic control studies, the present research findings demonstrate the risk of psychological distress when people do not feel in control of their experiences.

Finally, within the master theme of *Struggling to exercise control*, helplessness was identified. This offers insight into the research sub-question, ‘How do staff members feel when service-users talk to them about the content of their voice/s?’ When in the position of powerlessness, some participants experienced feeling helpless when hearing the distressing voice content, commenting that they “*could not intervene*” or “*lessen*” voice hearer distress.

If working in this environment continued to elicit feelings of helplessness, this could develop into a sense of ‘learned helplessness’ (i.e. if staff believe that they can no longer control their environment they may give up trying; Seligman, 1975). It seemed in the current research that participants were still motivated to try to help and influence service-user care, however the emotional impact of the work within such a powerful system was apparent.

Emotional impact of the work

The master theme of *Emotional impact of the work* offers insight into the main research question about staff experiences of working with voice hearers but also offers an indication of how staff feel when service-users talk to them about the content of their voices and how they have made meaning of these experiences.

Participants experienced their initial work with voice hearers in an acute mental health environment as shocking and disturbing, describing feelings of fear and

confusion. This experience parallels the initial ‘Startling phase’ reported by people hearing a voice for the first time (Romme & Esher, 1993). In voice hearing literature, many people describe the onset of their voices as sudden, eliciting feelings of anxiety and confusion (Intervoice, 2014). A similar emotional response has been found for carers/ family of young people with first episode psychosis (Burland, 1990; Horner, 2007). In a similar way to both voice hearers and carers, staff reported experiencing this ‘Startling phase’ to different degrees. Previous studies have suggested a difference between the emotional impact of work for MHNs and HSWs, with greater “*emotional exhaustion*” and “*workload stress*” for MHNs (Jenkins & Elliot, 2004, p. 622). Research suggests that this is due to MHNs having less service-user contact than HSWs, in turn linked with low job satisfaction (e.g. Sorgaard et al., 2010). In contrast, the present study identified intense emotional impacts for both MHNs and HSWs, and indeed the most intense emotional impact was experienced by a HSW.

For most participants they experienced intense emotions including anxiety. As highlighted in previous literature, the anxiety felt by participants when working with voice hearers could be understood as a “*negative experience that is associated with threat, harm, or demand*” (Baum, 1990, p. 660). Anxiety is often linked to a sense of uncontrollability and the fight/flight response to threat or danger (Zinbarg & Barlow, 1996). When the participants experienced working with voice hearers for the first time they were exposed to extreme levels of human experience previously unknown to them. The findings suggest that participants experienced this as a potential threat, as they described feeling fearful and anxious, often on “*tenterhooks*”. Uncontrollability is associated with anxiety, which is consistent with how participants experienced their work.

Within the master theme of *Emotional impact of the work*, participants experienced confusion, which likely compounded the feelings of anxiety and fear. Service-user qualitative research has elicited similar subthemes from experiences of mental health difficulties, for example, “*It’s confusing/ I don’t know what to do*” and “*It makes me afraid*” (Marcus et al., 2012). This suggests the parallel process between service-users and staff, both feeling frightened and confused about their experiences and feeling helpless, not knowing what they should do.

The present study identified a super-ordinate theme of *Performance anxiety and self-doubt*, which relates to previous research of stress among MHNs, for example, Edwards and Burnard’s (2003) systematic review highlighted “*professional-self-doubt*” as one of the main sources of stress in nursing practice (p. 195). Furthermore, a previous IPA study exploring stress among MHNs revealed a broad theme of “*staff anxiety*”, encapsulating “*fear of self-blame*” and “*blame from others*” (Currid, 2009, p.44), which

is consistent with the present study findings, most notably the subtheme of ‘What do they think of me?’

This finding also relates to recent literature on the use of a compassion focused therapy (CFT) formulation model (Gilbert, 2000) to understand “*task drift*” in mental health staff, which has shown staff fears of “*frustration, horror, sadness or helplessness*” (Kennedy, 2013, p.76). The CFT model separated *internal fears* of “*what staff think about themselves*” and *external fears* of “*what staff are concerned others will think of them*”, which they linked to “*professional competency and helpfulness*” (Kennedy, 2013, p.76). Interestingly, feelings of frustration often led to criticism of others’ practice, which was also found in the present study.

For staff particularly working with people with ‘psychosis’, Meaden and Hacker (2011) have developed a Shared Assessment, Formulation and Education (SAFE) approach to help staff and service users understand risk issues and behaviours that may be considered problematic. This approach uses a CBT formulation framework to help understand staff experiences of their work with the aim to “*ensure staff can engage in a more therapeutic way with their clients*” (Meaden & Hacker, 2011, p. 248). For this aim to be achieved the authors advocate continued professional development, staff training, clinical supervision and reflective practice. Reflective practice forums aim to provide an opportunity for staff to reflect on their views, values, and how they impact upon their work with an emphasis on *sharing* and *learning from others* (Meaden & Hacker, 2011). The findings of the present study suggests that it may be beneficial for staff working in acute mental health to engage in a team formulation approach to help them understand the emotional impact of their work, and reflective practice forums may allow them to reflect on their emotions and gain support from each other.

Performance anxiety and self-doubt also linked with previous studies highlighting MHNs concerns about opening up discussions about voices as “*it might make them worse*” and their “*lack of confidence*” in talking with service-users about the “*meaning of their voices*” (Coffey & Hewitt, 2008, p. 1598). Indeed, one of the subthemes for the current study was ‘*I might make things worse*’. This finding suggests that for some participants talking with voice hearers about the content of their voices was experienced as a stressful event and considered beyond their level of capability (Lazarus & Launier, 1978). This links with previous research, which highlighted psychiatrists’ reluctance to open up discussions about the content of voices with service users, due to potential feelings of anxiety and incapability (McCabe et al., 2002). In the present study however, for some participants, when they were in a powerful position and able to work successfully with voice hearers, they experienced a *good feeling inside* and felt *capable* and *confident*. This is consistent with literature on “*mastery*”, as the participants felt more in control and were able to complete the task, which has been

shown to reduce the impact of stressful events (Taylor & Stanton, 2007, p. 378). It is notable that the participant, who experienced the most intense emotional impact, did not experience a sense of mastery or confidence in their work.

Finally, a summary of Menzies Lyth (1960) study was presented in the Introduction chapter, which illustrated a social defence system, that helped staff to “*avoid conscious experience of anxiety, guilt, doubt and uncertainty*” by “*eliminating situations, events, tasks, activities and relationships that caused anxiety*” (p.452). In contrast to Menzies Lyth’s findings, staff in the present study consciously experienced feelings of anxiety, guilt, doubt and uncertainty and many approached these feelings with curiosity, going through a process of making sense, forming attachment relationships and having a sense of duty and responsibility to the people in their care and colleagues they worked alongside. However, within these ways of managing the emotional impact of their work, participants described using coping strategies that are aligned to the “*detachment and denial of feelings*” described by Menzies-Lyth (1960, p.445), as participants described pushing emotions down, splitting-off and following ritual tasks.

Ways of managing feeling overwhelmed

In the present study, the master theme of *Ways of managing feeling overwhelmed* offers further insight into the main research question and sub-questions. Firstly, participants experienced a *process of making sense*, which offers insight into the research sub-question, ‘How have staff members made meaning of these experiences?’

Finding meaning in our experiences is an important process for us all, which has been well documented within cognitive psychology (e.g. Bruner, 1990). It is often referred to in child development literature but it is a process that we continually employ throughout our lives to make sense of our experiences:

We try to make sense of them by treating them to memory, knowledge and association. We make them ‘mean’ by locating them in our own world (Bruner & Haste, 1987, p.10).

