Relating to voices: does voice identity influence degree of relating to the voice, and recovery style, in people who experience auditory hallucinations?

by

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## Contents

<table>
<thead>
<tr>
<th>Contents</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>4</td>
</tr>
<tr>
<td><strong>Academic Section</strong></td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health Essay</td>
<td>5 – 24</td>
</tr>
<tr>
<td>Critically discuss two therapeutic interventions for major recurrent depressive episode.</td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities Essay</td>
<td>25 – 42</td>
</tr>
<tr>
<td>Parenting skills can be assessed and taught to people with learning disabilities. Discuss.</td>
<td></td>
</tr>
<tr>
<td>Child Essay</td>
<td>43 – 61</td>
</tr>
<tr>
<td>Children who have been abused are more likely to become abusers themselves in adulthood. Discuss with reference to assessing and intervening with such children.</td>
<td></td>
</tr>
<tr>
<td>Older People Essay</td>
<td>62 – 81</td>
</tr>
<tr>
<td>What is the role of the clinical psychologist in services for people with dementia and their families? How can we evaluate our contribution as psychologists?</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Section</strong></td>
<td></td>
</tr>
<tr>
<td>Overview of Clinical Experience</td>
<td>83 – 86</td>
</tr>
<tr>
<td>Summary of Case Reports</td>
<td>87 – 109</td>
</tr>
<tr>
<td><strong>Research Section</strong></td>
<td></td>
</tr>
<tr>
<td>Service Related Research Project</td>
<td>111 – 139</td>
</tr>
<tr>
<td>Assessing the convergent validity of a newly devised Caseload Management tool within primary care and community mental health team settings.</td>
<td></td>
</tr>
</tbody>
</table>
Major Research Project

Relating to voices: does voice identity influence degree of relating to the voice and recovery style, in people who experience auditory hallucinations?”

Research Logbook
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Critically discuss two therapeutic interventions for major recurrent depressive episode.

1st Year

January 2003
Introduction

The impact of depressive disorders on society as a whole is becoming increasingly apparent. Research carried out by the World Health Organisation in 1990 found that major unipolar depression and suicide were responsible for 5.1% of the global burden of disease, thereby making them the fourth most problematic health issues in global terms (Murray & Lopez, 1996). Depressive disorders can range from mild to major and consist of a wide range of symptoms. Mild depression can be successfully treated and in many cases the individual will recover without any intervention (Freeman, 1990). In contrast, major depression has a debilitating effect on the individual and may include symptoms such as depressed mood, significant weight loss or gain without dieting, frequent insomnia and daily feelings of worthlessness (American Psychiatric Association, 2000). Research has concluded that unipolar major depression is a chronic illness that reoccurs in 80% of patients. In addition, the majority of individuals with major depression will have an average of four episodes within their lives, each lasting approximately 20 weeks (Judd, 1997, cited in Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau., 2000). Definitions of major recurrent depression (MRD) differ, but tend to require the individual to have had a minimum of two episodes of major depression without mania or hypomania according to DSM-IV (Fava, Rafanelli, Grandi, Conti, & Belluardo., 1998). In some cases, a minimum of three episodes is required, with no more than 2 ½ years between consecutive episodes (Frank, Kupfer, Perel, Cornes, Jarrett, et al., 1990). Some definitions also require the individual to have experienced repeated episodes of major depression, within a limited time-frame (e.g. Teasdale et al., 2000).

The treatment of MRD is an extremely important issue for various reasons. In addition to the impact it has on the individual, MRD has important economic, social and clinical consequences. Individuals with a history of MRD tend to be resistant to treatment (Cyranowski, Bookwala, Feske, Houck, Pilkonis et al., 2002) and consequently the development of successful interventions has become a clinical priority (Frank et al., 1990).
Historically, MRD has been treated using pharmacological and/or psychological interventions. Outcome studies of these two types of intervention vary in their findings, and there is evidence to suggest that in certain circumstances major depression may be resistant to standard antidepressant medication and psychotherapy (Fava, Savron, Grandi, & Rafanelli, 1997). Despite this, most interventions tend to consist of a combination of antidepressant medication and some form of psychological therapy (Frank et al., 1990).

The following discussion will focus on the strengths and limitations of Cognitive-behavioural therapy (CBT) and Interpersonal Psychotherapy (IPT) in the treatment of major recurrent depression. In part one of the essay, I will describe CBT for depression, in order to provide a context for the following discussion. This will be followed by a critique of this intervention, with reference to process and outcome. In part two of the essay, I will describe and critique IPT as a treatment for MRD. Due to the complexity of this disorder, assessing the effectiveness and efficacy of these interventions is not simply a matter of discussing short-term recovery rates. Instead, it is necessary to consider rates of recovery and relapse, the effects of continuation treatment (to reduce the likelihood of relapse) and maintenance treatment (to prevent new episodes of depression) and the effects of early treatment intervention.

**Part One**

CBT, as described by Beck (1991), is more widely used as a treatment for MRD than IPT, in both clinical and research settings. Beck’s cognitive theory of depression postulates a number of psychological symptoms of depression. Individuals with depression are said to experience negative automatic thoughts (NAT’s) or cognitions, which are involuntary, immediate reactions to a trigger event. These NAT’s refer to a negative view of the self, the world (the individual’s experiences) and the future: the cognitive triad. These views may include interpretations of past and present events, as well as thoughts about the future. As a consequence of these thoughts, additional physical and emotional symptoms occur, including loss of appetite, sleep difficulties, anxiety, poor concentration and flattened affect. These more tangible symptoms of depression, combined with the individual’s increasingly depressed mood, serve to
reinforce the NAT’s, which become increasingly frequent and intense. In contrast, rational thoughts diminish as they are displaced by the NAT’s. This relationship between depressed mood and NAT’s is described by Beck as a vicious circle, which serves to maintain the depression. In addition, cognitive biases regarding the interpretation of perceived information also contribute to the maintenance of depression such as selective abstraction and rumination. NAT’s are often mistakenly perceived as having a causal role in the development of depression rather than being seen as an effect of it. Beck (1991) comments:

"...it seems far-fetched to assign a causal role to cognitions because the negative automatic thoughts constitute an integral part of depression, just like the motivational, affective, and behavioural symptoms." (P.371)

This confusion may have arisen as a result of Beck’s use of the term “cognitions” as an alternative name for NAT’s. It is possible that individuals have interpreted “cognitions” as referring to dysfunctional beliefs (see below), which do play a causal role in the development of depression.

Causality

Beck (1967, 1976, cited in Beck, 1991) suggests that depression arises as a consequence of dysfunctional beliefs, combined with a critical incident/s. Early life experience, leads to the development of schemas – beliefs or assumptions about the world, that allow the individual to organise perceptions of situations and develop interpretations of information. Schemas are generally perceived as adaptive and functional, allowing the individual to manage day-to-day functioning. However, dysfunctional beliefs also develop as a result of inflexible assumptions, and these lead to rigid and unreasonable beliefs about the way in which the individual should behave. As a result, the individual may be inclined to have unreasonable beliefs about a certain aspect of their life (e.g. achievement, the need to be loved), which will not cause particular problems in isolation, but may contribute to the development of depression under specific circumstances – a critical incident. When an incident occurs that is congruent with a dysfunctional belief (e.g. an incident of being rejected when the
individual believes that they should always be loveable), these rigid beliefs become activated and the depression begins, with the development of NAT’s.

CBT for depression

CBT is described as “collaborative empiricism” (Beck, Rush, Shaw, & Emery, 1979) and uses a structured and time-limited approach for the treatment of depression. During the therapeutic process, the initial aim is to provide a reduction in symptoms by identifying NAT’s and then developing methods of testing the validity of these thoughts and beliefs. The client and therapist must then work together to elicit changes in these cognitions by identifying evidence to support alternative beliefs. CBT for depression aims to break the vicious cycle at the level of NAT’s and little emphasis is placed on the role of dysfunctional beliefs with regard to intervention. Following a reduction in symptoms, work can be carried out that looks at more permanent issues.

CBT uses guided discovery and Socratic questioning to elicit beliefs and cognitions, without ‘feeding’ the client or relying on persuasion. As a treatment for depression, CBT relies on the identification, monitoring and challenging of NAT’s, the use of distraction methods, activity scheduling and behavioural experiments. A strong emphasis is placed on the use of homework between sessions, to identify thoughts, undertake activities and complete behavioural experiments to find evidence to disprove NAT’s. By doing this, more adaptive thoughts are encouraged to develop. During the course of therapy, emphasis is also placed on the need to identify and use proactive strategies to reduce the risk of relapse. This may include work on the content of dysfunctional assumptions and the acknowledgement that the individual will face setbacks during the recovery process. Marlett and Gordon (1985) found that work around increasing awareness of high-risk situations and identification of early-warning signs provided useful information for the patient in preventing or reducing rates of relapse.
The use of CBT in the treatment of MRD

Current literature indicates that, although research has studied the effects of psychotherapy as a maintenance treatment for MRD, in clinical terms treatment does not continue past the acute stage of intervention. In contrast, antidepressant medication is used as a means of preventing relapse over substantial periods of time (Jarrett, Kraft, Doyle, Foster, Eaves & Silver, 2001). Whilst pharmacotherapy effectively induces remission and can maintain this state, the aim of CBT in the clinical setting is to avoid future relapse in the absence of further intervention. Theoretically, CBT should provide the patient with an increased self-awareness, as well as enabling the individual to develop a variety of proactive and reactive strategies for managing future potential critical incidents.

CBT has been studied as an acute intervention for individuals with MRD and has been found to vary greatly in its effectiveness at preventing future relapse. Over a two-year follow-up period, relapse rates have ranged from 74% to 21% (Jarrett, Basco, Risser, Ramanan, Marwill et al., 1998; Evans, Hollon, DeRubeis, Piasecki, Grove et al., 1992). Jarrett et al (2001) studied the effects of 20 sessions of CBT, as an acute intervention for major depression. Of the 130 patients who completed the acute stage, 68% were described as having responded to treatment (although this is not described as remission). It is not clear whether these substantial inconsistencies reflect differences in the quality of therapy between studies, or more obvious methodological differences. Fava et al. (1997) studied the effects of CBT as an acute intervention for MRD in individuals who had been unsuccessfully treated with antidepressant medication. Patients received between 11 and 19 sessions of CBT, and during this time antidepressant medication use was tapered off. At the end of acute intervention, 75% of the patients were in remission and only 25% of these individuals remained on antidepressant medication. Relapse rates were studied at a 2-year follow-up and 8.3% of the patients had relapsed.

The studies described above, provide evidence that CBT can be a useful method of treating MRD and may be an important tool in treating drug-resistant depression. Inconsistencies in rates of relapse following acute intervention using CBT imply the...
need for clear, standardised methodologies when using CBT as a research method or clinical intervention. Future research, which combines the strengths of past studies into CBT as a treatment for MRD (e.g. quality of therapy, duration, appropriateness of treatment) may provide clear evidence of the benefits of CBT as an acute intervention. Such information could make a valuable contribution to informing clinical practice.

The use of continuation treatment following remission, may provide a means for improving duration of remission without the need for long-term maintenance psychotherapy or antidepressant medication. Following their investigation into the use of CBT as an acute intervention for MRD, Jarrett et al. (2001) studied the effectiveness of CBT at preventing relapse when used as an eight-month continuation treatment. Comparisons of relapse rates, following the continuation treatment, found that CBT produced a significantly lower relapse rate than the ‘evaluation-only’ control group. Interestingly, this study found that participants with early-onset major depression and those that experienced unstable remission during acute intervention benefited greatly from continuation CBT, when compared with controls.

Fava et al. (1998) studied the effects of CBT as a continuation treatment for MRD following remission resulting from antidepressant medication. Patients who had recovered following pharmacotherapy were treated with 20 weeks of CBT or underwent clinical management (control group). Drug therapy was simultaneously tapered off and discontinued. Immediately following continuation treatment, patients who had undergone CBT had significantly fewer depressive symptoms, when compared with controls. In addition, at a two-year follow-up, 25% of the CBT group had relapsed compared to 80% of the control group. It is clear that CBT continuation treatment in these studies had a marked positive effect on relapse rates and severity of depressive symptoms, in the short-term and following prolonged follow-up periods.

Additional research on the effects of Mindfulness-Based Cognitive Therapy (MBCT) as a continuation treatment has found an interesting relationship between illness history, therapy style and rates of relapse (Teasdale et al., 2000). The study, which was carried out over a 60-week period, found that there was a significantly reduced rate of relapse following MBCT in patients with three or more previous episodes of
major depression, when compared with controls (‘treatment as usual’). However, there was no significant difference in relapse rates between the two intervention types, in patients who had experienced only two previous episodes.

Comparison of CBT as an acute intervention and a continuation treatment for MRD provide interesting results. Some studies indicate that relapse rates are similar regardless of the presence of continuation treatment (Fava et al., 1997). However, variations in rates of relapse are considerable when acute intervention is used in isolation. This discrepancy implies that continuation treatment may be unnecessary, provided that certain criteria are met. Factors, including patient age, stability of remission and number of previous episodes of depression all appear to contribute to the outcome of treatment. In addition, the quality, duration and frequency of therapy and the use of antidepressant medication appears to greatly affect outcome.

A recent study of meta-cognitive beliefs in individuals with MRD has investigated beliefs about the function of rumination in depression (Papageorgiou & Wells, 2001). Patients completed a semi-structured interview in order to identify cognitive and meta-cognitive processes during an episode of depression. The study found that patients considered some ruminations to be advantageous, whilst others were perceived to be detrimental. Rumination is often considered to be a negative process, which biases perception and contributes to the maintenance of depression. However, some patients felt that it served the purpose of a coping strategy. These findings have clinical implications and highlight the need for therapeutic strategies to modify these meta-cognitions, thereby allowing the individual to begin exercising greater control over their thought processes. The clinician needs to work with the client to stop the process of perseverative thinking, in order for the individual to begin to exercise greater control over their cognitions.

Part Two

IPT was initially used as a treatment for MRD in the early 1980’s as an alternative to pharmacotherapy and CBT (Weissman, Klerman, Rounsaville, Chevron & Neu, 1982). Markowitz (1999) describes IPT as “time-limited, diagnosis-targeted,
pragmatic and theoretically straightforward” (p. 556). IPT is based primarily on the interpersonal theories of Meyer, who conceptualized psychiatric disorders in terms of the individual’s psychosocial and interpersonal experiences (Weissman, et al., 1982). Meyer (1957, cited in Weissman et al., 1982) argued that mental health problems arise as a consequence of the individual’s attempts to adapt to stress and environmental influences, and that these responses are based on early developmental experiences. Within this framework, psychiatric disorders are described in terms of a number of core principles.

According to interpersonal theory, depression should be viewed within the medical model and is not the fault of the individual. Instead, the relationship between an individual’s mood and experienced life events is emphasised, in order to develop a focus for future treatment. Consequently, it is believed that by developing an understanding of the relationship between life events, social role and the depressed mood state, interpersonal problems can be solved by the individual, leading to the remission of the depression (Markowitz, 1999).

Empirical evidence suggests that recent stressful life events (Pearlin & Lieberman, 1977, cited in Weissman et al., 1982), insecure attachments and social isolation (Cyranowski et al., 2002), all contribute to the development and maintenance of major depression, when viewed within an interpersonal framework. These factors fit within four main “problem areas”, that form a major component of both the conceptualization and treatment of depression within IPT: grief, interpersonal role disputes, role transition and interpersonal deficits (Markowitz, 1999). By identifying abnormal grief reactions, interpersonal difficulties within the individual’s relationships, experience of challenging life events and a lack of social success, the therapist is able to diagnose depression and gain an understanding of the context in which the depression has arisen. One or two of these problem areas are then chosen as a focus for therapy, a process which highlights instances of coping and the individual’s positive mood. Therapy sessions also allow the patient and therapist to discuss interpersonal situations, which may be maintaining the depression. In doing this, it becomes possible to develop alternative strategies for coping with similar situations in the future (Markowitz, 1999). Therapy is terminated over a number of
sessions, during which the therapist emphasises any progress that the patient may have made. Psycho-educational work is also carried out, looking at the characteristics of depression and identifying factors which may increase the risk of relapse.

The empirical status of IPT as an intervention for MRD has been documented in terms of acute treatment, continuation treatment and maintenance treatment. Acute treatment refers to the initial stages of intervention, when the patient is suffering from severe depressive symptoms and receives intensive treatment in order to improve mood and social functioning.

Social Functioning

IPT aims to alleviate the symptoms of depression by improving the quality of the patient’s social functioning and interpersonal relationships. Therefore, one can assume social functioning will improve between episodes of depression and furthermore, it can be surmised that measures of social functioning will act as an indicator of treatment success. Research into the treatment of MRD, using IPT, provides varying evidence regarding this notion. Weissman, Prusoff, DiMascio et al. (1979) compared social functioning in individuals who had undergone a 16-week trial of IPT, compared with either pharmacological or combination treatment and found that changes in social functioning did not differ according to intervention. In a one-year follow-up study, looking at the effects of continuation treatment, patients who had undergone IPT demonstrated better social functioning than participants receiving pharmacotherapy or non-scheduled treatment, in terms of leisure activities, parental functioning and as a member of the family (Weissman et al., 1981). This improvement in social functioning was only detected eight months after IPT treatment, indicating that improvement in social functioning, as a result of IPT, may take up to eight months to develop. Similar results were found in a further study of changes in social functioning following IPT (Weissman & Paykel, 1974, cited in Weissman et al., 1982). In contrast to this research, Weissman et al. (1977) carried out a further study comparing IPT with pharmacotherapy as a maintenance treatment for MRD. At one-year follow-up it was found that improvements in social functioning were similar for both interventions. Therefore, despite a strong emphasis
on the role of IPT, as a means of improving social competence, this study indicated that IPT was no more effective at promoting this change than medication in severely depressed individuals.

The use of IPT as a continuation treatment provides the patient with time-limited additional support following remission, but for a shorter period than maintenance therapy. As a result of the level of commitment that maintenance treatment requires and the additional resources that it uses, it is important to establish the benefits and limitations of these two types of support. Although long-term maintenance treatment may appear to be less cost-effective, if it enables the patient to avoid relapse then future acute and continuation treatment may be avoided. Alternatively, if continuation treatment reduces the length of future acute intervention, this may be of greater benefit. If major depression is regarded as a chronic, persistent condition, is it realistic to 'hold' the patient by using maintenance treatment or is it more beneficial to provide the individual with a variety of skills to use in the future, but to limit the length of intervention?

**Continuation treatment**

Studies of continuation treatment in patients with MRD indicate that in order for this intervention to be of any value it should last for between four and six months (Kupfer, 1992). Weissman et al. (1981) carried out a 16-week continuation trial following remission, and studied the use of medication and visits to relevant health professionals over the following year. The study found that 38% of patients who had undergone IPT, used psychotropic medication following the continuation treatment and 50% accessed support from health professionals. Individuals from the IPT group had the least reported periods of using psychotropic medication and visits to health services. The study did not specify the relapse rates for different treatment styles. However, this study provides evidence that IPT may be a particularly effective continuation treatment in MRD.

Miller, Paradis, Houck, Hind Rifai, Mazumdar et al. (1996) researched the effects of a 16-week continuation programme of IPT on a sample of severely depressed patients.
with a minimum age of 60-years-old. The study found that the median time to remission was 13.1 weeks and that in 75% of patients, remission occurred by 29.1 weeks. Interestingly, rates of non-response to intervention were higher in older patients, reinforcing the idea that major depression becomes increasingly resistance to intervention as age increases. A similar study was conducted by Reynolds, Frank, Kupfer, Thase, Perel, et al. (1996), which compared time to relapse in mid-life patients (i.e. aged 21-59 years) and late-life patients (i.e. aged 60-91 years) with MRD, following acute and continuation treatment. Acute intervention combined antidepressant medication with IPT until remission, and this treatment was continued for 16 weeks. Following the continuation phase, no further intervention occurred and patients were monitored for signs of relapse. Rates of remission were actually found to be greater in the older patient group. However, ratings of depression were found to improve at a faster rate in the younger patients than in late-life patients. In addition, rates of relapse were higher in the late-life patients (15.5%) than the mid-life patients (6.7%) and relapse occurred significantly earlier in the late-life patients than the mid-life patients. Although these findings appear to confirm the notion that depression becomes less susceptible to intervention with increasing age, various methodological inconsistencies in the research should be highlighted. Firstly, patients were administered different medication across the two groups, which may have had an impact on the effect of the intervention and secondly, the IPT, which the late-life patients received, was modified and lasted four weeks less than the comparison group. Therefore, although this evidence indicates that older patients with MRD may display a more “brittle” response to IPT, it is necessary to consider these clinical inconsistencies.

Maintenance treatment using IPT has been studied in greater depth than continuation treatment and has yielded some interesting results. Early studies of the efficacy of antidepressant medication as a maintenance treatment for MRD found that the probability of remaining free of depression in the 2–3 years following remission, ranged from 50% to 80% (Glen, Johnson, & Shepherd, 1984, cited in Frank et al., 1990b). However, Frank et al (1990b) found that although monthly IPT had beneficial effects, when compared with a placebo, relapse times were far longer than in patients treated with antidepressant medication (61 weeks). A combination of IPT
and pharmacotherapy produced average lengths of remission of 92 weeks. A further study of the efficacy of IPT as a maintenance treatment for MRD studied the effect of therapy quality on 'time to relapse' following remission (Frank, Kupfer, Wagner, McEachran, & Cornes, 1991). Following remission, patients were assigned to various three-year maintenance therapies. IPT sessions were recorded and independently assessed for quality using the Therapy Rating Scale. A comparison was made of therapy quality and duration of remission and this indicated that the median time to recurrence in patients who underwent poorer quality IPT was 4.6 weeks. This figure rose to 101.7 weeks in patients who received higher quality IPT (ratings of quality referred to the therapist’s ability to focus on interpersonal issues). Whilst this may seem to be common sense it is interesting to note that depression severity did not differ between the two groups during the maintenance period, indicating that aspects of the therapy overlapped. However, it is likely that the poorer quality therapy had less emphasis on interpersonal issues, which may have contributed to the relapse, in contrast to the more focused, high quality IPT. These findings suggest that in order to improve the quality of IPT, it is essential that therapists receive adequate training to enable them to improve their skills through continuing professional development and receive suitable supervision. In doing this, the content of IPT sessions should remain focused on relevant interpersonal issues contributing to the depression.

Recent research has extended the debate on the use of IPT as an intervention for MRD in older adults, by comparing various maintenance treatment methods following remission, resulting from acute and continuation treatment with nortryptiline and IPT (Reynolds, Frank, Perel, Imber, Cornes et al., 1999). Patients received monthly maintenance treatment, over a three-year period, during which rates of recurrence were monitored. The study found that the most significant improvements occurred in the patients receiving combined antidepressant/IPT intervention, 80% of whom remained free of depression for the three-year period. IPT was found to be less effective than combination treatment and pharmacological treatment alone, with 64% of patients in the IPT group having a recurrent major depressive episode during the course of the study. This would suggest that IPT is a useful maintenance intervention in older adults with MRD, when used in conjunction with pharmacotherapy. However, this intervention may have limited use when applied in isolation.
The majority of research supports the use of IPT and pharmacotherapy as an acute intervention and therefore few comparisons can be made. This combined intervention appears to be extremely effective in the early stages of treatment, but is rarely a long-term option, either because of limited resources or non-compliance over time. IPT as continuation treatment seems to have some benefits, in terms of reducing the need for psychotropic drug use and medical support. The literature on IPT as a maintenance treatment suggests that, whilst it provides improved outcomes, when compared with placebo, it is less effective than pharmacotherapy. The evidence does suggest that IPT is of great value when combined with antidepressant medication and still has a valuable role in situations where medication is not an option.

IPT as a treatment for MRD in older adults appears to have limited success. However, it is important to note that research suggests that major depression in older patients is less susceptible to treatment, and that relapse rates are higher within this population (Reynolds et al., 1999).

Conclusion

The evidence discussed above indicates that CBT and IPT both have an important contribution to make to the treatment of MRD. The discussion highlights a number of issues relating to this condition, which are of great significance to clinical practice. Acute intervention of MRD tends to consist of combination treatment, which is effective in promoting rapid remission. The course of intervention from this point is more contentious and prompts a number of questions. Maintenance treatment classically involves the use of antidepressants rather than psychotherapy and this appears to be a simple and resourceful method of reducing rates of relapse. In reality, maintenance treatment using either CBT or IPT may place great strain upon current resources. Bearing in mind the prevalence of major depression – coupled with the Commission for Health Improvement’s aim of reducing waiting times for psychology services – the idea of psychologists preventing future relapse through indefinite monthly therapy sessions does not seem viable. Maintenance treatment via Community Psychiatric Nurses or outreach services may offer an alternative solution.
IPT and CBT conceptualise MRD in contrasting ways and consequently have different strengths. IPT follows a medical model and although blame is removed from the patient, there is still a sense that the professional is the expert. In addition, intervention in IPT is based on four aspects of abnormal social functioning – an idea which seems quite limiting, considering all the possible causal and maintaining factors of depression. Furthermore, intervention does not occur in all four areas and hence there is the potential for only part of the problem to be addressed. Despite this, IPT does make a valuable contribution to improving social functioning in people with MRD and is clearly a useful method of acute and continuation treatment in MRD, comparable to the effects of medication. Similar clinical issues arise when considering CBT as a treatment for MRD. Evidence suggests that CBT can be an effective continuation treatment for individual with MRD with respect to relapse rates.

Limited research has been carried out, comparing IPT and CBT as an intervention for MRD. Elkin (1994) found that IPT was more effective than CBT at preventing relapse in individuals with MRD, although overall effectiveness as an acute intervention was similar for both forms of therapy. Further research needs to be carried out to validate these results. In a sense, the relative merits of these two interventions are less important than the value of continuation or maintenance treatment per se. The value of maintaining a state of remission using pharmacotherapy or psychotherapy has to be assessed in terms of the needs and values of the client. A “non-significant” clinical change may be of the utmost importance to the individual, even though the therapist may not ascribe it great value. Likewise, a client may not entertain the notion of relying on medication or therapy as a long-term maintenance treatment, even if this seems the appropriate thing to do. The views of the client should be reflected in the chosen course of intervention. Further research needs to rigorously compare the effectiveness of different psychotherapies on the course of MRD, in terms that measure success according to the client’s perception, as well as general social values. Greater emphasis should also be placed on the use of relapse prevention strategies that encourage constructive, proactive support from family members and which provide the client with a greater understanding of their depression. Overall, current research indicates that although psychotherapy may help
to prolong the periods between relapse, individuals with MRD continue to be at risk of future relapse.
References


Parenting skills can be assessed and taught to people with learning disabilities.

Discuss.

1st year

August 2003
Introduction

The issue of parental competency in individuals with learning disabilities is of major concern for health and social services. Historically, attempts have been made to prevent people with learning disabilities from entering into sexual relationships or becoming parents – either through segregation (Gath, 1996) or compulsory sterilisation (Bass, 1963, cited in Dowdney & Skuse, 1993). As a result of the normalisation movement the emphasis has moved towards protecting the rights of these individuals, and consequently people with learning disabilities are more able to express and fulfil their desire to become parents (Feldman, 2002). Current estimates indicate that there are 250,000 parents with learning disabilities in the UK (McGaw, 1996) and this is likely to increase (Booth & Booth, 1993). Despite these positive changes there are various concerns regarding the welfare of children who have a learning disabled parent, as well as the vulnerability of such families (McGaw, 1996). The need for greater support for learning disabled parents was highlighted in the recent government white paper “Valuing People” (DoH, 2001), which indicates that, while people with learning disabilities can be good parents, they generally require support in this area and may place high demands on local services. Concerns regarding the ability of people with learning disabilities to provide adequate care for their children are widely reported and tend to highlight the potential for psychological or neglectful abuse (Feldman, 1998).

In order to fully appreciate this issue it is necessary to have some understanding of what “good” parenting is. In legal terms, parental competency is primarily understood in terms of the likelihood of the child being at risk of suffering “serious harm”, although this term is not clearly defined (Reder & Lucy, 1995). Generally, health and social services perceive parenting skill on a continuum and this is reflected in the idea of “good enough” parenting. This acknowledges that while the “perfect parent” does not exist, the majority of people are able to successfully rear their children despite the mistakes they make or the hardships they experience (Winnicott, 1965, cited in Cooper, 1985).
This review aims to discuss the literature regarding the assessment and teaching of parenting skills to people with learning disabilities. These areas are of great importance for a number of reasons. Firstly, assessment within a clinical setting can be used to highlight the specific learning needs of an individual so that appropriate support can be provided in order to improve parenting skills. Secondly, this information can also be used to inform legal decisions relating to the child’s welfare and the risk of abuse or neglect within the family. Thirdly, in order to support learning disabled parents in these areas, it is also important to assess their ability to develop their current parenting practice or learn new skills. Finally, the teaching of parenting skills to people with learning disabilities may be a long term commitment and will have important consequences. Therefore it is essential that any intervention is evaluated to ensure that it enables the individual to learn how to provide adequate parenting. In addition, it is imperative that maintenance of change and generalisability of skills are addressed by such interventions.

**Assessment of parenting skills**

In order to provide relevant support to a learning disabled parent, it is essential that a thorough multidisciplinary assessment is carried out, which can best identify the needs of the individual in addition to areas of risk. Various assessment models and frameworks have been developed which provide guidance on the issues which should be considered when working in this area, in addition to literature on specific parenting assessment tools (McGaw & Sturmey, 1994; McGaw, 1998; Feldman, 1986; Tymchuk, 1991). The following section will discuss the methods that are frequently employed during assessment.

**General models**

The literature on parenting in learning disabilities indicates that a number of areas should be assessed to provide sufficient information to inform future interventions. The Parental Skills Model (PSM) provides guidance regarding the areas which should be covered by a parenting assessment (McGaw & Sturmey, 1994). The model
identifies four main factors that contribute to parenting ability: life skills (including academic, language and social skills), family history (such as the individual’s experience of appropriate child rearing models and history of neglect), available support and resources (either family, friends or professional) and child care/development skills (concerning the individual’s ability to provide physical care/affection, security, guidance and independence). The PSM recommends that standardised assessments of IQ, adaptive behaviour and risk are utilised as part of the process. Interestingly, this model does not highlight the need to consider the impact of socio-economic or cultural factors when assessing parenting skills. Historically, studies of parenting needs in learning disabled adults have suffered from a lack of appropriately matched non-learning disabled participants (Stoneman, 1989, cited in Dowdney & Skuse, 1993). Consequently it has been erroneously concluded that the observed standard of parenting is a result of the parent’s learning disability rather than the quality of their environment (McGaw, 1996). Gath (1995) suggests some additional areas of assessment, including parental physical disorders (e.g. epilepsy, cerebral palsy and sensory impairment), dual diagnosis and the individual’s relationship with their partner.

The following section will discuss some of the techniques that are currently used to assess specific areas of parenting and the issues that arise during this process.

**Life skills**

The issues of parental IQ and adaptive behaviour have been discussed in the literature and it is suggested that there is no clear correlation between IQ and parenting ability in individuals with an IQ greater than 60 (McGaw, 1997). However, there is some indication that as IQ decreases below 60, parenting ability decreases proportionally (Gath, 1988). A review by Dowdney and Skuse (1993) indicates that information from IQ assessments should be used with caution:

*Formal assessments of intelligence do not attempt to measure intellectual capacities that are likely to have a direct influence upon parenting skills, such as the ability to understand and deal effectively with social and interpersonal events, to plan and*
organise household routines and to provide adequate child care.' (Dowdney & Skuse, 1992, p. 34)

However, IQ assessments can provide useful general information regarding the strengths and needs of an individual and these can be interpreted with respect to parenting (i.e. memory skills, sequencing and problem solving ability). Such issues may impact on the parent's ability to constantly develop their parenting style or successfully engage in skills teaching during future intervention.

Assessments of adaptive behaviour (e.g. the Vineland scales of adaptive behaviour, Sparrow, Balla & Cicchetti, 1984) provide information about an individual's independent and daily living skills. These assessments often focus on self-care rather than support for others and therefore may not be sufficiently related to the responsibilities that are associated with parenting (McGaw, 1998).

**Child care skills**

Various assessment instruments have been developed, which aim to assess the adequacy of parenting skills in learning disabled individuals. Feldman (1986) studied the quality of mother-child play interactions of parents with learning disabilities using the Caldwell Home Observation for the Measurement of the Environment (HOME) assessment tool (Caldwell & Bradley, 1978 cited in Feldman, 1986). The HOME is a 45-item questionnaire, which uses observational data to assess the quality of the child's home environment with respect to punishment, play, maternal involvement, variety, parental responsivity and environmental organisation. This study highlights a number of important issues, which must be considered when assessing the parenting skills of individuals with learning disabilities. Firstly, when using a psychometric instrument to assess a skill such as parent-child interaction, it is essential that the criteria for adequacy/inadequacy is clearly defined in terms of good enough parenting, rather than perfect parenting. In addition, if comparisons are to be made between different groups of parents, it is essential that they are matched with respect to aspects of social and family background. Failure to do so may reflect the influence of social factors on parenting ability, rather than those associated with the individual's
disability. Furthermore, a more fundamental question regarding the definition of parental adequacy may also be raised, as the issues of spontaneity of specific parenting behaviours or the frequency with which they occur may be of significance (Dowdney & Skuse, 1993). In addition, it is suggested by Tymchuk (1992) that "there is less consensual agreement about the necessity of a single normative style of interaction for adequacy of parenting" (p. 171). Therefore it would appear that assessments of parent-child interaction within a clinical framework need to consider the frequency with which both positive and negative interactions occur.

A lot of emphasis has been placed on the assessment of healthcare and safety skills in parents with learning disabilities. Clearly, these areas are of great importance, as research indicates that neglectful abuse, as a consequence of limited parental risk management skills, is a major concern (Feldman, Case & Sparks, 1992). Four instruments have been developed which are designed to assess issues of risk in the homes of individuals with learning disabilities (Tymchuk, 1991). These tools are designed to assess the presence of hazards in the home, the implementation of risk management, the occurrence of accidents and the parent's ability to identify household hazards. These tools cover 13 categories of risk, such as fire safety and poisons, and provide a comprehensive assessment of the household. Due to the nature of the assessment it is not possible to assess the likelihood of the individual carrying out hazard identification without the presence of the professional. By undertaking the assessment the parent is cued into the importance of assessing risk and therefore, it is possible that they will identify hazards, which they would overlook without supervision. Often parents are referred to services because some aspect of parental "inadequacy" has been identified and therefore specific areas of need may already have been identified. However, if the assessment concerns a general overview of parenting skills there may be value in gathering information from a variety of sources so that the individual's ability to spontaneously initiate hazard identification and reduction can also be established. Overall, such a tool appears to be of value, but needs to form part of a more general assessment, which considers the individual's ability to generalise skills and knowledge to different settings and to problem solve in situations where a novel hazard is identified.
General assessments of child care skills have also been developed, which obtain information from observation of the parent caring for the child in specific situations. The Child-care skills checklist (Case & Feldman, 1993 cited in Feldman & Case, 1999) is designed to assess child care skills, including newborn care, feeding, health and safety and positive interactions. These checklists are either based on analysis of specific tasks or are "what to do" lists which are completed by the professional using observational data. Such assessments have the potential to provide valuable information regarding the parent’s ability to problem solve and cope with multiple simultaneous tasks. However, again they are limited by the possible cueing effects that observation may have on the parent or the potential detrimental effects that observation may have, such as causing anxiety to the parent. Within the literature, there is little information to suggest how these visits are conducted. The use of unannounced visits may provide more valuable information regarding the parent’s ability to cope, but there are ethical issues around such practice and rapport between the client and the professional may be jeopardised. Checklists such as “When to call the doctor” provide specific information regarding the parent’s ability to identify the health needs of their child, but are potentially limited in their scope, if they fail to assess the parent’s ability to cope with unexpected events. Such checklists should be tailored to meet the needs of the individual child and should be devised in conjunction with a medical practitioner. In such situations, it is important to clarify the role of the clinical psychologist within the wider multidisciplinary teams.

There are a wide range of issues to consider when assessing parenting in adults with learning disabilities, but individual assessment tools or sources of information may have limited value. The following section will review the literature regarding parent skills training in learning disabled individuals.

**Intervention**

Outcome studies of different parenting training interventions have become increasingly popular over the past four decades and such studies provide valuable clinical information. Historically, there have been concerns that poor parenting by individuals with learning disabilities will result in family break up, child neglect or the
development of an acquired learning disability in the child (Gath, 1995). The following section will focus on the literature regarding the ways in which parenting skills may be taught to parents with learning disabilities, in order to ascertain whether such interventions provide successful means for effecting change. Emphasis will be placed on discussing interventions to develop general child care skills and parent-child interactions, which can have major repercussions regarding the child’s attachment and self-esteem in later life (Perkins, Holburn, Deaux, Flory & Vietze, 2002). These two areas are the most widely researched with respect to parenting in adults with learning disabilities.

Parent-child interactions

A number of studies have looked at the effects of teaching parent-child interaction techniques to learning disabled parents, with varying results. Feldman, Towns, Betel, Case, Rincover and Rubino (1986) taught seven learning disabled mothers to increase specific methods of parent-child interaction (including praising, talking, imitating, looking and prompting play) which they were displaying significantly less frequently than matched controls. The training combined relevant discussion with modelling of appropriate interactions and occurred in a group setting (and at home for some participants). Overall, there was an increase in the amount of positive parent-child interactions as a result of the intervention, which was also generalised from the group to the home setting. In some cases, prompting was required to remind parents which interactions required further attention. Although positive effects were maintained for up to ten months following intervention, it is important to note that in a number of cases there were occasions when the target behaviour(s) occurred at rates similar to those observed prior to intervention. Whether such fluctuations reflect changes in the level of interaction observed in the general population is unclear. However, this issue is of relevance to clinical practice as it highlights the possible need for regular evaluation of the intervention and continued prompting for the parent.

A similar study used a multiple baseline procedure to teach learning disabled mothers to increase the amount of praise and positive physical interaction with their children, in addition to increasing question asking and appropriate modelling (Tymchuk &
Andron, 1992). Teaching was carried out within both group and home settings and new target behaviours were introduced once the current behaviour had increased by 50% from baseline. Overall, intervention did increase rates of positive interaction, but mainly with respect to labelling and modelling. In addition, none of the behaviours reached rates observed in the control participants. It is important to note that the article indicates that control participants were similar for all variables, except that they had more children. Because these mothers had greater experience of parenting, it is possible they had learnt more about the need for appropriate interactions. Alternatively these results may reflect a trend among learning disabled parents to interact less with their children. As with Feldman et al’s study (1986) improvements were poorly maintained over a one month follow-up in half of the participants. Bearing in mind this poor maintenance rate and the short follow-up period, it is possible little improvement would have been observed in the long term. Tymchuk and Andron (1992) concluded that there appeared to be two groups of learning disabled parents – those that maintained positive change over time and those who demonstrated only limited and unstable change. However, bearing in mind the wide range of variables that can impact on an individual’s parenting style (and specifically exposure to appropriate parenting styles and levels of support) it is possible that the ability of an individual to modify their parenting is influenced more by their specific life experiences rather than just their learning disability.

Tymchuk and Andron (1988) studied the effects of an intervention programme designed to teach a learning disabled mother to use positive reinforcement methods with her children (aged 1.5 to 7.8 years) who were exhibiting “problem behaviours”. Training was carried out at home and in a clinical setting and focused on teaching the mother to identify appropriate behaviours and methods of reinforcement. Outcome was assessed in terms of individual parent-child interactions and family interactions. Gains were observed in the two older children on a one-to-one basis and the oldest and youngest when interacting as a family group. As the study was a single case design it is not possible to assess whether these improvements were due to the intervention, or other variables. However, this research indicates that improvements in the behaviour of older children may still occur as a result of changes in parenting style. Future research could look at the effect of using such interventions in different
families (e.g. number of parents present, number of children) to evaluate which factors may contribute to a positive outcome. The use of parenting skills training as a proactive measure may result in a reduction in child neglect, as well as enabling the parent to apply these skills to future offspring.

A recent study of a group intervention on the relationships of parents with learning disabilities used a cognitive-behavioural approach to teach social awareness and interpersonal communication skills to individuals receiving support from a parenting service (McGaw, Ball & Clark, 2002). Although the study aimed to improve a variety of interpersonal relationships, emphasis was placed on parent-child interactions. The majority of the children had been abused — either physically or sexually — and a number of children had already been removed from the families. Parents completed a 14-week intervention which combined group tasks with homework assignments (to encourage generalisation to other settings), in addition to home-based teaching on various aspects of parenting. A control group was also used, that received the home-based intervention without the group intervention.

Evaluation of the effects of intervention on the parent-child relationship was carried out at 14 and 27 weeks post-group, using the Judson self rating scales. Although improvements were observed in ratings of “feelings towards child” and “judgement of child’s capabilities”, these were not statistically significant and similar gains were observed in the control group. In their conclusion, McGaw et al. (2002) indicate that parents in the experimental group may have prioritised improvements in family functioning above improvements specifically in the parent-child relationship and that the group work may have detracted from the home-based intervention. It is also possible that the combination of home and group interventions placed too many demands on parents who were already finding it difficult to cope with running the home. The study may have benefited from a third group of participants who attended the group without additional home-based intervention. This would have provided valuable information regarding the specific effectiveness of the group (and whether improvements are maintained without regular visits), as such interventions will be of increasing necessity, as more learning disabled parents are identified and resources are further stretched. McGaw et al. (2002) also highlighted the lack of observational data
for the study as a potential criticism. Despite the limitations of observational techniques, such information may have highlighted improvements in interaction that the parents were not aware of and may have enabled the group facilitators to focus their intervention more specifically.

In clinical terms, this research highlights the need for interventions that are focused on specific and clearly defined parenting problems. It is also clear that evaluation of such work should be based on various information sources, including the views of the parent and observational data. The success of interventions relating to social relationships and interaction will be influenced by a number of personal and social issues and it is important that the clinician attempts to obtain relevant information regarding such issues.

It can be seen that the literature suggests that parent-child interactions can be improved as a consequence of clinical intervention, although gains may be small and fragile. The following section will focus on the literature regarding the teaching of child care skills in parents with learning disabilities.

**Child care skills**

In recent years, a number of studies have been carried out to assess the effectiveness of child care training programmes for parents with learning disabilities. Clearly, the physical well-being of the child is of the utmost importance and concerns regarding unintentional neglect have prompted research into the health, safety and physical development of the child (Feldman, 2002).

Feldman and colleagues have carried out numerous studies, using a number of different approaches to parent skills training. Feldman (1986, 1998) describes a home based early intervention service designed to teach parenting skills to individuals with learning disabilities. This service used a combination of approaches including training within the home, training probes, teaching strategies (such as modelling, task analysis and verbal praise) and training coupons in order to improve child care skills. Feldman (1986) describes a study which evaluated the effectiveness of a group training course
for eight learning disabled mothers which used discussion, modelling, role play and social reinforcement to teach the participants methods of treating choking. Teaching and evaluation was based on a task analysis of the skill and overall improvements were demonstrated in six participants. It is important to note that all participants did receive additional prompting during weekly home visits between sessions and therefore it is not possible to conclude that generalisation occurred between the group and home setting. In addition, evaluation was based on role play performance and therefore may not have reflected the mother’s ability to act appropriately in a real emergency. No information regarding follow up was provided and therefore it is unclear whether improvements were maintained over time. This study indicates that group interventions can be useful when teaching parenting skills, but also indicates that there is a need for individualised support. It also raises a question as to the appropriateness of using “rewards” to encourage parenting behaviour.

Further evaluations were carried out by the service using a randomised control trial for the teaching of skills associated with toilet training, feeding and sleep safety which had been observed as falling below the minimum required standard (assessed by comparison with a matched control group of non-learning disabled parents) (Feldman, 1998). Gains were observed during the follow up period, although this ranged from 2 to 76 weeks. In addition, the time taken for parents to reach criterion ranged from 2-29 weeks (mean = 7.7 weeks), indicating that in some cases a great deal of training and prompting was required. This study indicates potential positive effects of intensive individualised training, but also illustrates the need for long term support and the value of home based interventions. This is a theme which is repeatedly reflected in the parenting literature and it is essential that the appropriateness of settings is considered and reported in academic and clinical work (Llewellyn, McConnell, Russo, Mayes & Honey, 2002).