Sense making involves cognitive and social processes as we try to associate new information and novel experiences to our previously held beliefs and assumptions about ourselves, others and the world around us (Bruner, 1990). As highlighted in cognitive psychology literature we go through a process of organising our experiences, often through creating narratives e.g. “*stories, excuses, myths, reasons for doing and not doing, and so on*” (Bruner, 1991, p.4). We often search for explanations and meanings

of experiences that we find distressing and confusing (Thompson et al., 2001) therefore it was likely that the participants in the present study would experience a process of sense making due to the emotional impact of the work.

Interestingly, literature has highlighted the alignment of IPA with its primary focus on people's subjective experiences and sense making, accessed through narrative accounts, with Jerome Bruner's original concept of cognitive psychology "*as the science of meaning and meaning making*" (Smith, 2004, p.41).

In the present study, participants experienced the *process of making sense*, firstly, through finding a framework/ model to '*hang it on*'. One such framework was the medical model understanding of voice hearing experiences. This is consistent with the dominant view in Western cultures that voice hearing is part of a 'mental disorder' (Leudar & Thomas, 2000). Indeed, one MHN highlighted that within mental health nursing training, the biological understanding of voices as 'hallucinations' is presented, mirroring nursing training literature (e.g. Gagg, 2002; O'Carroll & Park, 2007). This was further demonstrated in Coffey and Hewitt's (2008) study, 'You don't talk about the voices', which referred to nursing training not advocating talking about the content of voices since they are understood as a symptom of a biological/ medical 'illness'.

Participants also drew on a trauma model to make sense of the voice hearing experiences of their service-users. This relates to current psychological understandings of voice hearing as corresponding to traumatic experience (Read et al., 2005). Some participants described using narrative interview tools to help facilitate personal meaning making of voice hearers' experiences, as they understood the link between early trauma and hearing voices. This was aligned to previous literature in acute mental health, which described the use of narrative tools by mental health workers to help service-users make sense of their voice hearing experiences (e.g. Place et al., 2011).

The findings also highlighted how participants made meaning of the phenomenon of hearing voices through previous experiences, such as watching films/ television programmes and caring for someone with dementia. This is consistent with previous voice hearing research that has shown that people experiencing voices and carers use both internal frames of reference and external models to help understand their experiences (Horner, 2007). Knudson and Coyle (2002) suggested that people make sense of voice hearing in multiple ways because of the level of uncertainty and different perspectives on the origins of voices. The present study's finding of the *process of making sense* also parallels the 'Organisational phase' that voice hearers go through to make sense of their experiences and learn ways of managing and integrating them into their lives (Romme & Escher, 1993).

Following the *process of making sense*, participants in the present study described *forming relationships* as a way of managing feeling overwhelmed. This super-

ordinate theme offers interesting insights into the third research sub-question, ‘What are staff members’ relationships with voice hearers like?’ and also offers some insight into how staff members have made meaning of these relationships.

Participants experienced *feeling close and connected* in their relationships with voice hearers, providing the necessary conditions to develop secure attachments and build a therapeutic alliance, including trust, empathy and congruence (Assay & Lambert, 1999). People may have secure or insecure attachment patterns, which can impact upon therapeutic relationships and building of a good working alliance (Bordin, 1979). As discussed in the Introduction, attachment may be understood as the bond between two people whereby one person experiences safety and security from the other at times of threat (Bowlby, 1982). Therefore, the findings of the present study suggest that participants formed secure attachment relationships with some voice hearers, which led to them approaching the participants when they were in crisis and in need of a secure base.

The participants experienced this feeling of closeness and connection through a mutual process of “*getting to know*” each other. This is aligned with previous IPA nursing literature that identified a theme of “*the personal versus the professional*”, highlighting that the therapeutic relationship “*involves the whole nurse and the whole patient*” in order to open up and share the “*meaningfulness of lived experience*” (Pieranunzi, 1997, p. 160). Furthermore, results were consistent with findings from a previous study of HSWs’ experiences of relationship formation in medium secure services (Evans et al., 2012). This research identified a theme of “*building bridges*” and a process of getting to know service users with reference to developing a “*bond*” or “*chemistry*” (Evans et al., 2012, pp. 107-108). Interestingly, previous research exploring the experiences of MHNs, HSWs and ward managers revealed a theme of “*making connections*”, which was considered to be a large part of the participants’ role, and seemed to be a way of “*shifting the balance of power*” (Lloyd, 2007, p. 489).

The finding of *forming relationships* links with previous literature highlighting the importance of building therapeutic relationships with people with ‘psychosis’ (Rogers et al., 1976). This literature also suggested the importance of using a structured approach with service users, for example, use of PSI techniques and CBT (e.g. Goering & Stylianos, 1988). Similarly, participants in the present study described using such strategies in their work with voice hearers.

A recent study looking at the role of the therapeutic relationship in the regulation of emotion in ‘psychosis’ has shown that a strong therapeutic alliance between staff and service user is associated with fewer difficulties in regulating emotions (Owens et al., 2013). This suggests that the building of a secure attachment

relationship and corresponding therapeutic alliance is beneficial for voice hearers in regulating emotions when experiencing distress from their voices.

Despite the formation of secure attachment relationships, participants also experienced times of *feeling disconnected and rejected* in their relationships with some voice hearers. Social rank theory suggests that the relationship between the voice hearer and their voice/s mirrors their social relationships (Byrne et al., 2006). Therefore when voice hearers try to distant themselves from their voice/s, avoiding communication with them and treating them with suspicion, this is likely to be reflected in their interpersonal style with others (Birchwood & Chadwick, 1997; Vaughan & Fowler, 2004). Indeed, participants in the present study experienced feelings of disconnection and rejection when voice hearers treated them with suspicion, questioning why they would want to talk to them about their voices and experienced this as being kept *'at arm's length'*.

Some participants experienced voices as a barrier to connection and this was often understood as voice hearers being *"too unwell"* to *"reach them"* and help them, often deferring to medical treatments at this time. This may represent staff anxiety around voice hearing experiences and the fear and confusion felt in those moments. This may lead to projection i.e. viewing the difficulty of forming a relationship as arising from the voices and voice hearer rather than considering the role of the staff member. Previous literature has warned that this may lead to avoidant or anxious attachment styles resulting in staff not understanding and failing to respond to service users' *"interpersonal needs"* (Berry et al., 2008, p. 356). Therefore, the finding of *feeling disconnected and rejected* might be representative of staff anxiety leading to avoidance of voice hearers when in acute distress, rather than voices necessarily being a barrier to connection.

A further way that participants managed feeling overwhelmed was developing a *sense of duty and responsibility*. This offers insight into the research sub-question, 'How have staff members made meaning of these experiences?' and provides further understanding of the emotional impact of their work and the types of relationships that they have with voice hearers, other service users and colleagues.

The *sense of duty and responsibility* relates to literature on altruism. Most 'helpers' report that they engage in altruistic acts because of a 'humanitarian duty' that makes them better people (e.g. giving blood, Piliavin & Callero, 1991). Altruism seems to go beyond social exchange and reciprocity, contributing to some kind of greater good, either at a wider societal or individual level (e.g. Byrne, 2008). The findings of the present study are consistent with recent research examining staff happiness and work satisfaction among mental health professionals (Baruch et al., 2013). The researchers asked participants to complete the Work-Life Satisfaction Questionnaire (WLSQ), which describes three different orientations; *"job"*, *"career"* or *"calling"*, the latter

refers to work as an “*end in itself with a belief that it contributes to the greater good*” (Baruch et al., 2013, p.443). The study found that that the mental health professions as a collective scored highest for calling followed by career then a job.

The *need to protect* relates to previous research on mental health workers’ experiences of working in secure services, with themes of maintaining boundaries and managing risk, encompassing the need to protect self and others (Evans et al., 2010). Interestingly, previous research has shown that staff members often respond “*pragmatically*” in order to manage feelings of distress (Bengtsson-Tops et al., 2009, p. 459). This is consistent with the present research, as participants would often follow risk protocols and management plans and carry out observations in order to protect others, serving to reduce their feelings of anxiety and self-doubt.