Greene, Norman, Searle, Daniels and Lubeck (1995) describe a training programme which was used to teach a learning disabled mother various child care skills such as feeding, home safety and nutrition. As the child had been removed into foster care, training had to occur during supervised visits and generally, the scope of the research was limited by these circumstances. Improvements were seen with respect to the
types of food that the mother fed her child during visits and the child gained weight during the intervention. Although this study indicates that positive gains may occur as a result of parenting training programmes, it is impossible to attribute these to the mother's participation in the programme.

It should be noted that a number of the studies regarding parenting and learning disabilities are methodologically flawed and suffer from small sample sizes or a lack of appropriate control groups. Although single case designs may provide useful information regarding a specific evaluation, limited conclusions can be drawn from these, as effects may not be reflected in larger groups. In addition, such interventions may involve unrealistic standards when applied in clinical settings where interventions may be time limited or under resourced.

As this area of clinical psychology has the potential to involve long term work, research has also been carried out to look at the possible use of self-instructional materials as a means of teaching child care skills to learning disabled parents. Feldman and Case (1997) studied the effects of using audiovisual, self-instructional methods as a means of teaching child care skills to thirteen parents with mild learning disabilities. Parents received pictorial child care manuals either with, or without an accompanying audio tape. Following a training and assessment session (to ensure that participants understood how to use the materials), they were left to be responsible for their own learning. Observations were carried out on a weekly basis within the home and prompts were not given to the parents unless there were no improvements during this time. In such cases minimal prompts would be given during the following session. Criterion was set at 80% of necessary tasks completed – a figure based on the performance on non-learning disabled parents.

The results of the study indicated that parents were able to learn new skills to a level which met criterion. Interestingly, skills taught using just the manual resulted in higher overall scores than those taught using the combined method. However, the combined teaching method did appear to result in slightly faster learning. These gains were maintained during follow up for 81% of the skills taught. However, it is unclear
whether there were gains in other aspects of child care or whether parents continued to have difficulty adapting their parenting with the development of the child.

Feldman and Case (1999) carried out a follow up study to assess the use of self learning techniques among a different group of learning disabled parents. A multiple baseline design was used and participants were not exposed to other teaching methods during the study. This research provided further evidence that self learning has some value when teaching parenting skills to learning disabled parents. The majority of participants reached criterion within four sessions and gains were maintained during the 4 month follow up. However, a number of parents had to be reminded to use the materials during this period, indicating that despite the potential gains to be had from using self-instructional teaching methods, monitoring is essential.

It is important that teaching materials match the reading and comprehension ability of the individual. The training manuals used in the two studies were assessed as having a reading level no higher than grade six (Feldman & Case, 1997). However, the mean reading level was 3.6 in the first study and 4.7 in the second (Feldman & Case, 1997; 1999). This implies that the manuals included information that could not be understood by the parent and greater gains may have been observed if the language had been simplified. Such interventions may be of use for learning disabled parents but it is essential that the clinician uses resources which are appropriate for the individual. In addition such programmes may be more beneficial to individuals who have access to a good support network.

**Conclusion**

It can be seen from the above discussion that the areas of assessment and intervention within parenting and learning disabilities are complex and raise many challenges for Clinical Psychologists. The ability of an individual to parent is influenced by multiple factors, including their social situation, childhood experience, cognitive ability and the presence of good support systems. Information about these areas used in conjunction with observations and ratings of the parent’s child care skills can enable the professional to identify areas of need which require intervention. Assessment should
also address whether the parent has the ability and motivation to learn new child care skills and the best method for teaching these. In contrast, decisions regarding the removal of the child from the family home will require further information and may place additional emphasis on the child’s development with respect to social skills, adaptive behaviour and academic ability. In such cases, the aim of assessment should be to demonstrate whether the strengths and needs that the parent has with respect to child care are sufficient to reduce the risk of serious harm.

The majority of research has focused on parenting of infants with little emphasis on older children. Psychologists working with such families need to consider the parental expectations of the child and how this may influence the child’s role within the family. ‘Valuing People’ (DoH, 2001) has highlighted the need for the provision of support to young carers and this is of particular relevance when working with the children of learning disabled parents.

The literature indicates that a variety of issues must be considered when implementing parenting skills teaching for individuals with learning disabilities. The use of group or individual work and the choice of teaching setting are important issues and generally there is agreement that work within the home environment produces more positive change than other settings. In addition, research findings suggest that the aims of an intervention need to be focused and that greater benefits may be observed if multiple aims are introduced sequentially, rather than simultaneously. Throughout the parenting literature the need for continuing support and prompting is highlighted and this has clear implications within the clinical setting. Employing a multidisciplinary approach should provide the parent with support in a number of key areas and should also allow for consistency if staff changes occur. The majority of the literature is biased towards individuals who are already parenting and who have been identified as providing inadequate care for their children. By taking a proactive approach to skills training, services may give the parent a better chance of succeeding and reduce the risk of crises in the future. As this issue continues to place greater demands on services, it will become increasingly important to offer interventions which are effective without stretching resources.
References


People with Learning Disabilities Essay


Children who have been abused are more likely to become abusers themselves in adulthood. Discuss with reference to assessing and intervening with such children.
Introduction

The issue of child abuse and the concept of a victim-perpetrator cycle is of major concern to professionals working in health, social and legal services and the population as a whole. Over the past four decades, the amount of research conducted in the area of child abuse has increased substantially (Oates & Bross, 1995) and during this period reported incidents of child abuse have also increased (Widom, 1998). The perceived failings of services designed to protect vulnerable children from abuse have been highlighted in the Victoria Climbie report (Laming, 2003). In response to this, the green paper ‘Every Child Matters’ (DoH, 2003) aims to provide a framework designed to enable services to protect children at risk of abuse. In addition, it suggests ways of working which promote positive outcomes for individuals in later life. The potential short- and long-term effects of child abuse are widely reported and include symptoms of post-traumatic stress, anxiety, depression, substance misuse, aggression (Saywitz, Mannarino, Berliner & Cohen, 2000) and increased sexualised behaviour (Browne & Finkelhor, 1986). However, responses to child abuse appear to vary considerably between individuals and may be mediated by a variety of factors (Haugaard & Reppuci, 1988). There is evidence to suggest that cycles of abuse only occur in a minority of cases (Salter, McMillan, Richards, Talbot, Hodges et al., 2003).

The term “child abuse” covers a variety of behaviours with the categories of physical, sexual, neglect and emotional abuse. Due to the limitations of this essay, it is proposed that discussion will focus primarily on issues relating to child physical abuse (CPA) and child sexual abuse (CSA). Both these areas include elements of neglect and emotional abuse and therefore such an approach will acknowledge the complexity of the area as a whole.

Definitions of CSA and CPA vary widely within the literature. The government document ‘Working Together to Safeguard Children’ (DoH, 1999) defines CSA as:

“...forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening,” including contact or non-
contact activities (DoH, 1999, p.6). The same document defines CPA as involving “hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child”, in addition to factitious illness when a carer feigns illness in the child (DoH, 1999, p.5).

Prevalence rates for CSA and CPA vary considerably within the literature, primarily as a result of discrepancies in definitions of abuse and also as a result of different research methodologies (Glasser, Kolvin, Campbell, Glasser, Leitch & Farrelly, 2001). Prevalence rates of CSA range from 59% for females and 27% for males (Kelly, Regan & Burton, 1991 cited in Glasser et al., 2001) to 12% for females and 8% for males (Baker & Duncan, 1985, cited in Glasser et al., 2001). Prevalence rates of CPA are also thought to be approximately 10% of the child population (Carr, 1999).

The following discussion will focus on the literature regarding cycles of CSA and CPA with reference to assessment and intervention. Part of this process will investigate specific social, family and abuse-related factors, which appear to mediate outcomes of abuse. In addition, intervention strategies for overcoming these risk factors will be discussed.

**Effects of Child Sexual Abuse and Child Physical Abuse**

Within the literature, there are a number of models which aim to describe the effects of CSA on the victim. In many cases, these models focus on the short-term effects of CSA, as this information is more readily available. The effects of CSA are often conceptualised within a model of posttraumatic stress disorder (PTSD), as abusive events can lead to symptoms associated with PTSD and outcome appears to be mediated by similar variables in both cases (Freeman & Morris, 2001). Although this model is limited to symptoms of PTSD, it has encouraged interest in CSA research and may help de-stigmatise the experience (Finkelhor, 1988).

An alternative four-element model of the traumatic effects of CSA was proposed by Finkelhor and Browne (1985). ‘Traumatic Sexualization’ describes the inappropriate sexual and interpersonal development of the child following the use of rewards for
sexual behaviour. This then leads to confusion regarding sexual behaviour and the development of associations between traumatic memories and later sexual activity. ‘Betrayal’ refers to the realization of the child that someone who they have relied upon has wished to do them harm. This can extend to individuals other than the abuser, such as non-offending family members (Finkelhor, 1988). ‘Stigmatization’ describes the messages that the child receives regarding the self as a consequence of the abuse. These have negative themes regarding shame, guilt and worthlessness and may be communicated by the perpetrator, wider systems or social attitudes (Finkelhor, 1988). The final dynamic ‘powerlessness’ relates both to the effect that threatened or actual physical injury has on the child and also the effect of repeatedly having one's wishes or choices over-ruled. This model considers wider issues than those described in a PTSD-model, but is unable to explain why some individuals do not appear to experience any trauma following CSA. In addition, there is a lack of rigorous empirical evidence to support it (Freeman & Morris, 2001).

Carr (1999) indicates that short- and long-term effects of CPA share many of the characteristics observed in CSA. In addition to physical consequences, such as scarring and neurological problems, there may be psychological disorders including: “negative self-evaluative beliefs ..., problems with affect regulation, and associated excesses of internalising and externalising behaviour problems and relationship difficulties” (Carr, 1999, p. 754). Difficulties with externalizing/internalizing behaviour, relationships and cognitive functioning have also been demonstrated in long-term studies of the effects of CPA, although such experiences appear to happen in the minority of cases (Malinosky-Rummell & Hansen, 1993; cited in Carr, 1999). The literature places great emphasis on the developmental effects of CPA, but does not replicate the type of models described for CSA.

Factors influencing outcome

The models described above provide some insight into the psychological problems which occur following CSA and CPA. In order to ascertain whether there is an increased risk of becoming an abuser following victimisation, it is essential to understand how an individual’s social and family background may affect outcome. In
addition, aspects of the abuse experience itself may be relevant and need to be considered. The following discussion will focus on the areas highlighted by the literature, which should be considered when carrying out an assessment of CSA and CPA.

Social and family background

The literature suggests that childhood experiences within the family are an influencing factor when considering long-term outcomes for sexually abused children. There is evidence to suggest that childhood experiences of intrafamilial violence may increase the risk of sexually abused children becoming perpetrators in later life (Skuse, Bentovim, Hodges, Stevenson, Andreou et al., 1998; Salter et al., 2003). The first of these studies provided useful information, using a design which compared outcomes between perpetrators and non-perpetrators using a range of multi-disciplinary assessments. However, participants were all male and came from a specialist service and therefore may not have reflected CSA victims in general. There is additional evidence to support the notion that experiencing or witnessing violence within the family is a risk factor in the victim-perpetrator cycle of CSA (Widom & Ames, 1994, cited in Salter et al., 2003).

In addition to intra-familial violence, Bagley (1995) found that the experience of emotional abuse (in addition to CSA) during childhood, was the strongest predictor of adult sexual interest in children and adolescents, within a cohort of 750 men, aged 18 to 27. Glasser et al. (2001) obtained similar findings in retrospective study of victims and perpetrators. A significant correlation was found between being a victim-perpetrator and having experienced poor emotional care or the absence of a parent during childhood. Further risk factors include a lack of material care or neglect in childhood, as highlighted by Bentovim (2002).

Kaufman and Zigler (1987) conducted a literature review of victim-perpetrator risk indicators in cases of CPA and found that they were mediated by the level of social support and the individual’s ability to recall and express feelings about their own abuse experience. A retrospective study, conducted by Egeland, Jacobvitz and Sroufe
(1988) also found that mothers who had broken the cycle of physical abuse were more likely to have had a supportive relationship with an adult during childhood and were significantly more likely to have engaged in psychological therapy. A possible limitation of this study was that participants were from poor socio-economic backgrounds and therefore results may not be generalizable. Another study, which reflects the findings of research in CSA, found that 'delinquent behaviour' in later life was significantly more likely to occur in abused and neglected children, regardless of gender, ethnicity and social class (Smith & Thornberry, 1995, cited in Widom, 1998).

The areas described above have been shown to be factors in the development of victim-perpetrator cycles of abuse. Pynoos, Sorenson and Steinberg (1993) (cited in Bentovim, 2002), argue that neglect and emotional abuse within childhood has an adverse effect on the process of personality development, in addition to placing the child in state of long-term stress and fear. Despite the adverse impact of lack of material care highlighted by Bentovim (2002), a meta-analytic study by Paolucci, Genuis and Violato (2001) found no evidence within the literature that socio-economic status per se is a risk factor within the sexual abuse cycle. These issues appear to highlight the potential negative impact of poor attachments of individuals abused as children. Fonagy, Steele, Steele, Higgit, and Targe (1993) suggest that children can have an insecure attachment with one adult, but may form a more secure attachment with another individual, even if that person is outside of the family. In such cases Bentovim (2002) argues that individuals who have been abused may benefit from a confiding relationship (with a peer or adult), as such support may serve as a protective factor. Following this rationale, it is plausible that children who have been neglected may also be at greater risk of developing attachments with an abusive adult. The quality of child-caregiver attachments should form part of any assessment relating to disclosed or suspected abuse, with particular regard to the first year of development. In addition, it is essential that information about presence of secure attachments is also obtained, when considering factors which may prevent cycles of abuse. Tools such as the Security Scale can be used to assess the child's experiences of the attachment figures availability, responsiveness, ability to communicate and reliability in times of stress (Kerns, Klepac & Cole, 1996).
It can be seen that the family background of an abused child can have an impact on the probability of the individual becoming a perpetrator of abuse in adult life. The development of an attachment with an abusive adult in childhood may be reflected in the relationships that the abused individual develops with children in the future (Alexander, 1992, cited in Bagley, 1995). Fraiberg, Adelson, and Shapiro (1985) highlighted two psychological mechanisms which appear to influence inter-generational transmission of abuse. The first of these is denial of the feelings associated with the trauma and the second is the extent to which the child identifies with the perpetrator. Carr (1999) argues that parents who physically abuse their children do so in ways that reflect their own experience as a victim. A study by Rocklin and Lavett (1987) appears to confirm the idea that perpetrators internalize an abusive model of adult-child interactions, which they apply in later life. Although the study was limited by the use of a group analysis design, certain themes emerged which are relevant to the current discussion. Rocklin and Lavett (1987) found that non-abusive parents reported making a conscious decision in childhood not to be like their abuser and feared the possibility of identifying with the perpetrator in any way. Such information should be obtained during assessment as beliefs about adult-child relationships and the use of aggression can be challenged during later intervention.

It is essential that the psychologist is sensitive to cultural and social factors when carrying out such assessments. Religious beliefs regarding sexuality and stigmatisation may have an impact on the family's perception of the child and issues regarding stigma of CSA (Avery, Hutchinson & Whitaker, 2002). Prendergast (1993) indicates that religious beliefs can be a mediating factor if they encourage forgiveness and positive development. However, religious beliefs that emphasise the role of sin may not encourage a supportive environment and therefore such information will inform the way in which the psychologist works. Different cultures may also have varying attitudes regarding the validity of children's allegations and definitions of what constitutes child abuse. Professionals need to be aware of such beliefs to inform their work and to protect vulnerable individuals. Cultural variations may also influence the child's decision or ability to disclose abuse in the first place.
Abuse-related risk factors

The literature indicates that there are a number of abuse factors which may contribute to the development of perpetrator behaviour in adulthood. Bentovim (2002) suggests that sexually abused children who externalize their emotional responses (i.e. display anger, intimidation or sexual aggression) rather than internalizing them (i.e. withdrawing or becoming depressed) are of particular concern when considering cycles of CSA. Evidence suggests that older children are more likely to externalize their emotional responses than younger (Friedrich, Urquiza & Beilke, 1986) and that boys tend to externalize more than girls (Carmen, Rieker & Mills, 1984, cited in Glasser et al., 2001). Methods of expressing emotion should be assessed following abuse, in order to ascertain whether the child is able to manage their feelings with appropriate support. Age and gender should also be considered in order to decide whether the child’s level of sexual knowledge or emotional expression is developmentally appropriate. The Child Behaviour Checklist is a self-report scale that can be used in the clinical setting to assess problem behaviours and the child’s tendency to internalize or externalize emotions (Achenbach, 1991).

There is increasing evidence to suggest that male victims of sexual abuse perpetrated by a female are at risk of becoming abusers in adulthood (Salter et al., 2003; Glasser et al., 2001). Glasser et al. (2001) found that incest perpetrated by a sister or mother was the highest predictor of abusive behaviour in later life. This study was based on a case note review and therefore the design was somewhat limited. However, Salter et al. (2003) used a longitudinal design and found that twice as many male victim-abusers had been abused by females compared with non-abusers. Glasser et al. (2001) argue that in such situations the development of a victim-perpetrator cycle may be a means by which the abused male child can assert their masculinity. These studies highlight the need for clear information regarding the perpetrator of the abuse, including the relationship with the child, the gender of the abuser and the victim’s beliefs about their masculinity and power. It should be noted that in their meta-analysis, Paolucci et al. (2001) found that ‘victim gender’ and ‘relationship to perpetrator’ were not risk factors for the development of a victim-perpetrator cycle.
However, this may reflect poor methodologies in existing studies and a lack of data within the abuse literature rather than indicating the absence of a causal relationship.

Assessment should also focus on protective factors regarding the abuse experience, although these are limited. Prendergast (1993) suggests that positive outcome is more likely if the situation is monitored by parents in order to reduce the chances of frequent abuse and also indicates that individuals with good sexual knowledge prior to the abuse are less likely to experience guilt about the experience.

It is clear that there are a number of areas that need to be assessed when working to reduce the likelihood of abuse victims becoming adult perpetrators. The literature suggests that the majority of victims do not become abusers in later life (Salter et al., 2003) and that outcome is mediated by the issues discussed above. In addition to the areas previously described, the clinician needs to carry out a general clinical assessment and should also utilise standardised measures of family functioning, abuse experience, trauma and parental response to disclosure (O’Donohue, Fannetti & Elliot, 1998). During assessment, the psychologist has a responsibility to consider abuse risk factors relating to other children in the home and to consider ways in which these issues can be addressed. If the need for wider support is identified, this may challenge the psychologist’s view of who the client is.

Following assessment, it is essential that these risk factors are addressed via clinical intervention. A variety of different treatment methods are described in the literature and the following section will discuss their efficacy with respect to preventing cycles of abuse.

**Intervention following abuse**

There are a wide range of possible interventions for victims of abuse. The suitability of these different approaches depends on a variety of factors including the age of the child, family functioning and (in cases of sexual abuse) whether the abuse occurred within the family. There is a dearth of longitudinal outcome studies for this population following specific intervention and therefore long-term outcomes are rarely described.
Bentovim (2002) suggests a multi-modal approach to intervention following CSA, which incorporates individual work with the child, family work and work with children who have already began to abuse others. The first aim of child-focused work should be to repair the child’s attachments, although it is suggested that the attachment should be developed between the child and therapist rather than family members. The second purpose of therapy should be to enable the child to manage emotional dysregulation, with an emphasis on anxiety reduction and the appropriate expression of emotion. The aim of this phase of work is to reduce the type of externalising behaviour, which is associated with later abusive behaviour. The final area of direct intervention with the child is to develop a positive sense of self in order to prevent re-abuse, re-attribute blame appropriately and to address cognitive distortions regarding their relationships with other children and beliefs about sexuality and affection.

Bentovim (2002) also emphasises the need to rehabilitate the child into the family following abuse. This is of particular importance for children who have experienced CSA within the family and those who have also been victims of emotional abuse and neglect by family members. The final recommendation considers work with young people who have already begun abusing, including further family work with victims.

Bentovim’s (2002) article provides useful guidance regarding potential areas of intervention with CSA victims, but is limited to reviewing previous research. In this respect, it does not provide outcome data regarding the effectiveness of such a treatment package.

A similar review by Oates and Bross (1995) of intervention outcome studies following CPA, indicated that research in this area was inconclusive and suffered from methodological flaws. They suggest a variety of interventions that can be used successfully to effect positive change, but encourage the use of treatment packages that offer families long-term support in order to challenge patterns of parental behaviour learnt in childhood. The majority of interventions following CPA fall into three categories – child-focused, parent-focused and parent-child interaction focused (Carr, 1999). Judging the most appropriate method of intervention is partly influenced by the treatability of the family, as some families are regarded as “untreatable” (Jones, 1987). This situation arises when it is felt that a child cannot safely live within the family, for risk of further abuse. Risk indicators for untreatability include parental
factors, such as being a victim of child abuse, denial of abuse and refusal to accept support. In addition, abuse that is deemed to be severe is more resistant to intervention. Such factors should be considered before the method of treatment is chosen, as direct support for the child may prove more beneficial than trying to involve family members.

The literature on the treatment of sexually abused children strongly supports the use of cognitive behavioural therapy (CBT) with children and their non-offending parents, but Saywitz et al. (2000) argue that this is primarily a reflection of the lack of outcome studies for other interventions. CBT is used to fulfil three aims: to relieve symptoms of anxiety and depression, to correct assumptions about blame and responsibility and to work on problem behaviours which have arisen following the abuse (Olafson & Boat, 2000). Cohen and Mannarino (1996b, cited in Saywitz et al., 2000) found that abuse-focused CBT with pre-school children and their parents was effective at reducing levels of externalising and sexualised behaviour when compared with play therapy. However, there is evidence to suggest that externalising and sexualised behaviours are not always ameliorated by CBT, and that change is less likely to occur in older children (Monck, 1997). In order for CBT to be used effectively in any population, it is essential that participants have insight into the relationship between thoughts and behaviour (Hawton, Salkovskis, Kirk & Clark, 1989). Kools and Kennedy (2002) urge caution in the use of CBT with younger children following their study into management of child sexual behaviour in abused children aged between 6 and 14 years. They argue that younger children will be unable to offer insight into the motivation behind their sexualised behaviour and that alternative, developmentally-appropriate interventions should be utilised. It is interesting to note that Deblinger, Lippman and Steer (1996) successfully used a cognitive-behavioural intervention with 7-13 year-olds and found that there was a significant improvement in functioning, implying that CBT can be used effectively in this population. Within the clinical setting, it is essential that the psychologist considers the ability of the child to identify emotions and to make links between their thoughts and behaviours, before adopting such an approach. In addition, issues such as homework completion may be compromised in chaotic or neglectful family environments or may cause distress to the child, which cannot be contained by family members.
The use of family interventions is also an important area to consider when working to prevent cycles of abuse. Grosz, Kempe and Kelly (2000) compared individual treatment of children or parents with family crisis counselling, a children’s group, a parent support group and alternative resources. Participants in this study had been abused by individuals outside of the family. The study found that family work, in conjunction with individual child and parent CBT was the most effective method of intervention. Unfortunately, the article does not describe family backgrounds of the children in terms of experiences of neglect or emotional abuse and it is unclear how parents had responded to disclosure. In addition, children who were displaying “seriously disruptive behaviour” or “extensive sexualized behaviour” were referred to other services and therefore were not included in the study. While this places some limitations on the conclusions that can be drawn regarding the effectiveness of using such an approach to prevent abuse cycles, the study did include individuals who were “acting out” sexualized behaviour towards their peers – another identified risk behaviour. Overall, the study found that maternal support was the single biggest factor in ameliorating negative symptoms of sexual abuse and family intervention served to encourage this relationship.

Monck, Bentovim, Goodall, Hyde, Lewin et al. (1996) suggest that family work can be used to address a variety of abuse related issues including responsibility, power, denial and the externalising behaviours which can occur as a response to such difficulties. Family interventions which address such issues, are clearly of greater relevance in situations where multiple types of abuse have occurred including neglect and emotional abuse.

Kolko (1996) conducted a trial comparing CBT with family therapy (FT) and community services (RCS) in 47 cases of CPA. The study found that both CBT (with parents and children) and FT were more effective at reducing levels of family conflict, parent-child violence and externalising behaviour in the children. In the majority of cases, these improvements were maintained at one-year follow-up. However, little change in the parent’s cognitive-behavioural repertoires (i.e. use of punishment, beliefs about parenting) and the children’s levels of aggression and social competence were reported. These results indicate that physical abuse-cycle risk factors such as
externalization and family violence may be reduced by the use of CBT or FT, but that other risk indicators may remain.

A recent review of family interventions following CPA suggests the use of multi-systemic treatment to prevent cycles of abuse (Corcoran, 2000). This approach involves using a variety of interventions including individual CBT, family therapy and work within broader systems (e.g. neighbourhoods and schools). Research indicates that multi-systemic treatment is able to successfully reduce internalising and externalising symptoms in children and increase levels of support within the family (Corcoran, 2000). In addition, such an intervention can also ameliorate mental health problems in parents and decrease intra-familial hostility (Henggeler, Borduin, & Mann, 1993). According to the literature discussed above, such improvements within an abusive family environment should greatly reduce the risk of intergenerational transmission of abuse. However, the literature in this area is sparse and limited resources may constrain the extent to which such an approach can be implemented within health services.

The use of group interventions has also been studied by a number of authors. Lindon and Nourse (1994) conducted a study of a group intervention for sexually abused adolescent girls using skills teaching, psychotherapeutic methods and psychoeducation. Following intervention, reports indicated improvements in self-esteem, emotional expression and family relationships. Improvements in family relating and emotional functioning were also observed at 6-month and 1-year follow-up. Grosz et al. (2000) also used a group condition in their study looking at abused 4-10 year olds and used similar methods to improve emotional functioning and enhance coping. One strength of group work is that it demonstrates to children that other people have had similar experiences (Grosz et al., 2000). In cases of intra-familial abuse, group-work may provide children with the opportunity to be open and honest about their experiences, in contrast to the family’s use of secrecy and avoidance (Olafson & Boat, 2000).
Additional considerations

Saywitz et al. (2000) make numerous recommendations regarding general principles to consider when carrying out such interventions. The primary aim should always be to ensure that the child will not be subjected to abuse in the future. Following this, the clinician needs to consider the most appropriate form of intervention including individual, family, group and psycho-educational approaches. Delays in treatment may cause further deterioration in functioning and can make problems more resistant to change. Salter et al. (2003) states that interventions are more likely to produce positive change, that can reduce perpetrator risk factors, if the intervention is carried out prior to adolescence. Therefore, the type of intervention and point at which it is offered are of great importance when planning treatment. Widom (1998) suggests that in cases of CPA early intervention is essential in order to prevent offending behaviour in children, which may continue to influence the individual throughout their life. It is also essential that professionals tackle issues of neglect, even if the initial focus of the work is on another area of abuse. Avery et al. (2002) suggest that social skills training may enable the child to develop appropriate relationships in the future if they have experienced neglect. Clearly, there are a wide range of possible therapeutic and social interventions that services can offer. However, it is essential that children and families have access to services that provide support that is designed specifically to meet the needs of the child and family. Interventions should also be sensitive to the child’s spiritual beliefs and the impact that abuse may have had on these.

Conclusion

Current opinion in child abuse research supports the notion that the transmission of abuse between generations is not inevitable and is mediated by a number of factors. The influence of family and social factors, poor attachments and childhood experiences of emotional abuse and neglect have been identified as major risk factors in cycles of abuse. Additional risk factors include the gender of the abuser, the ability of the child to express their feelings appropriately and the age of the child. In order to reduce the likelihood of abusive behaviour occurring in adulthood these risk factors should be assessed by the psychologist as part of a wider clinical assessment.
A variety of intervention methods can be applied when working with abused children, including individual therapy, family therapy and group work. General guidelines for intervention emphasise the need to enable the child to develop more secure attachments and manage emotional dysregulation. In addition, issues of neglect and emotional abuse need to be addressed within the family. Due to the vast scope of child abuse it is impossible to conclude that any one intervention is better than another. Variables such as the identity of the perpetrator, stability of the family, age of the child and severity of symptomology will influence decisions regarding the most appropriate form of intervention. Such decisions should be evidence-based and must promote the needs of the child. Whenever possible, it is recommended that multi-modal or multi-systemic treatment occurs at a number of levels, including individual work, family therapy and within wider systems.

There are numerous articles within the literature which address the issues of assessment and treatment of child abuse, but many appear to suffer from poor methodologies. Cases of abuse tend to be highly complex and it is a challenge for researchers to conduct randomized outcome studies, which adequately match participant’s social, family and abuse experiences. There are also ethical implications for conducting randomised control trials with abuse cases and longitudinal studies are constrained by limited resources and the practical difficulties of long-term data collection.

Future research should focus on longitudinal designs, which assess risk and protective factors in abused children into late adulthood. It is also important to gain long-term outcome data following different types of intervention, to assess whether specific interventions do reduce victim-perpetrator cycles. Despite the limitations of the literature, it is clear that clinical intervention can reduce the risk of victim-perpetrator cycles developing in adulthood.
References


What is the role of the clinical psychologist in services for people with dementia and their families? How can we evaluate our contribution as psychologists?
Introduction

The recent National Service Framework (NSF) for Older People has highlighted the need for more effective mental health services for older people, including improved support for individuals with dementia and their carers (DoH, 2001). The guidelines also highlight the need for early recognition and management of mental health problems, increased use of evidence-based care for individuals with dementia and the need for accessible and appropriate services for older people from diverse ethnic and cultural backgrounds.

The term dementia refers to a variety of neuro-degenerative disorders and includes Alzheimer's disease, Pick's disease and vascular dementia (Lezak, 1983). The International Classification of Diseases – 10 (WHO, 1992), indicates that dementia is: "a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is a disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement." (p.45). Due to the breadth of the term dementia, it is important to note that the different disorders that fall within this category vary considerably, but share the general characteristics of a decline in memory and thinking (WHO, 1992).

Within the UK, approximately 5% of the population aged over 65 years have dementia and this figure increases to 20% of people aged 80 years and over (DoH, 2001). In addition, it is predicted that this figure will continue to rise as the population of people aged over 65 increases (Duijnstee, 1992). The majority of people with dementia live in the community and are cared for by family members. Family carers often experience high levels of strain and depression as a consequence of the behavioural and psychological symptoms of depression (BPSD) (Marriott, Donaldson, Tarrier & Burns, 2000; Donaldson, Tarrier & Burns, 1997; Lawlor, 2002). Duijnstee (1992) states that the support offered by family members forms an essential component of the overall care received by individuals with dementia, as they are more able to offer continuous support. However, research suggests that the psychological and social burden that this places on the family caregiver often contributes to the individual with dementia being placed in residential care (Gilleast, Gilleast, Gledhill & Whittick,
1984). Such an outcome may have various detrimental personal and social consequences for both the older person and the care-giver. Therefore, great emphasis has been placed on methods of ameliorating the negative effects of informal caregiving, as a means of improving carer and client quality of life and delaying institutionalization (Bond, 1999; Marriot et al., 2000).

Until recently, there has been a lack of literature regarding the individual’s experience of having dementia, although this situation has improved in the last decade (Midence & Cunliffe, 1996). Accounts of the experiences of people with dementia report increased levels of depression and psychosis, changes in personality, and less opportunity to participate in favoured activities (Midence & Cunliffe, 1996; Sperlinger & McAuslane, 1994 cited in Midence & Cunliffe, 1996). Clearly, as the disease progresses and cognitive abilities deteriorate, it becomes increasingly difficult to obtain the client’s own perspective on the process of dementia. This poses a challenge for both professional and informal carers, in terms of understanding and meeting individual needs.

The following discussion will focus on the ways in which clinical psychologists work within services for people with dementia and their families, and the ways in which this contribution can be evaluated, with particular reference to client and carer experiences. A recent guidance document indicates that clinical psychologists should fulfil various roles in services supporting older people, including direct and indirect clinical work, consultancy, teaching, carer support and service evaluation (British Psychological Society (BPS), 1995). Therefore these ideas will also be considered.

**Assessment and disclosing a diagnosis of dementia**

Individuals with suspected dementia may be referred to psychologists working in various specialities, including teams working with older people and neuropsychological services. These referrals tend to occur following a decline in recent memory or a change in mood noticed by family members (Lezak, 1983). Whilst it is recognized that such referrals may also be made to learning disability and
working-age adult services, these client groups will not be included in the following discussion.

Initially, the clinical psychologist should ensure that older people with suspected dementia receive a comprehensive assessment that goes beyond changes in cognition and mood. The Audit Commission Report, 'Forget Me Not' (2000) recommends that initial assessments should employ a multi-disciplinary approach, including physical investigations to exclude other biological factors and an assessment of social needs. This report also highlights the need for GP's to receive training in the use of brief cognitive screening tools from suitable mental health professionals. This responsibility is suitable for the clinical psychologist to perform, given the professions expertise in cognitive theory, psychometric test administration and staff training.

As stated previously, early diagnosis is seen as a priority for both the individual and the family, as it allows intervention to begin earlier, provides more time for future planning and may enable those involved to come to terms with the implications of the diagnosis (DoH, 2001). Those individuals who receive an earlier diagnosis and whose cognitive abilities remain relatively intact, are also more likely to be able to participate in the process of making plans for their future (including advanced directives), to be able to provide informed consent for assessment or intervention and to advocate for their own needs (DoH, 2001). Although all health professionals have a duty to obtain informed consent, in my experience referrals are often made to psychologists to ascertain capacity to consent, partly due to a greater depth of understanding of and familiarity with relevant theory. Despite the value of early diagnosis, this process presents more challenges than later diagnosis, as dementia may be misdiagnosed as depression or delirium during its early stages (WHO, 1992). Although dementia may be diagnosed by a variety of different professionals including GP's, psychiatrists and neurologists, clinical psychologists play a unique role in the assessment of an individual's cognitive abilities. Whilst brief screening tools may provide useful preliminary information regarding a decline in cognitive or social functioning, they are unable to provide the degree of information necessary for care planning (American Psychological Association, 1998).
Research indicates that neuropsychological assessment continues to be the most effective means of identifying changes in cognitive ability and making differential diagnoses, not only between normal aging, dementia and depression, but also between the different sub-types of dementia (American Psychological Association, 1998). Neuropsychological assessment is a complex process and it is essential that the clinical psychologist is aware of their own strengths and weaknesses in this area and the limitations of the assessments they are using. Within my own clinical experience of conducting such assessments, it has become apparent that numerous psychometric tools do not provide normative data for older people, thereby limiting the scope of standardised assessments available to the psychologist. This is particularly problematic in situations where baseline information has been obtained using such a tool, as conclusions regarding the level of deterioration following future re-assessment may be unduly limited. Similar problems also occur when assessing older people from diverse cultural and ethnic backgrounds, as tools may be culturally biased, or reliant on English as a first language, thereby potentially compromising their reliability or validity. When conducting an assessment, the clinical psychologist must consider the ethical implications of assessing abilities that are already known to be impaired; as such a process may provide the client with yet more experience of failure.

Within a multi-disciplinary team working with individuals with dementia, the clinical psychologist is in a position to promote the conceptualisation of dementia within a psychosocial framework, in conjunction with more traditional cognitive or biological models. Pratt and Wilkinson (2003) propose a psychosocial model to describe the experience of receiving a diagnosis of dementia, which relates to the issue of withholding diagnosis from the client and the effects of individual and social factors on coping ability. Their two-factor model proposes that coping with a diagnosis of dementia is mediated by the individual’s ability and desire to know the diagnosis, and the social context, including the influence of family, carers, social support and levels or perceptions of social stigma. The model indicates that four main coping styles may emerge: detachment, distress, maximizing strategies or denial / decline. By adopting such an approach to understand an individual with dementia’s experience of receiving a diagnosis, the clinical psychologist ensures that the care they provide is person-
centred and that a culture of secrecy is avoided, possibly as a result of improved diagnostic methods, or a reduction in the stigma attached to dementia (Kitwood, 1997). Husband (1999) indicates that by providing psychological support for the individual at the time of diagnosis, the clinical psychologist may be able to provide coping strategies regarding stigma and self-perception, leading to increased levels of self-esteem. By providing a positive experience of mental health services at this stage, engagement may also be improved in the future, when there has been some deterioration in cognitive and social functioning. Early, needs-lead intervention may enable the client to remain in their community for longer, rather than being cared for within an institution. It is possible that as a consequence of this, the individual may be able to retain a sense of independence for longer, with positive effects on mood and self-esteem.

Although the process of being diagnosed with dementia has the potential to cause distress, Pratt and Wilkinson’s (2003) model encourages professionals to reflect on the ways in which diagnosis is disclosed and the impact that withholding diagnosis may have on the individual. Whilst it is not necessarily the role of the clinical psychologist to advocate for all diagnoses of dementia to be disclosed, they certainly have a responsibility to encourage the service as a whole to consider the psychological and social context of individual cases. In addition, the clinical psychologist is in a position to promote the idea of professionals and family playing a role in shaping the social context of the individual, and the ways in which this can influence the client’s overall coping (Pratt & Wilkinson, 2003). In order to understand the type of social support that may be most beneficial, it is important to consider the specific needs of the individual. In addition, when considering potential types of social support the clinician must ensure that they do not make assumptions about what would be a valued means of support, thereby acknowledging the impact that different generational, cultural or social backgrounds may have on this.

In addition to participating in the assessment of cognitive and social strengths and weaknesses, it is also necessary for the clinical psychologist to ensure that an assessment of the carer’s needs is conducted (DoH, 2001). This may highlight difficulties that the carer is experiencing as a consequence of adopting such a role,
Older People Essay

which may be having a deleterious effect on their social functioning and psychological well-being or that of the client. By completing comprehensive assessments of the needs of the individual with dementia and their primary carer, it is possible for the clinical psychologist to develop a formulation, which will inform decisions regarding intervention and support. In addition to conducting direct clinical work with these individuals, the clinical psychologist should ensure that joint-working is carried out with relevant public-sector and voluntary agencies (DoH, 2001).

The following section will describe the role that the clinical psychologist can play in terms of offering direct and indirect intervention for the individual with dementia.

**Intervention with the individual**

**Psychosocial approaches**

Historically, a range of interventions have been offered to individuals with dementia, in order to reduce rates of cognitive deterioration or levels of emotional distress, including reality orientation and reminiscence therapy (Spector, Orrell, Davies & Woods, 2004). The literature indicates that during the early stages of dementia, the individual considers their memory difficulties to be the most problematic area and therefore, these may be considered a priority. Memory impairments can lead to decreasing self-confidence and depression and may cause frustration and strain in family caregivers (Clare, Woods, Moniz Cook, Orrell & Spector, 2004). Clearly, those individuals who present with apparent depression should be assessed for potential risk factors associated with suicide (DoH, 2001).

The NSF for Older people recommends the use of non-pharmacological treatment methods for dementia, including the use of ‘mental exercise’ (p.98, DoH, 2001). Reality orientation (RO) is an approach that has been used within services for people with dementia over the last four decades, although the term now covers a range of interventions (Scott & Clare, 2003). The overall aim of RO is to improve the client’s understanding of their environment, by providing information that enables the individual to be better oriented in time and place, either in a classroom setting, or on a 24-hour basis (Folsom, 1986). A recent Cochrane review of classroom RO indicated
that this approach may produce some beneficial effects for individuals with dementia, in terms of cognitive and behavioural functioning (Spector, Orrell, Davies & Wood, 2004). Due to the rigour of the review process, only six studies were included in the article and therefore may not be indicative of general experiences of applying RO. In addition, outcome was assessed in terms of cognitive and behavioural functioning, without considering the impact the intervention had on emotional well-being or social functioning.

Similar interventions may also be carried out using reminiscence therapy (RT), in which the individual is encouraged to talk about previous events or life experiences, thereby enabling them to communicate, whilst relying on relatively intact autobiographical memories (Spector et al., 2004). A review of reminiscence therapy conducted by Spector et al. (2004) was inconclusive regarding the potential benefits, primarily due to strict exclusion criteria. Whilst similar studies have also failed to find statistically significant effects of RT on cognition and behaviour, there is some indication that the process of conducting this type of intervention improves the quality of interaction between carers and clients (Scott & Clare, 2003; Thornton & Brotchie 1987, cited in Midence & Cunliffe, 1996).

Research suggests that the benefits of RO can be lost following the termination of intervention and therefore such a service needs to be offered on an ongoing basis (Reeve & Ivision, 1985). A clinical psychologist’s training and expertise in applying cognitive, systemic and psychodynamic principles, within a group setting, will lend them to the task of running RO and RT groups (Scott & Clare, 2003). If practical issues prevent this, the psychologist may provide consultancy or supervision for those professionals who are running such a service and be involved in training staff to provide cognitive strategies for individuals with dementia.

Psychologists may also offer memory training interventions to maximise the cognitive strengths of the individual that remain relatively intact. This may include the use of verbal or visual mnemonics, self-teaching methods and external memory aids (Smith & Winograd (1978), Scogin, Storandt & Lott (1985) both cited in Scogin, 1992; Bourgeois, Camp, Rose, White, Malone et al., 2003). Kasl-Godley and Gatz (2000)
indicate that in order for memory training interventions to be effective they need to incorporate a long training period, place greater emphasis on the use of recognition memory (which tends to remain more intact than self-initiated retrieval), and involve the carer in the process, so additional support is offered. By adopting such an approach, the individual can improve face-name association skills, prospective memory and quality of conversation content (Clare, Wilson, Breen & Hodges, 1999; Camp, Foss, Stevens & O’Hanlon, 1996). In addition, by involving the carer, it may increase their understanding of the difficulties that the client has, and may facilitate the generalisation of learnt skills to other social environments.

Whether the psychologist is directly or indirectly involved in the provision of cognitive rehabilitation strategies, it is essential that they have an awareness of the limitations of such an approach. Clare, Wilson, Carter, Breen, Berrios, & Hodges, (2002) indicate that methods of cognitive rehabilitation have the potential to increase levels of depression and anxiety in individuals with dementia and may increase levels of stress in carers. It is unclear whether this change is due to the client gaining additional insight into their cognitive impairment or other processes. In my experience of working with people with dementia, I have observed increasing levels of distress, as cognitive ability deteriorates and insight increases. In addition, reminiscence work may also focus on historical information that is emotive or challenging in a way that is not recognised by the professional. This may reflect differences in the way in which historical events are perceived by members of different generations, or assumptions that are made about clients’ life experiences.

**Behavioural and Psychological Symptoms**

The issue of the behavioural and psychological symptoms of dementia (BPSD) is also a key area of intervention for the clinical psychologist and may have an impact on the well-being of both the client and family members. These symptoms include those associated with mental health, including depression, anxiety and psychotic symptoms. In addition, there may be behavioural disturbances, including increased agitation or aggression and wandering behaviour (Purandare, Allen & Burns, 2000).
Various theories have been developed regarding the aetiology of BPSD, including biological, psychological and social factors. Purandare et al (2000), suggest that the increasing burden of coping with everyday tasks becomes unmanageable for the client and that BPSD’s occur as a reaction to this. In addition, they hypothesise that the carer’s reactions to these behaviours contribute to the development of a vicious cycle, in which the individual with dementia is unable to manage life stresses (including the carer’s responses), and the carer believes that the individual is in control of their behaviour. In such a situation, the psychologist can offer various interventions, which may be of benefit to both the client and family members. Kitwood (1997) suggests that the psychodynamics of long-term relationships that often exist between the carer and the individual with dementia may become exaggerated following changes in ability or functioning, resulting in the carer displaying a lack of empathy for the client.