The feeling of guilt experienced by participants when they felt unable to protect or fulfil their sense of duty and responsibility is consistent with acute mental health literature, which highlighted that staff often feel that they are offering a disservice to their service users due to the increased workload, resulting in less one to one therapeutic time (Hummelvoll & Severinsson, 2001). The present study showed that often participants felt guilty that they were letting people down, as they were not able to give the time they wanted to each allocated service user, which is aligned with previous literature (e.g. Robinson, 1996b; Sullivan, 1998). Services have tried to offer solutions to this by assigning dedicated ‘therapeutic time’, which is when staff have time booked out of usual work tasks to complete ward based interventions with their allocated service users, but studies have shown that this cannot always be facilitated due to staffing levels (Thomson & Hamilton, 2012).

Summary of findings

The findings of the present study offer insight into the main research question addressing staff experiences of working with voice hearers in acute mental health and provide further insight into the three sub-questions. First, participants experienced their work with voice hearers along a power continuum, experiencing different levels of *control* in their work. This relates to power literature, particularly considering power as either being wielded over them or ways in which they could feel powerful by influencing others. Power and control issues have been highlighted in previous research and parallels were made between service user experiences of feeling overpowered by their mental health difficulties, and staff feeling overpowered and helpless in their role with voice hearers. Second, the participants provided insight into the *emotional impact of their work* and how they felt when service users talked about the content of their voices. This included the initial shock and disturbance of hearing such distressing voice

content, mirroring the ‘startling phase’, reported by voice hearers when hearing a voice for the first time. All participants experienced a level of *performance anxiety and self-doubt*, questioning their own capabilities of working with voice hearers at times of acute distress. This was consistent with previous studies, which have raised staff concerns regarding the potential of making things worse, and not feeling confident to open up conversations about the content of voices. In contrast to previous research, similar levels of emotional impacts were found for both MHNs and HSWs interviewed. Also, in comparison to Menzies Lyth’s (1960) findings of social defence systems in psychiatric services, the participants in the present study described consciously attending to difficult feelings such as anxiety, doubt and guilt. Finally, the participants experienced *ways of managing feeling overwhelmed*, providing insight into their meaning making processes and relationships with voice hearers.

Strengths and Limitations

The present study contributes to the emerging literature into the lived experiences of mental health workers, providing novel insights into what it is like for frontline staff (MHNs and HSWs) working with voice hearers in extreme distress and in need of inpatient care to support them through acute crises.

The main research findings were consistent with previous research in the area of mental health and work specifically with voice hearers. The research however offered further insights into the experiences of control and power for staff, moving beyond physical control methods and service user empowerment. Results were consistent with literature relating to staff anxieties and self-doubt, however the participants in the current study did not seem to employ the level of social defence mechanisms highlighted in previous studies and were consciously attending to the feelings of emotional overwhelm. The findings also drew on psychological theory/ models, including attachment.

A number of steps were taken throughout the research process to ensure the credibility of the research findings. These included ongoing reflexivity, engaging in credibility checks throughout the data analysis phase involving both research supervisors and members of the QRPSG. I also used data extracts to illustrate the findings and provided examples of my coding. I used mindfulness skills to keep me grounded in the data, adopting an open and non-judgemental approach and noticing when my beliefs and assumptions may have impacted upon my interpretation of participants’ accounts.

Though there are a number of strengths to the present research, there are some limitations, which need to be considered. First, participants volunteered to participate in the study, which potentially may have biased the results, representing staff perspectives of individuals who are interested in working with voice hearers, rather than those who are not. Indeed, the majority of the participants had taken part in training in working with service users who hear voices and/or had knowledge of psychological approaches to working with voice hearers. Nonetheless, participants all described experiencing distressing feelings as a result of their work, rather than reporting positive impacts. This may indicate that participants wanted help and support with this part of their work, which they often found challenging, though rewarding at times. Also, the advertising material for the study was circulated by CTMs, which may have impacted upon motivation to volunteer. They may have felt obliged as their manager recommended the study, or it may have been perceived as evaluative through the potential association with management making some people reluctant to participate.

A further limitation may be due to the homogeneity of the sample. I consulted with acute service managers and mental health staff, including HSWs, MHNs, and OTs. From this consultation it was advised that I include both HSWs and MHNs in my research, excluding all other professional groups, as the former make up the frontline ward staff who engage more frequently in one to one conversations with voice hearers. Previous research, however had often considered MHNs and HSWs separately, with only a few studies combining both workers. I believe that my final sample, with five HSWs and three MHNs was representative of the ratio of workers on the ward. The greater number of HSWs was expected, in light of literature highlighting the increased pressures on nurses. Indeed two of the three nurses were late arriving for their interviews due to difficulties leaving the ward as the only qualified staff. When looking for themes across the participants for the group analysis there was no more difference in themes between MHNs and HSWs than there was between individual participants. There was enough similarity across participants to draw out the three master themes and not to split the findings into HSWs and MHNs. I believe that including both staff groups was beneficial, especially as contrasts with previous research emerged regarding the emotional impact of work on MHNs and HSWs.

Clinical Implications and Future Research

The main research findings suggest a number of clinical implications and potential areas of further research. First, the participants in the study all worked therapeutically with voice hearers using narrative interview tools, CBT, PSI or person centred approaches. This demonstrates that voice hearing interventions can be successfully delivered in an acute inpatient setting, despite the chaotic environment and increasing research stating that one-to-one time on acute wards is reducing (e.g. Csipke et al., 2014). The current findings are encouraging for other acute inpatient services that might look to develop such interventions on their wards, as with investment and support this work can be done.

Second, the theme of *Struggling to exercise control*, moving between positions of powerlessness and feeling able to influence, demonstrated the broader systemic power issues in acute mental health services, which seems to be an area neglected in previous research. Service-user literature has often focused on the concept of empowerment, usually limited to practical strategies, such as involvement in care planning and staff research has focused on physical control methods. There has been some power research into the lived experience of psychiatric nurses but the current research suggests that this could be explored further, including HSWs who have often been excluded from previous studies.

Previous literature highlights the fact that healthcare services are relying more on the 'unqualified' workforce to meet the increasing demands for nursing care (Dingwall et al., 1988). As such, authors have advised that more consideration is needed to the work and training of HSWs (McKenna et al., 2004). The present research findings suggest that HSWs not only feel the impact of power issues from working in a mental health system, but also feel the authoritative power of professionals further up the hierarchy, with reports of feeling powerless to question the practice of others that may be detrimental to service-user care. This is of particular interest in light of the Francis Report (2013) and recommendations on whistle blowing and competencies of health care professionals. Furthermore, the theme of *Struggling to exercise control* found in the present study suggests that there is potential for the development of learned helplessness should staff continue to feel out of control and unable to influence the people and system in which they work. This could lead to despondency and passive acceptance, which could negatively affect service user care and increase the likelihood of staff retention issues in acute mental health.

In addition to recognising the role of the HSW and risk of learned helplessness, one of the main implications from this research is the need for training in working with voice hearers in order for staff to feel more confident and competent in their work. Research suggests that staff members who are not trained, or following training do not

feel capable of opening up conversations about voice hearing, should not take part in this type of intervention and should work to their competency level (as recommended by Francis, 2013).

However, as the results of the present study have shown, the emotional impact of working with voice hearers in the context of acute mental health can be intense and overwhelming even when staff have received training in the area. Previous research has shown that frontline healthcare workers can experience vicarious trauma, leading to nightmares, avoidant behaviour and hyper-vigilance (Mitchell, 1985). Staff can take in the images and intense feelings of trauma victims that they are working with, which is sometimes referred to as ‘compassion fatigue’ (e.g. Courtois, 1993; Figley, 1995). The risk of vicarious trauma seems likely for staff working with voice hearers due to the links between hearing voices and past traumatic experiences (Read et al., 2005). It is therefore important to consider the potential risk of vicarious trauma for staff working in acute inpatient settings, ensuring that they have adequate supports and supervision in place.