Interventions directed at the individual with dementia include behavioural strategies, stimulus control via environmental modifications and methods of sensory stimulation (Orrell & Bebbington, 1995; Baker, Bell, Baker, Gibson, Holloway et al., 2001). In order to devise an appropriate intervention to reduce the impact of BPSD, the individual’s presentation should be understood within a bio-psychosocial model. Therefore, a comprehensive assessment of the individual’s social and physical environment should be conducted, in addition to assessing physical status and psychogenic factors, including life history, attitudes, habits and beliefs. The psychologist has a role in the assessment of psychogenic factors and should assess the quality of the caring environment, including the practices and attitudes of family carers. An assessment of BPSD should be carried out as early as possible, to reduce the detrimental effects on the individual and to reduce carer distress (Lawlor, 2002).

Within services for people with dementia, the psychologist may be in a position to work with or refer the individual to an occupational therapist on issues relating to environmental modifications. This may include practical aspects of the environment such as lighting, temperature and noise, or more psychologically oriented intervention such as increasing levels of meaningful stimulation or social contact (Purandare et al., 2000). This could also include introducing cognitive rehabilitation sessions into the day, to provide a comprehensive range of interventions to meet individual needs. The
success of such an intervention may be reflected in reductions in symptoms of depression and improved sleep quality (Teri & Wagner (1992), cited in Purandare et al., 2000).

**Carer support**

As stated previously, the impact of caring for an individual with dementia has a number of potentially detrimental effects on family carers, and can lead to institutionalization of the individual with dementia. The literature suggests a wide range of possible methods of intervention to reduce these effects, including respite, carer training programmes, psychosocial interventions and cognitive-behavioural approaches (Lee & Cameron, 2004; Gormely, 2000; Cooke, McNally, Mulligan, Harrison & Newman, 2001; Marriott, et al., 2000). Within services supporting people with dementia, it is important for professionals to be aware of the risk factors for carer stress or burden. These include a history of psychiatric problems in the carer, poor physical health, level of neuroticism and quality of family support (Welleford, Harkins & Taylor, 1995). Research also suggests that family carers who experience greater levels of burden, tend to exhibit greater levels of expressed emotion (EE) and utilise less effective coping strategies (Spruytte, Van Audenhove, Lammertyn & Storms, 2002).

Research looking at the levels of criticism between carer and client indicate that a wide range of factors may influence the quality of the relationship and the resulting distress (Spruytte et al., 2002). The level of behavioural disturbance in the older person predicted higher levels of EE, as did the carer’s attribution of the level of perceived control that the person had over their behaviour. Such issues could potentially be managed by adopting a cognitive-behavioural approach to care-giver support, such as the method described by Marriott et al. (2000), which incorporated carer education on dementia, stress management and the development of coping skills. Although this study was successful in moderating the behavioural symptoms of the older person and reducing levels of depression and distress in the carers, its sole emphasis was on providing the carer with skills to manage the situation, without considering ways in which factors, such as social support, could also be used to reduce distress. Other methods of support, which the psychologist could be in a position to
offer, either through direct or inter-agency working include the provision of respite care, referral to support groups such as the Alzheimer’s Society, provision of educational materials and bereavement counselling. A meta-analysis of carer interventions highlighted that a number of published articles in the field of dementia care produced effect sizes that did not reach clinical significance, despite being statistically significant (Schulz, O’Brien, Czaja, Ory, Norris et al., 2002). However, Schulz et al. (2002) also indicated that a number of these studies did meet their criteria for social validity, indicating that the participant’s experiences of the interventions were positive.

The importance of providing suitable services to family care-givers from diverse ethnic and cultural backgrounds has been highlighted in a number of publications, primarily based on North American samples (DoH, 2001; Gallagher-Thomson, Haley, Guy, Rupert, Argüelles et al., 2003; Haley, Roth, Coleton, Ford, West et al., 1996). Guidance on the development of culturally sensitive interventions for family caregivers indicates that service must be available and accessible to individuals from diverse ethnic backgrounds and that clinical psychologists can promote this idea through the pursuit of cultural competence, described as, “cultural awareness, knowledge, and culturally sensitive skills.” (p. 424, Gallagher-Thompson et al., 2003). This article also describes some of the key cultural features of the main minority groups within North America, including the perceived importance of the church and the structure of family in African American culture. Whilst such descriptions may provide some guidance regarding certain cultural themes, it is essential that the psychologist does not make assumptions about the caregiver’s perceptions of their caring role or that of the older person, based on cultural stereotypes or expectations. By participating in continuing professional development psychologists can ensure they are able to work confidently and effectively with individuals from diverse backgrounds.

The above discussion highlights a number of potential areas of assessment and intervention that the clinical psychologist may be involved with when working in services for individuals with dementia and their families. In order to ensure that the
clinical psychologist provides a valuable contribution to such services, it is essential that the impact of their work is evaluated.

**Evaluation**

The contribution that the clinical psychologist makes to services for people with dementia can be considered in terms of the outcome for the client or the impact that psychological support has on family members. Although research has primarily focused on the alleviation of distress or burden in family carers, there has been a shift towards considering the effect that psychological intervention has on cognitive abilities or the quality of life of the client (Gormley, 2000; Bond, 1999).

Clinical psychologists can evaluate the effectiveness of the cognitive rehabilitation interventions that they offer in a number of ways. Due to the degenerative nature of dementia, intervention may reduce the rate of deterioration, promote stabilization or result in improvement in functioning. The clinical psychologist’s contribution to the reduction of problems arising as a result of cognitive impairment is often assessed in terms of the impact that the intervention has on the individual or the primary carer.

For the individual with dementia, the impact of psychosocial intervention may involve the evaluation of changes in cognitive, behavioural or emotional functioning (Quayhagen & Quayhagen, 1989). These changes may then have a positive impact on the relationship that the individual has with the primary care-giver. However, research suggests that improvements in cognitive functioning may not affect the carer’s perception of burden, indicating that additional areas of psychosocial support may be required (Quayhagen & Quayhagen, 1996). Alternatively, Quayhagen and Quayhagen’s (1996) use of a measure of burden, rather than distress or coping, may not have captured the essence of the impact of cognitive impairment on carers.

The emotional and social impact of psychological therapies offered by the psychologist, or via professionals trained and supervised by the psychologist, can be assessed in terms of improvements in quality of life, psychological well-being, level of independence and quality of social or personal relationships (BPS, 2001). The
process of assessing quality of life, which encompasses concepts of social and personal functioning, health and life satisfaction, is particularly challenging when the professional is striving to ensure the voice of the older person is heard (Bond, 1999). By obtaining outcome information that reflects the needs and personal views of the individual with dementia, the clinical psychologist will be able to demonstrate the contribution they have made to improving the individual’s quality of life. Increasing the older person’s participation in the identification and evaluation of goals is a reflection of the contribution the psychologist is making to the service. By adopting an approach which considers the implications of different styles of working, such as person-centred as opposed to service-led practice, will provide the clinical psychologist with valuable information, which can inform decision-making regarding future service provision (BPS, 2001). Psychologists may also find that using assessments of service user satisfaction provide useful information from the perspective of the client and carer.

Evaluation of interventions for family care-givers can be assessed using a wide range of criteria, which should be informed by the individual’s areas of perceived need. There has been a great emphasis on studying the ability of individuals to manage the burden that arises as a consequence of their care-giving role and the impact that psychosocial interventions can have on reducing levels of burden (Marriott et al., 2000). In clinical terms, assessing reductions in levels of burden may be somewhat meaningless; as such a term may include symptoms associated with mental health problems, levels of social support, physical health problems and social activity restrictions (Marriott et al., 2000; Donaldson et al., 1997). Therefore, it may be of more value to agree clear aims of psychological intervention and to ensure that the methods that are used to evaluate their effectiveness are appropriate. Evaluation may also focus on the care-givers style of coping with their role and the way in which this has developed or evolved, as a consequence of the intervention (McKee, Whittick, Ballinger, Gilhooly, Gordon et al., 1997).

In addition to considering the contribution of the clinical psychologist in terms of outcome for the client or family carer, their potential value can also be evaluated in terms of the extent to which other team members understand the skills and
professional interests of the psychologist. Historically, the role of clinical psychologists in services for individuals with dementia has been primarily associated with neuropsychological assessment. Therefore, an increasing appreciation of the role that psychologists can play, in terms of supervision, intervention and service development, may reflect a shift in other professions perceptions of the value of psychological services (Bird, 1999). The psychologist may also be able to evaluate their contribution via an audit of the service, or via the application of task analysis, in order to evaluate the effectiveness of individual pieces of work that they have completed. This may also include the analysis of clinical outcome measures and re-referrals to the psychology service. On a less formal level, by reflecting on the specific types of referrals that they receive or are allocated, the psychologist may gain insight into their perceived role within the service, or the areas of their expertise that are particularly valued. Overall, evaluating the impact of psychological services is a complex process and as Conroy (1992) highlights, it is extremely difficult to separate the contributions made by different professionals working within a team.

Conclusion

The role of the clinical psychologist in services for people with dementia and their families is complex and multi-faceted. Historically there has been a tendency to focus on the needs of the family and consequently, the individual has often been overlooked. The development of person-centred theories has highlighted the need to obtain and respect the views and wishes of the individual with dementia, whilst continuing to provide support for the family during a period of change and loss. The clinical psychologist also has a role in terms of providing evidence-based interventions, the appropriateness of which will vary as the dementia progresses. This provides a constant challenge for services, which must adapt to meet the changing needs of the individual and their family.

Despite the increasing evidence base regarding psychological approaches to dementia, there continues to be a need for further research into client’s experiences of dementia and the ways in which the effectiveness of services can be evaluated. Although outcome measures are routinely used in psychology services, they only reflect a small
proportion of the work conducted by the psychologist. It is essential that psychologists working with older people continue to develop methods of evaluating their contribution to services for individuals with dementia.
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Clinical Section
Overview of Clinical Experience
Overview of Clinical Experience

Adult Mental Health Placement

Setting
This placement was based in a psychology department and included work with clients referred from a Community Mental Health Team and from primary care. The majority of this work was carried out in the psychology department.

Models
The main theoretical model was narrative.

Range of Experience
Clients’ presenting problems included depression, anxiety (including Obsessive Compulsive Disorder), phobias, anger problems, relationship difficulties, cognitive impairment arising from alcohol and drug use and night terrors. The placement also included a six-session anxiety management group, using cognitive behavioural therapy.

A research project was completed, looking at the concurrent validity of a newly devised caseload management tool. The results were presented to the service.

People with Learning Disabilities Placement

Setting
This placement was based in a Community Learning Disabilities Team. The majority of the clinical work was conducted in the community, at client’s homes, day-care services and residential and nursing homes.

Models
Models used during this placement included cognitive behavioural, behavioural and systemic.

Range of Experience
Presenting problems included anxiety, obsessive compulsive disorder, agoraphobia, self-injurious behaviour, bereavement issues, dementia, aggression and dual diagnosis.
Overview of Clinical Experience

(schizophrenia), eating disorders and parenting difficulties. I conducted a number of dementia assessments and neuropsychological assessments of memory.

During the placement I was also involved in staff training on schizophrenia and attended training on communication skills, facilitated by a Speech and Language Therapist.

**Child and Young People Placement**

**Setting**
This placement was based in a Child and Adolescent Mental Health Service.

**Models**
The models used included cognitive behavioural, behavioural, systemic and developmental. Additional neuropsychological work was also conducted.

**Range of Experience**
Presenting problems included sleep difficulties, physical and verbal aggression, conduct difficulties arising from physical abuse, anxiety, vomit phobia, anger problems, school refusal, social and communication difficulties and assessment of a child with possible Attention Deficit Hyperactivity Disorder.

I gave a presentation to the multidisciplinary team on intergenerational cycles of abuse and methods of intervention in this area.

**Older People Placement**

**Setting**
This placement was set in a Community Mental Health Team for Older People and included community and inpatient work.

**Models**
The models used included cognitive behavioural and schema-focused therapy.
Overview of Clinical Experience

Range of Experience

Presenting problems included bipolar disorder, depression, relationship difficulties, dementia, memory problems and confusion, health anxiety, night panic and obsessive compulsive disorder.

During the placement I conducted a staff training session on the use of the Repeatable Battery for the Assessment of Neuropsychological Status with Older people. I was also involved in reviewing the process of the referral meeting, via joint working with an external consultant.

Specialist Placement

Neuropsychology

This placement was split between four Community Rehabilitation Teams and a specialist neuropsychology service within a psychology department. The models used included cognitive behavioural, systemic, rehabilitation and neuropsychological. Presenting problems included stroke, depression and loss issues, vascular dementia, multiple sclerosis, head trauma, temporal lobe epilepsy, aggression and poor insight. The role combined neuropsychological assessment with rehabilitation work.

I also co-facilitated a group for individuals with acquired brain injury and their carers, which combined psychoeducation with rehabilitation and cognitive behavioural work.

Continuing Needs Service

This placement was based in a continuing needs service, incorporating assertive outreach, rehabilitation and recovery and inpatient services.

The models used included cognitive behavioural therapy and systemic therapy. Clinical work included individual and family work with people with bipolar disorder, schizophrenia and personality disorder. The role combined specific psychological assessment and intervention with more generic tasks. During the placement I was also involved in the development of a hearing voices group.
Summary of Case Reports

Note: Identifying details have been changed to preserve the anonymity of the client.
Summary of Adult Mental Health Case Report

Narrative and cognitive-behavioural therapy with a twenty six-year-old man with agoraphobia

Referral of the problem

A referral was received by the Psychology Department regarding a 26-year-old white, British man (John) who had been experiencing mild agoraphobia and vomiting for approximately three years. Medical investigations suggested the possibility of coeliac disease and consequently John had seen a nutritionist for dietary advice.

Presenting Problem

John reported experiencing anxiety when he went into novel situations or had to travel distances greater than ten miles. He continued to attend work on a daily basis without experiencing undue anxiety, although his role was sometimes limited by his inability to travel. At times when he was going into a situation that was new or important (such as a family function), he would experience physical symptoms such as nausea, heart palpitations, shaking and perspiration. He would be unable to eat for up to 24 hours prior to the event. John described various negative automatic thoughts, such as “I can’t be sick in public” and “I need to get home, then I’ll feel safe”. John’s anxiety was having a major impact on his quality of life and that of his girlfriend, as social and family events had been affected.

Initial assessment of the problem

Assessment was carried out on a one-to-one basis, over two fifty-minute sessions. John was encouraged to “tell his own story” as part of the process of narrative therapy and genogram work was carried out to look at the structure of John’s family and to identify possible themes. Detailed background information was also gathered, including information about his parents divorce and the original incident that had triggered John’s difficulties. In addition, we explored aspects of John’s previous
relationship, the impact of his ex-girlfriend's attempted suicide and his social and family relationships prior to the onset of agoraphobia. Additional psychometric information was gathered using the Beck Anxiety Inventory and the Clinical Outcomes in Routine Evaluation questionnaire (CORE).

**Initial formulation**

John's difficulties were conceptualised within a formulation that integrated a cognitive theory of agoraphobia (without panic) with narrative theory. This included an understanding of the impact of learning theory, in addition to factors relating to John's interpersonal relationships, family conflicts and family background (Thorpe and Burns, 1983). John's difficulties also appeared to have been maintained by avoidance of anxiety-provoking situations and negative thoughts relating to the perceived threat of a situation and his ability to cope.

John's difficulties were also formulated within a narrative framework, and John's problem-saturated story, which included themes of being "the voice of agreement" and "not being able to say no".

**Action Plan**

The aim of the narrative aspect of the intervention was to work towards developing an alternative story to his problem-saturated plot, in which he was able to participate more in valued activities. John described his frustration at feeling obliged to attend numerous family events that he did not want to go to and anger at people's perceptions of him as a malingerer. The use of cognitive-behavioural techniques was also proposed, with particular emphasis on graded exposure (Butler, 2000).

**Intervention**

Intervention was carried out on a one-to-one basis, over 11 fifty-minute sessions. The first five sessions focused on the use of narrative therapy, to look at John's stories regarding his passivity, his need for personal control and his "duty" to please others.
Externalising questions were used to create some distance between John and his difficulties and the concept of the function of “unwell” was deconstructed (Drewery and Winsdale, 1997). Issues of personal conflict were raised and the role of “unwell” as an effective means of avoiding family events was also highlighted. As these sessions progressed, exceptions to the dominant plot were also identified, which aided the process of re-storying John’s experiences. Cognitive-behavioural therapy (CBT) was employed in later sessions, including the use of exposure tasks and the identification of automatic thoughts that served to maintain John’s anxiety. Relaxation and distraction techniques were also introduced as part of a psychoeducation component and a narrative letter was sent to John at the end of therapy.

**Outcome and follow-up**

As therapy progressed, John was able to go to more social events, but felt less obliged to attend every family event. He described less feelings of guilt for “ruining” things and felt more assertive and confident. Scores across the CORE reduced during therapy and his BAI score reduced from 9 to 2.

**Reformulation**

Some reformulation occurred during the intervention, integrating information regarding John’s view of himself as a “person who ruined things for other people” and his “need to control his life and his stomach”. The evidence also suggested that John’s anxiety had generalised to social situations at home, as well as in public and that this had served to maintain his avoidant behaviour.

**Critical Evaluation**

Overall, the work led to a reduction in John’s symptoms of anxiety and he was more able to socialise and to assert himself. John found the CBT particularly useful, as it provided clear aims and strategies for him to focus on. However, the narrative therapy enabled him to consider the impact of interpersonal conflicts in his life and the ways
in which he could manage these more effectively. Integrative the two models was challenging and may have made the therapeutic process more confusing for John. In addition, it was unfortunate that it was not possible to conduct some joint work with John and his girlfriend.
Summary of People with Learning Disabilities Case Report

Bereavement Therapy for a 58 year-old lady with learning disabilities using the task theory of mourning

Referral of the problem

A referral was made to the psychologist in the Community Learning Disability Team regarding Anne, a 58-year-old white British woman with a learning disability, who was having difficulties with independent living, following the death of her mother three years earlier. An assessment of Anne’s strengths and needs was conducted by the psychologist and occupational therapist which indicated that further work was required, regarding the bereavement process.

Presenting Problems

Following her mother’s death, Anne had found it increasingly difficult to manage tasks of daily living, many of which she had received support with from her mother. In addition, she was felt to be at risk of exploitation and was finding it difficult to cope with the emotional impact of her mother’s death. Anne would frequently become tearful and indicated that she missed everything about her mother. She would often wake at night and would wander around the town. Anne also felt guilty that she had not been able to cry when her mother died and felt confused about the process of death and its relationship with her religious beliefs. As a consequence of these issues, Anne’s relationship with one of her brothers had become increasingly strained.

Initial assessment of the problem

Assessment was carried out on a one-to-one basis, over three fifty-minute sessions, following a meeting between myself, Anne and the Clinical Psychologist. Issues of consent and confidentiality were covered during the initial session and Anne’s current difficulties and aims of therapy were discussed. Information was also obtained from case notes and via discussions with professionals.
Anne described her life history and her family in detail and the impact that previous losses had had on her. In addition, she was able to talk about the process of her mother becoming ill and dying and her difficulties in accepting support from friends and family following her mother’s death.

**Present situation**

The work was carried out five years after the death of Anne’s mother, when Anne was still living semi-independently. Anne attended various daycare activities and received support from a support worker. She continued to experience distress regarding her mother’s death and there were concerns regarding her ability to care for herself.

**Initial investigations**

Initial investigations consisted of Anne’s descriptions of her problems, including early waking, crying and feelings of guilt. Anne’s knowledge of and beliefs about death were also assessed using a psychometric assessment scale, to guide future work and to act as a baseline (Yanok and Addis Beifus, 1993).

**Initial formulation**

Anne’s experience of the bereavement process were formulated within Worden’s task model of mourning (Worden, 1991), which involves accepting the reality of the loss, working through to the pain of the grief, adjusting to an environment in which the deceased is missing and emotionally relocating the deceased and moving on with life. Anne appeared to have experienced a degree of “complicated grief”, including guilt regarding her delay in grieving. In addition, her confusion regarding the permanence of death and her anger towards the hospital staff who had cared for her mother may have allowed Anne to avoid acknowledging any anger towards her mother. Finally, given the level of dependence that Anne had on her mother, it was hypothesised that the loss of this relationship may have led to a shift in her self-concept towards someone who was less strong.
**Action Plan**

It was proposed that the intervention would allow Anne to explore the impact of her unexpressed grief and would clarify the factors that differentiate life and death. In addition, the formulation suggested the need to highlight the changes that had occurred in Anne’s life following her mother’s death and how she had adjusted to this loss.

**Intervention**

Intervention was carried out on a one-to-one basis, over eight 50-minute sessions. The intervention included psychoeducation regarding the nature of death, the use of reminiscence to actualise her loss and reality testing around Anne’s beliefs about crying (Hollins and Sireling, 1989). Problem-solving strategies were also explored, which highlighted the difficulties that Anne had successfully managed and how she could apply these ideas to future problems. During this work it was important to clarify different factors which could be upsetting for Anne, as she had a tendency to relate all these situations to her mother’s death. In addition, Anne’s inability to cry at her mother’s funeral was understood in the context of her fears about the future at that time.

**Outcome and follow-up**

Anne reported a reduction in her crying, and although she continued to wake at night and have disagreements with her brother, she was less inclined to attribute these to her mother’s death. There was an increase in Anne’s knowledge about death when assessed using a psychometric measure. Over the course of intervention, Anne began to focus more on her future plans and found that developing a memory book (Read, Frost, Messenger & Oates, 1999) was useful when she began preparing to move into supported accommodation.
Reformulation

Over the course of intervention, it became apparent that Anne’s inability to cry following her mother’s death was a result of her anxiety regarding her future and how she would cope living alone, rather than complicated grief. This had impaired her ability to engage in cognitive restructuring, as a means of making sense of her loss. In addition, Anne’s confusion regarding her sadness at events in the here-and-now, rather than the loss of her mother was also highlighted and worked through during intervention.

Critical Evaluation

The intervention appeared successful in promoting a positive change in Anne’s life, including improvements in her mood and a reduction in her guilt. The main limitation of the work was the lack of outcome data, which made evaluation more difficult.
Summary of Child and Young People Case Report

Extended assessment of a six year old boy with aggressive and over-active behaviour

Referral of the problem

Jack Wright, a six-year-old white British boy was referred to the Child and Adolescent Mental Health Service (CAMHS) by his GP, requesting an assessment for possible Attention Deficit Hyperactivity Disorder and highlighting various family difficulties, a history of febrile convulsions and problems at school.

Presenting problem

Jack’s mother indicated that he had various difficulties including sleep problems, poor academic achievement, primary nocturnal enuresis, physical aggression towards his mother and younger brother and poor concentration. These difficulties had occurred over the past three years and appeared to be having a detrimental effect on Jack’s ability to form friendships. Despite this, his teacher commented that Jack was quite “emotionally needy” and indicated that he had experienced unspecified difficulties in early life.

Initial assessment of the problem

An initial assessment was conducted jointly with the supervisor, which was attended by Jack and his mother and brother. A developmental history was gathered and time was spent discussing the family’s current situation. A brief amount of time was spent discussing Jack’s difficulties and he appeared to find this difficult to tolerate. Jack’s development was delayed in the areas of speech and walking and it was observed at nursery that he was aggressive towards the other children and experienced separation anxiety. He was the second child and his younger brother was born when Jack was two. There had been a history of domestic violence and Jack had been physically
abused by his father, who he continued to see on a weekly basis during unsupervised contact.

**Present Situation**

Jack was living with his mother and brother and had regular contact with his father and older sister. His behaviour had increasingly been a cause of concern, for Mrs Wright and Jack’s teacher.

**Initial Investigations**

Initial investigations were carried out via information obtained from school, Mrs Wright and staff at a club Jack attended. Information on Jack’s behaviour at school was obtained using the Rutter Teacher’s Scale (Rutter, 1967), the results of which were within the clinical range. The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was also completed by Mrs Wright, Jack’s teacher and the leader of the boy’s brigade group he attended and suggested variation in Jack’s behaviour across settings.

**Initial Formulation**

When formulating Jack’s difficulties various factors were considered, including the possible influence of physical abuse and domestic violence, the impact of parental divorce and the possibility of ADHD. The assessment suggested that Jack may have ADHD, arising from a disorganised family background and lack of social support and psychological factors such as poor attentional control and difficulties with response inhibition arising from genetic, neurological or social / educational problems (Cooper, 1999). In addition, it was hypothesised that Jack’s primary attachment may have been insecure (Clarke, Ungerer, Chahoud, Johnson and Stiefel, 2002).
Action Plan

The assessment and formulation suggested that a thorough assessment of ADHD would be required, by obtaining information on key areas of functioning. This included conducting a neuropsychological assessment of Jack’s IQ and gathering additional information on his behavioural and emotional difficulties.

Extended Assessment

A second assessment session was conducted with Mrs Wright, which focused on Jack’s problems and the issues of physical abuse and domestic violence. Jack had witnessed domestic violence over the first three years of his life and physical abuse for some of this period.

The Wechsler Intelligence Scale for Children – III (WISC-III) was conducted with Jack to assess his strengths and weaknesses and to observe his behaviour within a formal testing environment. Jack was observed to have good insight into the impact that his difficulties were having on his academic and social progress. The results of the WISC-III indicated that Jack’s strengths were in verbal tasks, and that there was a lack of uniform development between verbal and performance ability. However, the profile was inconclusive regarding the possible presence of ADHD.

The Connors’ Rating Scale – Revised (CRS; Connors, 1997) was completed by Mrs Wright and Jack’s teacher to gather information regarding conduct, family, emotional difficulties, anxiety and anger. Discrepancies were observed between home and school reports, suggesting that factors within the environment were having a significant impact on Jack’s behaviour. Therefore it was concluded that Jack was unlikely to have ADHD, given his overall presentation.

Extended Formulation

The results of the CRS indicated that Jack clearly had difficulty with attention in the home and school environments, but without a full medical assessment a diagnosis of
ADHD could not be made. It was hypothesised that Jack’s experiences of aggression and his mother’s inability to protect him may have led to a disorganised attachment and a sense of ambivalence towards his mother. In addition, it appeared that he had begun to internalize an aggressive model of interaction, which was reinforced by his increased vigilance and interactions with his peers. Finally the results of the WISC-III suggested that Jack may have some specific non-verbal learning difficulty.

**Recommendations for Intervention**

It was recommended that Jack should be referred to the psychiatrist, to complete a medical assessment, in order to obtain a medical perspective on his difficulties. In addition, it appeared that Mrs Wright struggled to set boundaries with Jack and this appeared to be an important area of intervention, focusing on her tendency to use inconsistent methods of discipline. Finally, it was suggested to the school that Jack might benefit from group social skills training within the school environment, to improve his social relationships.

**Critical Evaluation**

The assessment process took a great deal of time, due to various cancellations by Mrs Wright. At times Mrs Wright would talk at length about matters outside of the psychologists remit and would also telephone between sessions. This may have reflected her lack of social support and made the work more challenging. Involving additional professionals would have provided a more detailed assessment, with additional emphasis on social and biological factors.
Summary of Specialist Case Report

Neuropsychological assessment of a 34-year-old man with memory problems and temporal lobe epilepsy

Referral of the problem

A referral was received from the neurologist, requesting a neuropsychological assessment of Paul, a 34-year-old white, British man with a diagnosis of left temporal lobe epilepsy (TLE). The referral also requested that Paul be taught strategies to help manage his poor memory.

Presenting Problems

The initial assessment session was attended by Paul and his father. They indicated that Paul was experiencing memory difficulties, and had impaired memory for his late adolescents, although this had improved more recently. Paul would forget appointments and telephone messages and was easily distracted. This had made it difficult for him to manage in his job as a shop assistant and he was concerned that he had lost what he described as a “photographic” memory.

History of presenting problem

Paul experienced an acute onset of cognitive difficulties, following his first seizure at the age of eighteen and these difficulties were exacerbated by the Phenytoin he was prescribed. Paul described memory and concentration difficulties, and indicated that he had also sustained a head injury following an assault three years earlier.

Medical History

The results of a previous CT scan were normal, although an EEG indicated unusual activity in the left temporal lobe, leading to tonic clonic seizures. Paul had his first
seizure aged 18 and further seizures aged 29, after which he was prescribed anticonvulsants.

**Personal History**

Prior to his first seizure, Paul had worked for a photographic company, after leaving school with four ‘O’-levels. Paul had continued to live with his parents and was an only child. He described himself as shy, but had developed friendships and had an interest in music. Paul had been unable to work or drive following his first seizure, although he began working in a shop during his late 20’s. He continued to live with his parents, although he hoped to move into his own flat.

**Previous Assessments**

Assessment information was only available from the neurologist, regarding Paul’s CT and EEG results.

**Literature Review**

Left TLE is characterised by a range of cognitive, emotional and behavioural characteristics, such as ponderous speech, over-attention to detail and increased levels of depression and anxiety. The temporal lobes are associated with memory, visual recognition, emotion and the processing of auditory information, with the left temporal lobe being associated more with memory for verbal information (Banich, 1997). Damage to the left temporal lobe can result in impaired language formation or comprehension, word finding problems and memory deficits (Selby, 2000). Individuals who experience late-onset TLE are more likely to exhibit clear lateralisation effects, rather than global deficits.
Hypothesis

It was hypothesised that Paul would have a neuropsychological profile consistent with late-onset left TLE, including more marked deficits in verbal memory and intelligence.

Rationale

Various assessments were selected, which assessed a range of cognitive abilities, while remaining focused on the referral question, including the Wechsler Test of Adult Reading (WTAR, Wechsler, 2001) to assess Paul’s premorbid IQ and the Wechsler Adult Intelligence Scale – III (WAIS-III) to assess his current functioning. In addition, the Wechsler Memory Scale – III (WMS-III) (Wechsler, 1997) was administered, to assess Paul’s memory functioning as well as the Stroop Colour-Word Test and the Trail Making Test. All these measures have been found to be reliable and valid.

Behaviour during assessment

Paul offered spontaneous conversation during the assessment and was orientated in time and place. He appeared to have good insight into his performance and was able to switch between tasks with apparent ease. Paul sometimes appeared to have difficulty finding the words to describe his thoughts and there appeared to be some difficulties with abstract thinking, when completing some sub-tests of the WAIS-III. Paul worked carefully and methodically on all tasks and this may have led to lower scores on timed tasks.

Findings and Discussion

Paul’s pre-morbid Verbal and Performance IQ were both in the average range. His WAIS-III performance was significantly better for verbal tasks than non-verbal, although a large amount of scatter was observed. Paul performed well on tasks of immediate visual and verbal memory and new learning, although his non-verbal
abilities were a comparative strength. His recognition memory was also a strength, suggesting that his encoding and storage of information were less impaired than his ability to retrieve information without prompts. His initial performance on the Stroop test was indicative of some impairment and was therefore re-administered. The results suggested that he could have dyslexia, or that his ability to inhibiting specific responses might be a particular strength. Paul’s performance on the Trail making test suggested that he might have particular difficulties with concentration and distractibility, as his performance was better on the more challenging of the two tasks. It was concluded that the pattern of results might indicate some memory impairment, although this seemed to be more global, rather than specific to one hemisphere.

Recommendations

I met with Paul for three sessions to conduct some psychoeducation, on methods of managing his memory and concentration problems. In addition, these sessions focused on further developing Paul’s problem-solving skills and his confidence in applying these skills in everyday situations. It was also recommended that Paul contact an organisation which supports individuals with disabilities in the work place if he felt this was necessary in the future, as he did not feel it was necessary to be referred at the time of discharge.

Critique

The assessment provided useful information, but was not able to fully answer the original referral question. Additional assessment of Paul’s prospective memory and mood may have contributed to a fuller formulation, although these issues were explored during the initial interview.
Summary of Older People Case Report

Cognitive-Behavioural and Schema-Focused Therapy with A 78-Year-Old Lady with Life Long Anxiety

Reason for Referral

Pamela, a 78-year-old white, British lady with English as a first language, was referred to the CMHT for Older People in October 2004 regarding her difficulties with anxiety. My initial assessment session with her was conducted in January 2005, to ascertain her current difficulties and to assess suitability for psychological therapy.

Presenting problem

Pamela was referred to the service regarding her life-long anxiety. Pamela experienced various negative automatic thoughts, in addition to physical symptoms such as heart palpitations, feeling hot and having a dry mouth.

Initial assessment of the problem

Assessment process

The assessment was conducted over two one-hour sessions, on a one-to-one basis at Pamela’s home. Pamela appeared to be relaxed during our first session, although in a subsequent session, she commented that she had worried about the assessment. Previously, Pamela had seen a psychiatrist in 1998 regarding her anxiety around decision making and being on her own for any length of time. Pamela described a good relationship with her parents, but stated that they favoured her sister, who was ten years younger. Due to her family’s social situation, Pamela left school at 15 to work in an office, as her wage was required to support her family. In 1959, Pamela returned to work and shortly after she developed obsessive compulsive disorder, characterised by checking behaviour when leaving the house.
Between 1985 and 2005, Pamela felt that there had been "one thing after another". Following her husband's retirement, Pamela's anxiety and depression became increasingly difficult to manage and she lost her self-confidence.

Pamela indicated that her relationship with her sister had deteriorated and consequently, they had stopped talking, although Pamela occasionally received correspondence from her.

**Present situation**

Pamela's initial scores on the Hospital Anxiety and Depression Scale were 4 and 3 for symptoms of depression and anxiety respectively. Due to Pamela's life-long anxiety, depression and obsessive-compulsive behaviour, the short form of Young's Schema Questionnaire (Young, 1994) was administered; to identify schemas relevant to Pamela's presenting anxiety. Pamela obtained particularly high scores on schemas relating to "subjugation" and "fear of abandonment".

**Initial formulation**

The assessment indicated that Pamela's main difficulties related to a life-long history of anxiety, which had been particularly pronounced since the death of her husband. Pamela's difficulties were formulated within a cognitive behavioural model, outlining the relationship between her early experiences, core and intermediate beliefs and current presentation, in terms of cognitive, behavioural, emotional and physiological symptoms. Prior to this, Pamela had become estranged from her sister, following a telephone conversation in which Pamela had been accused of being unsupportive following her brother-in-law's death in 2003. This triggered Pamela's current episode of anxiety. Pamela's early childhood experiences were dominated by poverty, her father's poor health and anxiety and his prolonged hospitalisation. Pamela mentioned these issues during the assessment and indicated that age was an important concept to her. Pamela's aim of therapy was to "feel less anxious", to go to church and the local shops without worrying and to have fewer physical symptoms of anxiety. Pamela indicated that anxiety was having a greater impact on her quality of life than depression and therefore this became the main focus of therapy.
Due to the limited time available, I was mindful of integrating CBT and schema-focused therapy in a way that was coherent and meaningful to Pamela. It was also important to consider potential functions that these schema may have served for Pamela, when developing the intervention.

**Intervention**

Intervention was conducted over ten sessions, on a one-to-one basis with Pamela.

**Sessions 1-3**
The first three sessions focused on socialising Pamela to the CBT model and providing literature on Generalised Anxiety Disorder and depression for Pamela to read as homework. Emphasis was placed on core beliefs and schemas, as part of the process of introducing schema-focused therapy at a later stage. As the intervention progressed, the content of the thought diary developed and was used to evaluate Pamela’s progress in sessions.

**Sessions 4-5**
In these sessions greater emphasis was placed on introducing methods of identifying cognitive distortions and their links with Pamela’s anxiety and avoidant behaviour. This information was used to develop alternative ways of thinking about situations, which were more representative of Pamela’s experiences and acknowledged her existing problem-solving skills. In addition, Pamela identified a number of factors which had contributed to her husband’s anger following his retirement and the impact this had on her own coping.

**Sessions 6-10**
In these sessions, emphasis was placed on using schema-focused techniques to address some of Pamela’s long-standing beliefs about abandonment and subjugation. I used this opportunity to explore Pamela’s distorted thoughts through the therapeutic relationship and we explored the evidence that Pamela had for her beliefs. I had aimed to adopt the point-counterpoint technique described by Young (1994), but
Pamela was reluctant to do this. Pamela indicated that her unorthodox, but strong religious beliefs had also been a source of strength for her.

This stage of intervention focused on challenging Pamela’s beliefs about her subjugated role and her fear of abandonment. Interestingly, her ratings of anxiety-related symptoms increased from 3 to 6 following intervention, suggesting a reduction in Pamela’s avoidant behaviour.

**Outcome and evaluation**

Pamela reported feeling more positive about her ability to cope with everyday difficulties and the anxiety that these provoked. In terms of the process of therapy, Pamela seemed acutely aware of our age difference and would comment “you don’t know what it’s like to be old when you’re young”. However, these comments provided the opportunity to explore these experiences and clarify the origins of Pamela’s beliefs about her age, old age in general and the nature of her upbringing.
References


Research Section
Service Related Research Project

Assessing the convergent validity of a newly devised Caseload Management tool within primary care and community mental health team settings.

1st Year

June 2003

Note: Identifying details have been removed to preserve the Trust's anonymity.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>113</td>
</tr>
<tr>
<td>Introduction</td>
<td>114</td>
</tr>
<tr>
<td>Method</td>
<td>116</td>
</tr>
<tr>
<td>Participants</td>
<td>116</td>
</tr>
<tr>
<td>Design</td>
<td>116</td>
</tr>
<tr>
<td>Materials</td>
<td>116</td>
</tr>
<tr>
<td>Procedure</td>
<td>117</td>
</tr>
<tr>
<td>Results</td>
<td>118</td>
</tr>
<tr>
<td>Convergent validity of the MHCET with the CORE</td>
<td>119</td>
</tr>
<tr>
<td>Comparison of case severity between teams</td>
<td>120</td>
</tr>
<tr>
<td>Discussion</td>
<td>121</td>
</tr>
<tr>
<td>References</td>
<td>124</td>
</tr>
<tr>
<td>Appendix</td>
<td>125</td>
</tr>
<tr>
<td>Appendix A</td>
<td>126</td>
</tr>
<tr>
<td>Appendix B</td>
<td>127</td>
</tr>
<tr>
<td>Appendix C</td>
<td>131</td>
</tr>
<tr>
<td>Appendix D</td>
<td>133</td>
</tr>
<tr>
<td>Appendix E</td>
<td>134</td>
</tr>
<tr>
<td>Appendix F</td>
<td>135</td>
</tr>
<tr>
<td>Appendix G</td>
<td>136</td>
</tr>
<tr>
<td>Appendix H</td>
<td>137</td>
</tr>
<tr>
<td>Appendix I</td>
<td>138</td>
</tr>
</tbody>
</table>
Abstract

Introduction: Recent government reports indicate that effective caseload management within mental health teams is a priority as greater demands are placed on these services. The present study aimed to assess the convergent validity of a newly devised caseload management tool (MHCET) by comparing it with a reliable and valid clinical measure (CORE).

Method: Initially written consent was obtained from all the participants. The MHCET was then completed by psychologists and community psychiatric nurses for fifteen clients and the CORE was completed by the corresponding clients (written consent was obtained). Data was collected from clients accessing primary care and community mental health team services to obtain a broad range of feedback.

Results: Correlations were carried out between the MHCET and the CORE and the results indicated a significant relationship between the overall scores of the two measures. Certain domains of the MHCET correlated very highly with the CORE. Comparison of scores between the two levels of service did not indicate a significant difference with respect to case complexity.

Discussion: Due to the low response rate results were interpreted with caution, although a positive trend was observed between the two measures. Reasons for the low response rate were discussed. Feedback from clinicians indicated that the research would be too time consuming. Further issues, including relevance to the service and perceived threat of the research, were also discussed.
Introduction
A major aim of the NHS plan is to ensure health services are run effectively and efficiently whilst working within a limited financial budget (DoH, 2000). The structure and objectives of the NHS are currently being reviewed as part of the modernisation agenda and particular emphasis has been placed on defining the role of mental health services (DoH, 2000). Consequently a new National Service Framework on adult mental health has been published, which highlights the need for change within services in order to meet client’s needs (DoH, 1999).

A recent review indicates that there are often gaps in current mental health services and consequently individuals who are in need of intensive and ongoing support are not being managed appropriately (DoH, 2001). The Care Program Approach placed greater emphasis on the needs of individuals with more severe mental health problems, and over the past decade these individuals have been targeted more intensively (Sheppard, 1998). However, the majority of people accessing mental health services do not fall into this group (Stratchdee & Jenkins, 1996). Therefore it is essential that services balance the needs of all clients in order to provide an effective service (Paxton, Shrubb, Griffiths, Cameron & Maunder, 2000).

Current literature suggests that the structures of many mental health services are inadequate and require refinement (Paxton, et al., 2000). Various frameworks have been suggested, including shared care between mental health and primary care services (Goldberg & Gournay, 1998), a matrix structure (Tansella & Thornicroft, 1998) and a tiered mental health service (Paxton et al., 2000). However, until a new structure is introduced it is imperative that mental health services have an effective system for prioritising the needs of clients and essential that managers must demonstrate that their team is able to effectively manage caseloads.

Further information has been published regarding the role of Community Mental Health Teams (CMHT’s), which highlights the three main functions of this type of service (DoH, 1999). Firstly, CMHT’s should work in a consultative capacity by offering advice on the management of mental health problems to other professionals (e.g. those working in primary care settings). In addition to this they should provide
treatment and care for individuals with time-limited disorders who will benefit from specialist intervention. The third primary function of CMHT’s is to provide treatment and care for those individuals with more complex and enduring needs (in contrast to primary care services which should focus on less severe and enduring cases). These guidelines also state that, in order to ensure clinical capacity is not compromised, the maximum caseload for staff working in CMHT’s should not exceed 35 clients. In order to be able to fulfil this objective and ensure effective use of resources it is essential that efficient caseload management is demonstrated via the use of a caseload management tool that is easy to use, shows good reliability and validity and is applicable to a range of professions. Currently there is no standardised method for assessing caseload within mental health services on a local or national level. Therefore staff within the trust that is the focus of the present study, devised an assessment tool, the Mental Health Caseload Evaluation Tool (MHCET) – designed to aid caseload management for all professionals working in mental health services. The MHCET is a seven-item questionnaire based on the Denver acuity scale (Sherman and Ryan, 1998) which assesses case complexity over various dimensions. It is designed to enable staff to ensure that caseloads are maintained at a size which allows individuals to have their needs met by mental health services.

The current study forms part of a wider research project into the reliability and validity of the MHCET, which is being carried out within the trust. The need for this research was identified by a member of the Psychology department, who felt it was a priority for all mental health services. The aims of this study are twofold: to assess the convergent validity of the MHCET when compared with a reliable and valid measure of clinical complexity (the CORE), and to compare case complexity across different mental health services to assess whether clients are accessing the most appropriate service. It is hypothesised that the MHCET will show good convergent validity when compared to the CORE and it is also hypothesised that MHCET and CORE scores will be significantly higher for clients accessing the CMHT service compared with clients accessing primary care services.
Method

Participants
A total of 15 CORE forms were completed by clients accessing either the psychology service or their local CMHT. This data was collected by the professional who was working most closely with the client. Five professionals were involved in the data collection process.

Initially 22 professionals within the psychology department and local CMHT were approached regarding their possible involvement in the study. Sixteen people felt they would be able to contribute to the study. The remaining six individuals were unable to participate for various reasons (e.g. newly employed /due to leave the service, trainees/students who felt they had already made additional demands of their clients). The potential sample size for the study was predicted to be 64, as feedback suggested that each professional would be able to recruit approximately four participants. A total of 200 questionnaires were distributed.

The research was conducted in three locations. The first of these was a CMHT based in a large town, with a diverse ethnic client group living primarily within an urban setting. In addition to this a CMHT and psychology department were also involved. These were based in a small hospital with a mainly white, British client group from urban and rural locations.

Design
The design of the study combines an independent groups design (comparison of caseload severity between CMHT and primary care clients) with a within-subjects repeated measures design (convergent validity of the MHCET with the CORE using correlation).

Materials
The research was questionnaire-based and involved the use of a standardised measure and a newly-devised caseload management tool. Because the study involved the collection of client-related data beyond that obtained during standard practice, it was
necessary to obtain ethical clearance (Appendix A). Consequently participants had to read a ‘patient information sheet’ and complete a consent form (Appendix B).

Each client completed a copy of CORE – a 34-item self-report measure of clinical severity, which provides information regarding how the client has felt during the previous week (Appendix C). The questions relate to risk, symptoms, functioning and subjective well-being and each question is scored on a five point Likert scale. It produces an overall score of clinical severity and scores for each of the sub-scale. CORE has good reliability (Cronbach’s alpha from .75 to .95) and convergent validity with other measures (Audin, Barkhan, Connell, Mellor-Clarke, Evans et al., 1998).