Case consultation, supervision and reflective practice are essential in creating the safety for staff to reflect on their work, offering the containment needed to attend to their emotional distress (e.g. Meaden & Hacker, 2011). Recent literature has drawn on a CFT approach to help staff teams reflect on their own clinical practice. This work highlights that staff predominantly operate within a threat system, preparing for danger, and therefore have limited resources in the self-soothing system in order to manage their distress (Kennedy, 2013). There may be a role for psychological practitioners working in acute services to provide a framework such as CFT to help frontline staff consider these areas and nurture the self-compassion, self-soothing response, which could involve emotional regulation skills and mindfulness skills.

With any implementation of staff consultation, supervision or reflective practice groups, consideration needs to be made to engagement of staff. Recent research by Long et al. (2014) into MHN and HSW experience of supervision in medium secure services showed that uptake was by 50% of the staff, and HSWs were less likely to engage and less likely to perceive benefits. This is associated with previous literature that has often identified lack of time and lack of support from colleagues to attend these supportive forums (e.g. Mathers, 2012). However, with services starting to dedicate ‘therapeutic time’ on the wards for one to one work with service users (e.g. Thomson & Hamilton, 2012) it would be advised for further protected time to be assigned for staff to attend reflective practice groups or other supervision forums to support their clinical work. This may require change to existing infrastructure, therefore would need service level management support.

Conclusion

The study explored the experiences of staff working with voice hearers in acute mental health. The research specifically explored the lived experiences of MHNs and HSWs working in one acute mental health hospital. The research findings were consistent with previous literature in the area of acute mental health and voice hearing however it provided new insights into the experience of control in this context from a staff perspective. Participants' experiences fell along continua, with different power positions, emotional distress and ways of managing feeling overwhelmed. Working with voice hearers was described as initially startling, encompassing feelings of shock, fear and confusion, though this subsided and participants were able to engage in conversations with voice hearers. However, this often left them feeling anxious and doubting of their own abilities. Previous research has provided disparity of opinions regarding talking about the content of voices. The present research suggests that this is a complex picture and depends on the level of training, competency and ability to contain the emotional impact of this type of work. When participants feel in a position to influence, feel confident and capable in their work with voice hearers this leads to positive feelings, however this often led to feelings of frustration when this work was not valued and supported by others. Therefore it seems that for both positive outcomes for voice hearers and staff wellbeing, there should be greater training, supervision and reflective practice opportunities for frontline staff who are left working with voice hearers at times of acute distress. I think that clinical psychologists have a place within acute services in order to help provide the necessary conditions for this work, providing the supervision, consultation and training for this level of voice hearing intervention.

Final Reflective Comments

When I embarked on this research, I assumed that talking to voice hearers about the content of their voices was the *right* thing to do and should be facilitated when voice hearers come into contact with acute mental health services. Through doing this research, I have come to realise that it is a much more delicate and complex picture than this, which needs careful consideration for both the voice hearer and the staff member so that trauma backgrounds are not unraveled without adequate safety and containment for both voice hearer and staff member.

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APPENDIX

Appendix I Literature Search

The process of literature searching involved the following steps:

1. The electronic database 'Ovid Medline' was initially searched for articles relating to voice hearing, acute mental health, and staff experiences. The database was searched for articles published between '1946 and Nov 2012'. This search yielded 114 articles. The titles and abstracts were read to assess their relevance to the present study. Of the 114 articles, 17 were considered relevant.
2. Following data collection, the electronic database 'Ovid Medline' was searched to identify any further articles relating to the present study. The database was searched for articles between '1946 and Nov 2013'. This search yielded an additional 31 articles. The titles and abstracts were read to assess whether they related to the present study. Of the 31 articles, 5 were relevant and included in the literature review.
3. Prior to submission, the electronic database 'Ovid Medline' was searched again to assess whether any recent articles had been published on the subject matter, including articles pertaining to the findings of the research. This search yielded 74 articles, of which 11 were relevant to the present study.
4. During the three literature searches outlined above, the reference sections of the relevant articles were reviewed. This elicited further articles of interest, which were included in the final Introduction and Discussion chapters.

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Department of Clinical Psychology, School of Medicine, Faculty of Medicine and Health

Research Project:**Staff experiences of working with voice hearers in acute mental health.****Are you a mental health nurse or health care support worker?****Do you currently work on an acute mental health ward?****Have you got experience of working with people who hear voices?**

If you answered yes to all of the above questions and would be interested in taking part in a research interview exploring your experience of this work please contact:

Elaine McMullan

Psychologist in Clinical Training

Email: jhs3ecm@leeds.ac.uk**Tel: 0113 343 2732**

Trust-wide Email:**Title:**

Research project - Staff experiences of working with voice hearers in acute mental health

Body of email:

- Are you a mental health nurse or health care support worker?
- Do you currently work on an acute ward at the _____?
- Have you got experience of working with people who hear voices?

If you answered yes to all of the above questions and would be interested in taking part in a research interview exploring your experience of this work please contact:

Elaine McMullan
Psychologist in Clinical Training
University of Leeds

Email: jhs3ecm@leeds.ac.uk, **Tel:** 0113 343 2732

Participant Information Sheet

Staff experiences of working with voice hearers in acute mental health

You are being invited to take part in a research project as part of my Doctorate of Clinical Psychology Training Course (D.Clin.Psychol) at the University of Leeds. Before you decide whether you would like to take part in the research it is important for you to understand why it is being done and what it will involve. Please take time to read the following information carefully and ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the research?

The purpose of the research is to explore staff experiences of working with people who are hearing voices whilst they are under the care of acute mental health services. The study particularly aims to explore the experiences of mental health nurses and health care support workers who are involved with day-to-day care of service-users on the wards. Research has demonstrated the importance of exploring the subjective experiences of voice hearing but there has been little focus on staff's experience of working with voice hearers. The aim of the study is to provide a psychological understanding of acute staffs' experiences of working with voice hearers.

Why have I been asked to take part?

I am asking all mental health nurses and health care support workers that are currently working on acute mental health wards if they would like to participate. I am hoping to recruit a minimum of 6 to 8 staff members in total.

Do I have to take part?

No, it is completely up to you whether you decide to take part in this research. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form.

What will the research involve?

If you consent to the study you will be invited to take part in one interview that should last between 45 to 60 minutes about your experience of working with voice hearers on the ward. The interview will be held off the ward, in a meeting room or outpatient clinic room within the Trust site where you work. Interviews can be facilitated prior to starting a shift, following the end of an early or day shift, or during your lunch break. At the start of the interview there will be an opportunity to ask any questions about the research. If questions are answered satisfactorily and you are still happy to participate, I will ask you to sign a consent form. The first 5-10 minutes of the interview will be dedicated to gaining brief demographic and work context information. I will then ask you some open questions about your experiences of working with voice hearers. Following data analysis, you will also be invited to comment on a summary of the emergent themes by email or telephone. This process would likely involve 15-20 minutes of your time.

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

All interviews will be audio recorded which will be used for transcription and analysis. The transcription made from the recording will be anonymised. No other use will be made of the recording without your written permission.

Can I withdraw from the research?

You can change your mind at any point during the interview and the responses you have already provided will not be used. You can further withdraw from the study up to 3 days following your interview. However, after this point it will not be possible to withdraw your information from the study, as the interview will have been transcribed and information anonymised.

What are the risks of taking part in this research study?

There is a potential risk that you may find some of the interview questions personal and/or distressing as they aim to explore your own personal experiences of working with voice hearers. Furthermore, previous research suggests that the topic area of voice hearing can cause some feelings of anxiety. I will verbally check your wellbeing at the end of the interview to ensure that you feel able to leave the research setting and return to work or home. I have also provided my contact details and details of staff support services in the Trust should you need further support following the interview. As I will be asking questions relating to your clinical work with voice hearers there is a potential for it to be viewed as an evaluation of your work. This is not the aim of the research and your participation and interview responses will remain anonymous.

What are the benefits of taking part in this research study?

It is hoped that the interview process itself may provide you with an opportunity to tell your story, empowering you to talk about your subjective experiences of your work with voice hearers. It is hoped that the findings from this research will contribute to the existing literature on voice hearing in acute settings. Findings will be disseminated to the appropriate services and may influence training and support of staff.

Will my taking part be kept confidential?

I will follow the Security Protocol for the collection, handling and storage of sensitive data obtained in relation to the D.Clin.Psychol at the University of Leeds. All information provided in the research interviews will be anonymised and non-identifiable. The caveat to this is if risk issues are raised during the course of the interview i.e. concern about risk to self or others, including concerns regarding professional misconduct. If this occurs I will be required to adhere to the following protocol:

At the end of the interview I will advise the participant to discuss the risk issue with their line manager. Following the interview, I will telephone my academic or field supervisor to discuss the issue and assess the need for further action. This may result in information being shared with the participant's line manager. In the absence of the participant's line manager, information will be handed over to another clinical team manager on site.

What will happen to the results of the research project?

The results will be used in the write up of my thesis as part of the D.Clin.Psychol at the University of Leeds. The findings will also be used in articles for publication and conference presentations. In all reports, only anonymised interview extracts will be included.

Who is funding the research?

The National Health Service (NHS) is funding the research as part of the D.Clin.Psychol at the University of Leeds.

How will I find out what happens with this research?

A summary of the findings will be presented to the acute mental health service that the interviews were conducted in, with a view to taking the findings to the Trust Clinical Governance meeting, if deemed appropriate by the Clinical Service Manager.

How do I take part?

Should you wish to participate in the research, please contact me (Elaine McMullan, Research Lead) by email or telephone using the contact details below. Alternatively please complete the opt-in slip at the end of this Participant Information Sheet and post it back to me using the FREEPOST envelope provided. I will then contact you by your preferred means of communication to arrange a convenient time to conduct the research interview.

Thank you for taking the time to read this information.

Staff Support Contact Details**Staff Support Counselling Services:****Paula Fawcett****Staff Support Service Co-ordinator**

Tel: 0113 3055299

Mobile: 07534 907451

Research Team Contact Details**Research Lead:****Elaine McMullan****Psychologist in Clinical Training**

Clinical Psychology Training Programme

Leeds Institute of Health Sciences

University of Leeds

Room G.04

Charles Thackrah Building

101 Clarendon Road

Leeds

LS2 9LJ

Tel: 0113 3432732

Email: jhs3ecm@leeds.ac.uk**Academic Supervisor:****Dr Sylvie Collins****Clinical Psychologist, Lecturer in Clinical Psychology**

Clinical Psychology Training Programme

Tel: 0113 3433407

Email: S.C.Collins@leeds.ac.uk**Field Supervisor/ Local Collaborator:****Dr Anjula Gupta****Consultant Clinical Psychologist**

Psychological Therapy Services

17 Blenheim Terrace

Leeds

LS2 9HN

Tel: 0113 3431962

Email: anjula.gupta@nhs.net

If you have a concern about any aspect of this study, please contact the Research Lead or Research Supervisors using the above contact details, who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting:

Clare Skinner**Faculty Head of Research Support**

Faculty of Medicine and Health Research Office

Room 10.110

Level 10

Worsley Building

University of Leeds

Clarendon Road

Leeds

LS2 9NL

Tel: 0113 3434897

Email: governance-ethics@leeds.ac.uk

Opt-in Slip

I have read the Participant Information Sheet and I am interested in taking part in the research project. I consent to being contacted by Elaine McMullan, Research Lead, to arrange a convenient time to conduct the research interview.

Name: _____

Preferred Contact Type (*please tick*):

Telephone (*please provide contact number*) _____

Email (*please provide email address*) _____

Please post this slip back to me using the FREEPOST envelope provided. If you have any questions at this point please contact me on 0113 3432732.

Appendix V Consent Form

**Consent Form for:
Staff experiences of working with voice hearers in
acute mental health**

	Add your initials next to the statements you agree with
I confirm that I have read and understand the information sheet dated 30/05/13 explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at anytime during the interview, and up to 3 days following the interview, without giving any reason and without there being any negative consequences. Please contact Elaine McMullan, Research Lead, by email jhs3ecm@leeds.ac.uk if you wish to withdraw from the study.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
I understand that my responses will be kept strictly confidential. However, information may be shared with my line manager should the researcher have concerns regarding my risk to self or others during the interview.	
I give permission for the interview to be audio recorded for subsequent transcription and data analysis. I understand that the audio file will be kept safe and secure in accordance with the University of Leeds Sensitive Data Protocol.	
I agree for the data collected from me to be used in relevant future research.	
I agree for the Research Lead to contact me by telephone (<i>please provide contact number</i> _____) or by email (<i>please provide email address</i> _____) to comment on the emergent themes from the analysis of my interview.	
I agree to take part in the above research project and will inform the Research Lead should my contact details change.	

Name of participant	
Participant's signature	
Date	
Name of project lead	
Signature	
Date*	

*To be signed and dated in the presence of the participant.

Appendix VI Ethical Approval Letter for Amendment

Faculty of Medicine and Health
Research Office

University of Leeds
Worsley Building
Clarendon Way
Leeds LS2 9NL
United Kingdom

☎ +44 (0) 113 343 4361



UNIVERSITY OF LEEDS

10 June 2013

Miss Elaine McMullan
Psychologist in Clinical Training
c/o Room G.04
Charles Thackrah Building
101 Clarendon Road
University of Leeds, LS2 9LJ

Dear Elaine

Re ref no: HSLTLM/12/060 – Amendment 1

Title: **Staff experiences of working with voice hearers in acute mental health: an Interpretative Phenomenological Approach**

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

Document	Version	Date
Participant Information Sheet. Version 3. 30.05.13	1	30.05.13

Please notify the committee if you intend to make any further amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@leeds.ac.uk)

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I wish you every success with the project.

Yours sincerely

Professor Darren Shickle
Acting Chair, LIHS/LIGHT/LIMM Joint REC, University of Leeds

Appendix VII NHS R&D Approval Letter

11 June 2013

Miss Elaine McMullan
 Psychologist in Clinical Training
 Leeds Institute of Health Sciences
 University of Leeds
 101 Clarendon Road
 Leeds
 LS2 9LJ

Dear Elaine

Project Title: Staff experiences of working with voice hearers in acute mental health

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within

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

Document	Version	Date
Thesis research proposal		
Participant Consent Form	2	10 June 2013
Participant Information sheet	3	30 May 2013
Poster advert	1	04 April 2013
University ethical approval letter		02 May 2013
University ethical approval letter for amendment		10 June 2013
Email text		
Interview schedule	1	04 April 2013

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval (where applicable) Failure to do this will lead to permission to carry out this project being withdrawn. If you make

any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.

- You must comply with the Trust's procedures on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care (RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator²**.

They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Trust are reminded of those organisations' obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

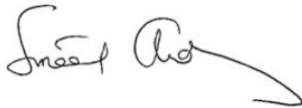
Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Sinead Audsley', with a long horizontal flourish extending to the right.

Sinead Audsley
Research Governance Manager

Cc. Sylvie Collins, University of Leeds
Anjula Gupta,

Appendix VIII Interview Schedule

Introductory Questions:

- How long have you worked in an acute mental health setting?
- How long have you worked with people with psychosis?
- Have you received any training on working with people who hear voices?
-If yes, what training was this?
- Can you tell me a bit about where you work currently?
 1. Ward size
 2. Male/female ward
 3. Staff mix
- Can you tell me a little about your current job role?