The professionals involved in the study completed a copy of the MHCET – a mental health service caseload evaluation tool developed within the trust (Appendix D). The MHCET is an adapted version of the Denver acuity scale which assesses the level of service required by the client (Sherman & Ryan, 1998). It is a seven-item questionnaire which assesses various dimensions (i.e. perceived needs of the individual over the past three months with respect to risk, engagement in services, substance misuse, carer needs and crisis incidents) on a five point Likert scale and produces a final score between 5 and 35, relating to one of five tiers of severity. These range from tier A to tier E (Appendix E). The MHCET is currently being assessed for reliability and validity via research and other projects within the trust.

Procedure
A priori power analysis was carried out to ascertain the number of participants required to detect a large effect (d=.50). This analysis indicated that a minimum of 102 clients would need to participate in the research (Appendix F).

Participants were approached by the professional during their clinical appointments in order to minimise disruption. Due to the design of the MHCET it was essential that the professional had known the client for at least three months. However, in order to reduce the possibility of floor effects, the questionnaires could not be administered at the end of therapy.
After written consent had been obtained the client completed the CORE form in accordance with the standardised instructions. The professional completed the MHCET at the same time, in order to reduce the possibility of data contamination.

In the four week period following initial questionnaire distribution a total of three were returned. During this period the research was included as an agenda item at weekly team meetings in the psychology department and CMHT. Additional informal one-to-one meetings were held with various individuals to encourage their participation. Following this phase a further 60 sets of questionnaires were distributed, split between the two teams. This aimed to remind people of the research, provided materials for people who had lost their blank forms, and encouraged recruitment of additional staff into the study. Staff were also prompted via memos, notice boards and conversations. After a further three weeks no further questionnaires had been completed. Following this a third CMHT was approached to be involved in the research. Forty questionnaires were distributed to members of this team and consequently twelve questionnaires were completed within a two week period.

Results

Fifteen sets of questionnaires were completed over a ten week period, indicating a 7.5% return rate. Of the 16 professionals who agreed to participate in the research a total of four returned questionnaires (three Clinical Psychologists and one Community Psychiatric Nurse (CPN)). Data was obtained from the Psychology Department and one CMHT. The fifteen clients who participated in the study had a mean age of 41.1 years (S.D. = 11.3). The majority of participants were female (n=8) and most were accessing primary care services (n=9) as opposed to the CMHT (n=6).

Table 1. Mean CORE and WSMHCET scores for primary care and CMHT clients.

<table>
<thead>
<tr>
<th></th>
<th>CORE well-being</th>
<th>CORE performance</th>
<th>CORE function</th>
<th>CORE risk</th>
<th>CORE total</th>
<th>WSMHCET total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>1.36 (0.78)</td>
<td>1.15 (1.02)</td>
<td>1.20 (0.80)</td>
<td>0.17 (0.33)</td>
<td>1.02 (0.71)</td>
<td>1.23 (0.25)</td>
</tr>
<tr>
<td>CMHT</td>
<td>2.33 (1.24)</td>
<td>2.00 (0.72)</td>
<td>1.69 (0.67)</td>
<td>0.53 (0.53)</td>
<td>1.67 (0.69)</td>
<td>1.62 (0.41)</td>
</tr>
</tbody>
</table>

N.B. Standard deviations in brackets.
Convergent validity of the MHCET with the CORE

The convergent validity of the MHCET with the CORE was assessed using correlation. Due to the small sample size and lack of normally distributed scores (Appendix G) parametric analysis could not be carried out. Therefore Spearman’s rho was used to identify any possible relationship between the two measures. Correlations between the mean total scores for the CORE and the MHCET were calculated and indicated a significant association ($r(15) = 0.73$, $p < .01$, 2-tailed test). This can be seen in figure 1. Further correlations were completed, comparing the four main factors of the CORE and the seven areas of functioning within the MHCET (Appendix H). These correlations indicated that certain elements of the MHCET did not display any positive trends with the CORE or other elements of the MHCET (e.g. risk to self, risk to others, engagement in treatment and crisis incidents). In contrast to this ratings of ‘symptom severity’ showed positive trends with all elements of the CORE and particularly those relating to ‘performance’ ($r(15) = 0.72$, $p < .01$, 2-tailed test). Interestingly there was a positive trend between the overall score for the MHCET and all elements of the CORE. Internal consistency of the CORE was calculated to ensure this reflected published values (Cronbach’s $\alpha = 0.94$).

![Figure 1. Scatter plot of total CORE and MHCET scores](image-url)
Comparison of case severity between teams

Statistical comparison of assessment scores between clients from primary care and CMHT services could not be carried out due to the small sample size. The following section serves to illustrate the scores of the two groups using descriptive data. By comparing the number of service users whose MHCET scores fell into each of the five tiers described earlier, it was possible to explore whether the perceived needs of each individual matched the level of service they were receiving (tables 3 and 4). In addition, mean total CORE scores were studied to confirm this.

Table 3. Total MHCET and CORE scores in CMHT clients.

<table>
<thead>
<tr>
<th>Client</th>
<th>MHCET total score</th>
<th>Corresponding tier</th>
<th>Mean total CORE score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>B</td>
<td>0.79</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>B</td>
<td>2.15</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>B</td>
<td>0.79</td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>B</td>
<td>2.06</td>
</tr>
<tr>
<td>5</td>
<td>16</td>
<td>C</td>
<td>2.00</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>B</td>
<td>2.24</td>
</tr>
<tr>
<td>Mean</td>
<td>11.3</td>
<td></td>
<td>1.67</td>
</tr>
</tbody>
</table>

Table 4. Total MHCET and CORE scores in primary care clients.

<table>
<thead>
<tr>
<th>Client</th>
<th>MHCET total score</th>
<th>Corresponding tier</th>
<th>Mean total CORE score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13</td>
<td>B</td>
<td>2.50</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>B</td>
<td>0.97</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>B</td>
<td>1.29</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>B</td>
<td>0.15</td>
</tr>
<tr>
<td>5</td>
<td>9</td>
<td>B</td>
<td>1.32</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>B</td>
<td>1.26</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>A</td>
<td>0.21</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>B</td>
<td>0.82</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>B</td>
<td>0.65</td>
</tr>
<tr>
<td>Mean</td>
<td>9.0</td>
<td></td>
<td>1.02</td>
</tr>
</tbody>
</table>

It can be seen from table 2 that the majority of clients accessing the CMHT obtained total MHCET scores corresponding to tier B (n=5) with the remaining individual corresponding to tier C. Table 3 indicates that the majority of primary care clients
also obtained total MHCET scores within tier B (n=8) and the remaining individual fell into tier A. These results do not indicate any large difference between primary care and CMHT client ratings, with the majority of service users corresponding to tier B.

Discussion
The results of the study indicated a positive association between scores on the MHCET and on the CORE, which may reflect some degree of convergent validity between these measures. The data suggested that although the participants came from two different services the majority were perceived as presenting with similar levels of case complexity.

These findings provide some useful preliminary information regarding the validity of the MHCET, but also indicate that certain items may be less related to measurements such as CORE. CORE relies on information about the client over the previous week and therefore its main dimensions (well-being, functioning, risk and performance) would expect to show temporal instability. However, ratings on the MHCET vary from months to weeks and therefore the time frame is dictated by the individual’s past needs. Therefore the MHCET may be more sensitive to enduring problems, in contrast to the CORE, which focuses on recent events.

The results indicated that there was little difference in case complexity when comparing primary care with CMHT clients. This may reflect a sampling bias towards clients who were perceived as presenting with less complex needs and who would be more able to give informed consent. This problem could have been overcome by randomly selecting individuals for possible inclusion in the study. The tendency for most individuals to be placed in tier B may indicate the need for a scoring method which is more sensitive to individual differences. Although the MHCET is designed to be a quick method of assessing caseload it may only capture a limited view of case complexity.

Due to problems with data collection it is not possible to draw any firm conclusions regarding the validity of the MHCET. Interestingly the process of applying for ethical approval did not delay data collection as this was granted early in the research. When
considering the low response rate it is important to remember that the need for this research was identified within the trust and therefore was perceived as valuable to services. Despite this, the majority of professionals did not complete any questionnaires. Feedback from staff indicated that they felt the process of administering the questionnaire would be time-consuming, while others felt the patient information sheet was too complicated to explain to clients. Although these reasons provide some insight into the difficulties encountered, it seems likely that additional factors contributed to the low response rate.

There are various possible reasons why the research was not well received. Certain types of enquiry may be perceived as threatening to members of staff who feel that their professional competence is being questioned. The current project relied on anonymous information from a variety of sources and therefore this explanation seems unlikely. An alternative explanation is that staff failed to appreciate the relevance of the research to their own practice. Although the rationale behind the research was explained to staff some individuals may have been unaware of the possible benefits of introducing a new caseload management tool. Alternatively, they may not have felt that such a system would be of benefit to them in terms of easing their workload or enabling them to meet client needs. One professional stated that the tool did not seem to be comprehensive enough and commented that some client’s needs were oversimplified by the MHCET when they actually placed major demands upon the service. Important issues such as recent criminal behaviour, previous psychiatric inpatient admissions and periods of homelessness and unemployment are not included in the MHCET. However, all these issues will increase the amount of work carried out by the professional and their inclusion in a caseload management tool would be an effective method of identifying individuals accessing inappropriate services (i.e. in need of Assertive Outreach support). Staff may have felt that the MHCET did not capture the essence of their duties or that the research would be a bureaucratic exercise within an already demanding job. Because the research was designed within a specific service but implemented in other teams it is likely that some staff felt a lack of ownership of the study. Alternatively they may not have perceived the aims of the study as being of importance compared to alternative research questions that were not addressed.
Staff did not raise any concerns regarding the way in which the data would be used, but additional information regarding this matter may have been useful. Although the study was designed to benefit the services involved, it may have been viewed with some cynicism or perceived as an academic exercise. It was not possible to feed back the findings of the study to the teams involved in the research prior to the completion of this research (Appendix I).

Overall the study provides useful information regarding the validity of the MHCET. Due to the limitations of the study additional research should be carried out to further assess its validity and reliability. Feedback regarding individual clinician’s experiences of using the tool in a formal setting would also be of benefit with regard to refining its content and application. However, additional work would be required to overcome the issue of low response rate encountered in this study.
References


Appendix
Appendix A

26 February 2003

*** **** ***
Dept of Psychology
*** Hospital
*** NHSTrust
***

Dear Mr ****

Re: 03/01/4c Comparison of a previously validated client-rated questionnaire of clinical severity (CORE) with a newly devised clinician-rated Mental Health Caseload Evaluation tool (The **** **** Mental Health Caseload Evaluation Tool) within primary care and community mental health team services.

Local application signed and dated 20/12/02; protocol; client information sheet version 1.0 19 December 2002 and Consent Form; Clinical Outcomes in Routine Evaluation (F) questionnaire; Mental Health Caseload Evaluation Tool. Client information sheet ver 2.0, 19 Jan '03 and consent form.

ACADEMIC SUPERVISOR, **** ****

The Chair of the ***** Research Ethics Committee has considered your response to the issues raised by the Committee at the earlier review of your application on 13 January as set out in our letter dated 17 January 2003. The documents considered were as follows:


The Chairman, acting under delegated authority, is satisfied that your response has fulfilled the requirements of the Committee. You are therefore given approval for your research on ethical grounds providing you comply with the conditions of approval set out below:

- You do not recruit any research subjects unless you have received a notification of no objection from the relevant locality agent
- You do not undertake this research in a NHS organisation until the relevant NHS management approval has been received
- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.
- You complete and return the standard progress report form to the REC one year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
- If you decide to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.
- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.
- The project must be started within three years of the date on this letter.

NHS RECs are compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the conduct of trials involving participation of human subjects.
CONSENT FORM

Title of Project: Comparison of an existing client-rated questionnaire of illness severity (CORE) with a newly devised clinician-rated Mental Health illness severity tool (The **** **** Mental Health Caseload Evaluation Tool) within community and hospital settings.

Name of Researcher: **** ****

Please initial box

1. I confirm that I have read and understand the information sheet dated 19th January 2003 (version 2.0) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

Name of Patient ___________________ Date ___________________ Signature ___________________

Name of person taking Consent ___________________ Date ___________________ Signature ___________________

Researcher ___________________ Date ___________________ Signature ___________________

1 for patient; 1 for researcher; 1 to be kept with hospital notes
Service Related Research Project

Version 2.0

Client Information Sheet.

Title of Project: Comparison of an existing client-rated questionnaire of illness severity (CORE) with a newly devised clinician-rated Mental Health illness severity tool (The *** *** Mental Health Caseload Evaluation Tool) within community and hospital settings.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Aim:
Currently psychologists working in local Community Mental Health Teams (CMHT) and Psychology services use a questionnaire named CORE (The Core Group, 1998) as a measure of the severity of an individuals mental health problems, which provides information regarding risk, severity of symptoms, day-to-day functioning and general well-being. CORE is a 34-item questionnaire which is completed by the client and has been found to be a good measure of the severity of an individual’s mental health problems. Within the NHS it is important to ensure that clients get the service that most suits their needs. The CORE is useful within psychology services, but may not be suitable for other professions. The *** *** Mental Health Caseload Evaluation Tool has been developed within the trust to be used by all professionals within mental health services to assess the complexity of their clients’ problems. It is designed to be simple and quick to use and should help staff to assess the complexity of people’s problems.

The present study has two aims: the first is to compare the newly developed tool with an existing assessment tool to see whether the new method produces similar results to more established and complicated assessments. The second aim is to look at the complexity of cases within different NHS mental health teams to see whether clients are accessing the service which best suits their needs.

Participation:
As a client accessing the Community mental health team or primary care services within the *** *** NHS trust it is felt that you would be a suitable participant for this study. We are hoping to recruit 60 individuals with some degree of mental health problem (ranging from mild to moderate) to participate in the study.
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

If you decide to take part in the study you will be required to complete a 34-item questionnaire about various aspects of your life. At the same time the professional that you are meeting with will complete a similar questionnaire. Following this you will not be required for any other research activities or follow-up work regarding the research. The questionnaire can be completed at a time when you are accessing mental health services so that you do not experience any disruption.

It is not necessary to make any changes to your normal daily activities prior to or following completion of the assessment.

The study will not be of direct benefit to you. The aim of the study is to ensure that the *** *** Mental Health Caseload Evaluation Tool is a useful assessment to use within the trust. In addition, the study will check the suitability of referrals to mental health services to ensure clients receive the best possible service.

Confidentiality:
All information which is collected about you during the course of the research will be kept strictly confidential. All forms will be anonymised and they will not include any information that could be used to identify you. Each form will have a code so that it can be matched with the corresponding form completed by the clinician. The researchers will not have access to any of your medical notes for the purposes of this research.

The results of the study will be used in two ways. Some results will be fed-back to the teams involved in the research to ensure that clients needs are being met. Results regarding the usefulness of the *** *** Mental Health Caseload Evaluation Tool will be fed back to these teams and at some point in the next two years will be published as part of a study into the value of this new assessment.

The study has been organised by *** ***, a Trainee Clinical Psychologist. The research is designed to be of value to adult mental health services within the trust and also forms part of the academic assessment process for the training programme. The **** research ethics committee has reviewed the study.

For additional information regarding the study please contact:
20/2/03

Dear,

Re: Service Related Research

I am a Trainee Clinical Psychologist working in the [redacted]. As part of my training I am required to complete a piece of service related research within my placement. I have chosen to study the validity and reliability of a newly devised caseload management tool (The Mental Health Caseload Evaluation Tool - MHCET) within primary care and CMHT’s. This tool is designed to be relevant to a variety of health professionals and should be relatively quick and simple to use.

In order to assess reliability and validity it is necessary to compare clinician ratings of caseload severity using the MHCET with client ratings of clinical severity using the CORE questionnaire, which has already been shown to be reliable and valid. Research into the value of the MHCET may be used to inform future decisions regarding the use of caseload evaluation tools.

I am aiming to recruit staff from primary care services and CMHT’s to be involved in the study and would welcome the opportunity to meet with you as soon as possible. It is hoped that by increasing the number of staff participating in the study it will only be necessary for each individual to complete a small number of evaluations. Staff who participate in the study will be required to complete a short caseload evaluation questionnaire while their client completes the 34-item CORE questionnaire. This process may be facilitated by recruiting clients who have been known to the staff member for a minimum of six months.

I will contact you within the next few days to arrange a time to meet on a one-to-one basis to discuss this research further. Thank-you for your time.

Yours sincerely,

[redacted]
CLINICAL OUTCOMES in ROUTINE EVALUATION (F)

Over the last week

1. I have felt terribly alone and isolated  
2. I have felt tense, anxious or nervous  
3. I have felt I have someone to turn to for support when needed  
4. I have felt O.K. about myself  
5. I have felt totally lacking in energy and enthusiasm  
6. I have been physically violent to others  
7. I have felt able to cope when things go wrong  
8. I have been troubled by aches, pains or other physical problems  
9. I have thought of hurting myself  
10. Talking to people has felt too much for me  
11. I have been happy with the things I have done.  
12. I have been disturbed by unwanted thoughts and feelings  
13. I have felt like crying  

Date received: 
Date form given: 
Age: 

IMPORTANT: PLEASE READ THIS FIRST. 
This form has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this. Please use a dark pen (not pencil) and tick clearly within the boxes.

Survey: 65 
Page: 1
Over the last week

<table>
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<tr>
<th>Item</th>
<th>Not at all</th>
<th>Only Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the Time</th>
<th>Agreed</th>
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<td>15 I have felt panic or terror</td>
<td></td>
<td></td>
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<tr>
<td>16 I made plans to end my life</td>
<td></td>
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<tr>
<td>17 I have felt overwhelmed by my problems</td>
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<tr>
<td>18 I have had difficulty getting to sleep or staying asleep</td>
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<td>19 I have felt warmth or affection for someone</td>
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<tr>
<td>20 My problems have been impossible to put to one side</td>
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<td>21 I have been able to do most things I needed to</td>
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<tr>
<td>22 I have threatened or intimidated another person</td>
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<td>23 I have felt despairing or hopeless</td>
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<td>24 I have thought it would be better if I were dead</td>
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<td>25 I have felt criticised by other people</td>
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<td>26 I have thought I have no friends</td>
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<td>27 I have felt unhappy</td>
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<tr>
<td>28 Unwanted images or memories have been distressing me</td>
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<tr>
<td>29 I have been irritable when with other people</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30 I have thought I am to blame for my problems and difficulties</td>
<td></td>
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<tr>
<td>31 I have felt optimistic about my future</td>
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<tr>
<td>32 I have achieved the things I wanted to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 I have felt humiliated or shamed by other people</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>34 I have hurt myself physically or taken dangerous risks with my health</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE.

Total Scores

<table>
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<tr>
<th>Score</th>
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</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Raw Scores

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<td></td>
</tr>
</tbody>
</table>

Total for each dimension divided by number of items completed in that dimension.

Survey: 65

Copyright MHF and CORE System Group.

132
## Appendix D

### Mental Health Caseload Evaluation Tool

**Research data collection**

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<th>Need Dimension</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td><strong>Risk to self / vulnerability</strong></td>
<td>Not apparent in the last three months</td>
<td>Not apparent in the last month but history</td>
<td>Apparent in the last month</td>
<td>Apparent in the last 7 days</td>
<td>Immediate risk</td>
</tr>
<tr>
<td><strong>Risk to others / dependants</strong></td>
<td>Not apparent in the last three months</td>
<td>Not apparent in the last month but history</td>
<td>Apparent in the last month</td>
<td>Apparent in the last 7 days</td>
<td>Immediate risk</td>
</tr>
<tr>
<td><strong>Compliance with treatment / engagement</strong></td>
<td>As planned in the last three months</td>
<td>Not as planned in the last three months</td>
<td>Requires help to maintain</td>
<td>Minimal</td>
<td>None</td>
</tr>
<tr>
<td><strong>Crisis incidents</strong></td>
<td>Not apparent in the last three months</td>
<td>Up to three in the last three months (average once a month)</td>
<td>Up to 6 in the last three months (average once every two weeks)</td>
<td>Up to 12 in the last three months (average once every week)</td>
<td>Continual 13+ (more than once a week)</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>No Symptoms or symptoms resolved</td>
<td>Intermittent symptoms evident</td>
<td>Intermittent symptoms evident</td>
<td>Fluctuating / unstable symptoms</td>
<td>Severe disabling, persistent symptoms</td>
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<tr>
<td></td>
<td></td>
<td>Slight impairment (mildly disabling)</td>
<td>Marked impairment (moderately disabling)</td>
<td>Severe impairment (very disabling)</td>
<td>Extreme impairment</td>
</tr>
<tr>
<td><strong>Substance misuse</strong></td>
<td>Non apparent in the last three months</td>
<td>Not apparent in the last month but history</td>
<td>Apparent in the last month</td>
<td>Apparent in the last 7 days</td>
<td>Continual</td>
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<tr>
<td><strong>Their Carer Needs</strong></td>
<td>The Carer has not required support in the last three months</td>
<td>The carer has not required support in last three months but has history of needing it</td>
<td>Support required</td>
<td>Carer needs regularly addressed during time with patient (carers care plan present)</td>
<td>Carers own needs are addressed separately, in addition to time spent with patient. (carers care plan present)</td>
</tr>
</tbody>
</table>

---

Adapted from: (Reference: Sherman, PS Ryan, CS (1998) Intensity and Duration of Intensive Case Management Services Psychiatric Services Vol 49 no12 p1585-1589)

Score

- **7** Tier A 8-14
- **Tier B** 15-20
- **Tier C** 21-25
- **Tier D** 26+
- **Tier E**

Developed by ****** (currently being validated)
Appendix E

Tier definitions

Because the MHCET is currently being developed there are no clear definitions for the five tiers of service level which are produced by this tool. Therefore these tiers are currently purely numerical entities. Until the MHCET has been found to be reliable and valid it is not appropriate to assign each tier to a specific level of service. One could speculate that the following definitions may be an approximation of the service which correspond with each tier:

Tiers A and B: GP attached services:
Tiers B, C & D: Specialist Mental Health Services (secondary)
Tiers C, D & E: AOT: Crisis Resolution services
Tiers D & E: Requiring in-patient admission.
Appendix F

A priori power analysis

Power analysis was based on the following values. Due to the limited scope of the research the minimum acceptable power value was used.

Effect size $d = 0.5$ (based on the conventional value for a medium effect size)

Alpha = 0.05 (conventionally set at this value)

Power = 0.8 (the minimum acceptable value).

Producing a minimum sample of 102 participants.
Appendix G

Distribution of total CORE scores

Mean = 1.28
Std. Dev = .75
N = 15.00

CORE totals

Graph

Distribution on total MHCET scores

Mean = 1.42
Std. Dev = .35
N = 15.00

Total MHCET scores
## Appendix H

### Correlation Matrix.

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</table>

Key: - = unable to calculate.  
COW = CORE well-being  
COF = CORE functioning  
COT = CORE total  
OTH = MHCET risk to others  
CRI = MHCET crisis incidents  
SUB = MHCET substance misuse  
TOT = MHCET total.

COP = CORE performance  
COR = CORE risk  
SEL = MHCET risk to self  
ENG = MHCET engagement  
SYM = MHCET symptoms  
CAR = MHCET carer needs

137
19th July 2005

Mr David Bennett

To whom it may concern,

I should like to commend the work that David Bennett did whilst on placement at West Sussex Health & Social Care NHS Trust. The work was particularly helpful as this is an area where we have long recognised the need to improve how case loads are managed. A key priority for mental health services is the ability to provide quick access and this can only be achieved if there is capacity within the system. The research undertaken by David was particularly helpful in considering the demands upon services and the relative complexity of care. This led to further work which we commissioned from the Audit Commission which used an almost identical tool for Inpatient wards.

This work hasn't been lost into a theoretical world of academia. It is very relevant and we continue to use the tools that David considered.

I am very happy to commend his work and the continuing value it has brought.

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Relating to voices: does voice identity influence degree of relating to the voice, and recovery style, in people who experience auditory hallucinations?

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Contents

Appendix

Appendix A

The Cognitive Assessment of Voices 214 - 220
The Voice and You 221 - 224
VAY questions corresponding to each scale 225
The Psychotic Symptoms Rating Scale 226 - 228
The Recovery Style Questionnaire 229
RSQ Scoring framework 230 - 231

Appendix B

Ethics application form 232 - 266
R&D proposal form 267 - 268
R&D confirmation letter (1) 269
NHS Ethic’s committee confirmation letter 270 - 271
R&D confirmation letter (2) 272 - 273
University Ethic’s confirmation letter 274 - 275

Appendix C

Patient Information Sheet 277 - 278
Consent Form 279
GP letter 280

Appendix D

Power Analysis 281

Appendix E

Tests of normality 282

Appendix F – N

Statistical analyses 283 - 293
Abstract

Title: Relating to voices: does voice identity influence degree of relating to the voice and recovery style, in people who experience auditory hallucinations?

Objective: Research on voice hearing suggests that cognitive and interpersonal factors, including the relationship with the voice, influence behavioural and emotional responses to voices. Individual differences in recovery style following a psychotic episode may also influence long term outcome. The present study aimed to investigate the effect of voice identity, on the individual’s relationship with their predominant voice and their recovery style.

Design: The study was a quantitative, case series design, which utilised both between-subjects and correlational methods.

Setting: The research was conducted across two NHS Trusts, within a range of community mental health services.

Participants: A total of 25 individuals participated, with a minimum of six months of voice hearing.

Main Outcome Measures: Individuals were assessed using the ‘Cognitive Assessment of Voices’ and the ‘Voice and You’ measure, ‘Recovery Style Questionnaire’ and the ‘Psychotic Rating Scale’.

Results: Incognito voices were related to from a greater distance than identified voices although more distant relating was not associated with greater hearer distress. Voice identity and hearer distance were not found to influence recovery style.

Conclusions: The findings suggest that increased knowledge of the voice’s identity, may lead to closer relating to the voice. Within a therapeutic context, exploration of the voice’s identity may highlight it’s relevance to the individual’s previous and current life experiences.
**Introduction**

1.1 The impact of voice hearing:

Voice hearing is described in various historical documents ranging from the writings of Homer in the Iliad (Leudar & Thomas, 2000), to more recent accounts such as those offered by Romme and Escher (1994). Individual experiences of voice hearing vary widely, and may include one or more voices, heard inside or outside the head and with varying styles of content (Copolov, Trauer & Mackinnon, 2004). Voices may provide a running commentary of the individual’s behaviour, or make observations about personal strengths or weaknesses. Voices may issue commands, which may be perceived as threatening and powerful (Fox, Gray & Lewis, 2004). There is continued debate as to whether voice hearing is necessarily indicative of mental pathology, or whether it can be placed on a continuum of functioning and this has led to variations in its definition (Davies, 2002). David (2004) attempts to combine traditional medical and cognitive definitions, with more recent developments in our understanding of voice hearing, by proposing the following definition:

"A sensory experience which occurs in the absence of corresponding external stimulation of the relevant sensory organ, has a sufficient sense of reality to resemble a veridical perception, over which the subject does not feel s/he has direct and voluntary control, and which occurs in the awake state." (David, 2004; p.110).

When considering the constellation of symptoms associated with psychosis, voice hearing has been identified as one of the most troubling (Forchuk, Jewell, Tweedell & Steinnagel, 2003). Over the past three decades, research into voice hearing has become increasingly concerned with understanding the factors which mediate the distress that it causes. By comparing the effective management of voice hearing, with individuals who experience distress and reduced quality of life, it is possible to establish the psychological and social factors that may need to be addressed by mental health services. This style of working challenges the assumption that voice hearing must be eliminated in order to reduce distress, and may be of particular value for those
individuals with "treatment resistant psychosis". Consequently, increasing emphasis has been placed on the need to develop psychological therapies that enable the individual to understand and manage their voice hearing experiences, in a way that reduces distress. This has included an exploration of the cognitive factors, which influence the degree to which the individual is able to cope with hearing voices, and more recent interest in the social relationship between the hearer and their predominant voice, in terms of its power and proximity (Chadwick & Birchwood, 1994; Vaughan & Fowler, 2004)

The current study aims to develop the evidence base, regarding a theory of social relating between people who hear voices and their predominant voice, by extending Hayward's (2003) study. The research will also explore the extent to which this relationship influences individual perceptions of voice hearing, and the recovery process, and will relate directly to the development of future practice within the therapeutic context. Despite the potential benefits of comparing the experiences of patients and non-patients within this field, a decision was made to only study individuals accessing mental health services. This reflected the practical constraints of the research, particularly in terms of recruitment and data collection.

During the process of developing this study, literature was considered from a variety of sources. The following literature review will consider the impact of voice hearing upon the individual, with particular emphasis on the factors which mediate distress. Emphasis will also be placed on the notion of a relationship between the voice and hearer, and the application of relating theory within the field of voice hearing. This will lead to a critique on the literature regarding recovery in psychosis, and its links with distress and social relating to the voice.

1.2 Historical approaches to managing voices

Research suggests that psychological characteristics, such as beliefs about the self and the voice, coping style and previous experiences of trauma, have an effect on the way in which the individual responds to their voices (Wykes, 2004). Within the therapeutic context, clinical psychologists strive to apply psychological concepts as a
means of enabling the individual to experience less distress and improved quality of life. By developing our understanding of the factors which mediate cognitive, behavioural or emotional responses to voice hearing, this knowledge can be applied within the clinical setting.

Historically, cognitive-behavioural techniques have been applied in conjunction with pharmacotherapy, as the main treatment method for individuals with disorders such as schizophrenia and schizo-affective disorder (Davis, 2002). Behavioural techniques, such as wearing ear-plugs or humming, have been used as a means of reducing the intensity of voices (Wykes, 2004). Such approaches have been based on research, which suggests that voices may arise as a consequence of difficulties with the monitoring of internal speech, and are frequently associated with the presence of sub-vocalisations (Frith, 1992; Green & Preston, 1981). However, these methods overlook the cognitive processes which influence levels of distress, and provide only short-term solutions to the problem. The following discussion will consider the research on cognitive processes that mediate responses to voice hearing.

1.3 Beliefs about the voice and the self

1.3.1 The cognitive model of voices

The need for a greater understanding of the cognitive processes that may influence an individual’s responses to voice hearing was highlighted by Chadwick and Birchwood (1994). They proposed a cognitive model of voice hearing, in which behavioural and emotional responses to voices were mediated by beliefs about the voice, rather than its features or content. They interviewed 26 people using the Cognitive Assessment of Voices (CAV), and found that 31% of participants held beliefs about the voices power and malevolence that were incongruent with the content or form of the voice. It was consistently found that individuals, who believed that their voices were malevolent, feared their voices and would resist them, whilst voices that were believed to be benevolent were engaged with. These results suggested that experiences of the voice’s malevolence or benevolence were made on the basis of beliefs about the voice’s identity, purpose and power, rather than voice content alone. These findings
offered preliminary support for a cognitive model, although the methodology had limitations. This included a lack of objectivity in the measurement of cognitive and behavioural elements of voice hearing, and a need for greater clarity regarding the degree of overlap between the concepts of malevolence and benevolence (Chadwick & Birchwood, 1994).

In response to these limitations, Chadwick and Birchwood (1995) developed the Beliefs About Voices Questionnaire (BAVQ), a 30-item psychometric instrument which measured cognitive (e.g. ‘My voice is punishing me’), behavioural (e.g. ‘When I hear my voice I usually shout back at it’) and affective (e.g. My voice frightens me’) reactions to voices, using a “yes/no” response. They assessed the validity of the cognitive model of voices, using data from 62 individuals assessed using the CAV and the BAVQ (Birchwood & Chadwick, 1997). Beliefs about the power and meaning of the voice were found to be related to coping behaviour and emotional responses, although the form and topography of the voice was not associated with behaviour or affect. The majority of participants (72.6%) beliefs about the voice showed no relationship with the content of the voice, or had to be inferred from the content. Increased levels of depression were frequently associated with voice malevolence, thereby illustrating the relationship between beliefs about the voice and resulting affect. Despite this supporting evidence, an inconsistency was found in the data, which suggested that beliefs about power could not entirely explain the mediation of responses. Birchwood and Chadwick (1997) reported that of the individuals who perceived their voice as powerful, 70% still reported that they could stop the voice from talking, using techniques such as distraction or concurrent verbalisation. This suggested that even voices perceived as very powerful and therefore distressing could frequently be controlled by the individual.

Attempts at replicating these findings have provided mixed results. Close and Garety (1998) interviewed 30 participants using the CAV, and found that reports of voice omnipotence and omniscience were less frequent than was described by Chadwick and Birchwood (1994). In addition, voice perception was primarily mediated by content of the voice, rather than the combination of content and hearer beliefs described previously. A revised cognitive model was proposed, in which the process
of voice hearing served to activate beliefs about the self, leading to behavioural and emotional responses, which served to strengthen cognitions relating to the voice’s purpose and the individual’s ability to cope. In critiquing the cognitive model, Close and Garety (1998) highlighted the lack of data on the reliability and validity of the CAV and also indicated that, unlike Chadwick and Birchwood (1994), participants frequently struggled to categorise their voice as either malevolent or benevolent, or were uncertain about the voices intent.

The lack of sensitivity of the BAVQ and its over-simplified method of assessing power, led to the development of a revised measure (BAVQ-R), which incorporated more response options and additional items regarding power (Chadwick, Lees & Birchwood, 2000). The results of interviews with 73 psychiatric patients indicated that increased levels of anxiety were associated with beliefs about the voice’s malevolence and omnipotence, and the degree of resistance to the voice. Chadwick et al. (2000) suggested that a profile of voice hearing was developing, in which the voice was perceived by the individual as problematic, anxiety-provoking and powerful. In addition, this power and malevolence would lead to negative affect and resistant behaviour.

Beck and Rector (2003) suggested that, for individuals who perceive their voices as uncontrollable, negative beliefs about the self may be activated, which relate to more general issues of lack of control in everyday life. Core beliefs about the self and the world, based on early life experience, may be reflected in the content of the voice’s speech and can influence the individual’s appraisal of the voice’s power, identity and omnipotence, in a way that mediates perceptions of malevolence. Beliefs other than those regarding the voice’s power may also influence the degree of distress associated with the voice commands, with behaviour and affect being influenced by beliefs about the possible effects of transgressions, the perceived social acceptability of required behaviour, and the potential value that compliance might have with respect to achieving goals (Beck-Sander, Birchwood & Chadwick, 1997).

A recent study extended the cognitive model of voices, by assessing the voice-hearing experiences of 54 participants using the (BAVQ), the Beck Depression Inventory
Major Research Project

Major Research Project

(BDI; Beck, Rush, Shaw & Emery, 1979) and the Spielberger State-Trait Anxiety Scale (SSTAS – Van der Ploeg, Defares & Spielberger, 1980, cited in Van der Gaag, Hageman & Birchwood, 2003) and found that meaning, identity and intention of the voice were important predictors of distress (Van der Gaag, Hageman & Birchwood, 2003). However, the study also supported Close and Garety’s (1998) finding that there is rarely a complete discrepancy between voice content and belief about the voice. In addition, Van der Gaag et al. (2003) found that despite distress relating to the perceived power of the voice, a similar relationship was not observed between power and engagement with the voice. This indicated that it was the individual’s interpretation of power, as either malevolent or benevolent, that led to distress and attempts to resist the voice. A limitation of this study was the use of the original BAVQ, rather than the revised version, which may have led to the forced categorisation of voices as benevolent or malevolent, thereby overlooking the subtle variations in beliefs about the voice’s intent.

The cognitive model highlights various processes that mediate behavioural and emotional responses to voices. Individuals who present to psychiatric services frequently view their voices as omnipotent and problematic. In addition, distressing voices are primarily perceived as malevolent and are more likely to lead to negative symptoms, such as increased anxiety and depression, and attempts to resist the voice. The evidence described above indicates that there is interplay between beliefs about the self and the world, and more specific beliefs about the meaning of the voice-hearing experience for the individual. A key factor in the cognitive model concerns the beliefs that lead to the interpretation of voices as an external “other”, rather than self-generated thoughts (Chadwick, Birchwood & Trower, 1996). Benjamin (1989) suggests that individuals can develop relationships with their voices, in ways that are meaningful, complementary and “interpersonally coherent”. She suggests that such relationships can serve an adaptive purpose and may provide company and support, as well as enabling the externalisation of part of the self. This interplay between the cognitive model of voices and interpersonal relating is tentatively described by Chadwick et al. (1996) in the following way:
"...it is possible to view an individual's relationship with a voice as interpersonal, and indeed the relationship shows many of the dynamics common in ordinary relationships. While it is known that a common first reaction to voices is puzzlement (Maher, 1988), individuals evolve different ways of interacting with their voices” (p.106).

Such claims have led to the development of theories regarding the interpersonal nature of the relationship between voice and hearer. This has produced a number of creative ideas regarding the use of interpersonal theory within clinical practice.

1.4 The interpersonal relationship with the voice

1.4.1 Voice identity

Research into response mediation in people who hear voices has become increasingly concerned with the way in which the individual’s perception of their relationship with the predominant voice influences affect. Benjamin (1989) studied the relationships that 30 psychiatric patients had with their voices, using the Structural Analysis of Social Behaviour Questionnaire, and found that all participants had an “integrated, interpersonally coherent relationship with their voice” (p.308) and a degree of interpersonal complementarity. Different groups of patients also described qualitatively different relationships with their voices, on the basis of symptomology. These findings suggested that the development of a social relationship with the voice could serve an adaptive function for the individual.

One participant in Benjamin’s (1989) study recognised the similarity between his relationship with his voice, and the relationships within his family. This may be partially explained by the results of a phenomenological study conducted by Nayani and David (1996). They interviewed 100 psychiatric patients who heard voices, looking at the features, content and development of auditory hallucinations using a semi-structured interview based on the Schedules for clinical assessment in neuropsychiatry (SCAN) assessment scales (World Health Organization, 1992). The
majority of participants (61%) could identify their voice, and these were frequently aligned to a known individual. Participants were also able to distinguish between the different voices, which presented with individual characteristics. Leudar and Thomas (2000) described a woman who heard five voices with clear supernatural identities, all of whom shared key characteristics with people in her real social world, including her father, herself and the therapist. The idea that voices may be aligned to people in the real world, with whom the individual has experienced a social relationship, suggests that elements of that person may be internalised by the individual and further supports the notion of an interpersonal relationship with the voice.

Leudar, Thomas, McNally and Glinski (1997) extended the research on the relationship between voice hearing and inner speech, by considering the pragmatic properties of voices experienced by 14 individuals diagnosed with schizophrenia and 14 non-psychiatric voice-hearers. The research also aimed to clarify the process by which this inner speech becomes split from the individual and acquires an identity based on the work of Mead (1934/1962, cited in Leudar et al. 1997). They studied various pragmatic properties of the voice hearing experience, including the way in which voices were differentiated and perceived as having a stable identity over time, the voice’s position in conversations and its influence on the individual’s actions. Recurrent voices were identifiable through voice characteristics, such as gender and approximate age, but were unnamed and did not represent a known individual. In contrast to these “incognito” voices, 64% of voices were aligned to people known within the individual’s social world, such as family members, public figures or supernatural entities, thereby supporting the findings of Nayani and David (1996). The voices of people with schizophrenia were found to be more commonly aligned to public figures, while non-patient’s voices were frequently aligned with family members. It was hypothesised that the tendency for individuals with a diagnosis of schizophrenia to report hearing the voice of a famous person was not a result of the two groups internalising different members of their social world, but instead a result of the clinical group recoding the voice’s original identity as a means of defending the self. Voice hearers were frequently positioned as the target of the voice’s utterances, and content usually focused on the individual. The results suggested that a dialogue would frequently be established between the voice and the individual, and 39% of
participants would sometimes initiate interaction with the voice, suggesting that the voice was perceived as an entity with which meaningful interaction could occur.

1.4.2 Social relating

Social relating to voices was examined by Birchwood, Meaden, Trower, Gilbert & Plaistow (2000), using social ranking theory (Price, Sloman, Gardner, Gilbert, & Rohde, 1994), to determine whether the relationship with the voice was based on a paradigm of social relationships in general. Social ranking theory proposes that life events are experienced as depressogenic if they lead to the losses that have a detrimental effect on the individual’s status or rank. The experience of being in a position of relative subordination or power occurs via social comparison, which leads to the development of ranks, relating to power, attractiveness and talent (Gilbert, Price & Allan, 1995). They interviewed 59 voice hearers using Hustig and Hafner’s (1990) measure of voice topography, the BAVQ (Chadwick & Birchwood, 1995), the Social Comparison Scale (Allan & Gilbert, 1995) and the Voice Power Differential scale (VPD); a measure of the power differential between voice and hearer (Birchwood et al., 2000). Hearer subordination was associated with experience of subordination and marginalization in other social relationships, in terms of power and rank. This occurred regardless of whether the voice was perceived as malevolent or benevolent, thereby supporting the findings of Chadwick and Birchwood (1994; Birchwood & Chadwick, 1997). In addition, they explored the relationship between social rank and depression and found that perceptions of lower social rank were associated with greater depression. Birchwood et al. (2000) stated that potentially, interpersonal schemata could influence beliefs about the voice and levels of depression, or beliefs about the voice could affect the individual’s interpersonal schemata and experiences of depression. These differences in the direction of causality have significant clinical implications. The first model suggested the use of novel interventions such as assertiveness training and group identification work as a means of reducing distress (Birchwood et al., 2000). In contrast, the second model highlighted the possible value of aiming to eliminate the voice-hearing experience, although Birchwood and Iqbal (1998, cited in Birchwood et al., 2000) suggested that there was little empirical support for this idea.
This study suggested a possible model of voice hearing, in which beliefs about social relating impact on the individual’s beliefs about and response to the voice. In Vaughan’s (2000) critique of Birchwood et al.’s (2000) study, she suggests that a combination of social variables and the presence of a malevolent voice may provoke a sense of feeling subordinate to the voice, rather than social variables in isolation. The use of the BAVQ, rather than the revised version of the measure was a further limitation of the study and Birchwood et al. (2000) suggested that the inclusion of additional information regarding positive and negative symptoms may have clarified the interplay between social schemata, beliefs about the voice and affect. Despite these limitations, the study highlighted the value of exploring the relationship with the voice, and led to the application of an alternative theory of interpersonal relating described by Birtchnell (1996, 2002).

1.5 Relating theory

1.5.1 The axes of power and proximity

Birtchnell (1996; 2002) described an interpersonal theory of relating based around the two constructs of power and proximity. These axes were developed into the interpersonal octagon, which has since been applied in the area of voice hearing research. The following section will describe the two axes of relating and the interpersonal octagon. This will lead to a discussion of the application of this theory within the field of voice hearing.

Relating is defined by Birtchnell (1996) as:

"An active process...which one organism or person does to another or to others...Relating includes being aware of, adopting attitudes towards and attempting to influence other animals, plants and objects, but particularly animals and more particularly still, animals of the same species. Relating may assume the form of direct action ... but usually it involves simply conveying signals, which may be visual, auditory or olfactory. In man,
Relating theory can apply to organisms of any type, although the following discussion will focus on human relating (Birtchnell, 1996). Experiences of relating are closely associated with emotions, with positive states of relatedness serving to reinforce the actions that have led to that state. Birtchnell (1996) proposes that by its very nature relating includes the presence of an "other" with whom to relate. However, this may also include internal representations of people whom we relate to, in the absence of an external object with whom to relate. Individuals may also relate to internalized authority figures, which may be perceived both as a source of love, but also as being judgemental or authoritarian. Birtchnell’s theory is sufficiently flexible to allow the inclusion of individuals’ internal representations of supernatural entities, reflected in spiritual and supernatural beliefs and the relationship that may develop between people, the voices that they hear and representations of other forms of relationships.

Within a clinical context, a key component of relating theory is the distinction between positive and negative relating. Indeed, Birtchnell and Evans (2004) suggest that an aim of psychotherapy is often to reduce the degree of negative relating. Positive relating refers to the ability to attain and feel confident with various relating styles, in a way that does not harm others (Birtchnell, 1996). In contrast, negative relating may occur when an individual is fearful of a particular style of interpersonal relating. This includes fear of certain types of relating or obtaining a state of relatedness with another object, in a way that serves the needs of the individual at the expense of the other. The idea of negative relating will be elaborated upon in the course of the following discussion.

The two axes of “power” and “proximity” describe the distance that may exist between two individuals and the amount of influence that one individual may have over another (Figure 1) (Birtchnell, 1993). In this context, the term proximity refers to the closeness or distance that may exist between people at a given time, according to the changing needs of each individual.
Closeness serves to provide protection and may help with the provision of food and shelter, as well as providing social support and the development of close relationships. Distancing behaviour can increase the individual’s self-reliance and aids the development of one’s personal identity, which Birtchnell (1996) argues, arises from a need to experience the self as separate from others.

Within this model, the power axis encompasses various forms of power, including intelligence and knowledge, the structure of social hierarchies and material possessions. Upperness relates to the concept of having power over an individual, such as greater knowledge or authority, whilst lowerness describes a position of reduced power in relation to the other individual. Despite the different functions of closeness, distance, upperness and lowerness, they are considered to be of equal value.
within relating theory and may reflect effective or maladaptive styles of relating (Birtchnell, 1996).

1.5.2 Birtchnell’s Interpersonal Octagon:

Birtchnell’s theory extended previous models of relating (e.g. Freedman et al., 1953; Leary, 1957; both cited in Birtchnell, 1993), by developing a relating theory which combined the power and proximity axis to produce eight octants describing the four “neutral” styles of relating (distance, closeness, upperness and lowerness) and the blending of each of these positions. In addition, Birtchnell’s theory moved away from the notion of an ideal style of relating, towards one which acknowledged the benefits and limitations of each position. To illustrate the potential benefits and difficulties that may arise when relating from any of the eight positions, Birtchnell (1993) developed two octagons; one describing positive (adaptive) relating and a second, describing negative relating (Figure 2). The interpersonal octagon is limited in its ability to truly describe interpersonal relating, due to the complexity of each of the potential relating positions that may occur. In addition, such a representation needs to differentiate between positive and negative relating and “relating to” or “being related to”. Despite these limitations, Birtchnell’s theory remains a versatile method of conceptualising interpersonal relating.

Birtchnell (2002) suggests that during early development the child needs to have experiences that allow it to convert innate objectives into styles of interpersonal relating, as a means of survival. Individual’s who can relate confidently and competently from a range of positions are said to relate positively and are described by Birtchnell as “competent relatiers” Failure to develop competence in a range of relating styles may lead to negative relating, such as “avoidant, insecure and unreasonable” relating. Avoidant relating occurs when the individual tends not engage in a specific style of relating, thereby assuming an interpersonal style that is inappropriate for their needs. Insecure relating occurs when an individual is able to
Figure 2. Characteristics of the negative interpersonal octagon (from Birtchnell, 2004).

**Diagram Description**

- **UN**: upper neutral
- **UC**: upper close
- **ND**: neutral distant
- **NC**: neutral close
- **LC**: lower close
- **LD**: lower distant
- **LN**: lower neutral

**Characteristics**

- UD: pompous, boastful, dominating, insulting
- UC: intrusive, restrictive, possessive
- ND: suspicious, uncommunicative, self-reliant
- NC: fear of separation and of being alone
- LD: acquiescent, subservient, withdrawn
- LC: helpless, shunning, responsibility, self-denigrating
- LN: fear of rejection and disapproval

**Additional Notes**

- UN: upper neutral; UC: upper close; NC: neutral close; LC: lower close; LN: lower neutral; LD: lower distant; ND: neutral distant; UD: upper distance.
attain a particular relating style, but is then fearful of losing that state, whilst unreasonable relating refers to the process of adopting a style of relating, without considering whether it is acceptable to the other person. Research on clinical populations suggests that a negative "lower close" position is frequently adopted by individuals with psychiatric problems (Birtchnell, 2002), which is indicative of "pathological dependence" (Birtchnell & Evans, 2004).

1.6 Interpersonal relating to voices

1.6.1 Relating and malevolence

Birtchnell's theory has been applied to the study of relationships between individuals and their voices, as a means of understanding the distress caused by the voice-hearing experience. Vaughan and Fowler (2004) studied the relationship between distress and the interpersonal relationship with the predominant voice, in 30 individuals with various psychiatric diagnoses. The bi-directional relationship with the voice was assessed using the 'Hearer to Voice' and 'Voice to Hearer' Questionnaires, both of which were adapted from the Couples Relating to Each Other Questionnaire (Birtchnell, 1994, cited in Vaughan & Fowler, 2004). The BAVQ and the BDI-II were also completed to assess beliefs about the voice and depression (Chadwick & Birchwood, 1995; Beck, Steer & Brown, 1996 all cited by Vaughan & Fowler, 2004).

They found a strong positive correlation between voice malevolence, distress and a distant style of hearer relating. Distressing voices were also frequently perceived as relating from a position of upperness. This suggests that individuals who perceive their voices as malevolent and distressing, may feel that the voice is powerful and domineering, leading to feelings of suspicion in the hearer. Vaughan and Fowler (2004) suggested that the tendency to create distance from a malevolent voice reflected the resistance to malevolent voices, described by Chadwick and Birchwood (1997). Interestingly, they found that as distress increased, distant relating increased; indicating that attempts to resist the voice might have a detrimental effect on mood, particularly if such attempts were considered to be unsuccessful. Vaughan and Fowler (2004) also found that the relationship between styles of relating and subsequent
distress was relatively independent of cognitive factors, such as beliefs about the voice’s power, thereby challenging aspects of the original cognitive model. They hypothesised that “it is not the perceived powerfulness of the voice per se that is problematic, but perhaps the way in which the voice is perceived to use its power” (p. 150).

Vaughan and Fowler (2004) highlighted various limitations to their study. The psychometric properties of the Hearer to Voice Questionnaire were variable, and there was some indication that the internal consistency and factor structure of this measure required further exploration. The study also omitted information regarding variations in relating style with the voice over time, focusing purely on the here-and-now.

As previously mentioned, voices are often aligned to people that are known to the individual in the real world. Vaughan and Fowler (2004) suggested that the exploration of relationships with voices could be extended by comparing relating to voices and the hearer’s more general style of relating.

1.6.2 Mirroring of social relationships

Hayward (2003) interviewed 27 psychiatric patients with experience of voice hearing and compared voice relating with their general relating style. Participants were interviewed using the CAV and the ‘You to Voice’ Questionnaire (the same measure as the ‘Hearer to Voice’ Questionnaire; Vaughan & Fowler, 2004). Psychotic symptoms, depression and beliefs about voices were also assessed. The study assessed the uni-directional relating style of the hearer towards the voice and found a significant relationship between general styles of social relating and styles of relating to the predominant voice, with respect to upperness, lowerness and closeness. A similar relationship was not observed with respect to relating from a position of distance, and therefore may have been a “unique characteristic of relating to voices”.

Participants frequently adopted a distant position in relation to their predominant voice, suggesting that these individuals wished to keep their voices at a “safe distance”. However, this distancing was not associated with the higher levels of
distress observed by Vaughan and Fowler (2004), indicating that it may have been those individuals who unsuccessfully attempted to distance their voice that experienced most distress (Hayward, 2001). In addition to distant relating, participants frequently adopted a position of ‘close / low’ relating, which was described by Hayward (2000) as dependent relating. This study also indicated that voice identity was associated with variations in relating style, with incognito voices being kept at a greater distance than those voices that had an identity, possibly reflecting greater suspicion of unknown voices. In addition, the relationship between voice-relating, social relating and distress was found to be independent of voice beliefs, thereby supporting the findings of Vaughan and Fowler (2004).

Hayward (2003) proposed a model of relating, in which the individual’s social schemata are activated in relation to the voice, based on previous and current experience. Relating to an identified voice relies on the individual’s previous experiences of that person, and the way they have related to them in their social world. However, incognito voices will be related to more on the basis of voice content, and if this is negative the individual will tend to adopt a distant, protective position. These findings suggest that there is scope to offer psychological intervention that will improve the individual’s social relating skills, as described by Birchwood et al. (2000). This might include the development of an individual’s social status through group identification, the development of assertiveness skills or increased problem-solving skills. In addition, intervention could focus specifically on the relationship with the voice and the identification and modification of negative forms of relating. Hayward (2003) suggests that a process of ‘relating therapy’ (Birtchnell, 2002) may increase the individual’s awareness of their negative forms of relating to the voice, and may also allow for its modification. Such a process might include the identification of incognito voices (or traits that are similar to known individuals) and the integration of various sources of information, concerning voice identity, previous trauma and distress. Identifying such links may lead to an alternative understanding of the voice, which has greater personal meaning for the individual.

A limitation of Hayward’s (2003) study was that it failed to explore experiences of “being related to” by either the voice or in other relationships. This reflected a
limitation of the original You to Voice Questionnaire and led to the development of a measure of inter-relating (the Voice and You; Denney, 2004). Further limitations of the study highlighted by Hayward (2003) included the small sample size and the exploration of a purely clinical sample.

1.6.3 Relating and the exploration of personal meaning

The phenomenological differences between relating to the voice from a particular position, are conceptualised by Hayward (2000) as mirroring the different recovery styles observed in individuals with psychosis (McGlashan, Docherty & Siris, 1976). Distancing behaviour, in which the individual does not engage with the voice as a means of protecting the self, is seen as corresponding to sealing over, in which the individual avoids talking about their experiences of psychosis and sees it as an external, uncontrollable event. Additional parallels are drawn between relating from a ‘dependent’ (lower/close) position and an integrative recovery style, which is associated with curiosity and greater insight (Hayward, 2000).

Recently, emphasis has been placed on the potential therapeutic value of exploring the social and psychological factors which lead to the development of voice hearing (Romme & Escher, 1994; 1996). Hayward’s (2001) proposal that identifying the predominant voice could lead to a closer position of relatedness, suggests that the individual may gain a greater understanding of the meaning of the voice within the context of previous experiences. This shift in understanding may be associated with changes in the individual’s ability to acknowledge the meaning of their voice, in terms of making links with past interpersonal experiences. This in turn may be reflected in the individual’s recovery style.

1.7 Recovery from psychosis:

1.7.1 Models of recovery

Over the past three decades, increasing emphasis has been placed on exploring the processes which occur during recovery from psychosis and developing an
understanding of its connection with relapse, insight and outcome. The term recovery is frequently associated with a reduction in the positive or negative symptoms of the individual, based on the observations of a professional, and concepts such as insight and engagement (Forchuk et al., 2003; Shaha, Trower, Iqbal, Birchwood, Davidson & Chadwick, 2004). In contrast to these more traditional models, Deegan (1997) provides an alternative definition:

"[Recovered individuals] experience themselves as having recovered a new sense of self and of purpose within the limits of the disability...Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of their disability. Recovery is a process, a way of life, an attitude and a way of approaching the day's challenges. It is not a perfectly linear process." (p. 5)

The process of monitoring an individual's style and pattern of recovery can be of great clinical value, as it may highlight information relating to risk of relapse and the efficacy of a particular medical or psycho-social intervention (Drury, 1994).

Theories of recovery from psychosis tend to fall into two broad categories: stage models and dimensional models (Drury, 1994). Stage models propose that the individual passes through certain stages during the process of recovery that tend to be the same stages that occur during relapse, in the reverse order. Donlan and Blacker (1973) proposed a four stage model of recovery. In the first of these the individual withdraws into their delusions and lacks insight. In the following stage the individual experiences increased distress, regarding feared loss of control. The subsequent stage includes depressed mood, followed by various cognitive difficulties such as racing thoughts and poor concentration. Drury (1994) suggested that the model placed too much emphasis on psychodynamic process, with insufficient consideration of the qualitative or quantitative changes that may be observed in the individual during the transition between stages. In addition, there is marked overlap between the stages, rather than each of them being mutually exclusive, as would be expected of a stage model.
Carr (1983) suggested that recovery from psychosis could be better conceptualised within a dimensional model, in which change could occur simultaneously across a range of dimensions, relating to concepts such as the degree of thought disorder, motor or emotional “retardation” and dysphoria. This led to the development of a five-dimension model of recovery described in terms of the degree of “psychotic disorganisation”, the individual’s conviction in their delusional beliefs, the amount of impulsive behaviour, the degree of neuroticism and the degree of depression and anxiety. Drury (1994) suggested that this model also has various weaknesses, such as the multi-dimensional concept of psychotic disorganisation and the lack of overlap between the different elements of delusional beliefs (Brett-Jones, Garety & Hemsley, 1987, cited by Drury, 1994).

1.7.2 Recovery style

McGlashan et al., (1976) conceptualised recovery in terms of two distinct processes, based on psychoanalytic theories of ego development. Individuals who adopt an integrative recovery style show an interest in their psychosis and strive to place it in a meaningful context. Those that “seal-over” tend not to think about their psychosis and attempt to distance themselves from the experience. McGlashan et al. (1976) described the recovery experiences of two women with schizophrenia, who were treated using psychotherapy, following an inpatient admission resulting from “severe psychosis”. Despite similarities in the clinical presentation of the two women and a reduction in symptoms over time, they responded very differently to their experiences of psychosis.

The two factors that distinguished the different experiences of the two patients were their individual experiences of psychosis, and specific “aspects of the patient’s social relatedness” (p.328. McGlashan et al., 1976). Individuals who integrate tend to have a greater understanding of the impact that psychosis has had on their life and may view the experience as life-altering. They also tend to take greater responsibility for their thoughts, feelings and behaviour during episodes of psychosis, and often strive to understand their experiences in a way that is personally meaningful and that makes links with previous life experiences. An integrative recovery style is associated with a
positive attitude to mental illness following recovery and a greater desire to seek and utilise help that is available, as a means of understanding and coping with the psychosis. In contrast, individuals who adopt a sealing over approach often minimise the impact of their psychosis and may see the process of recovery as returning to the life they had prior to the illness. McGlashan et al. (1976) described people who seal over as having "polarised views" regarding responsibility for behaviour and thoughts during episodes of psychosis, whereby the individual feels they have either total control, or no control over their actions. Individuals who seal-over often fail to make connections between their psychosis and previous life experiences, and are unable to identify the meaning of their psychosis.

McGlashan et al. (1976) suggested that sealing over may enable the individual to develop and express a sense of autonomy, whilst defending against internal and external events that could overwhelm the individual. Integration appears to be facilitated if the environment can tolerate the emotions and behaviours that the individual finds distressing, thereby enabling the individual to develop their own tolerance for previously intolerable experiences. In contrast, individuals that adopt a sealing over recovery style may exhibit hostile and rejecting behaviour, that leads to a similar response from other individuals (McGlashan et al., 1976). It is unclear whether an integrative recovery style can be engendered in an individual, via the presence of a therapeutic environment that promotes integration, despite the rejecting behaviour of the individual. Psychotherapy promotes the development of an integrative recovery style and McGlashan et al. (1976) suggest that its aim is to, "weld together the numerous split ideal and persecutory internal representations into a whole, constant, good object representation." (p.334).

McGlashan (1987) developed this theory of recovery by investigating the association between recovery style and long-term outcome in 231 patients with schizophrenic spectrum disorder and personality disorder. Integration was associated with better outcome, particularly with respect to the amount of follow-up work that was conducted and the individual’s number of social contacts. Integration was also associated with higher IQ, better premorbid work / education stability and higher treatment motivation. These variables suggested that personality factors and the
individual's personal coping resources influence recovery style (McGlashan, 1987). However, this conclusion may have overlooked the effects of variations in socio-economic background or beliefs about mental illness originating within the family or the individuals wider culture. McGlashan (1987) highlighted that the use of correlational analysis meant the direction of causality could not be established. There was also some indication that rater bias may have influenced outcome ratings. McGlashan (1987) concluded that both recovery styles could lead to good outcomes and suggested that psychological or pharmacological intervention should work with the individual's recovery style, rather than attempting to alter it.

1.7.3 Recovery style and early life experiences

Drayton, Birchwood and Trower (1998) investigated the relationship between early attachment experience, depression and recovery style in 36 people diagnosed with schizophrenia, using the recovery style questionnaire (RSQ), the Calgary Depression Scale for Schizophrenia (Addington, Addington & Maticka-Tyndall, 1993, cited by Drayton et al. 1998) and the Evaluative Beliefs Scale (Chadwick, Trower & Dagnan, 1999). Participants with moderate to severe depression frequently adopted a sealing over recovery style, whilst individuals with mild depression tended to adopt an integrative recovery style. Sealing over was also associated with lower perceived levels of parental caring and greater levels of over-protection in childhood, compared with integrators. Recovery style was not associated with insight, suggesting that these two concepts may be less dependent on each another than has previously been assumed.

Drayton et al. (1998) argued that recovery from psychosis is primarily influenced by the individual's personality, their available defence mechanisms and their experiences of the development of self, based in part on attachment style and the subsequent core beliefs about the self and the world that develop in childhood. This may lead to interpersonal difficulties, and reflects Hayward's (2003) finding that negative relating to the voice may be indicative of more pervasive interpersonal difficulties that inhibit the development of adaptive methods of relating. The development of a "fragile" sense of self may also lead to excessive negative self-evaluation, reflected in increased
levels of depression, critical voice content and negative evaluation of the voice-hearing experience. Individuals with psychosis who have adopted a maladaptive recovery style may benefit from psychological intervention that focuses on the development of strategies to cope with depression (Drayton et al., 1998). The role of early life experience, insecure attachments and negative self-evaluation was also studied by Tait, Birchwood and Trower (2004), who found that sealing over was associated with an insecure sense of self and a belief that other people viewed the individual as worthless. Participants who sealed over also reported having received lower levels of parental care and experienced greater anxiety regarding current adult relationships. However, in contrast to the findings of Drayton et al. (1998) sealing over was not associated with increased levels of negative self-evaluative beliefs or depression when compared with individuals who integrated. They hypothesised that individuals who seal over do not develop sufficient adaptive psychological resources during childhood to cope with the potential trauma of experiencing an acute episode of psychosis (Tait et al., 2004).

1.7.4 Variations in recovery style over time

The degree to which an individual is able to engage in services is a key factor in preventing relapse and has implications for treatment compliance. Research suggests that recovery style is an important factor in engagement with services, and may be used to predict future service engagement. Tait et al., (2003) examined the relationship between recovery style, insight and engagement in 50 individuals with psychosis, during an acute episode and at three- and six-month follow-up. A sealing over recovery style was associated with a tendency to avoid engaging with services, and recovery style was not related to insight, replicating the earlier findings of Drayton et al. (1998). Recovery style also changed over time, with integration being the principal recovery style at baseline (72%), but sealing over occurring most frequently at six-month follow-up (59.5%).

This pattern of results suggests that recovery is a key indicator of service engagement, rather than insight or symptom severity, suggesting that recovery style and related personal and social factors should form a key focus of intervention. Intervention may
also be modified over time, to reflect the individuals changing recovery style. The study had some methodological limitations, as the data collection process was not blind and therefore some bias may have occurred during this process. It is also possible that a sampling bias occurred, whereby individuals who were less able to cope with their psychosis declined to participate in the study (Tait et al., 2003).

The relationship between recovery and outcome at 12-months was investigated by Thompson, McGorry and Harrigan (2003) using the Integration /Sealing over scale (ISOS – McGlashan, 1987), on which the RSQ is based. They found that individuals who sealed over at the point of stabilisation, following their first episode, reported lower quality of life and more marked psychiatric symptoms when compared with individuals who integrated. A relationship was also observed between recovery style and diagnosis, with greater numbers of people with schizophrenia utilising a sealing over style, compared to individuals with affective disorder and mixed diagnosis.

Recovery style was found to be stable in the majority of participants (55.6%) at 12-month follow-up, although the remaining 44.4% had changed recovery style. These changes were primarily from a more sealing-over recovery style to one that was mixed or integrative.

These results partially supported Tait et al’s (2003) findings that recovery style is not a stable trait. However, the direction of change between the two recovery styles was different between the two studies. Thompson et al. (2003) argued that the relative instability of recovery style over time indicated that recovery is not purely a trait of the individual’s personality and may be influenced by therapeutic intervention and “psychoeducation”. In addition, Tait et al. (2003) suggested that increasing insight and recovery may lead to the individual becoming increasingly aware of the negative effects of their experiences of psychosis, prompting the development of a sealing over recovery style. These suggestions challenge McGlashan’s (1987) notion that recovery style is a stable trait, but also highlight the value of offering interventions that reflect the individual’s current recovery style, as a means of promoting psychological adjustment and developing coping skills.
1.8 The current investigation

Despite the literature's focus on the relationship between recovery style and a general notion of psychosis, parallels can be drawn with experiences of voice hearing. Romme and Escher (1994) highlight the value of individuals engaging in discussions about their voices, as a means of recognising patterns of behaviour and identifying the voice's personal meaning. In addition, they suggest that an acceptance of the voice may lead to an appreciation of positive elements of the voice-hearing experience. These ideas share many of the concepts that underlie an integrative recovery style (McGlashan, 1987).

The literature suggests that the way in which the individual makes sense of their psychosis is influenced by early life experiences, either in the form of attachment style, or via the development of beliefs relating to the self and others. Such beliefs have a direct impact on recovery from an episode of psychosis, which in itself may affect long term outcome. In addition, previous life experiences may influence the way in which the individual relates to their voice. It has been demonstrated that the process of identifying the predominant voice may lead to greater exploration of the personal meaning of the voice. However, the potential relationship that may exist between having an identified predominant voice and recovery style has not been established and requires further investigation. In order to explore the factors which might influence such a relationship, the impact of relating style must also be considered.

1.9 Aims and hypotheses

1.9.1 Aim 1

To determine the impact of voice identity on the individual's style of relating to their predominant voice.
Hypothesis 1.

*Individuals whose predominant voice is incognito will relate to their voice from a more distant position than those individuals whose predominant voice is either supernatural or personified.*

1.9.2 Aim 2

To assess the effect that variations in voice identity and the amount of distance between the hearer and the predominant voice has on the hearer’s ability to make sense of their voice, within the context of their wider life experiences.

Hypothesis 2.1.

*Individuals whose predominant voice is personified or supernatural will tend to adopt a more integrative recovery style than those individuals whose predominant voice is incognito.*

Hypothesis 2.2

Greater hearer distance will be positively correlated with a more sealing over recovery style, irrespective of voice identity.

1.9.3 Aim 3

To describe a profile of the phenomena of the voice hearing experience of individuals, on the basis of voice identity and recovery style.

This investigation included an attempt to replicate previous findings, in addition to conducting exploratory analysis. The impact of voice identity on the phenomenology of the voice hearing experience was investigated to determine whether identity influences the experience of voice hearing. The relationship between recovery style and the voice hearing experience was also investigated.
Method

2.1 Design and participants

2.1.1 Design

A quantitative case series study design was used, investigating clinical indicator symptoms (voice hearing). Hypothesis one was a between subjects design, which aimed to compare the mean distance scores of the Voice And You (dependent variable) on the basis of voice identity (independent variable). Hypothesis two was also a between subjects design, with the Recovery Style Questionnaire score as the dependent variable and voice identity as the independent variable. The third hypothesis was a correlational design between hearer distance and recovery style score.

2.1.2 Participants

In total, 25 participants were recruited from community mental health services across two NHS trusts, in the south east of England. A further four individuals chose to withdraw from the study prior to participating and twelve people declined to participate. Demographic data on non-participants was not available and therefore comparisons with the participant group could not be made. All participants had been hearing voices for a minimum of six months and had received a diagnosis of a psychotic disorder (including Schizophrenia, Schizo-affective disorder and Psychotic depression) according to the ICD-10 criteria (World Health Organisation, 1992). Individuals with a primary diagnosis of organic psychosis were excluded from the study, due to potential differences in phenomenology (Ingram, 1985). In addition, people with personality disorder (PD) were excluded from the study, as evidence suggests that psychotic experiences in individuals with a personality disorder may be "atypical", and may have relatively little impact on the individual's life (Dowson, Sussams, Grounds & Taylor, 2000).
Participants were recruited from a range of secondary- and tertiary- community mental health services, including two Community Mental Health Teams, three Assertive Outreach Teams, four Rehabilitation Teams and two Day Services. Individuals who accessed these teams came from a combination of urban and rural locations, including one major city with a diverse social and cultural population, which was reflected in the overall sample. It was not possible to employ interpreters for the study due to a lack of funding for such resources, and therefore participants were required to be able to speak English to a level that provided an adequate description of their voice hearing experiences. In addition, data on the reliability and validity of the assessment scales used in the study would not have been available for interpreted versions. As a result of ethical limitations, it was not possible to include individuals from in-patient services.

2.2 Measures

Each participant was interviewed using a schedule based on the Cognitive Assessment of Voices (Chadwick et al., 1996). In addition, the Voice and You (VAY) questionnaire (Denney, 2004), the Recovery Style Questionnaire (RSQ) (Drayton et al., 1998) and the Psychotic Symptoms Rating Scale – auditory hallucinations scale (PSYRATS) (Haddock, McCarron, Tarrier & Faragher, 1999) were administered (Appendix A).

2.2.1 The Cognitive Assessment of Voices (CAV)

The CAV is a semi-structured interview schedule, which assesses the individual’s experiences of hearing voices within a cognitive framework (Chadwick & Birchwood, 1994). The schedule is designed to elicit information regarding the individual’s beliefs about the identity and power of the voice, antecedents to episodes of voice hearing, the behavioural and affective impact of the voice hearing experience and the individual’s beliefs about the power of the voice. This also includes the individual’s beliefs regarding the potential consequences of complying with or resisting commands made by the voice. The CAV adopts an ‘ABC’ approach to the assessment of voices, based on Chadwick and Birchwood’s (1994) cognitive model of voice-hearing. This
approach emphasises the value of obtaining information relating to activating events (A), beliefs about the voice (B) and the individual’s behaviour and affect arising from the voice-hearing experience (C). Activating experiences may include factors such as the content of the voice’s utterances, its location in either internal or external space, the presence of concurrent symptoms and the identification of cues or contextual factors, which may activate the voice in specific situations. Assessment of the impact of the voice on the individual’s behaviour and affect tends to place particular emphasis on the coping strategies of the individual and the distress that the voice causes. This information also provides an insight into the person’s beliefs about the voice’s identity and meaning; its perceived power and whether the voice is experienced as benevolent or malevolent. Chadwick et al. (1996) also suggest that by adopting cognitive-behavioural techniques such as thought-chaining (Padesky & Greenberger, 1995), information from the CAV can be used to obtain an understanding of the voice that includes information regarding the individual’s negative self-evaluations that are defended against by the development of delusional beliefs. The CAV includes various questions, instructions and techniques for the assessment of cognitive, behavioural and emotional factors, and is designed to be used flexibly, as a semi-structured interview. The CAV was primarily used to ascertain whether the individual knew the identity of the voice and if so, on what basis had they ascertained this. However, the entire CAV was completed, so that additional descriptive analysis could be conducted if necessary.

Close and Garety (1998) conducted a study of the cognitive model of voices, which included an assessment of the CAV’s reliability and validity. They found that the CAV had good inter-rater reliability on all categories except “events attributed to the voice”, which had a kappa of $\kappa = .151$. All other categories had inter-rater reliabilities ranging from $\kappa = .625$ to $\kappa = 1.00$. Test-retest reliability over a one-week period also varied considerably, from $\kappa = .137$ (also for “events attributed to the voice”) to 1.00 for voice identity.
2.2.2 The *Voice and You* (VAY)

Vaughan and Fowler (2004) adapted the *Couple's Relating to Each Other Questionnaire* (CREOQ) (Birtchnell, 1994, cited in Vaughan & Fowler, 2004) to produce two scales, called the Hearer to Voice (HTV) and the Voice to Hearer (VTH), which were designed to assess the relationship between an individual and their predominant voice. These two scales assess the style of relating made by both the voice and the individual, thereby highlighting the potential for reciprocal states of relatedness between the hearer and their predominant voice. Both the HTV and the VTH have 40 items, designed to assess Birtchnell’s four main positions of relatedness; upperness, lowerness, distance and closeness. Each item is scored on a four-point ordinal scale from 0 (mostly no) to 3 (mostly yes).

Statistical analysis of both the HTV and VTH indicated that three of the eight subscales lacked internal consistency and were not reliable and therefore these were removed (Hayward, 2003). The remaining five subscales were subject to item refinement and correlational analysis suggested that the two scales of closeness and lowerness of the Hearer to Voice Questionnaire were measuring similar constructs. Therefore, these two scales were combined to produce a scale of hearer dependence on the voice. The new measure consisted of 29 items, which contributed to scores on four scales; voice upperness, hearer dependence, voice closeness and hearer distance. Face validity of the VAY was assessed and confirmed by two service users and questions that were perceived to be confusing were re-written and responses were rated on a four-point Likert scale (0 - rarely true; 1 – sometimes true, 2 – quite often true; 3 – nearly always true). Item scores of the VAY are ordinal, but each scale score represents the total score for all items on that scale. Higher scores reflect a greater degree of negative relating from the specified position. The number of items that contribute to each of the four scales varies between scales.

2.2.3 The *Psychotic Rating Scale* (PSYRATS)

The PSYRATS is a 17-item rating scale, which assesses the individual’s experiences of hallucinations and delusions across two separate scales, with the aim of developing
a greater understanding of the cognitive processes that contribute to psychosis and associated distress (Haddock, McCarron, Tarrier & Faragher, 1999). The questionnaire employs a multiple-choice design, with responses being scored on a five-point Likert scale, ranging from 0-4. The auditory hallucination subscale includes 11 items on specific traits of the voice including its volume, location, frequency and duration, the amount and degree of negative content of the voice, the amount of distress caused by the voice and its perceived controllability. The PSYRATS has been found to have good inter-rater reliability, with reliability coefficients ranging from .79 to 1.0 (Haddock et al., 1999). The present study investigated responses to individual questions rather than producing a total PSYRATS score for each participant. Information on the individual’s delusional beliefs was not required for the present study and therefore this scale was omitted, for the sake of brevity.

2.2.4 The Recovery Style Questionnaire (RSQ)

The RSQ is a 39-item self-report questionnaire, which measures an individual’s style of recovery from a psychotic episode (Drayton, Birchwood & Trower, 1998). It is based on McGlashan, Levy and Carpenter’s (1975) recovery style interview, but is shorter and does not require a clinician’s rating of the individual. Statements regarding the individual’s experiences of psychosis are rated as either “agree” or “disagree”. In total, 13 subscales are measured by the RSQ and these correspond to the elements that form the Integration Sealing Over Scale (ISOS), developed by McGlashan et al. (1976). These sub-scales relate to concepts such as the individual’s curiosity about the psychotic experience, its perceived educative value, the individual’s sense of optimism and their attitude towards mental illness. The RSQ assesses each of these scale concepts on the basis of responses to three specified questions. An integration score = 1 or a sealing over score = 0 is assigned to each of the 13 subscales, depending on whether the majority of responses to the three specified questions corresponds to either integration or sealing-over. The total number of integrative responses is then calculated as a percentage (i.e. if eight of the 13 subscales are scored as integrative, the integration score will be 62%). These percentages then map onto a six-point scale that corresponds with the ISOS rating.
Major Research Project

scale. McGlashan (1987) indicates that these six points range from ‘integration’ to ‘sealing over’ and include ‘tends towards integration / sealing over’ and ‘mixed picture in which integration / sealing over predominates’. Tait et al. (2004) used a four-point scale to rate RSQ responses, consisting of the original “integration” and “sealing over” categories and two further categories consisting of “mixed picture in which integration / sealing over predominates”. Although such a method may be less sensitive to variations across a sample, it was felt that such an approach might be more suitable for the present study, given the potential for a small sample size.

Drayton et al. (1998) found that the RSQ had acceptable test re-test reliability (Spearman $r = .81$) and internal reliability (Cronbach’s $\alpha = .73$). In addition, the RSQ has good criterion-related validity when compared with the ISOS ($r = .92$).

2.3 Procedure

Approval for the project was obtained from the relevant NHS Research and Development committees, the NHS Research ethics committee allocated to assess the project, local research ethics committees for site-specific assessment and the University of Surrey’s Advisory Committee on Ethics. Appendix B contains documentation and correspondence regarding the process of obtaining ethical approval and Appendix C contains the patient information sheet, consent form and GP letter.

Participants were recruited to the study by various team members, following presentations at team meetings across the services. Each participant’s psychiatrist and GP were informed of the individual’s involvement in the study, via verbal and written information. To ensure ethical research practice, all participants were required to give informed written consent, and each individual was provided with written and verbal information regarding the aims and methodology of the study and the limits of confidentiality, prior to participation. In order to preserve confidentiality a coding system was utilised, which allowed for the future identification of participants who might wish to withdraw from the study, whilst ensuring that data was kept confidential. It had originally been intended that demographic information on non-
consenting individuals would also be collected, for comparison with participant information. However, in order to complete this task the data would have to have been collected by team members, thereby increasing their workload to impractical levels.

Potential participants were approached by their keyworker or care co-ordinator and had a brief, informal discussion regarding the study. Service users who showed an interest in participating were provided with the patient information sheet, and the contact details of the individual were forwarded to the researcher. A minimum of 24 hours was allowed before contact was made, to provide the individual with time to consider their participation in the study.

Prior to data collection, informed written consent was obtained from each participant by the researcher. This process included a discussion about the patient information sheet and consent form and highlighted the individual’s right to withdraw from the study at any point without jeopardising the services they were receiving.

The researcher interviewed participants using the CAV as a guide in order to provide a structure to the interview. Additional questions were asked if the individual appeared not to have understood the question, or if there was a lack of clarity or consistency in the descriptions provided. Administering the CAV took approximately 40 minutes, but varied according to the individual’s insight into their experiences and ability to talk in any depth about these issues. The potential for distress was also discussed at this stage and the individual’s mood and willingness to continue was informally monitored throughout the session.

In order to identify the predominant voice, participants were asked to describe the voice or voices that caused them the most distress or were most difficult to manage. Some individuals were able to clearly identify one voice that fitted this criteria, although participants frequently indicated a sense of ambivalence towards specific voices. In addition, some individuals were unable to specify an individual voice and indicated that they heard a group of voices that caused equal distress. These “community” voices were described as being incognito and belonged to unknown
members of the local community. Participants indicated that they perceived and experienced these voices in similar ways and therefore, although these voices were individuated, they were responded to in a consistent manner. Consequently, participants were required to complete the measures as if the community voices represented a single entity, rather than having to choose a particular voice to focus on.

Following this, the VAY, PSYRATS and RSQ were administered and this order was maintained throughout the study. These questionnaires were read aloud by the researcher, in order to aid the process of engagement in the study and to reduce inaccurate or missing data. Standardised instructions were followed to ensure consistency between interviews and to increase the reliability and validity of the data obtained. If necessary, the assessment was divided into two sections, with a break between the CAV and the questionnaires. The duration of the break was kept to a minimum in order to reduce possible practical difficulties and also to encourage the individual to remain engaged in the research process and promote a sense of collaboration.

The process of assigning voices to the three categories of personified, incognito and supernatural was based on the individual’s response to the CAV (Chadwick & Birchwood, 1996). Additional guidance on this process was also sought from Leudar, Thomas, McNally and Glinski’s (1997) description of identifying individuated voices, via the perceived gender, age, name or sound of the voice and its similarity or difference from known individuals. Voices identified as either a family member, acquaintance or famous person were classified as “personified” as such voices were aligned to a known person in the individual’s social world. The decision to include the voices of famous people was made on the basis that participants would have some knowledge of the individual’s public persona and would have beliefs about hearing the voice, beyond that of perceived omnipotence and the voice’s content. Voices that were identified as being of a known individual, but who behaved in a manner that was seemingly unconnected with that person were described as impostors and voices that had a name but were not aligned to a person in the social world were classified as being incognito.
2.4 Data Analysis

2.4.1 Power analysis

The VAY distance scale was identified as the key dependent variable in the study and was used as a focus for power analysis. Relating to the voice from a more distant position has been found to be an aspect of the relating experience which appears to be a unique form of relating (Hayward, 2003).

Previous data from Hayward’s (2003) study, comparing distant relating on the basis of voice identity, produced a large effect size (F = .743), with alpha = .05 (G*Power; Erdfelder, Faul & Buchner, 1996). This produced a power value = .910 (using a sample size of 27), which exceeds the minimum cut-off point of .80 suggested by Cohen (1988). It should be noted that the high power value obtained in the study was partly a result of a marked difference in distancing behaviour between incognito and supernatural groups. A priori power analysis was carried out on the basis of these results, which suggested that with a power = .80, an alpha = .05 and an effect size of d = 0.85, a minimum sample size of N = 36 would be required, using a one-tailed t-test.

Post hoc power analysis was conducted on the results of a one-tailed t-test, comparing hearer distance ratings on the basis of identity. This produced an effect size d = .899 and a power = .67. These results suggested that the study was under powered and therefore there was an increased risk of making a type II error (Appendix D).

2.4.2 Analyses

Data was analysed using the Statistical Package for Social Sciences (SPSS Inc., Chicago, Illinois, USA) version 12.0.1. Clark-Carter (1997) states that the assumptions for the use of parametric tests are, that the data is normally distributed, is interval or ratio and (in the case of independent t-tests) exhibits homogeneity of variance. Although the VAY is based on ordinal data, total scale scores can be treated as interval data, as each score is the sum of numerous multi-item Likert scales, producing a range of scores greater than 20 (Clark-Carter, 1997). In order to check
for conformity to the assumptions of parametric testing, preliminary analysis of the data was conducted using the Kolmogorov-Smirnov test of normality, which requires a value of \( p = 0.05 \) or greater to ensure that the data is normally distributed. The data was found to be normally distributed, with respect to respondents' age \( p = 0.200 \), time since first episode \( p = 0.075 \) and the VAY measures of upperness \( p = 0.196 \), distance \( p = 0.200 \) and closeness \( p = 0.071 \). All other data did not conform to this test of normality and was subject to transformation. Wright (2003) suggests that such methods should be used cautiously, to avoid regression to the mean. With the exception of the dependence scale of the VAY, which produced a value of \( p = 0.200 \) following square root transformation, the data continued to be skewed, despite attempting various methods of transformation (Tabachnick & Fidell, 1996). Therefore, this data was analysed using non-parametric tests, which are less powerful than parametric methods (Clark-Carter, 1997). Appendix E contains the data on the process of testing the distribution of data and conducting the transformation.
Results

3.1 Overview

Post hoc power analysis indicated that there was an increased risk of type II error occurring. Therefore results should be interpreted with caution.

A number of different stages of analysis were conducted and these will be considered in turn. Firstly, there will be a description of the sample group who participated in the study, including data on aspects of their voice hearing experiences. Secondly, where possible, data will be analysed which replicates previous research, in order to ascertain whether previous findings are supported in the current study. Thirdly, the way in which individuals related to their predominant voice will be explored, with respect to aspects of the voice hearing experience highlighted in previous studies. A similar exploration will also be made regarding recovery style and its correlates. Finally, there will be a section on hypothesis testing, exploring the specific relationships between voice identity, relating from a position of distance and recovery style.

3.2 Sample

3.2.1 Demographics

Twenty five individuals participated in this study and the sample consisted of 16 men (64%) and nine women (36%). The participants ages ranged from 21 to 66 years, with a mean of 37.36 (SD = 13.28). Diagnostic information could not be obtained via medical notes due to ethical constraints, and therefore this information was obtained from each participant. Consequently, this may have affected the reliability of diagnostic information. Participants frequently had a primary diagnosis of schizophrenia (N=21, 84.0%). The remaining participants were diagnosed with psychotic depression (N=2, 8.0%) or first episode psychosis (N=2, 8.0%), for which additional information was not available. Duration of voice hearing experience ranged from two to 35 years, with a mean of 13.68 (SD = 10.57). All participants were on antipsychotic medication and additional pharmacotherapy, for the treatment
Major Research Project

of additional mental health difficulties and to alleviate side-effects. A total of 23 participants (92%) had been hospitalised at some point as a result of their mental health problems, although data regarding the number of admissions was not collected.

Due to the small number of participants with a supernatural predominant voice, the decision was made to combine this data with that for personified voices, on the basis of the results of Hayward (2003), which did not find a significant difference between these two groups. Demographic data on participants in the personified and incognito groups are presented in Table 1. T-tests were conducted and indicated that there was no significant difference in age (t (23) = -0.899, p = .378, 2-tailed) or duration of voice hearing experience (t (11.7) = -0.510, p = .620, 2-tailed) on the basis of voice identity. In addition, no significant difference was found in the frequency of male and female participants hearing either personified or incognito voices ($\chi^2$ (1, n = 25) = -0.132, p = .509, 2-tailed).

Table 1. Sample demographics for the individual voice identity groups

<table>
<thead>
<tr>
<th>Identity</th>
<th>N</th>
<th>Age (years)</th>
<th>Duration of voices</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Male</td>
</tr>
<tr>
<td>Personified</td>
<td>16</td>
<td>35.56 (3.185)</td>
<td>12.75 (2.175)</td>
<td>11</td>
</tr>
<tr>
<td>Incognito</td>
<td>9</td>
<td>40.56 (4.796)</td>
<td>15.33 (4.577)</td>
<td>5</td>
</tr>
</tbody>
</table>

Comparison with previous research suggests that the characteristics of the sample were similar to previous studies. The ratio of male to female participants closely matched previous studies, which have reported ratios of approximately 2:1 (Birchwood & Chadwick, 1997; Hayward, 2003). The mean age of participants was very similar to the sample described by Hayward (2003) (M = 39.52 years; SD = 10.73) as was the mean duration of voice hearing experience (M = 12.59; SD = 8.3).

3.2.2 Identity of the predominant voice

The individual’s knowledge of the identity of the predominant voice and its characteristics were assessed using the CAV. Twelve of the voices were identified as
male (48%) and eight as female (32%). The gender of the remaining voices could not be ascertained by the individual, and were described by one participant as seeming "androgynous". Table 2 describes the different identities of the predominant voices, which formed the basis for later statistical analysis. The majority of voices were found to be aligned to a person in the individual's social world, such as family members, acquaintances and famous people (56.0%). Incognito voices, identifiable only by gender and voice content, were also frequently reported (36.0%), although there were few supernatural voices, such as God, the devil or angels (8.0%). One voice was described as having the characteristics of a family member, but was described by the individual as an impostor who clearly was not that person. Vaughan and Fowler (2004) also reported similar results, with 43.3% of voices being personified, 36.7% being incognito and 13.3% being supernatural (with a further 6.7% being familiar but not known). However, Hayward (2003) did report a more equal distribution across the three groups.

Table 2. Identity of predominant voice.

<table>
<thead>
<tr>
<th>Identity</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supernatural</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>Incognito</td>
<td>7</td>
<td>28.0</td>
</tr>
<tr>
<td>Identified but not aligned</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>Impostor</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>Family member</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>10</td>
<td>40.0</td>
</tr>
<tr>
<td>Famous person</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

3.3 Characteristics of the voice hearing experience

3.3.1 Phenomenology of the voices

The results of the PSYRATS provided information regarding each individual's experience of hearing voices (Appendix F).

Frequency of voice hearing varied considerably across the group, with 28.0% of participants hearing voices at least once per week and 32.0% hearing voices almost
constantly. The majority of participants (60.0%) heard their voices for several minutes at a time, with a minority hearing their voices for up to an hour at a time (8.0%). However a large part of the sample (32.0%) reported hearing voices for hours at a time.

The location of the voices varied considerably across the sample, with the majority of participants reporting that their voices sounded like they were inside their head only (32.0%).

Voice content was often unpleasant, with 40.0% of participants describing their voices as being unpleasant more than half the time. Overall, there was a fairly even split, with half of participants falling in the occasional / minority categories and the other half experiencing negative content on most or all occasions. This negative content frequently took the form of abuse regarding the individual’s self-concept (28.0%) or personal threats of harm (32.0%).

A number of participants reported a degree of distress associated with the voice-hearing experience, with 24.0% reporting that the experience was always distressing. However, 28.0% of participants experienced occasional distress and 4.0% reported that the experience was never distressing. The majority of participants reported at least some level of distress, with the majority rating the experience as moderately or very distressing (60.0%).