Interview Guide:

1. Can you tell me about your first, or an early experience of working with someone on the wards who heard voices as part of their experience of psychosis?
 1. What was your experience of this like?
 2. How did you work with them?
 3. Tell me more about that.
2. Can you tell me about a more recent time when you have worked with someone on the ward who hears voices?
 1. What was your experience of this like?
 2. How did you work with them?
 3. Tell me more about that.
3. Can you tell me about a time when a service-user has spoken to you about their voices?
 1. What was this like for you?
 2. Tell me a bit more about that.
4. How have you felt when service-users have talked to you about their voices?
 1. Can you tell me about any other feelings you may have noticed?
5. I am wondering whether you can tell me why you may have felt this way?
 1. How have you understood your feelings when service-users have talked about their voices?
 2. Can you talk to me a bit about that?
6. How would you describe your relationship with people who hear voices on the ward?
 1. Can you bring someone to mind and tell me a little about your relationship/ interactions on the ward?
 2. Tell me more about that.
7. Is there anything else you would like to tell me about your experience of working with people who hear voices that we haven't already covered?

Appendix IX Demographic Sheet

Brief Demographic Information

Participant ID:

Gender:

Age:

Job title:

Length of time qualified as mental health nurse/ in post as health care support worker:

Appendix X Confidentiality Statement for Transcribers

Confidentiality Statement for Transcribers**Ethics Committee, School of Psychology, Leeds University**

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

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

General

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

Transcription procedure

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

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

Print name.....

Researcher.....

Project title.....

Appendix XI Coded Interview Extract

Interview 2

	154		
	155	PARTICIPANT	
Anxiety/ uncertainty	156	Erm, I'm trying to think really... I suppose there's a few	
	157	when I first started on Ward (number), that were	Anxiety, uncertainty –
	158	quite... more predominantly psychotic than like I said,	how to work with
	159	than that previously worked with before. Erm, and I	psychosis – emotional
	160	suppose I was anxious really, I was unsure how to	side comes out straight
Medical understanding	161	kind of work with that. Erm, so for example, I	away
	162	remember one lady was in the lounge and she	'Responded',
	163	responded quite a lot, so she would just be sat... we'd	'hallucinations' –
	164	be watching TV and she wouldn't just be responding	medical language
Unpredictability	165	to a presume, you know, voices or ... hallucinations,	
	166	and ... yeah, I did find it I suppose a bit ... maybe a bit	Unpredictable, not
	167	unpredictable, kind of like not knowing erm... yeah not	knowing what was
'Uncertainty – don't know what's going on	168	knowing what was going on really. Because you know,	going on -
	169	you can't ... you don't know what the voices are, if	overwhelmed
	170	they're not telling you what they're saying. And she	
	171	was quite, quite unwell actually in that if you did speak	Didn't know what the
	172	to her, she found... she was quite difficult to engage in	voices were saying –
Illness framework	173	conversation because I suppose her psychosis was	understood as lady
	174	quite ... what's the word? Quite strong, I suppose, at	'quite unwell' –'strong
	175	that moment. But then... I think it was just gaining the	psychosis?'
	176	experience, just built the confidence up and then	
Fear reduces with experience/ confidence	177	made me realise that actually, it's not so ... scary I	With experience and
	178	suppose (laughter).	confidence, not so
	179		scary
	180	INTERVIEWER	
	181	So you said, with that lady, so you kind of created that	
	182	picture for us, as you said, kind of going in and seeing	
	183	her kind of responding to the voices and you said you	
	184	felt anxious. Did you notice anything else for you, in	
	185	kind of that moment when you were kind of in the	
	186	room with her?	
	187		
	188	PARTICIPANT	
Avoidance/ distancing to cope with anxiety	189	Um... I suppose, what sort of, how I was feeling? [I:	Anxiety and fear –
	190	Yeah]. Well, yes maybe it was a bit of anxiety and a bit	unsure - approach her
	191	of fear, I don't know. Erm, maybe it actually made me	less – <u>distancing/</u>
	192	want to approach her less, which obviously as a... just	<u>avoidance?</u>
	193	because I was a bit unsure, it wasn't that I didn't want	
	194	to obviously speak to her or kind of... you know get to	

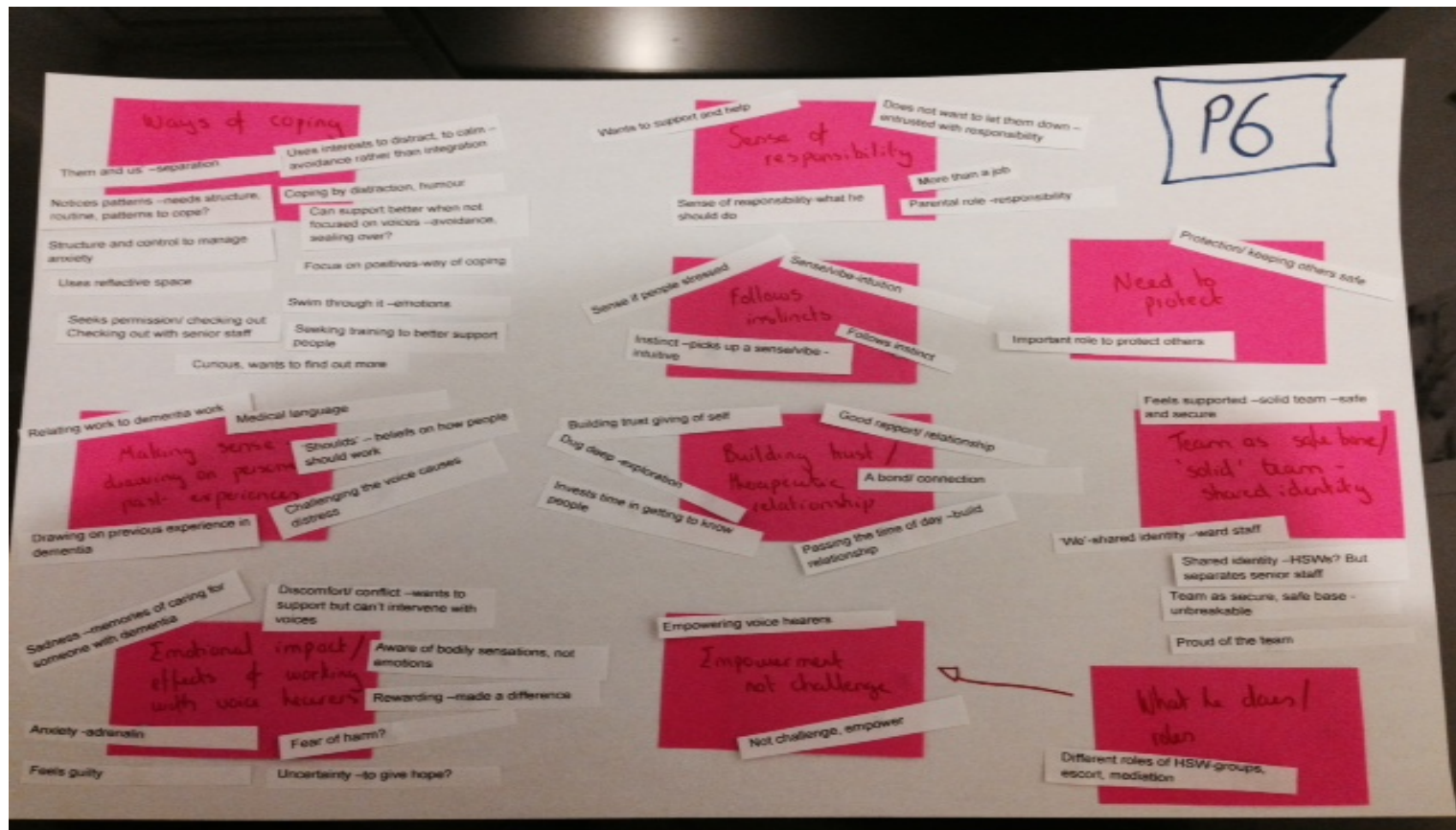
Interview 2

	195	know her. I thought it was just based on my like	
	196	understanding of it and erm maybe coming from quite	Formative influential
Threat/ risk	197	a secure forensic unit where risk was quite a ... key...	experience – forensic,
focus	198	like focus on how we worked with patients, to an acute	risk focus
	199	ward where it's still obviously important but ... it's an	
	200	open ward. Like most of the women, they can have	
	201	access to things that ... the women on the forensic	
	202	ward couldn't so... Like I said, I'd worked with women	
Hyper-vigilant/	203	where violence and aggression was quite high, so	On edge, not knowing –
on edge	204	maybe that influenced my approach as well. Like that,	hyper-vigilant for threat
	205	Oh, a bit on edge and not knowing really. Erm, but ...	and aggression?
	206	to be honest that soon went away, I think ... because	
	207	there were so many women at that time, I remember,	On edge feeling soon
Increased	208	let me think, when I first started... I'm thinking of that	went away with
exposure,	209	lady in particular because I know she's in the (name of	increased exposure
reduces anxiety/	210	unit) again now, but on the other ward. So I've seen	
fear	211	her around and she's still quite similar presentation but	
	212	... you know she's out in the smoking area and she	
	213	always seems, I suppose it's about her getting as well	Deterministic –always
	214	as she can be, like the voices are obviously going to	have that presentation-
Determinism/	215	be there for her. So she probably will always respond	well/ unwell distinction
fatalism	216	and she will... she might ... she will always have that ...	
	217	presentation. I'm just trying to think about ladies ...	Speech hard to follow,
	218		incomplete thoughts
	219	INTERVIEWER	
	220	So you said, you noticed anxiety [P: Yeah], you said	
	221	you felt scared [I: Yeah]. And you said that kind of	
	222	unknown was it, or uncertain? [P: Yeah, yeah] And did	
	223	you ... did you notice that with other people?	
	224		
	225	PARTICIPANT	
	226	Okay, erm...(long pause) probably at the time, I'm just	
	227	trying to think. Do you know, I think she probably	
	228	stands out in my mind because I think she might be	
	229	one of the ... first... my first day on the ward, I think	Importance of first
	230	when I was being shown around, she was one of the	person met on ward
	231	first patients that I met or like that I was introduced to.	
	232	So I do think that's probably why... I'm kind of focusing	
	233	on her. [I: Yeah]. Erm...yeah, as ... and I actually	
	234	remember like... in supervision, saying, oh actually like	
	235	you know I'm quite confident working with personality	

Interview 2

	236	disorder, even personality disorder is obviously ... a lot	
	237	of those women experience voice hearing. Although	
Voice hearing as part of personality disorder	238	it's probably slightly different to obviously psychotic	Voce hearing as part of personality disorder – use same narrative approach
	239	voice hearing but they still ... it's still to them voices.	
	240	And you know, we still have to work with it in that	
	241	same kind of way, well like ...in the sense that we'd do	
	242	narratives with them. Erm, and I remember saying to	
Uncertainty	243	my supervisor, I felt confident working, yes, with other	Unsure of how to work with psychosis
	244	areas and even, you know sort of like depression,	
	245	anxiety and stuff, but with psychosis, I was just quite	
Reassurance seeking	246	unsure, like the approach really. And I think my	Supervisor role to reassure and dispel fears
	247	supervisor just kind of reflected back to me that ... you	
	248	know, maybe to keep the same approach, you know to	
	249	still... approach them in the same kind way (laughter)	
More experience, lessened anxiety	250	you know, ask them how they are and don't have that	
	251	fear really or that kind of unknown because ... at the	
	252	end of the day they're still ... you know their all	Less anxiety as gained more experience
	253	patients on the ward. They all need that same support	
	254	from the team and the staff so ... So I think it just... like	
	255	the experience just made me less anxious, and I	Observing colleagues – modelling
Learning through modelling	256	suppose watching other staff as well, how they kind of	
	257	like worked with them. Because I remember this one	
	258	lady, I remember someone that I worked with, you	<u>Worked with 'them' – feel of 'them' and 'us'</u>
'Us and them'	259	know she just... she just had a laugh with her, even	
	260	though she was still responding she was still like	
	261	erm... cant' remember ... she obviously she had a	
	262	name, but she didn't like being called that, she didn't	
	263	think that that was her name. She thought her name	Realisation that can have usual conversations and interactions with voice hearers –process of gaining insight
	264	was this random word! And I remember this member	
	265	of staff, [name], she just like had a laugh with her	
Naive discovery	266	about it almost. And ...yeah she'd just sit in the lounge	
	267	and like, she'd still engage with her and then I just	
	268	realised, oh yes... so there is other ways to do it. And	
	269	yes, just kind of gained... yeah, like insight like that,	
'Us and them'	270	working with them.	<u>Repetition of 'working with them'</u>
	271		
	272	INTERVIEWER	
	273	So you described then seeing... somebody else kind	
	274	of working, as you said in that way. What was like for	
	275	you then, to see them, working with the client in that	
	276	way?	
	277		

Appendix XII Example of Participant Theme Map



Participant Theme map

A. Team as a secure base

- i. 'Solid' – safe and supportive
- ii. Shared identity - 'we'

B. Sense of moral duty/ responsibility

- i. More than a job
- ii. Parental role
- iii. Support and help others
- iv. Protection/ keeps safe
- iv. 'Shoulds'

C. Follows gut instinct/ intuition

- i. Picks up sense/ vibe

D. Doing/ role

- i. Group activities
- ii. Escort
- iii. Mediation
- iv. Empowers rather than challenges

E. Emotional impact/ Effects of working with voice hearers

Negative

- i. Anxiety
- ii. Guilt
- iii. Discomfort – wants to support but can't intervene with voices
- iv. Fear –causing harm
- v. Uncertainty – can I give hope?

Positive

- i. Pride
- ii. Rewarding

F. Making sense through past experiences

- i. Previous work experience
- ii. Medical framework

G. Ways of coping

a. Distancing

- i. Compartmentalisation

- ii. Intellectualization –facts of what happened
- iii. Following patterns/ routine
- iv. Distancing through distraction

b. Humour and positives

- i. Humour
- ii. Focus of positives

c. Reassurance and permission seeking

- i. Checking out with senior colleagues

d. Seeks understanding

- i. Training
- ii. Attends psychology group –reflective forum

Approach mechanisms

- i. 'Swim through it'

H. Entrusted relationships

- i. Giving of self
- ii. Good rapport
- iii. A bond/ connection
- iv. 'Passing the time of day'
- v. 'Dug deep' –can explore experiences

Appendix XIII Example of Clustering for Group Analysis

*Emotional impact - when talk about content of voices?
Negative effects/ impacts?*

a. Negative impacts/ effects P3

i. Anxiety/ wariness - don't want to upset - "You need to ... I suppose when I first started ... you'd be a bit sort of wary of not wanting to upset somebody by saying, "no actually it's not real what you're hearing" (p.9/316-319) P3

iv. Anxious/ worried - "I might seem as if I'm being the person that's not empathising, you know ... I'll worry that ... I just worry for them really more than anything. I just think ... they might not ... feel it's a personal thing ... but I just ... it's more worry I think" (p.9/344-348) P3

i. Anxiety/ Uncertainty - "I didn't necessarily talk to her about them because I didn't sort of know what to say, you know, say I'd just seen her really really distressed then the next day I see her sitting with a cup of tea and it almost feels like, what do you talk to somebody about?" (p.25/1000-1005) P7

ii. Anxiety/ Uncertainty - "What am I doing? What am I achieving here?" Don't what you'd call that. Well you think, "Is it helping you coming up to me and talking to me all the time, is it worth having a chat to somebody else, getting a different view point?" But then, I suppose it can look as if you're passing the buck when ... you're not, you're just offering a different view point but it depends on how it comes across to people" (p. 528-536)

iii. Uncertainty/ anxiety - "But yes, it was a bit like ... you don't really know what to do and you're just trying to manage a situation because obviously if he's chastising something really inappropriate, it was racially inappropriate, and there's lots ... other service users, well, staff and service users ... well anyone's going to find that offensive but you've got to think about other people as well" (p. 6/186-194) P4