The disruption to participant’s lives as a consequence of their voices was generally described as minimal (48.0%) or moderate (44.0%). Although one participant indicated that the experience had caused complete disruption to her life, she was not hospitalised and therefore her experiences did not fully match the criteria for that response. It should be noted that due to ethical considerations, inpatients were not included in the study and participant’s mental health had to be stable at the time of interview. Therefore these results probably reflect this selection bias. Only 24.0% of participants felt that they had no control over their voices at all, with the same number feeling they had total control over their voices. This is in marked contrast to the
findings of Hayward (2001), who found that 50% of participants felt they had no control over the voices and only 3.7% reporting complete control over the voices.

3.3.2 Styles of relating

The results of the VAY provided information regarding the ways in which the participants related to their predominant voice (see Appendix G).

The mean score for uppermess was 9.32 (SD = 5.73) and ranged from 0 to 21 (maximum possible score = 21). Scores for this scale were normally distributed. The mean score for the dependence scale was towards the lower end of the scale (M = 7.32; SD = 7.32) and scores ranged from 0 to 25 (maximum = 27), indicating that the highest possible scores were not achieved. These scores were positively skewed, but were transformed using square root transformation. Ratings of closeness ranged from 0 to 18, with the majority of scores being in the lower range, reflected in the relatively low mean score (M = 7.80; SD = 4.75). The mean rating for distance was the highest of the four scales (M = 11.88; SD 5.88), with scores ranging from 0 to 20. Results were fairly evenly distributed across this range, indicating wide variation in styles of relating across the sample. The results of the present research were compared with a previous study of relating and it was found that overall, ratings of negative relating were lower in the current study (Table 3). This difference suggests that participants in the current study generally related to their voices from a less distant but slightly more dependent position and perceived their voices as relating less dominantly and less closely than the sample described by Denney (2004).

Table 3. Comparison of mean VAY scores with the results of Denney (2004).

<table>
<thead>
<tr>
<th></th>
<th>Mean Voice Uppermess (SD)</th>
<th>Mean Voice Closeness (SD)</th>
<th>Mean Hearer Dependence (SD)</th>
<th>Mean Hearer Distance (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present study</td>
<td>9.32 (5.73)</td>
<td>7.80 (4.75)</td>
<td>7.32 (7.32)</td>
<td>11.88 (5.88)</td>
</tr>
<tr>
<td>Denney (2004)</td>
<td>16.08 (6.73)</td>
<td>12.04 (5.70)</td>
<td>6.25 (6.24)</td>
<td>16.21 (5.10)</td>
</tr>
</tbody>
</table>
3.3.3 Relationships between the four scales of the VAY

Pearson's correlations were conducted between the three normally distributed scales of the measure and the transformed dependence data. As can be seen from Table 4, half of the correlations between scales were small and non-significant. However, a significant negative correlation was observed between dependence and distance \((r(25) = -.576, p=.003, \text{2-tailed})\) and a negative correlation was also observed between dependence and upperness \((r(25) = -.419, p=.037, \text{2-tailed})\). A positive correlation was also found between distance and upperness \((r(25) = .696, p=.000, \text{2-tailed})\), suggesting that as distance from the voice increases, the voices style of relating is perceived to become increasingly dominant.

### Table 4. Correlations between the scales of the VAY.

<table>
<thead>
<tr>
<th></th>
<th>Upperness</th>
<th>Dependence</th>
<th>Closeness</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upperness</td>
<td>1.00</td>
<td>-0.419*</td>
<td>0.145</td>
<td>-0.696**</td>
</tr>
<tr>
<td>Dependence</td>
<td></td>
<td>1.00</td>
<td>-0.076</td>
<td>0.207</td>
</tr>
<tr>
<td>Closeness</td>
<td>-0.419*</td>
<td>-0.076</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Distance</td>
<td>-0.696**</td>
<td>-0.576**</td>
<td>0.207</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**p < 0.01 level; * p < .05

3.3.4 Relationship between the VAY and PSYRATS

For the purposes of comparison with previous findings, the results of the VAY were correlated with the results of the PSYRATS, using non-parametric analysis (Table 5).

### Table 5. Bivariate correlations (Spearman's rho) between scales of the VAY and dimensions of the PSYRATS.

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Duration</th>
<th>Loudness</th>
<th>Amount negative content</th>
<th>Degree negative content</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upperness</td>
<td>-0.145</td>
<td>0.064</td>
<td>-0.034</td>
<td>0.380</td>
<td>0.152</td>
<td>0.001</td>
</tr>
<tr>
<td>Dependence</td>
<td>-0.115</td>
<td>0.168</td>
<td>0.120</td>
<td>-0.140</td>
<td>-0.063</td>
<td>-0.225</td>
</tr>
<tr>
<td>Closeness</td>
<td>0.423*</td>
<td>0.310</td>
<td>0.022</td>
<td>0.122</td>
<td>0.022</td>
<td>0.230</td>
</tr>
<tr>
<td>Distance</td>
<td>-0.003</td>
<td>0.069</td>
<td>0.030</td>
<td>0.237</td>
<td>-0.147</td>
<td>0.174</td>
</tr>
</tbody>
</table>

* p < .05
Hayward (2003) found a significant positive correlation between hearer distance and the amount of negative content of the voice, suggesting that the individual attempts to create distance between themselves and voices that are critical, abusive or threatening. The current study did not support this finding, although a significant positive correlation was observed between closeness and frequency of voice hearing activity (Spearman's rho = .423, p < .05, 2-tailed) and voice upperness and hearer distress (Spearman's rho = .398, p < .05, 2-tailed).

3.3.5 Distress and distance

The relationship between hearer distance and distress was also studied, in order to clarify previously conflicting results (Appendix H). The results of the current study did not suggest that distress increases with relating from a distant position. A non-parametric correlation was conducted between distance and intensity of distress and was found to be non-significant (Spearman's rho = .203, p = .331, 2-tailed) and corroborated the findings of Hayward (2001). For the purposes of further comparison with Hayward's (2001) results, distance scores were divided into tertile ranges and mean distress results were produced (Table 6). The results of a Kruskal-Wallis test indicated that relating from a more distant position did not increase the intensity of distress experienced by the individual (H = 3.224, p = .199, 2-tailed).

Table 6. Intensity of distress ratings for participants whose distance scores were in each tertile range.

<table>
<thead>
<tr>
<th>Tertile range</th>
<th>N</th>
<th>Mean distress rating (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>5</td>
<td>1.40 (1.140)</td>
</tr>
<tr>
<td>Second</td>
<td>9</td>
<td>2.44 (1.014)</td>
</tr>
<tr>
<td>Third</td>
<td>11</td>
<td>2.45 (1.036)</td>
</tr>
</tbody>
</table>

Hayward (2003) found that intensity of distress was highest for individuals whose distance scores were in the second tertile suggesting that if distance from the voice can be attained, distress decreases. In contrast, Vaughan and Fowler (2004) found a significant correlation between distance and distress, suggesting that relating to the voice from a position of distance is associated with increased hearer distress.
3.3.6 Recovery style

The results of the RSQ were analysed and produced scores on a four-point ordinal scale according to the scoring criteria described by Tait et al. (2004). Figure 3 highlights the degree of positive skew in these results, with the majority of participants adopting an integrative recovery style (56%). When considering recovery style in terms of a dichotomous construct, 80% of participants adopted a purely or predominantly integrative recovery style (Appendix I). Only one participant obtained a score of sealing over, suggesting a degree of bias in the data. Hypothesis testing relating to recovery style was conducted using the four-point scale, in order to retain the sensitivity of the data whilst ensuring that appropriate statistical analysis could be conducted. Drayton et al. (1998) found that at the point where individuals were identified as having stable mental health following an acute episode, 72% of individuals had adopted an integrative recovery style. The current study produced similar result, although participants were at varying stages of the recovery process.

Figure 3. Frequency of participants adopting a specific recovery Style

<table>
<thead>
<tr>
<th>Style of recovery</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>18</td>
</tr>
<tr>
<td>Mixed - Integration</td>
<td>14</td>
</tr>
<tr>
<td>Mixed - Sealing</td>
<td>6</td>
</tr>
<tr>
<td>Sealing</td>
<td>2</td>
</tr>
</tbody>
</table>

Std. Dev = .90
Mean = 1.7
N = 25.00
3.4 Hypothesis testing

The main hypotheses of the study were assessed using t-test and correlational analyses.

3.4.1 Hypothesis 1:

It was predicted that individuals who perceived the identity of their predominant voice to be incognito would relate to their predominant voice from a significantly more distant position, when compared to individuals whose voice was personified or supernatural. As previously mentioned, the ‘distance’ data from the VAY was normally distributed and was found to be of equal variance according to the results of Levene’s test (F=2.265, p=.146). Therefore, a parametric comparison of independent means (t-test) was conducted, comparing the distance scores for “incognito” and “personified and supernatural” voices (Appendix J). The decision to combine these two groups was made on the basis of Hayward’s (2003) finding that there was no significant difference in distance scores for these two groups. In addition, the small number of participants with a supernatural voice would have excluded this data from analysis.

Figure 4 provides information regarding the range of distance scores obtained for individuals with personified or incognito voices. The bold horizontal line represents the median of the scores, with the box indicating the middle 50% of scores and the whiskers representing the upper and lower fences (Clark-Carter, 1997). It can be seen that there is a marked difference in the median scores, although there is some degree of overlap between the scores.

Due to the directional nature of the predicted effect, the decision was made to use a one-tailed analysis. A significant difference was found between the two groups (t (23) = -2.043, p<.05, 1-tailed), with participants with incognito voices tending to relate from a greater distance (M=14.89, SD=4.106) when compared with personified and supernatural voices (M=10.19, SD=6.145). The 95% confidence interval for the t-value ranged from -9.461 to .058. It is recognised that the small sample size and use
of a one-tailed test may have increased the risk of a type I error occurring. These results support Hayward’s (2003) preliminary findings and offer support for this hypothesis.

Figure 4. Box plot of VAY distance scores for personified / supernatural and incognito voices

3.4.2 Hypothesis 2.1

It was predicted that individuals whose predominant voice was personified or supernatural would tend to adopt a more integrative recovery style than those individuals whose predominant voice was incognito. Non-parametric analysis was conducted (Appendix K), due to the skewed distribution of the data, and the results of the Mann-Whitney were not significant (U=54.00, p=.257, 2-tailed). The results of the analysis indicated that individuals whose voices were incognito tended to adopt a recovery style which was ‘mixed, with predominant integration’ recovery style (Median = 2.00, inter-quartile range = 2.00), whilst individuals whose voice was personified / supernatural tended to adopt an integrative recovery style (Median = 1.00, inter-quartile range = 1.00). This hypothesis was not supported.
3.4.3 Hypothesis 2.2

It was predicted that there would be a positive correlation between greater hearer distance and a sealing over recovery style, irrespective of voice identity. The results of a correlation (Appendix L) were non-significant (Spearman’s rho = .140, p = .505, 2-tailed). Therefore, this hypothesis was not supported.

3.5 Additional analysis

3.5.1 A profile of the voice hearing experience, based on voice identity

The results of the study indicate that there are various elements of the voice-hearing experience that may be influenced by, or related to the identity of the predominant voice. Therefore, additional analysis was conducted, in order to highlight potential areas for future exploration. The impact of voice identity on the overall voice hearing experience was assessed, by conducting Mann-Whitney analysis on the PSYRATS data (Appendix M). This data is summarised in Table 7.

The analysis indicated that scores for PSYRATS dimensions did not differ significantly, on the basis of voice identity. There was some indication that incognito voices were experienced as having higher and more extreme levels of negative content than personified voices and this difference was approaching significance (U = 39.0, p = .051, 2-tailed). In addition, there was some indication that voices that were incognito were experienced as being more externally generated than those that were personified or supernatural. Although this difference was not significant, it may suggest some difference in the way the voice’s origins are understood by the hearer.

The potential effect of voice identity on the other styles of relating was also investigated using t-tests, for comparison with previous findings (Hayward, 2003). No significant differences were found between the groups on scores for uppperness, (t (23) = -1.340, p = .193, 2-tailed), closeness (t (23) = -.069, p = .946, 2-tailed) or dependence (t (23) = .175, p = .866, 2-tailed) (Appendix N). There was some discrepancy between means for uppperness, with incognito voices (M = 11.33, SD =
4.90) being higher than those for personified / supernatural voices (M = 8.19, SD = 5.99). However, this difference was not significant.

Table 7. Mean PSYRATS dimension scores according to predominant voice identity.

<table>
<thead>
<tr>
<th>PSYRATS dimension</th>
<th>Voice Identity</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of voice</td>
<td>Personified</td>
<td>2.81</td>
<td>1.167</td>
</tr>
<tr>
<td>hearing</td>
<td>Incognito</td>
<td>2.11</td>
<td>1.269</td>
</tr>
<tr>
<td>Duration of voice</td>
<td>Personified</td>
<td>2.69</td>
<td>.946</td>
</tr>
<tr>
<td>hearing</td>
<td>Incognito</td>
<td>2.78</td>
<td>.972</td>
</tr>
<tr>
<td>Location of voices</td>
<td>Personified</td>
<td>2.56</td>
<td>1.413</td>
</tr>
<tr>
<td></td>
<td>Incognito</td>
<td>2.33</td>
<td>1.000</td>
</tr>
<tr>
<td>Loudness of voices</td>
<td>Personified</td>
<td>1.94</td>
<td>.854</td>
</tr>
<tr>
<td></td>
<td>Incognito</td>
<td>2.00</td>
<td>.500</td>
</tr>
<tr>
<td>Origins of the voices</td>
<td>Personified</td>
<td>2.56</td>
<td>1.094</td>
</tr>
<tr>
<td></td>
<td>Incognito</td>
<td>2.89</td>
<td>1.364</td>
</tr>
<tr>
<td>Amount of negative</td>
<td>Personified</td>
<td>2.00</td>
<td>1.095</td>
</tr>
<tr>
<td>content</td>
<td>Incognito</td>
<td>2.89</td>
<td>.928</td>
</tr>
<tr>
<td>Degree of negative</td>
<td>Personified</td>
<td>2.44</td>
<td>1.315</td>
</tr>
<tr>
<td>content</td>
<td>Incognito</td>
<td>3.00</td>
<td>1.118</td>
</tr>
<tr>
<td>Amount of distress</td>
<td>Personified</td>
<td>2.38</td>
<td>1.310</td>
</tr>
<tr>
<td></td>
<td>Incognito</td>
<td>2.44</td>
<td>1.236</td>
</tr>
<tr>
<td>Intensity of distress</td>
<td>Personified</td>
<td>2.25</td>
<td>1.291</td>
</tr>
<tr>
<td></td>
<td>Incognito</td>
<td>2.22</td>
<td>.667</td>
</tr>
<tr>
<td>Disruption to life</td>
<td>Personified</td>
<td>1.63</td>
<td>.885</td>
</tr>
<tr>
<td></td>
<td>Incognito</td>
<td>1.33</td>
<td>.500</td>
</tr>
<tr>
<td>Degree of control over</td>
<td>Personified</td>
<td>2.69</td>
<td>1.078</td>
</tr>
<tr>
<td>voices</td>
<td>Incognito</td>
<td>2.44</td>
<td>1.236</td>
</tr>
</tbody>
</table>

Recovery style was also correlated with the results of the PSYRATS, in order to develop a greater understanding of the relationship between the voice hearing experience and the way the individual made sense of their experiences (Table 8). A significant correlation was found between recovery style and degree of control over the voice (Spearman’s rho =.408; p <.05. 2-tailed), indicating that an increased sense of voice controllability is associated with a more integrative recovery style.
Table 8. Spearman correlation of recovery style and the PSYRATS.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Duration</th>
<th>Loudness</th>
<th>Amount negative content</th>
<th>Degree negative content</th>
<th>Distress: intensity</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>.335</td>
<td>.222</td>
<td>-.173</td>
<td>.318</td>
<td>.136</td>
<td>.230</td>
<td>.408*</td>
</tr>
</tbody>
</table>

* p< .05

3.6 Summary of main findings

3.6.1 Voice identity and voice hearing experience

Evidence was found to support the findings of Vaughan and Fowler (2004), that the majority of voices were identified as personified. Voices were frequently experienced as unpleasant, with the majority of participants experiencing some distress as a consequence of the voice. A statistically significant difference was observed between ratings of hearer distance on the basis of voice identity, thereby supporting the findings of Hayward (2003).

3.6.2 Relating and the voice hearing experience

The four scales of the VAY were correlated to varying degrees, with significant relationships between ‘dependence and upperness’, ‘distance and upperness’ and ‘distance and dependence’. A difference in mean scores on the four scales of the VAY was observed, when the results of the current study were compared with the findings of Denney (2004), with participants in the current study reporting less negative relating. The mean distance score was found to be the highest of all the scales of the VAY.

A significant relationship was found between the VAY measure of closeness and the frequency of voice hearing. There was no additional support for Hayward’s (2003) findings, regarding hearer distance and amount of negative content. Although analysis of distress data on the basis of hearer distance did not produce significant
results, the observed trend supported Vaughan and Fowler’s finding that increased distance was associated with more intense distress, resulting from voice hearing.

3.6.3 Identity and distance

The study found a significant difference between distancing behaviour, on the basis of voice identity, thereby supporting Hayward’s (2003) findings. Incognito voices were related to from a significantly more distant position than personified and supernatural voices.

3.6.4 Impact of identity on recovery

The majority of participants adopted an integrative recovery style. No significant relationship was found between voice identity and recovery style, with most participants adopting an integrative recovery style. In addition, no relationship was found between distance and recovery style.
4.1 Overview

The aim of the study was to further explore styles of interpersonal relating between individuals and their predominant voice, with particular emphasis on clarifying the impact of voice identity, on relating from a position of distance. In addition, the research aimed to explore the impact of relating from a position of distance on recovery style, in terms of the individual's tendency to integrate or seal over their experiences of psychosis.

The following discussion will consider the main research findings regarding interpersonal relating, recovery and the individual's experience of hearing voices. These results will be considered within the context of current theory and the findings will be integrated into the existing literature. The clinical implications and methodological limitations of the study will be highlighted, leading to a discussion on ideas for future research.

4.2 Summary and interpretation of findings

To ensure that the findings of the present study could be interpreted in a meaningful way, the extent to which the results generalised to previous studies was examined. Demographic variables, including age, duration of voice hearing and gender matched those of previous studies, and similar inpatient admission rates were also found (Birchwood & Chadwick, 1997; Hayward, 2003). The majority of voices were identified as personified, with supernatural voices being relatively uncommon. These results reflected the findings of Vaughan and Fowler (2004), Leudar et al. (1997) and Nayani and David (1996), although they were markedly different from the sample described by Hayward (2003). In the present study, frequency of voice hearing was greater than that described by Nayani and David (1996), but was generally of shorter duration.
Post hoc power analysis indicated that the study was under-powered and therefore there was an increased risk of making a type II error. This suggests that the study was not robust and therefore the results of the analysis should be interpreted with caution. It should be noted that previous studies into voice hearing experiences frequently report small sample sizes, and this reflects the challenge of recruiting individuals who may find it difficult to engage with mental health services.

4.3 Relation of results to aims and hypotheses

Aim 4.3.1.

To determine the impact of voice identity on the individuals style of relating to their predominant voice.

Hypothesis 1.

*Individuals whose predominant voice is incognito will relate to their voice from a more distant position than those individuals whose predominant voice is either supernatural or personified.*

The results found evidence of a significant difference in degree of distance between the voice and hearer on the basis of voice identity, thereby supporting Hayward’s (2003) findings. Therefore this hypothesis was supported by the data.

Further analysis of the relating data indicated that voice identity did not lead to different styles of relating on the three remaining relating scales of the VAY. The absence of a significant difference between the two groups supports Hayward’s (2003) findings and suggests that variations in relating style are influenced by factors other than voice identity, with the exception of hearer distance.
Aim 4.3.2.

To assess the effect that variations in voice identity and the amount of distance between the hearer and the predominant voice has, on the hearer's ability to make sense of their voice, within the context of their wider life experiences.

Hypothesis 2.1.

*Individuals whose predominant voice is personified or supernatural will tend to adopt a more integrative recovery style than those individuals whose predominant voice is incognito.*

This hypothesis was not supported. No difference in recovery style was found between the two groups, on the basis of predominant voice identity. This suggests that voice identity does not influence the way in which individuals attempt to manage their voice hearing experiences, or their beliefs about the impact of their voices on their life. It is possible that developing an understanding of the voices alignment to known individuals may provide greater understanding of the voice, if this information can be used in a therapeutic manner. However, this knowledge in itself does not appear to lead to an integrative recovery style.

Hypothesis 2.2

*Greater hearer distance will be positively correlated with a more sealing over recovery style, irrespective of voice identity.*

The results of the analysis indicated that hypothesis 2.2 was not supported. The lack of a significant correlation between hearer distance and recovery style indicates that the process of recovery is not mediated by the hearer adopting a position of distance. This suggests that even if the individual adopts a position of greater proximity to the voice, this may not lead to a greater personal understanding of the voice hearing experience, in the form of an integrative recovery style. Alternatively, it could be argued that attaining a position of greater proximity to the voice does not, in itself,
lead to a greater understanding of the personal meaning of the experience. The under­representation of participants who had adopted a sealing over recovery style might have masked any significant effect, with respect to either voice identity or hearer distance.

Aim 4.3.3

To describe a profile of the phenomena of the voice hearing experience on the basis of voice identity and recovery style.

Clarification was required, regarding the role of hearer distance in mediating distress. The results of the analysis were non-significant, indicating that variations in hearer distance did not influence the intensity of distress.

Phenomenological aspects of the voice hearing experience were studied, on the basis of voice identity. It was found that there were no significant differences in participant’s experiences of voice content, frequency or perceived controllability on the basis of voice identity.

A significant positive correlation was observed between recovery style and the perceived degree of control that participants had over the voice. This result indicated that individuals who adopted an integrative recovery style reported a greater sense of control over their voice. This point will be discussed in greater depth at a later stage.

4.4 Relevance of the results to the existing literature

4.4.1 Contributions to the literature on relating to the voice

The results of the study provide additional information regarding negative interpersonal relating, between the individual and their predominant voice. The significant correlations between scales of the VAY suggest that there is a negative correlation between “hearer dependence and hearer distance”. This finding supports the notion of power and proximity being two relatively distinct forms of relating, with
the hearer feeling less fear of abandonment by the voice if they are relating from a position of greater distance. However, it is more likely that these findings reflect the origins of the dependence scale (which combined the original scales of hearer closeness and lowerness) as one would expect a negative correlation between ratings of hearer distance and hearer closeness. Therefore, these results reflect a degree of independence between the two scales, as would be predicted.

The significant negative correlation between “hearer dependence and voice upperness” indicates that individuals, who tend to relate to their voice from a less dependent position, perceive the voice as relating more dominantly. This reflects the original structure of Birtchnell’s (1996) axes of power and proximity, and the idea that hearer loweness (and therefore dependence), can be considered to be in a reciprocal relationship with voice upperness. The positive correlation between “hearer distance and voice upperness” can also be understood in terms of a reciprocal relationship between voice and hearer, in which the individual attempts to create greater distance from a domineering voice. Alternatively, this relationship can be construed as the voice’s attempt to control a hearer who is attempting to maintain greater distance.

When considering the two axes of relating described by Birtchnell (1996, 1999), voices were primarily related to from a position of distance, thereby reflecting the findings of Vaughan (2000) and Hayward (2003). In Birtchnell’s theory, adopting a negative-distant position of relating may reflect the individual’s limited capacity to become involved with the voice, or a desire to protect oneself from intrusion, via attempts to ignore or disengage from the voice. Such behaviour might be construed as an attempt to feel that one is safely distanced from the voice. Unfortunately, information regarding the perceived intent of the voice was not obtained, so investigations into possible links between distance and perceived malevolence of the voice could not be made.

A relationship was not observed between voice closeness and upperness, indicating that these two constructs are differentiated by the VAY. This suggests that perceptions of the voices power and proximity were independent of one another, and indicates that powerful voices were not necessarily perceived as attempting to relate
from a position of closeness. The study found that perceptions of voice closeness did not influence the relating style of the individual. In contrast, the upperness of the voice was negatively associated with dependence and positively associated with hearer distance. Although the analysis was unable to identify the direction of causality, these results tentatively suggest that the perceived power of the voice may result in more distant relating. However, firm conclusions cannot be drawn as a result of the low power of the study and the use of correlational statistics.

Previous research on the impact of distant relating on intensity of distress has produced conflicting results. Vaughan and Fowler (2004) found that distress increased with distance from the voice. In contrast, Hayward (2001) did not find a significant relationship between distance and distress. The current study did not find any evidence to suggest that distant relating leads to increased hearer distress. In addition, previous research has only identified a correlational effect, and consequently it has not been possible to ascertain a sense of causality. It is possible that the findings of Vaughan and Fowler (2004) and Denney (2004) reflected a desire on the part of the hearer to distance themselves from a distressing voice, rather than indicating that the process of attaining distance necessarily leads to increased distress.

The presence of a significant correlation between voice upperness and hearer distress also replicated the findings of Vaughan and Fowler (2004), and provides tentative support to the notion that being related to by a domineering and powerful voice is associated with greater hearer distress. It should be noted that causality has not been established in the present study or that of Vaughan and Fowler (2004). Consequently it is likely that there are additional factors which might contribute to such a relationship, including personality factors, beliefs about the voice and the self or the impact of social and family support.

Analysis of the data concerning voice closeness indicated that being related to from a negative-close position was reported less frequently than in previous studies (Denney, 2004). A significant positive correlation was found between voice closeness and frequency of voice activity. This suggests that voices that spend more time talking to the individual might be perceived by the individual as exhibiting more “clinging”
behaviour such as jealousy and anger at attempts at being excluded. Alternatively, these results could indicate that techniques aimed at reducing or excluding the voice, such as distraction, might lead to increased levels of voice activity.

4.4.2 Contributions to the literature on recovery style

The results of the present study suggest that the majority of individuals adopted an integrative recovery style, or a ‘mixed recovery style in which integration predominated’. This suggests that the participants had developed an understanding of the impact that their voices had had on their lives, and were keen to seek support in this area. Previous research suggests that greater levels of sealing over would be predicted in a sample consisting primarily of people with a diagnosis of schizophrenia (Thompson et al., 2003). The inconsistencies between the results of the present study and previous research into recovery style may be a consequence of variations in the sample demographics. McGlashan (1987) studied recovery in severely ill psychiatric patients, who had been discharged from long-stay hospitals. The research was based on follow-up interviews conducted with patients or carers and adopted the original ISOS technique, rather than using the RSQ, which might account for some of the discrepancy. Drayton et al. (1998) also found a more even spread of recovery styles in people with schizophrenia. However, it was unclear whether their sample consisted entirely of people who were considered to be stable at the time of participating. It is likely that the criteria of stability and the exclusion of inpatients also influenced the results of the present study.

The positive correlation between recovery style and perceived controllability of the predominant voice provides preliminary evidence that individual’s who are curious about their psychosis and who are able to make links with their previous experiences, have a greater understanding of the methods which will allow them to control the voice. McGlashan (1987) stated that individuals who seal over tend not to investigate their symptoms, and rarely attempt to develop an understanding of their experiences. The present findings indicate that the perceived lack of control described by individuals who seal over may reflect a lack of exploration of the processes which may allow them to influence the voice. In addition, it suggests that these individuals
have an inability to utilizing internal or external resources, which would enhance a sense of personal resilience. Therefore, reports of voice uncontrollability may suggest that the individual has not experimented with different techniques for controlling the voice, rather than indicating that the voice cannot be controlled.

4.4.3 Contributions to the literature on the impact of voice identity

The evidence suggests that voice identity may influence the extent to which the individual relates to their predominant voice from a position of distance, but does not have an impact on other forms of negative relating. These results suggest that individuals whose predominant voice is incognito are more likely to feel the need to protect themselves from the voice, or to disengage from it. In contrast, it appears there may be more tolerance of personified voices and a certain level of acceptance of the voice’s knowledge of the individual. These findings offer support for the results of Hayward (2003), who found clear evidence of different degrees of distant relating on the basis of voice identity.

Additional analysis also indicated a potential relationship between voice identity and the amount of negative voice content, with this difference approaching statistical significance. Such a pattern suggests that incognito voices might be perceived by the hearer as being critical, abusive or commanding, more frequently than voices that have a known identity. It is interesting to note that despite this difference in the content of the voices utterances, there was no difference in the levels of distress associated with the voice’s presence.

4.5 Contributions to theories of voice hearing

The current study offers some support for the model proposed by Hayward (2001), which suggests that the individual’s relating style is influenced by the identity of the predominant voice and by the activation of schemas of interpersonal relating based on childhood experience (Birchwood & Chadwick, 1997; Benjamin, 1989). The results of the present study also provide support for the notion that it is a combination of voice identity and perceived threat that leads to more distant relating, with incognito
voices being associated with more hostile voice content. The role of voice content in creating greater distance from the voice, suggests that beliefs about the voice’s malevolence influence the degree to which the individual feels the need to protect themselves from the voice. Relating distantly might represent the resistance described by Chadwick et al. (2000), which is activated by the voice’s perceived malevolence.

The absence of a significant relationship between hearer distance and recovery style is surprising. It suggests that attempting to keep an unknown voice, that might be perceived as unpredictable and potentially threatening, at a distance is not associated with recovery style. If one adopts the model proposed by Hayward (2001), the activation of a relating schema will be influenced by the voices identity, with incognito voices being related to on the basis of content and potential unpredictability. Bell and Zito (2005) indicate that individuals who adopt a sealing over recovery style tend to interact at a superficial level and frequently avoid intimate relationships. In addition, Tait et al. (2004) suggest that sealing over is associated with greater vulnerability to believing that one is viewed in a negative way. Therefore, it is possible that recovery style influences the way in which a person relates to the voice, regardless of its identity. Style of relating may be more greatly influenced by the individual’s beliefs about how they are perceived by the voice, on the basis of early attachment experiences and current adult relationships. The absence of a relationship between hearer distance and distress in the present study suggests that relating to the voice from a position of greater closeness is not associated with more positive affect or reduced distress.

The finding that a more integrative recovery style is associated with a greater sense of control over the voice is also of potential importance. The role of exerting or experiencing control in relation to the voice is highlighted in the literature on recovery style and is associated with beliefs about the self and the world. As previously mentioned, Beck and Rector (2003) suggest that voice uncontrollability may activate negative beliefs about the self, which reflect a lack of control in everyday life. Therefore, a perceived lack of voice controllability in people who seal over may be a result of the individual’s negative beliefs about their ability to cope with, or control the voice, rather than a reflection of the voice’s capacity to be controlled. If – as Tait
et al. (2003) suggest – individuals who seal over are “unable” to face up to the 
personal impact of psychosis, it seems likely that they will not allow themselves the 
opportunity to experiment with the voice. This may lead to a situation in which they 
constantly strive to deny their experiences, whilst overlooking the potential coping 
strategies (such as challenging beliefs about voice controllability) that may reduce 
distress.

4.6 Clinical implications:

The results of the study suggest some potential areas of clinical intervention, although 
the underpowered sample and lack of significant results suggests that greater research 
is required in this area before firm conclusions can be drawn regarding clinical 
applications.

Hayward (2003) has previously suggested that the identification of possible 
alignments between the voice and a known individual, may lead to increased 
knowledge about the voice and a reduction in the need to protect oneself from an 
unknown ‘other’. The value of developing a sense of personal meaning, that links the 
voice with past and current life events, is highlighted by Romme and Escher (2000), 
who suggest that this process may be facilitated by the identification of the voice. 
Despite these conclusions, the findings of the current study do not suggest that 
identifying the predominant voice and reducing hearer distance leads to reduced 
distress. In addition, it could be argued that the development of a closer relationship 
with a voice that is perceived by the individual as distressing might have a detrimental 
effect on the individual. There is the potential for closer relating to the voice to lead 
to the individual reducing their exploration of their other social relationships, or 
becoming over-dependent on the voice. In addition, there is the potential for the 
individual to increasingly identify with a voice that continues to be critical or abusive 
of them. The process of investing in the relationship with the voice and developing a 
closer relationship with it might also lead to a loss of privacy or reduced self 
confidence, resulting in a form of psychological incapacity (Benjamin, 1989). 
Consequently, it appears that greater investment in exploring the clinical value of 
developing a closer relationship with the predominant voice is required.
In situations where multiple voices are heard, psychological therapy may require a change of focus, towards the development of stronger relationships with positive voices that have an identity. By developing a greater understanding of these voices, it may be possible to develop allies that can aid the process of managing a distressing, incognito voice. This idea is consistent with previous suggestions that positive voices should be engaged with, as a means of coping with difficult voices (Romme & Escher, 1994; Birchwood & Chadwick, 1997; Leudar & Thomas, 2000).

4.7 Limitations of the study

There were various limitations to the study, which may have affected the outcome. As previously stated, the study was under-powered as a result of the sample size. This reflects the difficulties that arise when conducting a research project with individuals who frequently have difficulties engaging with services or who are reluctant to talk about their experiences. The sample size was similar to a number of studies that have utilised the same measures, including Hayward (2003) and Vaughan and Fowler (2004). In addition, some of the analysis was exploratory and therefore cannot be interpreted with confidence until it has been replicated using more powerful samples. The use of correlational analysis in this and previous studies also means that causality cannot be established and there may have been other factors which contributed to significant results.

The process of identifying and categorising predominant voices was problematic, due to the variations in how the participants experienced their voices. Individuals described hearing voices that were aligned to a person in their social world, but whom they knew not to have the same personality or character as that individual (e.g. hearing a critical and abusive voice, which was perceived as sounding like a kind and loving relative). In addition, some individuals described hearing a voice which had initially been incognito, but whom they had subsequently met in their social world. Although these participants explained these experiences in terms of clairvoyance, on occasions the distinction between supernatural, incognito and personified voices was less clear. Whilst this issue is a limitation of the study, further research into the classification of
voice identity would primarily be an academic pursuit, as the categorisation (as opposed to identification) of voices is of less clinical relevance.

A number of participants indicated that they heard multiple voices, and identifying a predominant voice was sometimes difficult. The tendency for research to focus on one voice, rather than the whole voice-hearing experience, suggests that valuable information may be overlooked. In addition, the extent to which findings can be generalised to the clinical setting may also be compromised. It is possible that such an approach may also fail to capture the dynamics that can occur between voices, as well as between the hearer and their voices.

The individuals who participated in the study were all out-patients, who were stable at the time of interviewing and therefore represented a very specific population. The lack of normally distributed data, and the under-representation of individuals who sealed over, suggests that there was a sampling bias towards individuals who had a greater understanding of their experiences and who were less inclined to protect themselves from negative self-evaluation by the interviewer. Consequently, it is possible that additional exploration of the research hypotheses may highlight more marked differences, between individuals who integrate or seal over. The inclusion of a non-clinical sample of people who hear voices would have provided valuable information, as comparison between these two groups may have highlighted differences in social relating and recovery.

The absence of a relationship between voice identity and recovery style may partly have reflected the participant's levels of understanding of their voices. Although specific data was not collected on the participant's experiences of mental health services, the majority had received psychological therapy, or had attended hearing voices groups, and therefore may have developed a greater understanding of the voice's personal meaning, even if they remained incognito.

The assessment scales that were used in the study were suited to the task, but there were specific questions that participants found difficult to respond to. Some items of the VAY were perceived as making assumptions about the individual's degree of
control over the voice, that were not always representative of their experiences. For example, the question “I prefer to keep my voice at a safe distance” was felt to imply a degree of choice as to whether or not they could distance themselves from the voice.

**4.8 Directions for future research**

There are various aspects of the study which would benefit from additional research. The primary hypotheses require further exploration, with a sample that is comprised of a greater number of individuals who seal over. In addition, the variation in the relationship between voice identity, relating and recovery style over time may provide some important information.

There is an ongoing need to clarify the extent to which recovery style represents a static or dynamic construct and whether this relates to specific elements of the voice, personality factors or earlier life experiences. Previous research has demonstrated the clinical value of using the RSQ to predict long-term outcome and the potential importance of encouraging an integrative recovery style (Thompson et al. 2003). However, it remains unclear whether recovery style can be modified by clinical intervention and if this would be an effective means of intervention. Despite the absence of a significant relationship between relating and recovery style, further research using a larger sample, would also help to clarify the extent to which these two constructs may relate to one another.

Despite previous exploration of the VAY’s reliability and validity, the research raised questions regarding the assumptions that are inherent in certain items, regarding the individual’s position of relatedness to the voice. By modifying these items in a way that reduces the concept of hearer choice, the VAY might become more valid and easier for participants to complete.

Research on relating and distress remains inconclusive and has been limited by small sample sizes and an over-emphasis on clinical populations and the use of correllational analysis. A valuable aim of future research would be to extend the evidence base, by attempting to assess a wider range of potential variables that might mediate distress
relating to voice hearing. This might include the use of qualitative research methods to develop a greater understanding of the personal factors which impact on the individual’s ability to cope with the voice, thereby extending Romme and Escher’s original work. In addition, the use of statistical methods which can assess the relative contribution of numerous variables (such as multiple linear regression) would broaden the scope of the literature. This might include information relating to beliefs about the self and voice, the relationship with the voice and the impact of social and family factors. In addition, greater exploration of these factors in non-clinical voice hearers would allow for consideration of the factors that mediate distress between these groups, rather than within a purely clinical population.

Within the literature on voice hearing, there is a lack of longitudinal studies and consequently the extent to which beliefs about the voice, the self and the interpersonal relationship with the voice can change over time is unclear. By obtaining this sort of data it might be possible to establish a sense of causality between these (and other) factors and their potential for change.

It remains unclear as to whether the VAY will be of value within clinical practice. Some of the practical difficulties which were encountered when completing the VAY and RSQ suggest that these tools might benefit from additional refinement and further validation within a clinical setting. At this stage it is unclear whether these measures would be of value to the professional or the client within a therapeutic context. Further investigation of the extent to which the notion of an interpersonal relationship with the voice is meaningful to the individual would be useful, as would an exploration of the use of these tools as outcome measures. This could include the evaluation of different therapeutic interventions (e.g. traditional cognitive-behavioural therapy, assertiveness and social skills training or an exploration of the personal meaning of the relationship with the voice with respect to power and proximity) in order to ascertain the effect of these interventions on the relationship with the voice. By comparing outcome on the VAY and RSQ with traditional outcome measures associated with distress, a greater sense of the role of recovery and relating to the voice in mediating distress could be established.
4.9 Summary

This research found evidence that distant relating to the predominant voice, is associated with incognito voices, thereby supporting the findings of Hayward (2003). In addition, evidence was found to suggest that hearer distress is associated with increased hearer distance, suggesting that this position of relatedness has a detrimental impact on the individual’s mood. These findings suggest that within the therapeutic context, there is potential value in identifying the predominant voice and developing a model which incorporates the individual’s previous and current life events, and their relationship with the voice. Such a process should allow for greater exploration of the relationship with the voice, leading to a potential reduction in distress. The study found that voice identity was not associated with recovery style, suggesting that the process of identifying the voice does not lead to a position where the individual is more able to incorporate their experiences into their wider life, or to think more flexibly about these experiences. However, a relationship was found between recovery style and voice controllability, indicating that the development of an integrative recovery style, may allow for a greater sense of self-efficacy with respect to the voice. Overall, the study provides some support for existing theories of relating and recovery, and highlights additional factors which have potential value for reducing distress within clinical practice.
References


This pack contains those materials which we use to assess voices from a cognitive perspective. There is a semi-structured schedule to guide a clinical interview, and this includes a section specifically for command hallucinations.

The Beliefs About Voices Questionnaire (BAVQ) is a self-report measure which helps determine if an individual believes the voice to be malevolent, benevolent, or neutral, and if he or she resists the voice or engages with it. The scoring guidelines are enclosed. The BAVQ is completed for one voice at a time; before administering the measure you will need to establish if the person hears more than one voice, and if so to ask him or her to complete it for the dominant voice only. You may wish to complete the measure for each additional voice.

Also, we have enclosed a self-report Personal Knowledge Scale; this measures the amount of personal knowledge about the individual the voice appears to have.

We hope the pack is of use.
Cognitive assessment of voices: Interview schedule
(Chadwick & Birchwood, 1993)

The following semi-structured schedule is intended to guide the cognitive assessment interview. The schedule enquires about the voice, the individual's feelings and behaviour in relation to the voice, and his or her beliefs about the voice's identity, power, purpose or meaning and about the likely consequences of obedience and disobedience.

Try to use it flexibly; the structure is for convenience based on the cognitive ABC model and will not be the order in which all individuals will want to talk.

It is important that you familiarize yourself with the schedule prior to the interview - certain sections contain detailed notes for the interviewer.
VOICE

How many voices do you hear?
Does the voice come through the ears or from inside your head?
Is the voice a man or woman, or are you unsure?

CONTENT
Does the voice talk to you or about you?
Has the voice used your name?
Can you tell me what kinds of things the voice says? (Record 2 or 3 recent examples)

Explore if the voice ever says the following (record examples)

Commands: Does the voice ever tell you to do something

Advice: Does the voice ever give you advice or suggestions

Commentary: Does the voice ever comment on what you are doing or thinking?

Criticism & abuse: Does the voice say unpleasant things about you or someone else?
Self
Other
**Hostility:** Does the voice ever threaten to harm you or someone else?

Self...................................................................................................................

Other............................................................................................................

**ANTECEDENTS (CUES)**

We have found that most peoples voices are more active at certain times: perhaps last thing at night, or when they are shopping or in pubs, or when they are feeling nervous. Are there certain times or occasions when your voice is more active?

Are there times when you don't hear the voice? Perhaps when you have company and are talking to someone?

**AFFECT**

How do you feel when the voice speaks? (scared, tormented, reassured, amused)

Are there times when you hear the voice and do not feel this way? (record feelings)

**BEHAVIOUR**

When the voice talks what do you usually do?
Do you:

Listen because you feel you have to
Listen because you want to
Shout and swear at the voices
Talk to the voice
Do what the voice says willingly
Comply unwillingly
Ignore the voice
Try and stop it talking

Is there anything you have found to do that makes the voice go away or seem less intense (e.g. T.V., talking, reading, drugs...)

IDENTITY

[Often individuals will initially not reveal the identity. Encouragement at this point can be helpful: something like "Have you ever had any vague ideas, however strange they might have seemed" or "Many people I've spoken to have thought their voices might be some kind of god or devil, others have thought their voices might be a friend or member of their family. Have you ever wondered something similar?". If unsuccessful simply move on and be prepared to return.]

Do you have an idea whose voice you hear?

How sure are you that the voice is (give name)?

What makes you think the voice is (give name)?

0. Voice identifies itself
1. Inferred from voice ("sounds like her", "it talks about the Bible", "only he could know that")
2. Belief is based on guilt, visual hallucinations etc.
3. Other (please specify)
MEANING

Prompt: "Most people I've spoken to have found that they really needed to try and make sense of hearing voices, some thought the voice might be punishing them or getting at them in some way, others that it might be trying to help them."

Have you any idea why it is that you hear this particular voice?

Do you think the voice is trying to harm you in some way (e.g. punishment for bad deed, undeserved persecution)?

Rate conviction

Is the voice trying to help you (e.g. protection, developing special power)?

Rate conviction

Has the voice said this is its purpose? Yes No.

If No, explore evidence: say something like "So you have worked this out for yourself. What makes you think the voice is (give meaning)"

POWER

Is the voice very powerful? Y/N

What makes you think this? (e.g. Voice makes me do things, reads my mind)

Can you control the voice? Y/N How sure are you of this

Can you "call up" the voice? Y/N

Can you stop it talking? Y/N

Can you have a conversation with it (e.g. ask questions and get answers)?
COMPLIANCE

The following section is intended for those individuals whose voices give commands. [We have found it helpful to explore the feelings and thoughts that influence if someone obeys or disobeys a command. However, the act of compliance can be very significant and often produces a secondary “chain” of thoughts and feelings. For this reason we also explore people’s reactions to having complied with a command.] Usually people comply either because they think it in their best interest, or because the voice leaves them alone once they have complied, or because they are frightened of what will happen to them if they don’t. This meaning then determines how they subsequently view their compliance. For example, if they comply unwillingly through fear, they may subsequently feel very guilty and down, have thoughts of self-harm and view themselves as weak and bad people.

Ask about how individual feels when he or she complies/resists, and probe for associated thoughts and beliefs.

Explore secondary feelings, behaviour and thoughts about the previous compliance/resistance.
The Voice and You

A PERSON'S ASSESSMENT OF THE RELATIONSHIP THEY HAVE WITH THEIR PREDOMINENT VOICE

Mark Hayward

Psychology Department
University of Surrey
Guildford
2003
PLEASE READ THIS BEFORE YOU START

The statements listed here are the sorts of feelings and attitudes which people sometimes have about or towards the voices they hear. Please read each statement carefully and indicate, by ticking the appropriate column, the extent to which you think it applies to you in relation to your predominant voice.

Try to be completely frank and honest about yourself. Avoid answering the way you would like to be or the way you would like others to think of you, rather than the way you really are.

Try as far as possible, to place your ticks in the “Nearly always true” and “Rarely true” columns. The two middle columns are really for if you cannot make up your mind.

Please state -

Your age: .................................

Sex:  M / F

Duration of voice hearing experience (years) ...............................

Diagnosis: (if relevant) ________________________________

Are you currently taking anti-psychotic medication?  Yes / No
<table>
<thead>
<tr>
<th></th>
<th>Nearly always true</th>
<th>Quite often true</th>
<th>Sometimes true</th>
<th>Rarely true</th>
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</thead>
<tbody>
<tr>
<td>1. My voice wants things done his/her way</td>
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<td>2. My voice helps me make up my mind</td>
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<td>3. My voice needs to have me around a lot</td>
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<tr>
<td>4. I prefer to keep my voice at a safe distance</td>
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<tr>
<td>5. My voice makes hurtful remarks to me</td>
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<td>6. My voice does not let me have time to myself</td>
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<td>7. I have a tendency to look up to my voice</td>
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<td>8. When my voice gets too close to me, it makes me feel uneasy</td>
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<td>9. My voice constantly reminds me of my failings</td>
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<td>10. My voice dislikes it when I exclude him/her by showing an interest in other people</td>
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<td>11. I allow my voice to take control of me</td>
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<td>12. I feel I have little to offer my voice</td>
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<td>13. It is easy for my voice to change my mind</td>
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<td>14. My voice does not give me credit for the good things I do</td>
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<td>Nearly always true</td>
<td>Quite often true</td>
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<td>My voice tries to accompany me when I go out</td>
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<td>16.</td>
<td>I feel deserted when my voice is not around</td>
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<td>17.</td>
<td>I try to hide my feelings from my voice</td>
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<td>18.</td>
<td>My voice tries to get the better of me</td>
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<td>19.</td>
<td>My voice dislikes spending time on his/her own</td>
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<td>My voice’s judgment is better than mine</td>
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<td>I do not like to get too involved with my voice</td>
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<td>My voice makes me feel useless</td>
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<td>I need to have my voice around me a great deal</td>
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<td>I don’t like my voice to know what I am thinking</td>
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<td>I have difficulty letting go of my voice</td>
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<td>26.</td>
<td>My voice tries to make me out to be stupid</td>
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<td>27.</td>
<td>My voice finds it hard to allow me to have time away from him/her</td>
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<td>I have a great need to talk to my voice</td>
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<td>29.</td>
<td>I don’t wish to spend much time listening to my voice</td>
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VAY questions corresponding to each scale

Voice Upperness:

1. My voice wants things done his/her way
5. My voice makes hurtful remarks to me
9. My voice constantly reminds me of my failings
14. My voice does not give me credit for the good things I do
18. My voice tries to get the better of me
22. My voice makes me feel useless
26. My voice tries to make me out to be stupid

Hearer Dependence:

2. My voice helps me make up my mind
7. I have a tendency to look up to my voice
11. I allow my voice to take control of me
13. It is easy for my voice to change my mind
16. I feel deserted when my voice is not around
20. My voice’s judgment is better than mine
23. I need to have my voice around me a great deal
25. I have difficulty letting go of my voice
28. I have a great need to talk to my voice

Hearer Distance:

4. I prefer to keep my voice at a safe distance
8. When my voice gets too close to me, it makes me feel uneasy
12. I feel I have little to offer my voice
17. I try to hide my feelings from my voice
21. I do not like to get too involved with my voice
24. I don’t like my voice to know what I am thinking
29. I don’t wish to spend much time listening to my voice

Voice Closeness:

3. My voice needs to have me around a lot
6. My voice does not let me have time to myself
10. My voice dislikes it when I exclude him/her by showing an interest in other people
15. My voice tries to accompany me when I go out
19. My voice dislikes spending time on his / her own
27. My voice finds it hard to allow me to have time away from him/her
PSYCHOTIC SYMPTOM RATING SCALES (PSYRATS)

A Auditory hallucinations

1. Frequency
   0. Voices not present or present less than once a week
   1. Voices occur for at least once a week
   2. Voices occur at least once a day
   3. Voices occur at least once a hour
   4. Voices occur continuously or almost continuously
   i.e. stop for only a few seconds or minutes

2. Duration
   0. Voices not present
   1. Voices last for a few seconds, fleeting voices
   2. Voices last for several minutes
   3. Voices last for at least one hour
   4. Voices last for hours at a time.

3. Location
   0. No voices present
   1. Voices sound like they are inside head only.
   2. Voices outside the head, but close to ears or head. Voices inside the head may also
      be present
   3. Voices sound like they are inside or close to ears and outside head away from
      ears
   4. Voices sound like they are from outside the head only

4. Loudness
   0. Voices not present
   1. Quieter than own voice, whispers.
   2. About same loudness as own voice
   3. Louder than own voice
   4. Extremely loud, shouting

5. Beliefs re-origin of voices
   0. Voices not present
   1. Believes voices to be solely internally generated and related to self
   2. Holds < 50% conviction that voices originate from external causes
   3. Holds > 50% conviction (but < 100%) that voices originate from external
      causes
   4. Believes voices are solely due to external causes (100% conviction)
6. **Amount of negative content of voices**
   0. No unpleasant content
   1. Occasional unpleasant content (< 10%)
   2. Minority of voice content is unpleasant or negative (< 50%)
   3. Majority of voice content is unpleasant or negative (>50%)
   4. All of voice content is unpleasant or negative

7. **Degree of negative content**
   0. Not unpleasant or negative
   1. Some degree of negative content, but not personal comments relating to self or family e.g. swear words or comments not directed to self, e.g. 'the milkman's ugly'
   2. Personal verbal abuse, comments on behaviour e.g. 'shouldn't do that or say that'
   3. Personal verbal abuse relating to self-concept e.g. 'you're lazy, ugly, mad, perverted'
   4. Personal threats to self e.g. threats to harm self or family, extreme instructions or commands to harm self or others.

8. **Amount of distress**
   0. Voices not distressing at all
   1. Voices occasionally distressing, majority not distressing (< 10%)
   2. Minority of voices distressing (< 50 %)
   3. Majority of voices distressing, minority not distressing (>50%)
   4. Voices always distressing

9. **Intensity of distress**
   0. Voices not distressing at all
   1. Voices slightly distressing
   2. Voices are distressing to a moderate degree
   3. Voices are very distressing, although subject could feel worse
   4. Voices are extremely distressing, feel the worst he/she could possibly feel

10. **Disruption to life caused by voices**
    0. No disruption to life, able to maintain social and family relationships (if present)
    1. Voices causes minimal amount of disruption to life e.g. interferes with concentration although able to maintain daytime activity and social and family relationships and be able to maintain independent living without support
    2. Voices cause moderate amount of disruption to life causing some disturbance to daytime activity and/or family or social activities. The patient is not in hospital although may live in supported accommodation or receive additional help with daily living skills
    3. Voices cause severe disruption to life so that hospitalization is usually necessary. The patient is able to maintain some daily activities, self-care and
relationships while in hospital. The patient may also be in supported accommodation but experiencing severe disruption of life in terms of activities, daily living skills and/or relationships.

4. Voices cause complete disruption of daily life requiring hospitalization. The patient is unable to maintain any daily activities and social relationships. Self-care is also severely disrupted.

11. Controllability of voices

0. Subject believes they can have control over the voices and can always bring on or dismiss them at will.
1. Subject believes they can have some control over the voices on the majority of occasions.
2. Subject believes they can have some control over their voices approximately half of the time.
3. Subject believes they can have some control over their voices but only occasionally. The majority of the time the subject experiences voices which are uncontrollable.
4. Subject has no control over when the voices occur and cannot dismiss or bring them on at all.
RSQ

Written below is a list of statements about your illness. Please read them carefully and tick the box to show if you agree or disagree.

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>There was a gradual build up to me becoming ill</td>
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<tr>
<td>2.</td>
<td>My illness is not part of my personality</td>
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<tr>
<td>3.</td>
<td>I am responsible for what I think when I am ill</td>
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<td>4.</td>
<td>I am not interested in my illness</td>
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<td>5.</td>
<td>My illness taught me new things about myself</td>
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<td>6.</td>
<td>I need help to solve the problems caused by my illness</td>
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<td>7.</td>
<td>My illness was caused by my difficulties in coping with life</td>
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<td>8.</td>
<td>I have had a nervous breakdown</td>
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<td>9.</td>
<td>I can see positive aspects to my illness</td>
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<td>10.</td>
<td>My illness had a strong impact on my life</td>
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<td>11.</td>
<td>I am not frightened of mental illness</td>
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<td>12.</td>
<td>I liked some of the experiences I had when I was ill</td>
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<td>13.</td>
<td>My illness has helped me to find a more satisfying life</td>
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<td>14.</td>
<td>My illness came on suddenly and went suddenly</td>
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<td>15.</td>
<td>My illness is part of me</td>
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<td>16.</td>
<td>I am not responsible for my actions when I am ill</td>
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<td>17.</td>
<td>I am curious about my illness</td>
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<td>18.</td>
<td>I understand myself better because of my illness</td>
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<td>19.</td>
<td>I can manage the problems caused by my illness alone</td>
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<td>20.</td>
<td>Others are to blame for my illness</td>
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<td>21.</td>
<td>I have had a medical illness</td>
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<td>22.</td>
<td>Nothing good came from my illness</td>
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<td>23.</td>
<td>My illness has had little effect on my life</td>
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<td>24.</td>
<td>I am frightened of mental illness</td>
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<td>25.</td>
<td>I didn’t like any of the unusual experiences I had when I was ill</td>
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<td>26.</td>
<td>It’s hard to find satisfaction with life following my illness</td>
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<td>27.</td>
<td>My illness came on very suddenly</td>
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<td>28.</td>
<td>My illness is alien to me</td>
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<td>29.</td>
<td>I am responsible for my thoughts and feelings when I am ill</td>
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<td>30.</td>
<td>I don’t care about my illness now that I am well</td>
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<td>I want to be the person I was before my illness</td>
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<td>32.</td>
<td>Others can help me solve my problems</td>
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<td>33.</td>
<td>My illness was caused by stress in my life</td>
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<td>34.</td>
<td>I have suffered an emotional breakdown</td>
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<td>35.</td>
<td>Being ill had good parts too</td>
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<td>36.</td>
<td>I’m not really interested in my illness</td>
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<td>I liked some of the unusual experiences I had when I was ill</td>
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<td>My life is more satisfying since my illness</td>
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<td>39.</td>
<td>My attitude to mental illness is better now then before I was ill</td>
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© Drayton and Birchwood
## RSQ scoring framework

<table>
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<tr>
<th>Subscale number</th>
<th>Question number</th>
<th>Score</th>
<th>Subscale total</th>
<th>Subscale rating (integration/seal over)</th>
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Number of subscale ratings integration overall = \[ \frac{X}{100} = 13 \]

**Percentage of integration (Drayton et al., 1998)**

<table>
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<tr>
<th>0-17%</th>
<th>18-33%</th>
<th>34-49%</th>
<th>50-67%</th>
<th>68-82%</th>
<th>84-100%</th>
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<tbody>
<tr>
<td>Sealing Over</td>
<td>Tending towards sealing over</td>
<td>Mixed picture in which sealing over predominates</td>
<td>Mixed picture in which integration predominates</td>
<td>Tending towards integration</td>
<td>Integration</td>
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**Tait et al. (2004)**

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<tr>
<th>0-33%</th>
<th>34-49%</th>
<th>50-67%</th>
<th>68-100%</th>
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<tbody>
<tr>
<td>Sealing over (including tending towards SO)</td>
<td>Mixed picture - SO predominating</td>
<td>Mixed picture - integration predominating</td>
<td>Integration (including tending towards int.)</td>
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Appendix B
APPLICATION FORM

This form should be completed by the chief investigator, after reading the guidance notes. See glossary for clarification of different terms in the application form.

**Short title and version number (maximum 70 characters – this will be inserted as header on all forms):**
Voice hearing: identity and recovery style (Version 1)

**Name of NHS research committee to which application for ethical review is being made:**
South West Surrey Research Ethics Committee

**Project reference number from above REC:** 04/Q1909/52
**Submission Date:** 06/10/2004

---

**A1. Title of Research**

**Full title:** Relating to voices: does voice identity influence degree of relating to the voice and recovery style in people who experience auditory hallucinations?

**Keywords:** Voice hearing, voice identity, recovery style

---

**A2. Chief Investigator**

**Title:** Mr
**First Name/Initials:** David
**Last Name:** Bennett
**Post:** Trainee Clinical Psychologist
**Qualifications:** BSc, MSc
**Organisation:** University of Surrey
**Address:** Clinical Psychology, University of Surrey, Guildford, Surrey
**Post Code:** GU2 7XH
**E-mail:** d_m_bennett@hotmail.com
**Telephone:** 0784 309 5238
**Fax:** 01243 699 557

---

**A3. Proposed Study Dates and Duration**

**Start Date:** 01/11/2004
**End Date:** 01/09/2005
**Duration:** Months 10

NHS REC Application Form - Version 3.0

233
A4. Primary purpose of the research: (Tick as appropriate)

- [ ] Commercial Product development and/or licensing
- [ ] Publicity funded trial or scientific investigation
- [ ] Educational Qualification
- [ ] Establishing a Database/Data storage Facility
- [ ] Other

If other, give details:

A5. Tick the box if your research:

- [ ] Involves testing a medicinal product
- [ ] Involves testing a medicinal device
- [ ] Involves additional radiation above that for clinical care
- [ ] Involves using stored samples of human biological material (e.g. blood, tissue)
- [ ] Involves taking new samples of human biological material
- [ ] Involves only patient records or data with no other direct patient contact
- [ ] Involves prisoners or others in custodial care
- [ ] Involves adults with incapacity
- [ ] Has the primary aim of being educational (e.g. student research a project necessary for a postgraduate degree or diploma, other than MD or PhD)

A6. Do you consider that this research falls within the category where there is no local investigator?

- [ ] Yes
- [ ] No

If yes please justify:

Advice can be found in the guidance notes on this topic. Some studies do not require further consideration of site-specific issues by local research ethics committees, but will still require approval to proceed from the host organisation(s).
A7. What is the principal research question/objective? (Must be in Language comprehensible to a lay person.)

The objective of the research is to investigate whether individuals with experience of voice hearing whose voices are 'incognito' (i.e. those that can only be identified by gender or content of speech) will relate to the voice more distantly when compared with voice hearers whose voices are personified (i.e. those who hear the voice of a family member, acquaintance or famous person) or supernatural (i.e. God, the devil, aliens).

A8. What are the secondary research objectives/questions? (If applicable must be in Language comprehensible to a lay person.)

The research also aims to investigate whether individuals whose voices are incognito will use a 'sealing over' style of recovery, and whether individuals who experience personified or supernatural voices will use an 'integrative' style of recovery. Sealing over refers to a process of recovery in which the...

A9. What is the scientific justification for the research? What is the background? Why is this an area of importance? (Must be in Language comprehensible to a lay person.)

Romme and Escher (1989) studied voice-hearing in clinical and non-clinical samples and found that an individual's ability to cope with the experience was influenced by their interpretation of the voice. Further research in this area has highlighted a variety of factors which influence the individual's responses (whether thoughts, feelings or behaviours) to voice-hearing. Chadwick and Birchwood (1994) found that individuals held beliefs about the identity and meaning of the voice (whether it was benevolent/kind or malevolent/evil) and Close and Garety (1998) found a direct relationship between the content of the voice and the individual's beliefs about the voice, with positive content being viewed as benevolent and negative content as malevolent. These findings highlighted the potential clinical value of challenging beliefs about the voice, rather than attempting to completely eliminate the voice-hearing experience, in order to reduce distress.

In addition to the factors described above, the nature of the relationship between the voice and the voice-hearer has been found to have an impact on levels of distress. Voices are often identified as being aligned to people within the individual's social world (i.e. the voice belongs to someone that the individual has had experience or at some point in their life - Leuder, Thomas, McNally and Gilmski, 1997; Nyani and David, 1996). Research also suggests that the way in which the voice-hearer interacts with the voice reflects interactions with the identified individual in the real world (Benjamin, 1989). In addition, voices that are identifiable (friends, family members, God or the devil) have been found to be related to more closely than those that are incognito (Hayward, 2003). Hayward (2003) suggests that the identification of the voice within a therapeutic context may lead to closer relating to the voice. This may also have the effect of enabling the individual to make greater sense of their voice hearing experience within their previous and current life experiences (Romme and Escher, 2000).

Research into the recovery process following episodes of psychosis has highlighted two styles of recovery. Integration occurs when an individual who has experienced voice-hearing incorporates this experience into their overall life experience, while in sealing over the individual isolates their psychosis from other life experiences (Thompson, McGorry and Harrigan, 2003). Individuals who use integration as a method of recovery tend to be more flexible in their style of think... Cont'd on Additional Pages.
A10. Give a brief synopsis/summary of methods and overview of the planned research. This should include a brief description of how prospective research participants and concerned communities (not necessarily geographical) from which they are drawn have been consulted over the design and details of the research. (Where appropriate a flow chart or diagram should be submitted separately. It should be clear exactly what should happen to the research participant, how many times and in what order.)

32 adult mental health patients who have experienced auditory hallucinations for at least six months (diagnosed with schizophrenia, schizo-affective disorder or affective psychosis conforming to the criteria of DSM IV (American Psychiatric Association, 1994)) and who are either stable or receiving antipsychotic medication will be recruited for the study across two NHS Trusts. Individuals with drug-induced or organic psychosis will be excluded. Participants will be recruited via professionals in the team or service user groups. A control group is not required as the research is not an outcome study. Due to the limitations of the research (student research) it has not been possible to consult individuals from potential participant communities in relation to the design of the study.

Following screening for inclusion participants will meet with the chief investigator to participate in a semi-structured interview based on the Cognitive Assessment of Voices (CAV) and will then complete the following assessments tools with the researcher:

You to Voice (YTV) - questionnaire Vaughn and Fowler (2004). - The YTV is an adapted, 40-item questionnaire of the Couple's Relating to Each Other Questionnaire (CREOQ) (Birchmeil, 1985) and is designed to measure style of relating to the voice. It consists of four subscales (Upper Neutral, Lower Neutral, Neutral Close & Neutral Distant) of the original CREOQ, each of which was found to have good internal reliability (Cronbach's alpha of 0.65, 0.86, 0.75 & 0.66 respectively).

Recovery style questionnaire (RSQ) Drayton, Birchwood and Trower (1998) - The RSQ is a 39-item questionnaire designed to assess recovery style using questions about the patients attitude towards their psychosis. It has been shown to have good reliability (test-retest r= 0.81, Cronbach's alpha = .73) and good face- and criterion-validity (Drayton, Birchwood and Trower, 1998).

Psychotic Symptoms Rating Scale - auditory hallucinations scale (PSYRATS) Haddock, McCarron, Tarrier & Faragher (1999) - The auditory hallucinations sub-scale of the PSYRATS is an 11-item measure which assesses various elements of the voice-hearing experience (Haddock, McCarron, Tarrier & Faragher, 1999). The scale has been shown to have good inter-rater reliability (greater than 0.9 for 8 of the 11 items).
**A11. Would any intervention or procedure, which would normally be considered a part of routine clinical care, be withheld from the research participants?**

- [ ] Yes
- [x] No

**Give details:**

<table>
<thead>
<tr>
<th>Additional intervention</th>
<th>Average number per Patient</th>
<th>Average time taken (mins/hrs/days)</th>
<th>Details of additional intervention or Procedure, who will undertake it, and what training they have received</th>
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**A12. Will the research participants receive any clinical intervention(s) or procedure(s) including taking samples of human biological material over and above that which would normally be considered a part of routine clinical care?**

- [ ] Yes
- [ ] No

**Additional intervention**

- [ ] Routine Care
- [ ] Research

**Average number per Patient**

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<th>Routine Care</th>
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**Average time taken (mins/hrs/days)**

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<th>Routine Care</th>
<th>Research</th>
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**Details of additional intervention or Procedure, who will undertake it, and what training they have received.**

- [ ] Yes
- [ ] No
**A13. Will the research participant be subject to any non-clinical research-related intervention(s) or procedure(s)?**

<table>
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<tr>
<th>Additional intervention</th>
<th>Average number per Patient</th>
<th>Average time taken (mins/hr/day)</th>
<th>Details of additional intervention or Procedure, who will undertake it, and what training they have received.</th>
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<tr>
<td>Face to Face Interview</td>
<td>1</td>
<td>45 minutes</td>
<td>An interview based on the Cognitive Assessment of Voices Tool will be carried out by the chief investigator. The interviewer has received training in clinical case... Cont’d on Additional Pages.</td>
</tr>
<tr>
<td>Other Questionnaire</td>
<td>1</td>
<td>30 minutes</td>
<td>Each participant will complete three questionnaires: the You to Voice questionnaire (Vaughn and Fowler, 2004), the Recovery style questionnaire (Drayton, Birchwood... Cont’d on Additional Pages.</td>
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**Please give details for other(s):**

**A14. Will Individual or group Interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews/group discussions, or use of screening tests for drugs)?**

Give details of procedures in place to deal with these issues.

The proposed measures are routinely used in clinical practice and it is not anticipated that they will cause distress. However, should a participant appear to experience distress at any time during the interview they will be... Cont’d on Additional Pages.

*The information Sheet should make it clear under what circumstances action may be taken.*
A15. What is the expected total duration of participation in the study for each participant?

It is expected that the maximum duration of participation for each participant will be 1.5 hours.

A16. What are the potential adverse affects, risks or hazards for research participants either from giving or withholding medications, medical devices, ionising radiation, or other interventions (including non clinical)?

It is not predicted that the individuals who participate in the study will experience any of the adverse effects described above as the study does not involve the giving or withholding of treatment.

A17. What is the potential for pain, discomfort, distress, inconvenience or changes to life-style for research participants?

The proposed measures are routinely used in clinical practice and it is not anticipated that they will cause distress. The process of interviewing individuals about their voice-hearing experience has the potential to evoke emotions in the participants but it is not predicted this will cause distress. However, should a participant appear to experience any distress during the interview they will be given the opportunity to terminate the interview. In addition, if an individual does appear to experience an increase in distress the principal researcher will make contact with the relevant care team supporting the individual to inform them of this.

A18. What is the potential for benefit for research participants?

By participating in the study there is the potential for individuals to benefit in terms of increasing their insight and understanding of the experience of voice-hearing. The process of describing the voice-hearing experience may also provide the individual participant with the opportunity to describe their experiences to someone who values their opinions and is able to respond in an empathic and non-judgemental manner.

A19. What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience for researchers themselves? (If any)

Conducting the research may evoke emotions and thoughts in the researcher which are challenging and may have the potential to be distressing. Such feelings are an expected part of being a therapist and would... Cont’d on Additional Pages.
A20. How will potential research participants in the study be (i) identified, (ii) approached and (iii) recruited?

Give details for cases and controls separately if appropriate.

Initially the chief investigator will conduct presentations to the relevant care teams (including consultants and key workers) to inform them of the aims, rationale and methodology of the study. Consultant Psychiatrists within the relevant services will be invited to refer clients to the study. These clients will be approached by their keyworker / care co-ordinator. Therefore a client invitation letter will not be used, as such an approach may be inappropriate and confusing for this client group.

If the client wishes to meet with the chief investigator, this meeting will be arranged. The prospective participant will then be given verbal and written information (see patient information sheet) about the aims of the proposed study. At least 24 hours will be allowed for potential participants to consider this information. Should they wish to participate, each client will be asked to sign a written consent form prior to the beginning of assessment. Following completion of the assessment meeting there will be no further contact between the chief investigator and the participant.

A21. Will research participants be recruited via advertisement?

☐ Yes ☐ No

Give details:

Enclose a copy of the advertisement/radio script/website/video for a television (with a version number and date).
A22. What are the principal inclusion criteria? (Please justify)

The following inclusion criteria will be used in the study. Participants will have to be adults who have experienced a minimum of 6 consecutive months of voice-hearing. Participants should be in a stable phase (i.e. not having an acute episode of psychosis). Due to the limitations of the research it is essential that all participants have English as first language as the research does not have the resources to provide interpreters or translations of assessment information.

All participants will have to meet the diagnostic criteria for either schizophrenia, schizoaffective disorder or affective psychosis according to DSM-IV (American Psychiatric Association, 1994).

A23. What are the principal exclusion criteria? (Please justify)

Individuals will be excluded from the study if their psychosis has arisen as a consequence of from substance misuse (i.e. drug-induced psychosis) or if they have a diagnosis of organic psychosis. In addition, individuals with a diagnosis of a learning disability will also be excluded.

Individuals who do not have English as a first language will be excluded from the study due to the nature of the research (student research for a qualification). Due to limited time and resources it is not possible to include participants who have English as a second language or who are unable to speak English.

A24. Will the participants be from any of the following groups? (Tick as appropriate)

- [ ] Children under 16
- [ ] Adults with learning disabilities
- [ ] Adults who are unconscious or very severely ill
- [ ] Adults who have a terminal illness
- [ ] Adults in emergency situations
- [ ] Adults with mental illness (particularly if detained under Mental Health Legislation)
- [ ] Adults suffering from dementia
- [ ] Prisoners
- [ ] Young Offenders
- [ ] Adults in Scotland who are unable to consent for themselves
- [ ] Healthy volunteers
- [ ] Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students
- [ ] Other vulnerable groups

Justify their inclusion:

The research question is concerned with gathering information about individuals who hear voices with particular reference to the style of recovery. Although a small minority of the general population experience auditory hallucinations without accessing mental health services the probability of gaining access to these individuals is extremely small. In addition, the research is concerned with voice hearing experiences in mental health populations and the process of recovery from psychosis and therefore it has to include participants with mental illness. It is not proposed that the research will include individuals detained under mental health legislation.
A25. Will any research participants be recruited who are involved in existing research or have recently been involved in any research prior to recruitment?

Give details and justify their inclusion:

Participants will be asked as part of the interview process if they have been involved in current or previous research and the nature / extent of their involvement.

A26. Will informed consent be obtained from the research participants?

Give details of who will take consent and how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material.

If participants are to be recruited from any of the potentially vulnerable groups listed in A24, give details of extra steps taken to assure their protection. Describe the arrangements to be made for obtaining consent from a legal representative.

If consent is not to be obtained, please explain why not.

Written consent will be obtained by the principal researcher from each participant after they have had the opportunity to consider information (from the patient information sheet) about the aims of the study. This information will make it clear that neither participation nor non-participation within the study will affect clinical care in any way. This information will be provided at the first point of contact and will provide the individual with the opportunity to ask questions regarding the study.

All of the individuals that will be approached for participation within the study will be receiving ongoing clinical care and will be receiving support from a clinician about their voices. Should an individual present with any difficulties of clinical significance during any stage of the contact I will seek permission from him/her to pass concerns on to their Consultant Psychiatrist or relevant service provider. If a participant discloses information that leads the chief investigator to believe he/she will harm him/herself or others, the investigator will be obliged to pass on this information. These limits of confidentiality will be made explicit prior to start of the interview. These guidelines will apply to individuals who consent to and complete the interview process, individuals who consent to and subsequently withdraw from the process and individuals who do not give consent (and consequently do not participate).

At the beginning of the assessment session (the second point of contact) each participant will be given the opportunity to discuss any voice activity that may have followed or been triggered by the first point of contact. Any implications this may have for ongoing or potential therapeutic interventions will also be explored.

The anonymity of information provided by participants ... Cont'd on Additional Pages.

Copies of the written information and all other explanatory material should accompany this application.

A27. Will a signed record of consent be obtained?

Attach a copy of the consent form to be used, with a version number and date.

If answer is no, please justify.
A28. How long will the participant have to decide whether to take part in the research?
The participants will have a minimum of 24 hours to decide whether they wish to participate in the study and will be encouraged to seek the advice of friends, family, their GP, keyworker or any other relevant professional. It is expected that in the majority of cases participants will have long... Cont'd on Additional Pages.

A29. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English? (E.g. translations, use of interpreters etc.)
Due to the limitations that are placed on this study as a consequence of it being a student project with a limited financial budget it will not be possible to include individuals who are unable to understand English instructions. Funding is not available to employ interpreters or to include translated written materials.

A30. What arrangements are in place to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?
Individuals will be contacted via the Consultant Psychiatrist if information becomes available that has an impact on their continued participation. It is not envisaged that this will occur during the present study.

A31. Does this study have, or require, approval of PIAG (Patient Information Advisory Group) or other bodies with a similar remit? (see Guidance notes)
Give details:

A32. Will the research participant’s General Practitioner be informed that they are taking part in the study?
Enclose a copy of the information sheet/letter for the GP with a version no. and date.
Will permission be sought from the research participants to inform their GP before this is done?

Explain why not:
A33. Will individual research participants receive any payments for taking part in this research?  

Indicate how much and on what basis this has been decided:  

- Yes  
- No

A34. Will individual research participants receive reimbursement of expenses or any other incentives or benefits for taking part in this research?  

Indicate how much and on what basis this has been decided:  

Participants will be reimbursed for travel expenses, funded by the £200 research grant provided by the University of Surrey. Due to the nature of the research (student project) additional payment or benefits / incentives are not available.

A35. What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for negligent harm?  

The University of Surrey holds insurance policies for public liability and professional negligence for £25m and £7.5m respectively.

A36. What arrangements have been made to provide indemnity and/or compensation in the event of a claim by or on behalf of, participants for non-negligent harm?  

The above insurance policies also include no-fault compensation extension policies with a limit of £5m.

Please forward copies of the relevant documents.
### A37. How is it intended the result of the study will be reported and disseminated? *(Tick as appropriate)*

- [x] Peer reviewed scientific journals
- [ ] Internal report
- [ ] Conference presentation
- [ ] Other publication
- [ ] Submission to regulatory authorities
- [ ] Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- [x] Written feedback to research participants
- [x] Presentation to participants or relative community groups
- [x] Other/none e.g. Cochrane Review, University Library

*If other/none of the above, give details and justify:*

The research will be written up as a thesis and form part of a portfolio for the Psychology Clinical Psychology course. This will be available from the university library. In addition the research will be written up for publication in a peer reviewed scientific journal.

### A38. How will the results of research be made available to research participants and communities from which they are drawn?

A copy of the final research will be disseminated to the team involved. A de-briefing sheet will also be disseminated to all participants, describing the findings of the research and feedback sessions will be conducted for participants and professionals involved in the study. Participants will be asked whether they wish to receive this at the time of the interview.

### A39. Will the research involve any of the following activities at any stage (including identification of potential research participants)? *(Tick as appropriate)*

- [ ] Examination of medical records by those outside the NHS, or within the NHS by those who would not normally have access
- [ ] Electronic transfer by magnetic or optical media, email, or computer networks
- [ ] Sharing of data with other organizations
- [ ] Export of data outside the European Union
- [ ] Use of personal addresses, postcodes, faxes, emails or telephone numbers
- [ ] Publication of direct quotations from respondents
- [ ] Publication of data that might allow identification of individuals
- [ ] Use of audio/visual recording devices
- [ ] Storage of personal data on any of the following:
  - [x] Manual Files including X-Rays
  - [x] NHS computers
  - [ ] Home or other computers
  - [x] University computers
  - [ ] Private company computers
  - [ ] Laptop Computer

*Further details:*

There will be paper records of the semi-structured interview and psychometric assessments, which will be stored in a secure NHS location, in a locked filing cabinet. No personal data will be stored on NHS or personal computers, but psychometric data will be analysed using a PC. This information will be anonymised and coded.
### A40. What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or other anonymisation procedures have been used, and at what stage:

All information will be anonymised and codes will be used in order to cross-reference different sources of information (i.e. questionnaires). Codes on data sources will correspond with the codes used on consent forms to ensure that individuals can withdraw their participation from the study at any time. Coded information will be stored separately from consent forms.

### A41. Where will the analysis of the data from the study take place and by whom will it be undertaken?

Analysis of the data will take place on NHS or university computers and will be conducted by the chief investigator with supervision from the university research supervisor and tutor.

### A42. Who will have control of, and act as the custodian for, the data generated by the study?

The chief investigator will have control of, and act as custodian, for the data.

### A43. Who will have access to the data generated by the study?

The chief investigator, university supervisor and principal investigators will have access to the data generated by the study.

### A44. For how long will data from the study be stored?

Data will be stored in a locked filing cabinet at the Psychology Department, University of Surrey, as per the MRC good practice guidelines.
### A45. How has the scientific quality of the research been assessed? (Tick as appropriate)

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<td>Review within a company</td>
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<td>Review within a multi-centre research group</td>
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<td>Internal review (e.g. involving colleagues, academic supervisor)</td>
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<td>None external to the investigator</td>
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<td>Other, e.g. methodological guidelines</td>
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**If other, give details:**

If you are not in possession of any referees or other scientific critique reports relevant to your proposed study, justify and describe the review process and outcome. If review has been undertaken but not seen by the researcher, give the details of the body who has undertaken the review.

*A copy of any referees comments or other scientific critique reports relevant to the proposed research must be enclosed with the application form.*

### A46. Has similar research on this topic been done before?

- **Yes**

The study partly replicates that carried out by Hayward (2003) but extends this by looking at the relationship between a) voice identity and style of relating and b) relating to the voice and recovery style. In order to look at the relationship between these factors it is necessary to collect some of the data that replicates aspects of Hayward's 2003 study.

### A47. Have all existing sources of evidence, especially systematic reviews, been fully considered?

- **Yes**

Please give details of search strategy used:

Literature searches on PsychInfo and Medline using the following search terms:

- voice hearing
- relating
- voice identity
- psychosis
- recovery style
A48. What is the primary outcome measure for the study?
Outcome is not being assessed as the study does not aim to assess the effectiveness of an intervention or procedure. The measures being used in the study are:
The Cognitive Assessment of Voices (CAV) Chadwick and Birchwood (1994),
You to Voice (YTV) - questionnaire Vaughan and Fowler (2004),
Recovery style questionnaire (RSQ) Drayton, Birchwood and Trower (1998),
Psychotic Symptoms Rating Scale - auditory hallucinations Cont'd on Additional Pages.

A49. What are the secondary outcome measures? (If any)
Not applicable

A50. How many participants will be recruited? How many of these participants will be in a control group?
The study will not include a control group for the reasons highlighted above. A total of 32 participants will be recruited for the study (see power analysis below).

A51. Has the size of the study been informed by a formal statistical power calculation?
© Yes ○ No
Indicate the basis upon which this was done, giving sufficient information to allow the replication of the calculation:
Post hoc power analysis of previous studies looking at experiences of voice hearing in people with schizophrenia indicate effect sizes of between 0.8 and 0.9, with power of approximately 0.8 - 0.9. A priori power analysis with alpha = 0.05, effect size (d) = 0.9 and power = 0.8 indicates that N = 32 participants will be required.

A52. Has a statistician given an opinion about the statistical aspects of the research?
Give the name and contact details: © Yes ○ No
Statistical advice has been obtained from Dr. James Murray, Research Tutor on the PsychC Clinical Psychology training course, University of Surrey, Guildford, Surrey.
Give a brief summary of advice offered, and attach a copy of the comments if available:
Advice regarding the use of power calculations and the testing of hypotheses using either parametric or non-parametric tests, depending on the nature of the distribution of the results and the type of variable (i.e. ordinal, continuous or categorical). This discussion informed the choice of tests described in A53.
A53. Describe the statistical methods and/or other relevant methodological approaches (e.g. for qualitative research) to be used in the analysis of the results. Give details of the methods of randomization process to be used if applicable:

The data obtained from the study will be subjected to the following statistics:

a) Hypothesis one will be assessed using an independent groups t-test or Mann-Whitney test, as a clear prediction is being made about the direction of the result. The data is unlikely to be suitable for an ANOVA. Independent variable is the grouping of voices according to identity (categorical), assessed using the CAW, dependent variable is proximity / distance of the voice assessed using the YTV (continuous scale).

b) Hypothesis two will be assessed using a correlation. This will either be Pearson’s rho or Spearman’s rank, depending on the distribution of the variables. One variable will be style of relating (YTV - continuous scale) and the second will be recovery style (RSQ - continuous scale).

A54. Where will the research take place? (Tick as appropriate)

- [ ] UK
- [ ] Other States in the European Union
- [ ] Other States in the European Economic Area
- [ ] Other

Give details:
The research will take place in two NHS Trusts (South West London and St George’s NHS Trust and Surrey Hampshire Borders NHS Trust). Within these trusts it is proposed that the research will be conducted in a maximum of 4 community mental health services.

A55. Has this or a similar application been previously rejected by a research ethics committee in the U.K. the European Union or in the European Economic Area?

- [ ] Yes
- [ ] No

Name of research ethics committee or regulatory authority:

Decisions and date taken:

Research ethics committee reference number:
A56. In how many and what type of host organisations (NHS or other) in the UK is it intended the proposed study will take place?

Include the type of organisation by ticking the box and give approximate numbers if known.

- [ ] Acute teaching NHS Trusts
- [ ] Acute NHS Trusts
- [ ] NHS Community and/or Primary Care Trusts
- [X] NHS Trusts providing mental healthcare
- [ ] NHS Care trusts
- [ ] Social Care Organisations
- [ ] Prisons
- [ ] Independent hospitals
- [ ] Educational establishment
- [ ] Independent research units
- [ ] Other (Give Details)

Number of organisations:

2

A57. What arrangements are in place for monitoring and auditing the conduct of the research?

The research will be continuously monitored via regular supervision from the university research supervisor.

Will a data monitoring committee be convened?

☐ Yes ☐ No

What are the criteria for electively stopping the trial or other research prematurely?

It is not envisaged that the issue of stopping the research prematurely will occur.
Major Research Project

Date: 06/10/2004

Reference: 04/Q1809/52

A58. Has funding for the research been secured?

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Amount: £ Duration: Months

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Postcode:
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Amount: £ Duration: Months

If No, what arrangements are being made to cover any costs of the research? If no external funding is being sought, please say The University of Surrey provides £200 per trainee funding. Cont’d on Additional Pages.

A59. Has the funder of the research agreed to act as sponsor as set out in the research Governance Framework?

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<th>Organisation</th>
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</table>

Postcode:
UK Contact:
Telephone:
Fax:
Email:

A copy of documentation indicating that the organisation has accepted the role of sponsor should be enclosed if the sponsor is not the main funder or chief investigator's employer.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A60. Has any responsibility for the research been delegated to a subcontractor?</td>
<td></td>
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<tr>
<td>Give details including: Name of research contract organisation/site management, and summary of delegated responsibility</td>
<td></td>
<td></td>
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<tr>
<td>A61. Will individual researchers receive any personal payment over and above normal salary for taking part in this research?</td>
<td></td>
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<tr>
<td>Indicate how much and on what basis this has been decided:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A62. Will individual researchers receive any other benefits or incentives for taking part in this research?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicate how much and on what basis this has been decided:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A63. Will the host organisation or the researchers department(s) or institution(s) receive any payment or benefits in excess of the costs of undertaking the research?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give details:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A64. Does the chief investigator or any other key investigator/collaborator have any direct personal involvement (e.g. financial, share-holding, personal relationship etc.) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give details:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A65. Other relevant reference numbers if known (give details and version numbers as appropriate):

Applicant's/organisation's own reference number, e.g. R&D (if available):
Sponsor's/protocol number:
Funder's reference number:
International Standard Randomized Controlled trial Number (ISRCTN):
European Clinical Trials Database (EUDRACT):

Project website:

A66. Other key investigators/collaborators (all grant co-applicants should be listed)

i. Title: Dr
   First Name/Initials: Tom Last Name: Barker
   Post: Principal Clinical Psychologist
   Qualifications: Psych D. Clinical Psychology (1997); B.A. (Hons) Social Science (1992)
   Organisation: South West London and St. Georges NHS Trust
   Address: Morden CMHT, Memorial Wing
             Nelson Hospital, Kingston Road
             London
   Postcode: SW20 2DB
   Telephone: 0208 254 1029
   Fax: 0208 254 1027
   Email: tom.barker@swlstg-tr.nhs.uk

ii. Title: Ms
    First Name/Initials: Amanda Last Name: Ediriweera
    Post: Clinical Psychologist
    Qualifications: DipClinPsychol (1993); BSc (Hons) (1988)
    Organisation: Surrey Hampshire Borders
    Address: Hollies CMHT, Willow House
             23, Grosvenor Road,
             Aldershot, Hampshire
    Postcode: GU11 1DF
    Telephone: 01252 350 307
    Fax: 01252 350 391
    Email: Amanda.ediriweera@shb-tr.nhs.uk

iii. Title: Dr
     First Name/Initials: Mark Last Name: Hayward
     Post: Clinical Psychologist
     Qualifications: BA, DClinPsy
     Organisation: University of Surrey
     Address: Clinical Psychology, Department of Psychology,
              University of Surrey, Guildford, Surrey
     Postcode: GU2 7XH
     Telephone: 01483 682 881
     Fax: 01483 609 551
     Email: m.hayward@surrey.ac.uk

iv. Title: Ms
    First Name/Initials: Michelle Last Name: Hardie
    Post: Assistant Psychologist
    Qualifications: Degree in Psychology
    Organisation: West Sussex Health and Social Care
    Address: Chichester Assertive Outreach Team
             Barnfield House, 5 College Lane
             Chichester, West Sussex
    Postcode: PO19 6PQ
    Telephone: 01243 815 191
    Fax: 01243 815 191
    Email: jehardie@tiscali.co.uk

v. Title: 
    First Name/Initials: Last Name: 
    Post: 
    Qualifications: 
    Organisation: 
    Address: 
    Telephone: 
    Fax: 
    Postcode: 
    Email: 

If further collaborators are required, please enter at end of session or attach a further sheet.
If the research involved a specific intervention (e.g. a drug, medical device, dietary manipulation, lifestyle change etc), what arrangements are being made for continued provision of this for the participant (if appropriate) once the research has finished?

Not applicable

PART A: SUMMARY OF ETHICAL ISSUES

What do you consider to be the main ethical issues or problems that may arise with the proposed study, and what steps will be taken to address these?

All of the individuals that will be approached for participation within the study will be in receipt of ongoing clinical care and will have an existing dialogue with clinicians about their voices. Should an individual present with any difficulties of clinical significance during any stage of the contact I will seek permission from him/her to pass concerns on to their Consultant Psychiatrist or relevant service provider. If a participant discloses information that leads the investigator to believe he/she will harm him/herself or others, the investigator will be obliged to pass on this information. The limits of confidentiality in this respect will be made explicit prior to commencement of the interview. These guidelines will apply to individuals who consent to and complete the interview process, individuals who consent to and subsequently withdraw from the process and individuals who do not give consent (and consequently do not participate).

At the beginning of the second meeting each participant will be given the opportunity to discuss any voice activity that may have followed or been triggered by the first meeting. Any implications this may have for ongoing or potential therapeutic interventions will also be explored.

The anonymity of information provided by participants will be ensured through the coding of interview data. Each participant will be allocated a number by which all data will subsequently be identified. The key to the numbers allocated will be kept separate from the data at all times. The participants will consequently not be identifiable on any forms and computer records, or in any aspect of the write-up.

Do you need to add further information about certain questions in part A?

This question is not applicable for the online version of Corec form.
A70. Give details of the educational course or degree for which this is being undertaken:

Name and level of course/degree: PsychD Doctorate in Clinical Psychology.