v. Uncertainty - can I give hope? - "If you've come in sound about lunchtime, just 12 o'clock, start the shift at 12, on a late shift, you usually find he seems quite low in mood. And you think ... usually people say, "they've not turned up again" so ... I think some of the times you actually say, "maybe they'll turn up another time" but I don't know if that's a good or a bad thing really" (p.10/374-381) P6

vi. Out of control - "Anyway I think it was when we loaded in HMV and Michael Jackson started talking to him from the record shelf and he was talking back, bearing in mind that was my third month as a student and I had no healthcare experience prior so we sort of managed it by sort of shuffling him out and I was thinking, "what the hell is going on" (p. 14) P2

intense

perceptions external

internal + external

perceptions internal's sort of making things experience

a. Negative feelings/ distress P3

i. Scared - "yes just getting an awareness of what can go on ... it's quite scary really. But it's not unlike anything you could see in a horror movie. I guess it's just ... that it's real" (p.14/521-524) P3

ii. Fear/ scared - "Quite scary, yes! (Laughter). Yes we were just like, right ok, we just need to keep a little bit further away and you just think ... oh God is something going to kick off?" (p.14/417-419) P1

iii. Fear - "you don't want to do something wrong, you want to do the best for the patient, you don't want to say the wrong thing because you don't want to escalate something" (11/417-421) P2

ii. Shocking - "I suppose that's difficult to hear as god you know, "you hear that all the time, how shocking" (p.13/486-487) P7

iii. Disturbing - "It was actually really disturbing (laughter)" (p.6/213) P7

ii. Disturbed - "I guess, well, it's quite disturbed isn't it. I don't ... (long pause) yeah, it's not a very nice thought to hear, you know what I mean" (p.11/421-422) P3

vi. Stressful/ difficult to cope - "basically what she was hearing was the voices of her abusers saying things to her and I found that really difficult to cope with just because it was so graphic" (p.18/699-702) P7

iii. Helplessness - "Well it's difficult really because ... you want to try and support him but at the same time ... you can't really intervene" (p.20/741-743) P6

b. Vicarious trauma P3

i. Stayed with me/ got deep - "Unnerved me, it stayed with me like maybe was in the back of my ... like in my subconscious for a while, you know, a couple of weeks ... just ... where it might have maybe come up in dreams ... I don't think it did. But that sort of thing where it can maybe come up in your dreams a bit because it's got down in a bit deeper" (p.12/449-455) P3

ii. Shaken up - "she hears voices but she was talking about her childhood and just horrific abuse like ... sexual and physical and emotional and afterwards you know, I was just shaken up by it. I couldn't quite shake it off" (p. 11/427-431) P3

iii. Absorbed the distress - "Then later on, she'd go into more detail and ... like it was sort of unswallowing a little bit for her and ... letting it go a bit. You know, not just keeping it so much in ... it might have helped her. But again, I worried that I'm absorbing it too much" (p. 12/463-468) P3

Appendix XIV Reflexive Interview Excerpt

Interviewer: So through the process of spending time with them, you started to hear their stories naturally anyway and started to try and make sense, or started to try and connect, you were theorising naturally in a way weren't you?

Participant: *Yes and I think I was just naturally curious and interested and I would ask people about it and they would talk to me, which was good.*

Interviewer: It also sounds like your colleagues at this time were people who were very much influenced by a medial model?

Participant: *Yes, very much so.*

Interviewer: Were you aware of that at the time?

Participant: *I think, I suppose all I was aware of was that they had had different training to me and at that time I thought, 'oh, there's obviously a different realm within mental health and this is what they need to do for the medication side of things and they need that specific nursing intervention'. It all felt very fragmented...we did have a psychologist that came in, but I didn't find out too much of what they did and it felt like everyone was doing their own separate thing. So to me it just seemed like, 'oh that's another part of it', but I think it soon became apparent that that was the main approach that people were getting. It was a select few that were getting seen by a psychologist and actually the language that was being used to do with peoples continued detention under the mental health act and people being 'well' or 'unwell' was the main way of understanding things. A nurse was supervising me at that time as I was a health support worker and there wasn't much room to think beyond that a part from me being... just curious and asking questions and saying, 'oh I have noticed this'...*

Interviewer: Can you remember the first time when, did you have any experience of working with people with psychosis and were hearing voices, do you have any memories of that?

Participant: *I remember the first person that I ever met with a diagnosis of psychosis. I had started as a support worker at a rehab unit and I went in on my first day before any service users were there. We had time to get to know the team and things first. Obviously there was a lot of experienced practitioners ...there was a lot of introduction work about restraint procedures and breakaway techniques and things like that ...and leaving work after my first day I was left thinking, 'oh my god what are these service users going to be like when our whole prep has been about keeping ourselves safe?' So I went in the next day quite apprehensive about who was going to be there... and my task was to go with*

service users to their rooms to go through the inventory of their belongings. There was this young chap ...I had this thought, 'What on earth do I say, what do I talk to him about?' Are they going to be alright with me? We've just had all this security talk, is everything going to be OK?' I think it was awkward for the first few minutes ...and I think it was him that broke the ice and said, 'do you mind if I put some music on while we do this?' He just got out his new music system and started talking about listening to a lot of dance music, asking if I knew certain music artists ... I was suddenly aware of just this sense of relief, it's just a normal conversation and ...it wasn't as scary as I thought it was going to be.

Interviewer: What sense did you make of that later?

Participant: *I think for myself, I was critical of myself, questioning how I could have held such a belief that someone was going to be really dangerous and I wasn't going to be able to talk to them just like I would with any other person, that there was something else that was going to be there and I felt embarrassed that that was the opinion that I had.*

Interviewer: Now looking back at you at that time, what do you see now?

Participant: *I think I see an understandable inexperienced young girl fresh out of university working in this institution of mental health who had all of that training and induction and meeting with other people before meeting a single client...In some respects I wish they'd had it all set up and I'd just come in and got to meet the service users from day one...when I look back, I didn't know what to expect.*

Interviewer: Since then, things have moved on and I'm interested now to know what sense do you make these days about hearing voices, how they come about and the influence of more recent training on that understanding?

Participant: *I think in contrast to that time I was seeing this as very separate. I'd heard of voice hearing, I didn't give that name to it at the time, but people had heard things that I couldn't see, and I saw that as a very positive experience and someone was very fortunate to have that sort of gift... and then seeing it in a mental health context, I just saw them as separate experiences. But now as things have gone on I think I see it as across that continuum and that's where it sits more comfortably for me, or that's how I understand it, that there is this continuum of human experience of which some people are voice hearers and some are not. But there might be specific circumstances in peoples lives that the content of the voices or why the voices might be there might come from a trauma understanding that some people have had such traumatic experiences that part of themselves has almost had to be disowned from themselves because it was just so intolerable to really acknowledge... I have seen that when people have been able to make sense of that and try to integrate it into their lives that they then have a better*

relationship with those voices or that certain voices have gone away. Then I've seen the other side that there are people that are living in communities that have never accessed mental health services and their voice hearing experience has continued to be positive or something that they value in their lives. So I can see and hold onto both sides now.

Interviewer: Moving onto thinking about these interviews you've been doing, let me just ask, what are you hoping to find?

Participant: *I thought I might find lots of versions of myself. Well I think that's what I thought I might find, that there would be people who have gone through a similar kind of process of being really inexperienced, feeling quite anxious, thinking that you might say the wrong thing, asking themselves whether they can just hold an every day conversation with someone that's hearing voices and going through the journey of 'yes you can' and the importance of that. I thought that the people who would be interested in the study may have come through a similar journey and that might be what triggers their interest in working with voice hearers, something has changed or it's a part of their work that they really enjoy. Equally, for my research I was hoping that I would also get people who still hold quite a medicalised view of voice hearing, or are interested in it but are unsure of it so haven't really worked with people, they might want to find out a little bit more about it.*

Interviewer: What has your experience been so far? How have you felt?

Participant: *It's been changeable really, my first couple of people... it just felt very much a similar to story to that of my own, especially the first support worker that I interviewed...*