Name of educational establishment: University of Surrey

Name and contact details of Educational supervisor:
Dr Mark Hayward, Clinical Psychology, Department of Psychology, University of Surrey, Guildford, Surrey, GU2 7XH

A71. Declaration of supervisor

I have read and approved both the research proposal and this application for ethical review. I undertake to fulfill the responsibilities of a supervisor as set out in the Research Governance Framework for health and social care. I have been delegated authority to sign on behalf of my academic institution, that any necessary indemnity or insurance arrangements are in place.

Signature: .................................................................
Date: .................................................................
Print Name: Mark Hayward

A one-page summary of the supervisor's CV should be submitted with the application.
The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

I undertake to abide by the ethical principals underlying the Declaration of Helsinki, and good practice Guidelines on the proper conduct of research.

If the research is approved I undertake to adhere to the study protocol without unagreed deviation and to comply with any conditions set out in the letter sent by the NHS Research Ethics Committee notifying me of this.

I undertake to inform the NHS Research Ethics Committee of any changes in the protocol, and to submit annual reports setting out the progress of the research.

I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patent or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.

I understand that research records data may be subject to inspection for audit purposes if required in future.

I understand that personal data about me as a researcher in this application will be held by the Research Ethics Committee and its operational managers, and that this will be managed according to the principals established in the Data Protection Act.

Signature of the Chief Investigator: [Signature]

Date: 06/10/2004

Print Name: [Signature]

1. Do you need to add further information about certain questions in part B?
   
   This question is not applicable for the online version of Corec form. No
**APPLICATION FORM**

This form should be completed by the principal investigator for each site (see glossary).

**Name of NHS research ethics committee to which application for ethical review is being made:**
South West Surrey Research Ethics Committee

**Project reference number form above REC:** 04/Q1909/52

**Name of site NHS REC (or R&D Department) undertaking site-specific assessment:**

**Site NHS REC (or R&D department) Identifier:**

Questions C1, C4, C5, C6, C7 and C8 correspond to questions A1, A2, A6A, A10, A12 and A13 on main application Form respectively and will populate automatically:

**C1. Title of Research (Populated from A1)**

<table>
<thead>
<tr>
<th>Full title</th>
<th>Relating to voices: does voice identity influence degree of relating to the voice and recovery style in people who experience auditory hallucinations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key words</td>
<td>Voice hearing, voice identity, recovery style</td>
</tr>
</tbody>
</table>

**C2. Who is the principal investigator for this study at this site?**

<table>
<thead>
<tr>
<th>Title</th>
<th>Dr</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name/Initials</td>
<td>Tom</td>
</tr>
<tr>
<td>Last Name</td>
<td>Barker</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post</th>
<th>Principal Clinical Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications</td>
<td>Psych D. (1997); B.A. Social Sciences (1992)</td>
</tr>
<tr>
<td>Organisation</td>
<td>South West London and St. Georges NHS Trust</td>
</tr>
<tr>
<td>Address</td>
<td>Morden CMHT, Memorial Wing, Nelson Hospital, Kingston Road, London</td>
</tr>
<tr>
<td>Postcode</td>
<td>SW20 2BE</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:tom.barker@swlstg-tr.nhs.uk">tom.barker@swlstg-tr.nhs.uk</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>0208 254 1029</td>
</tr>
<tr>
<td>Fax</td>
<td>0208 254 1025</td>
</tr>
</tbody>
</table>
C3. Indicate the number of trials/projects within the organisation that the local Principal Investigator has been involved with in the previous 12 months: 0

How many are still currently (active or recruiting)? 0

Give Details of other members of the local research team responsible to the local Principal Investigator:

- Title: First Name/Initials: Last Name:
  - Position:
  - Qualifications:
  - Role in team:

- Title: First Name/Initials: Last Name:
  - Position:
  - Qualifications:
  - Role in team:

- Title: First Name/Initials: Last Name:
  - Position:
  - Qualifications:
  - Role in team:

If there are more members of the local research team, details should be provided at question C18 or on an attached sheet.

C4. Chief Investigator. (Populated from A2)

Title: Mr First Name/Initials: David Last Name: Bennett
Post: Trainee Clinical Psychologist
Qualifications: BSc, MSc
Organisation: University of Surrey,
Address: Clinical Psychology,
University of Surrey,
Guildford, Surrey
Postcode: GU2 7XH
Email: d_m_bennett@hotmail.com
Telephone: 0784 309 5238
Fax: 01243 689 553

C5. Other relevant reference numbers if known (Populated from A65):

- Applicant's/organisation's own reference number (if available):
- Sponsor's/protocol number:
- Funder's reference number:
- International Standard Randomized Controlled trial Number (ISRCTN):
- European Clinical Trials Database (EUDRACT):
- Project website:
C6. Give a brief synopsis/summary of methods and overview of the planned research. This should include a brief description of how prospective research participants and concerned communities (not necessarily geographical) from which they are drawn have been consulted over the design and details of the research? (Where appropriate a flow chart or diagram should be submitted separately. It should be clear exactly what should happen to the research participant, how many times and in what order.) (Populated from AW)

32 adult mental health patients who have experienced auditory hallucinations for at least six months (diagnosed with schizophrenia, schizoaffective disorder or affective psychosis conforming to the criteria of DSM IV (American Psychiatric Association, 1994)) and who are either stable or receiving antipsychotic medication will be recruited for the study across two NHS Trusts. Individuals with drug-induced or organic psychosis will be excluded. Participants will be recruited via professionals in the team or service user groups. A control group is not required as the research is not an outcome study. Due to the limitations of the research (student research) it has not been possible to consult individuals from potential participant communities in relation to the design of the study.

Following screening for inclusion participants will meet with the chief investigator to participate in a semi-structured interview based on the Cognitive Assessment of Voices (CAV) and will then complete the following assessments tools with the researcher:

You to Voice (YTV) - questionnaire Vaughn and Fowler (2004). - The YTV is an adapted, 40-item questionnaire of the Couple's Relating to Each Other Questionnaire (CREOQ) (Birtchnell, 1985) and is designed to measure style of relating to the voice. It consists of four subscales (Upper Neutral, Lower Neutral, Neutral Close & Neutral Distant) of the original CREOQ each of which was found to have good internal reliability (Cronbach's alpha of 0.65, 0.86, 0.75 & 0.86 respectively).

Recovery style questionnaire (RSQ) Drayton, Birchwood and Trower (1998) - The RSQ is a 39-item questionnaire designed to assess recovery style using questions about the patients attitude towards their psychosis. It has been shown to have good reliability (test-retest r=.81, Cronbach's alpha = .73) and good face- and criterion-validity (Drayton, Birchwood and Trower, 1998).

Psychotic Symptoms Rating Scale - auditory hallucinations scale (PSYRATS) Haddock, McCarron, Tarrier & Faragher (1999) - The auditory hallucinations sub-scale of the PSYRATS is an 11-item measure which assesses various elements of the voice-hearing experience (Haddock, McCarron, Tarrier & Faragher, 1999). The scale has been shown to have good inter-rater reliability (greater than 0.9 for 9 of the 11 items).
C7. Will the research participants receive any clinical intervention(s) or procedure(s) including taking samples of human biological material over and above that which would normally be considered part of routine clinical care? *(Populated from A12)*

<table>
<thead>
<tr>
<th>Additional Intervention</th>
<th>Average number per Patient</th>
<th>Average time taken (mins/hrs/days)</th>
<th>Details of additional intervention or Procedure, who will undertake it, and what training they have received.</th>
</tr>
</thead>
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Do you need another page?

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</tbody>
</table>

NHS REC Application Form - Version 3.0
## C8. Will the research participant be subject to any non-clinical research-related intervention(s) or procedure(s)?

<table>
<thead>
<tr>
<th>Additional intervention</th>
<th>Average number per Patient</th>
<th>Average time taken (mins/hrs /days)</th>
<th>Details of additional intervention or Procedure, who will undertake it, and what training they have received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to Face Interview</td>
<td>1</td>
<td>45 minutes</td>
<td>An interview based on the Cognitive Assessment of Voices Tool will be carried out by the chief investigator. The interviewer has received training in clinical ass. Cont’d on Additional Pages.</td>
</tr>
<tr>
<td>Other Questionnaire</td>
<td>3</td>
<td>30 minutes</td>
<td>Each participant will complete three questionnaires: the You to Voice questionnaire (Vaughn and Fowler, 2004), the Recovery style questionnaire (Drayton, Birchwood...Cont’d on Additional Pages.</td>
</tr>
</tbody>
</table>

**Please give details for other(s):**
C9. Name of NHS or other organisation where the research will take place.
South West London and St. Georges NHS Trust

C10. Specify the location(s)/department(s) within the NHS or other organisation where the research will take place.
It is proposed that participants will be recruited from Community Mental Health services covering Sutton, Merton and Wandsworth in order to be as inclusive as possible. This may include East and West Mitcham, Morden, Wimbledon, Sutton, Carshalton, Wallington, Cheam, Wandsworth and Battersea.

C11. How many research participants/samples is it anticipated will be recruited/obtained from this organisation in total?
It is anticipated that approximately half (N=16) of the total sample (N=32) will be recruited from each of the two organisations... Cont'd on Additional Pages.

C12. Give details of who will be responsible for obtaining informed consent locally, their qualifications and relevant expertise and training in obtaining consent for research purposes:
Informed consent will be obtained by the chief investigator. The chief investigator is a PsychD Trainee Clinical Psychologist with experience of obtaining informed consent from individuals within areas of clinical practice and research.

C13. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English. (E.g. Translation, use of interpreters etc.)
Due to the limitations of the study (student research) resources and funding are not available to include participants who do not have English as a first language.

C14. What arrangements have been made to inform those responsible for the care of the research participants of their involvement in the research?
As part of the process of obtaining informed consent it is proposed that each participants GP will be informed of their participation in the study, assuming they consent to this.
C15. Are the facilities and staffing available locally adequate to perform any necessary procedures or interventions required for the study, and to deal with any unforeseen consequences of these? (This should include consideration of procedures and interventions in both control and intervention arms of a study)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

Indicate what arrangements are being made to deal with the situation:

In order to conduct the research it is only necessary for the chief investigator to be present. All aspects of the research will be conducted on NHS premises within office hours and in teams staffed by mental health professionals.

C16. Give details of a contact point where participants may obtain further information about the study.

Participants will be able to obtain additional information from the chief investigator, via messages left at Morden CMHT.

Please specify the header paper to be used for the patient information sheet.

South West London and St. Georges (Morden CMHT) headed paper will be used for the patient information sheet for potential participants in this section of the study.

C17. If there is no Principal investigator at local level, Is there a local individual who is undertaking a task relating to the research?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

Give details:

C18. Do you need to add further information about certain questions in Part C

This question is not applicable for the online version of Corec form. No
DECLARATION

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

- I undertake to abide by the ethical principals underpinning the declaration of Helsinki, and Good Practice Guidelines on current proper conduct of research.

- If the research is approved I undertake to adhere to the study protocol without agreed deviation and to comply with any conditions set out in the letter sent by the NHS Research Ethics Committee notifying me of this.

- I undertake to inform the NHS Research Ethics Committee of any changes in the protocol, and to submit annual reports setting out the progress of the research.

- I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patent or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.

- I understand that research records/data may be subject to inspection for audit purposes if required in future.

- I understand that personal data about me as a researcher in this application will be held by the Research Ethics Committee and its operational managers, and that this will be managed according to the principles established in the Data Protection Act.

*The Chief Investigator should sign where there is no local Principal Investigator for the research locality

PART C is now complete and should be submitted to the NHS Research Ethics Committee or NHS organisation conducting site-specific assessment

Date: 06/10/2004
Print Name: David Bennett
voice-hearing experience is isolated from other life events by the individual, while integration involves the incorporation of psychosis into general life experience.

Answer from Question A9 Cont’d...

integration may “turn [the voice hearing experience] into a positive situation rather than something that needs to be avoided” (pp.32 Thompson et al., 2003). Individuals who seel over tend to be more rigid in their thinking and may treat the experience as a disruption to their life rather than a life-experience. Thompson et al’s (2003) study found that an integrative recovery style predicts better quality of life and fewer symptoms at 12-month follow-up. The present study aims to investigate whether an individual’s awareness of a voices identity leads to closer relating to the voice. In addition, the study aims to investigate whether the distance of the voice affects the individual’s ability to relate the experience to their everyday life, reflected in an integrative style of recovery.

Answer from Question A13_1 Details Cont’d...

assessment as part of the PsychD training in Clinical Psychology.

Answer from Question A13_2 Details Cont’d...

and Trower, 1998) and the Psychotic Symptoms Rating Scale – auditory hallucinations scale (Haddock, McCarron, Tarrier & Faragher, 1999).

Answer from Question A14 Cont’d...

e given the opportunity to terminate the interview.

Should an individual present with any difficulties of clinical significance during any stage of the contact I will seek permission from him/her to pass concerns on to their Consultant Psychiatrist or relevant service provider. If a participant discloses information that leads the investigator to believe he/she will harm him/herself or others, the investigator will be obliged to pass on this information. The limits of confidentiality in this respect will be made explicit prior to commencement of the interview. These guidelines will apply to individuals who consent to and complete the interview process, individuals who consent to and subsequently withdraw from the process and individuals who do not give consent (and consequently do not participate).

Answer from Question A19 Cont’d...

be reflected upon and discussed with the principal investigator or university supervisor.

Answer from Question A26 Cont’d...

will be ensured through the coding of interview data. Each participant will be allocated a number by which all data will subsequently be identified. The key to the numbers allocated will be kept separate from the data. Therefore participants will not be identifiable on any forms and computer records, or in any aspect of the write-up.

Answer from Question A28 Cont’d...

er than 24 hours to make this decision and will be provided with more time if they are
undecided after this period.

Answer from Question A46 Cont’d...

ons scale (PSYRATS) Haddock, McCarron, Tarrier & Faragher (1999).
All measures have been shown to demonstrate good reliability and validity.

Answer from Question PartB Section1 B Cont’d...

d by the NHS) to cover research expenses.

Answer from Question C8_1 Details Cont’d...

ssment as part of the PsychD training in Clinical Psychology.

Answer from Question C8_2 Details Cont’d...

and Trower, 1998) and the Psychotic Symptoms Rating Scale - auditory hallucination:
scale (Haddock, McCarron, Tarrier & Faragher, 1999).

Answer from Question C11 Cont’d...

olved in the study. Depending on the success of the recruitment of participants
there may be some variation in this.
**R&D proposal form**

1 **Project Title**

Relating to voices: does voice identity influence degree of relating to the voice and recovery style in people with schizophrenia?

2 **Background to the research**

Rome and Escher (1989) studied voice-hearing in clinical and non-clinical samples and found that the individual's ability to cope with the experience was influenced by their appraisal of the voice. Further research in this area has highlighted a variety of factors which mediate cognitive, affective and behavioural responses to voice-hearing. Chadwick and Birchwood (1994) found that individuals held beliefs about the identity and meaning of the voice (whether is was benevolent or malevolent) and Close and Garety (1998) found a direct relationship between voice content and the individuals beliefs about the voice, with positive content being viewed as benevolent and negative content as malevolent. These findings highlighted the potential clinical value of challenging beliefs about the voice, rather than attempting to eliminate the experience, in order to reduce distress. In addition to the factors described above the nature of the relationship between the voice and the voice-hearer has been found to mediate levels of distress. Voices are often identified as being aligned to people within the individual's social world (Leuder, Thomas, McNally and Glinski, 1997; Nyani and David, 1996) and research suggests that the interaction with the voice reflects interactions with the identified individual in the real world. In addition, voices that are identifiable (friends, family members, god or the devil) have been found to be related to more closely than those that are incognito (Hayward, 2003). Hayward (2003) suggests that the identification of the voice within a therapeutic context may lead to closer relating to the voice. This may also have the effect of enabling the individual to make greater sense of their voice hearing experience within their previous and current life experiences (Romme and Escher, 2000). Research into the recovery process following episodes of psychosis has highlighted two styles of recovery. Integration occurs when the individual incorporates their psychosis into their overall life experience, while in sealing over the individual isolates their psychosis from other life experiences (Thompson, McGorry and Harrigan, 2003). Thompson et al's (2003) study found that an integrative recovery style predicts better outcome and functioning. The present study therefore aims to investigate whether awareness of a voices identity does lead to closer and less submissive relating to the voice. In addition the study aims to investigate whether the distance of the voice does have an impact on an individual's ability to relate the experience to their everyday life, reflected in an integrative style of recovery.

3 **Aims/Objectives of the project**

The present study aims to investigate the relationship between style of relating with the voice (in terms of power and proximity of the voice) and recovery style (with respect to integrating the voice hearing experience into ones wider life experience or sealing over, in which the psychotic experience is isolated from other life events).

4 **Principal Research Question**

(a) Individuals whose voices are incognito will relate more distantly to their voices than individuals whose voices are personified or supernatural.

(b) Individuals whose voices are incognito and related to 'distantly' will not relate their voice-hearing experience to their previous life experience as well as those whose voices are related to more closely. This will be shown by the use of a "sealing over" style of recovery for voices related to more distantly and less powerfully.
### 5 Methodological Description:

**Participants:** 30 adult mental health patients who have experienced auditory hallucinations for at least six months and who are either stable or receiving antipsychotic medication will be recruited for the study across two NHS Trusts (see power analysis below). Individuals with substance misuse problems or organic psychosis will be excluded. Participants will be recruited via professionals in the team or service user groups. A control group is not required as the research is not an outcome study.

**Procedures:** Following screening for inclusion participants will meet with the researcher to participate in a semi-structured interview (CAV) and will then complete the following assessments:

- A semi-structured clinical interview based on the Cognitive Assessment of Voices (CAV) – Chadwick and Birchwood (1994),
- You to Voice (YTV) questionnaire – Vaughn and Fowler (2004),
- Recovery style questionnaire (RSQ) – Drayton, Birchwood and Trower (1998),

All measures have been shown to be reliable and valid.

### 6 Outcome Measure Descriptions:

The current study is not an intervention trial and therefore outcome is not being assessed.

### 7 Anticipated data analysis

"How will I know if I have answered the question?"

NB. You need to include a power calculation or explain why one is not needed

On the basis of Hayward’s (2003) a priori power analysis was carried out, which suggested that with a power = .80 and alpha = .05 and \( d = .90 \), a minimum sample size of \( N = 21 \) would be required.

The data obtained from the study will be subjected to the following statistics:

- a) Independent groups ANOVA (assuming scores are normally distributed) with a Scheffe post-hoc test. However, because there is a clear prediction of the outcome of this analysis, a t-test could be carried out.
- b) Correlation (Pearson's/Spearman's depending on distribution of variables).

### 8 Classification of study

The proposed research project is a quantitative case series study, investigating clinical indicators symptoms (voice hearing) in a cohort of individuals who have experienced voice hearing for a minimum of six months.

### 9 Selected References:


Dear [Name]

Re: MRP Research Proposal: Relating to voices: does voice identity influence degree of relating to the voice and recovery style in people with schizophrenia.

Thank you for coming to see me on 03 August 2004 to discuss the above project. I understand that the research project is conducted as part of a post-graduate education leading to a clinical doctoral degree whilst on clinical placement at [MHBB] within our Trust.

On behalf of the Trust, I write to confirm that the Trust is supportive of this high quality project subject to you obtaining approval from a research ethics committee.

As discussed, the Trust will submit basic information about your project to the National Research Register to share good practice with colleagues in the NHS. The Trust would be glad of a copy of your thesis or abstract when you are in a position to do so.

Yours sincerely

[Signature]

Interim Director of Nursing
Trainee Clinical Psychologist
Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH

Dear [Name],

Relating to voices: does voice identity influence degree of relating to the voice and recovery style in people who experience auditory hallucinations?

Thank you for your letter of 19 November 2004, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully. As you will see, the document is a standard one and some sections of it will clearly not apply to your study.

An advisory committee to Surrey and Sussex Strategic Health Authority
Approved documents

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

ii) Your Curriculum Vitae (undated)
iii) Curriculum Vitae (undated)
iv) Study Protocol, Version 1, dated 6 October 2004
v) Flow Diagram, Version 1, dated 6 October 2004
vi) Letter concerning indemnity arrangements from the University of Surrey dated June 2004
vii) Cognitive Assessment of Voices Schedule (undated)
viii) Psychotic Symptoms Rating Scales (undated)
ix) Recovery Style Questionnaire (undated)
x) YTV – A person’s assessment of themselves in relation to their predominant voice (undated)
xii) GP Information Letter, Version 1, dated 6 October 2004
xii) Participant Information Sheet, Version 2, dated 13 November 2004
xii) Participant Consent Form, Version 1, dated 6 October 2004

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely

Co-ordinator

Copy to: Dr University of Surrey

An advisory committee to Surrey and Sussex Strategic Health Authority
Dear [Name]

Research Title: Relating to voices: does voice identity influence relating to the voice and recovery style in people who experience auditory hallucinations?

Project ID: PF206

Following various discussions your project has now been approved. This letter ensures that you and the researchers holding a Trust/NHS contract are indemnified by the Trust under DoH (HSG (98) 48) (only for non-commercial research). Under your contract of employment you are required to adhere to the Research Governance Framework and Trust research monitoring procedures.

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- **Patient contact**: Only trained or supervised researchers holding a Trust/NHS contract (honorary or full) are allowed to make contact with patients.

- **Informed consent**: is obtained by the lead or trained researcher according to the requirements of the ethics committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.

- **Data Protection**: All data involving patient data will remain anonymised, where possible, and held on protected systems so as not to compromise the Data Protection Act.

- **Adverse events reporting**: Adverse events or suspected misconduct must be reported to the R & D department, in conjunction with the Ethics committee.
Terms and conditions of Approval

• **Annual review:** An annual review form will be sent to you, which you will be required to complete and return to the R & D Department.

• **Closure Form:** On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the R & D Department.

• **Publications:** Any publications will need to be reported to the R & D Department. This is vital in ensuring the quality and output of the research for your project and the Trust as a whole.

The R & D Department needs to be informed of any changes to the protocol such as patient recruitment, funding, etc. If any major changes are made to the protocol then this would need to go to the R & D Committee.

If you have any queries regarding the above points please contact [R&D Co-ordinator name], e-mail: [R&D Co-ordinator email].

Yours sincerely,

[Chairman name]
Chairman
Research & Development Committee.
08 March 2005

Dear Mr. [Name]

Relating to voices: does voice identity influence relating to the voice and recovery style in people who experience auditory hallucinations? (EC/2005/03/Psych) - FAST TRACK

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 08 March 2005

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

Document Type: Application
Dated: 04/01/05
Received: 11/01/05

Document Type: Approval Letter from the NHMREC
Dated: 16/12/04
Received: 11/01/05

Document Type: Insurance Proforma
Received: 11/01/05

Document Type: NHS Research Ethics Committee Application Form
Version: 3.0
Dated: 16/10/04
Received: 11/01/05

Document Type: Your Response to the Committee's Comments
Dated: 27/01/05
Received: 02/02/05
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

[Signature]
Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
[Name], Supervisor, Dept of Psychology
NHS
13th November 2004
Version 2.

Patient Information Sheet

**Title of project:** Does voice identity affect the way people relate to their voices or recover from an episode of psychosis?

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

**Aim:**

Research into peoples experiences of hearing voices indicate that the way in which the experience is understood by the individual may have an effect on their ability to cope with the experience. In addition, the things that the voice says may also have an effect on the amount of distress that the person feels.

Studies have also shown that in some cases the identity of the voice is the same as someone that the person knows or has seen at some point in their life (such as a family member or a famous person). When the identity of the voice is known, the person may allow the voice to be closer to them. The current study aims to look at the way in which the identity of different voices may affect the way people interact with their voices. The research will also look at the way in which different types of interaction with the voices may affect the process of recovery.

**Participation:**

You are being invited to take part in this study because you have reported to your consultant / keyworker that you hear voices. We are hoping to recruit 30 individuals who have heard voices for at least six months.

It is up to you to decide whether or not to take part in the study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw from the study at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

If you decide to take part in the study you will be required to meet with the researcher to talk about your experiences of hearing voices and to fill in three questionnaires. The discussion will look at your experiences of hearing voices and the way in which
you relate to the main voice that you hear. The questionnaires include questions about the relationship that you have with the main voice you hear and also the way in which you have managed the experience of hearing voices. This process should not take more than 1 ½ hours.

It is not necessary to make any changes to your normal daily activities prior to or following completion of the assessment.

You will not experience any direct benefits from participating in the study. The aim of the research is to increase our understanding of people's experiences of hearing voices. This information can then be of used to develop the ways in which people carry out psychological therapy with people who hear voices, to try and reduce their feelings of distress.

Confidentiality:

All information which is collected about you during the course of the research will be kept strictly confidential. It is not anticipated that the research will cause you any discomfort. If you do feel distressed at any time the researcher will contact a relevant member of staff such as a keyworker, GP or other health worker with your permission, so that you get the right support. If you feel that you have other mental health difficulties that require further professional attention, an appropriate service or psychiatrist will be contacted with your permission to assess this further. All forms will be anonymised and they will not include any information that could be used to identify you. Your GP will be informed of your participation in the study.

The research will be written up as a dissertation for a postgraduate qualification. In addition, the research will be written up to be published as an article in a national journal.

The study has been organised by *** ****, a Trainee Clinical Psychologist. The research is designed to be of value to mental health services and clients and forms part of the academic assessment process for the training programme.

For additional information regarding the study please contact:

*** *** at *** *** on *** *** ***.

Thank you for your cooperation.

*** ****

Trainee Clinical Psychologist

Centre Number:
Study Number:
Patient Identification Number for this trial:
CONSENT FORM

Title of Project: Relating to voices: does voice identity influence relating to the voice and recovery style in people who experience auditory hallucinations?

Name of Researcher: *** ***

1. I confirm that I have read and understand the information sheet dated 13th November 2004 (version 2.0) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

Name of patient __________ Date __________ Signature __________

Name of person obtaining consent (if different from researcher) __________ Date __________ Signature __________

Researcher __________ Date __________ Signature __________

1 for patient, 1 for researcher; 1 to be kept with hospital notes
[Date]
[GP Address]

Dear Dr [Name],

Re: Patient’s name, DOB, Address

Participation in a research project

I am a third year trainee clinical psychologist on the University of Surrey PsychD course and I am currently conducting my major research project. The research is concerned with patient’s experiences of hearing voices and aims to investigate the relationship between the identity of the predominant voice, they way in which the individual relates to the voice and the style of psychological recovery that they adopt.

The patient named above has given informed consent to participate in the study, which involves an interview and the completion of three questionnaires. This process is not expected to cause any detrimental effects and the relevant mental health team will provide support if the interview process does cause any distress. The relevant services, including the Consultant Psychiatrist, are aware of this individual’s participation in the study.

If you wish to discuss this matter further please do not hesitate to contact me on the number above.

Yours sincerely,

[Signature]

Trainee Clinical Psychologist
Appendix D

Additional Notes on Power Analysis:

Post Hoc power analysis using the results of Hayward (2003):

F-test (ANOVA)

Mean 1 = 1.50 \hspace{1cm} N1 = 10
Mean 2 = 12.44 \hspace{1cm} N2 = 9
Mean 3 = 23.88 \hspace{1cm} N3 = 8

Sigma (within each group) = 6.2818

Produces an effect size = 0.743
Alpha = .05
Total N = 27
Number of groups = 3
Power = 0.9103

A priori power analysis:

d = 0.90
alpha = .05
power = 0.8
N = 32

Post hoc power analysis (present study):

Mean 1 = 14.89 \hspace{1cm} N1 = 9
Mean 2 = 10.19 \hspace{1cm} N2 = 16
Sigma = 5.226
d = 0.899

Power = 0.673
Appendix E

Tests of Normality (VAY data)

Tests of Normality for original VAY data

<table>
<thead>
<tr>
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<th>Kolmogorov-Smirnov(a)</th>
<th>Shapiro-Wilk</th>
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</thead>
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<td>Dependence</td>
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* This is a lower bound of the true significance.
a Lilliefors Significance Correction

Tests of Normality for dependence data following square root transformation

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<th>Kolmogorov-Smirnov(a)</th>
<th>Shapiro-Wilk</th>
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<td>SqDe</td>
<td>.093</td>
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* This is a lower bound of the true significance.
a Lilliefors Significance Correction
## PSYRATS frequency data

### Frequency of voice hearing

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<thead>
<tr>
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<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tr>
<td>at least one per week</td>
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<td>28.0</td>
<td>28.0</td>
<td>28.0</td>
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<tr>
<td>at least one a day</td>
<td>5</td>
<td>20.0</td>
<td>20.0</td>
<td>48.0</td>
</tr>
<tr>
<td>at least one an hour</td>
<td>5</td>
<td>20.0</td>
<td>20.0</td>
<td>68.0</td>
</tr>
<tr>
<td>continuous</td>
<td>8</td>
<td>32.0</td>
<td>32.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
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</tbody>
</table>

### Duration of voice hearing

<table>
<thead>
<tr>
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<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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</thead>
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<td>several mins</td>
<td>15</td>
<td>60.0</td>
<td>60.0</td>
<td>60.0</td>
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<tr>
<td>at least 1 hour</td>
<td>2</td>
<td>8.0</td>
<td>8.0</td>
<td>68.0</td>
</tr>
<tr>
<td>hours</td>
<td>8</td>
<td>32.0</td>
<td>32.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
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### Location of voices

<table>
<thead>
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<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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</thead>
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<tr>
<td>inside only</td>
<td>8</td>
<td>32.0</td>
<td>32.0</td>
<td>32.0</td>
</tr>
<tr>
<td>outside and inside</td>
<td>5</td>
<td>20.0</td>
<td>20.0</td>
<td>52.0</td>
</tr>
<tr>
<td>but close</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inside or out</td>
<td>4</td>
<td>16.0</td>
<td>16.0</td>
<td>68.0</td>
</tr>
<tr>
<td>but close by outside</td>
<td>8</td>
<td>32.0</td>
<td>32.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
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### Loudness of voices

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<td></td>
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<tr>
<td></td>
<td>louder</td>
<td>3</td>
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<tr>
<td></td>
<td>shouting</td>
<td>1</td>
<td>4.0</td>
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<td>Total</td>
<td>25</td>
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<td>100.0</td>
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### Origins of the voices

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</tr>
<tr>
<td></td>
<td>less than half external</td>
<td>10</td>
<td>40.0</td>
</tr>
<tr>
<td></td>
<td>less than half internal</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>external</td>
<td>10</td>
<td>40.0</td>
</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
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### Amount of distress

<table>
<thead>
<tr>
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<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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</thead>
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<td>4.0</td>
</tr>
<tr>
<td></td>
<td>less than 10%</td>
<td>7</td>
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<td>less than 50%</td>
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<td></td>
<td>more than 50%</td>
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</tr>
<tr>
<td></td>
<td>always</td>
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<tr>
<td>Total</td>
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### Intensity of distress

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<th>Percent</th>
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<th>Cumulative Percent</th>
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<tr>
<td></td>
<td>slight</td>
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<tr>
<td></td>
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<td></td>
<td>very</td>
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</tr>
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<td></td>
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<td>Total</td>
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284
### Disruption to life

<table>
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<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
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<td>4.0</td>
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</tr>
<tr>
<td>Total</td>
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### Degree of control over voices

<table>
<thead>
<tr>
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<th>Frequency</th>
<th>Percent</th>
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<td>24.0</td>
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<td>no control</td>
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Appendix G

**VAY descriptives**

Descriptive Statistics

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<td>18</td>
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<td></td>
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### Spearman's rho correlation – hearer distance and intensity of distress

**Correlations**

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<th>Distance</th>
<th>Intensity of distress</th>
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<td>Coefficient</td>
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<td>25</td>
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<tr>
<td>Intensity of distress</td>
<td>Correlation</td>
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<tr>
<td></td>
<td>Coefficient</td>
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<td></td>
<td>N</td>
<td>25</td>
</tr>
</tbody>
</table>

### Kruskal Wallis – effect of hearer distance on distress (tertile ranges)

**Ranks**

<table>
<thead>
<tr>
<th>Intensity of distress</th>
<th>Distance in tertiles</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st tertile</td>
<td>5</td>
<td></td>
<td>7.90</td>
</tr>
<tr>
<td>2nd tertile</td>
<td>9</td>
<td></td>
<td>14.33</td>
</tr>
<tr>
<td>3rd tertile</td>
<td>11</td>
<td></td>
<td>14.23</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Test Statistics (a,b)**

<table>
<thead>
<tr>
<th>Intensity of distress</th>
<th>Chi-Square</th>
<th>df</th>
<th>Asymp. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.224</td>
<td>2</td>
<td>.199</td>
</tr>
</tbody>
</table>

a. Kruskal Wallis Test
b. Grouping Variable: Distance in tertiles
Appendix I

RSQ frequencies

<table>
<thead>
<tr>
<th>Style of recovery</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid integration</td>
<td>14</td>
<td>56.0</td>
<td>56.0</td>
<td>56.0</td>
</tr>
<tr>
<td>mixed - integ predom</td>
<td>6</td>
<td>24.0</td>
<td>24.0</td>
<td>80.0</td>
</tr>
<tr>
<td>mixed - SO predom</td>
<td>4</td>
<td>16.0</td>
<td>16.0</td>
<td>96.0</td>
</tr>
<tr>
<td>sealing over</td>
<td>1</td>
<td>4.0</td>
<td>4.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Appendix J

T-test – voice identity and hearer distance

Group Statistics

<table>
<thead>
<tr>
<th></th>
<th>Identity of dominant voice</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance</td>
<td>personified</td>
<td>16</td>
<td>10.19</td>
<td>6.145</td>
<td>1.536</td>
</tr>
<tr>
<td></td>
<td>incognito</td>
<td>9</td>
<td>14.89</td>
<td>4.106</td>
<td>1.369</td>
</tr>
</tbody>
</table>

Independent Samples Test

<table>
<thead>
<tr>
<th></th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Dist Equal variances assumed</td>
<td>2.265</td>
<td>.146</td>
</tr>
</tbody>
</table>

N.B. SPSS does not provide information regarding one-tailed tests. Significance levels for one-tailed tests were obtained from Clark-Carter (1997).
# Appendix K

## Mann-Whitney – Effect of voice identity on recovery style

### Ranks

<table>
<thead>
<tr>
<th>Identity of dominant voice</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Style of recovery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>personified</td>
<td>16</td>
<td>11.88</td>
<td>190.00</td>
</tr>
<tr>
<td>incognito</td>
<td>9</td>
<td>15.00</td>
<td>135.00</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Test Statistics (b)

<table>
<thead>
<tr>
<th>Style of recovery</th>
<th>Mann-Whitney U</th>
<th>Wilcoxon W</th>
<th>Z</th>
<th>Asymp. Sig. (2-tailed)</th>
<th>Exact Sig. [2*(1-tailed Sig.)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>personified</td>
<td>54.000</td>
<td>190.000</td>
<td>-1.134</td>
<td>.257</td>
<td>.329(a)</td>
</tr>
</tbody>
</table>

a Not corrected for ties.
b Grouping Variable: Identity of dominant voice
Appendix L

**Spearman's rho – hearer distance and recovery style**

Correlations

<table>
<thead>
<tr>
<th>Stages</th>
<th>Distance</th>
<th>Style of recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman's rho</td>
<td>1.000</td>
<td>.140</td>
</tr>
<tr>
<td></td>
<td>Coefficient</td>
<td>.505</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Style of recovery</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Correlation</td>
<td>.140</td>
</tr>
<tr>
<td></td>
<td>Coefficient</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.505</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>25</td>
</tr>
</tbody>
</table>
## Appendix M

**Mann-Whitney – effect of voice identity on voice phenomenon (PSYRATS)**

### Test Statistics (b)

<table>
<thead>
<tr>
<th>Voice Frequency</th>
<th>Voice Duration</th>
<th>Voice Location</th>
<th>Voice Loudness</th>
<th>Voices origins</th>
<th>Neg content - amount</th>
<th>Neg content - degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann-Whitney U</td>
<td>49.000</td>
<td>68.000</td>
<td>65.000</td>
<td>64.500</td>
<td>62.500</td>
<td>39.000</td>
</tr>
<tr>
<td>Wilcoxon W</td>
<td>94.000</td>
<td>204.000</td>
<td>110.000</td>
<td>200.500</td>
<td>198.500</td>
<td>175.000</td>
</tr>
<tr>
<td>Z</td>
<td>-1.350</td>
<td>-.261</td>
<td>-.412</td>
<td>-.484</td>
<td>-.577</td>
<td>-.1954</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.177</td>
<td>.794</td>
<td>.680</td>
<td>.628</td>
<td>.564</td>
<td>.051</td>
</tr>
<tr>
<td>Exact Sig. [2*(1-tailed Sig.)]</td>
<td>.207(a)</td>
<td>.846(a)</td>
<td>.718(a)</td>
<td>.677(a)</td>
<td>.598(a)</td>
<td>.065(a)</td>
</tr>
</tbody>
</table>

a Not corrected for ties.
b Grouping Variable: Identity of dominant voice

<table>
<thead>
<tr>
<th>Am' distress</th>
<th>Intensity of distress</th>
<th>Disruption to life</th>
<th>control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann-Whitney U</td>
<td>70.500</td>
<td>70.000</td>
<td>57.000</td>
</tr>
<tr>
<td>Wilcoxon W</td>
<td>206.500</td>
<td>115.000</td>
<td>102.000</td>
</tr>
<tr>
<td>Z</td>
<td>-.088</td>
<td>-.117</td>
<td>-.946</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.930</td>
<td>.907</td>
<td>.344</td>
</tr>
<tr>
<td>Exact Sig. [2*(1-tailed Sig.)]</td>
<td>.934(a)</td>
<td>.934(a)</td>
<td>.419(a)</td>
</tr>
</tbody>
</table>
# Appendix N

## T-test – effect of voice identity on relating (all VAY scales including transformed dependence data)

### Group Statistics

<table>
<thead>
<tr>
<th>Identity of dominant voice</th>
<th>Upperness</th>
<th>Distance</th>
<th>Closeness</th>
<th>SqDe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Mean</td>
<td>Std. Deviation</td>
<td>Std. Error</td>
<td>Mean</td>
</tr>
<tr>
<td>personified</td>
<td>16 8.19</td>
<td>5.991</td>
<td>1.498</td>
<td></td>
</tr>
<tr>
<td>incognito</td>
<td>9  11.33</td>
<td>4.899</td>
<td>1.633</td>
<td></td>
</tr>
<tr>
<td>personified</td>
<td>16 10.19</td>
<td>6.145</td>
<td>1.536</td>
<td></td>
</tr>
<tr>
<td>incognito</td>
<td>9  14.89</td>
<td>4.106</td>
<td>1.369</td>
<td></td>
</tr>
<tr>
<td>personified</td>
<td>16  7.75</td>
<td>4.091</td>
<td>1.023</td>
<td></td>
</tr>
<tr>
<td>incognito</td>
<td>9  7.89</td>
<td>6.030</td>
<td>2.010</td>
<td></td>
</tr>
<tr>
<td>personified</td>
<td>16 2.5749</td>
<td>1.48136</td>
<td>.37034</td>
<td></td>
</tr>
<tr>
<td>incognito</td>
<td>9  1.7094</td>
<td>1.48753</td>
<td>.49584</td>
<td></td>
</tr>
</tbody>
</table>

### Independent Samples Test

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
</tr>
<tr>
<td>Upper</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>assumed</td>
<td></td>
<td></td>
<td>-1.420</td>
</tr>
<tr>
<td>Equal variances</td>
<td>2.265</td>
<td>.146</td>
<td>-2.043</td>
</tr>
<tr>
<td>Dist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances</td>
<td>4.012</td>
<td>.057</td>
<td>-0.069</td>
</tr>
<tr>
<td>assumed</td>
<td></td>
<td></td>
<td>-0.062</td>
</tr>
<tr>
<td>Equal variances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not assumed</td>
<td>.001</td>
<td>.970</td>
<td>1.400</td>
</tr>
<tr>
<td>SqDe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>assumed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not assumed</td>
<td>1.399</td>
<td>16.65</td>
<td>.180</td>
</tr>
</tbody>
</table>
LOG BOOK OF RESEARCH EXPERIENCE

<table>
<thead>
<tr>
<th>Research skill/experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill/experience acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a literature search</td>
<td>1. Conducted a computerised literature search on the topic of anger management state / trait assessment using PubMed (a version of Medline), PsychInfo and Ovid via online resources. Used keywords (and derivatives of) “anger” “state” “trait” “questionnaire” “interview” and “assessment”. Learned how to widen the scope of the search by replacing characters with ? and * to represent single and multiple characters. Also learnt how to exclude specific types of publication and how to combine specific search terms. 2. Completed a literature search on caseload management in mental health services and the use of caseload management tools, the national service framework on mental health, the modernisation agenda and service structures using Medline, PsychInfo, the Cochrane Library and the Department of Health Website. This information was used to develop the initial literature review for the service related research project (SRRP). 3. Conducted a literature search using the above resources, using the terms “assessment” “intervention” “voices” “schizophrenia” “psychosis” “learning disabilities” “learning difficulties” and “mental retardation”. 4. Completed repeated literature searches using PsychInfo, Medline and ejournals (online electronic journals) to develop major research project (MRP) proposal, using keywords “psychosis” “schizophrenia” “voices” “relating” “interpersonal” and “recovery”.</td>
<td>21/10/02 (Year 1)</td>
</tr>
</tbody>
</table>
| Conduct a literature search cont. | 5. Completed literature search for qualitative research project using the above resources, with keywords “religion” “spiritual” “beliefs” “psychology” “student” “undergraduate” and “qualitative”.

6. Completed additional literature searches for major research project, using the above keywords in addition to “interpersonal theory” “cognitive model” “distress” and “recovery style questionnaire”. Also used ebooks (online electronic books) and the Cochrane library, British Psychological Society, Hearing Voices Network and Department of Health websites. | 01/02/04 (Year 2) |
| Critically review the literature | 1. Completed a literature review on the role of primary care and specialist mental health services and the impact of service development on caseload management as part of the SRRP.

2. Carried out literature reviews for a total of four essays, including a discussion on the use of two therapeutic interventions for major recurrent depression, parenting and people with learning disabilities, preventing intergenerational cycles of child abuse and the role of the clinical psychologist in services for people with dementia. In addition, literature reviews were conducted for five case reports, including the use of CBT and narrative therapy for the treatment of agoraphobia, bereavement work in people with learning disabilities, assessment of possible ADHD, neuropsychological assessment of memory loss in an individual with temporal lobe epilepsy and intervention for life-long anxiety using schema focused therapy. Additional reviews of the literature were conducted on placement, to inform all stages of the clinical process. | 05/05/03 (Year 1) 29/10/02-31/03/05 (Years 1-3) |
| Critically review the literature cont. | 2. Conducted a literature review on “Managing voices and schizophrenia in people with learning disabilities”, which was presented to support staff at a community home. |
| 3. Carried out a literature review on preventing inter-generational cycles of abuse, which was presented to staff during my child placement. |
| 3. Conducted a literature review titled “Does voice identity affect the way people relate to their voices or recover from an episode of psychosis?” as part of the MRP write-up. |
| 4. Carried out a literature on the use of neuropsychological assessment in the diagnosis of dementia, with particular reference to the use of the Reputable Battery for the Assessment of Neuropsychological Status (RBANS). This information formed part of a presentation / teaching session for members of the CMHT for Older People whilst of placement. |

| Formulate a specific research question | 1. Discussed service related research project with placement supervisor and decided to do a project looking at the convergent validity of a caseload management tool with other clinical measures in primary care and CMHT services in West Sussex. The aims of the research were twofold: to assess the convergent validity of the newly devised caseload management tool when compared with a reliable and valid measure of clinical complexity and to compare case complexity across different mental health services to assess whether clients were accessing the most appropriate service. |

| 29/06/03 |
| (Year 1) |
| 25/02/04 |
| 01/02/05 |
| (Year 3) |
| 12/02/05 |
| (Year 3) |
| 06/11/02 |
| (Year 1) |
| Formulate a specific research question cont. | 2. Discussed major research project with supervisor following initial conversation regarding research in the area of voices and distress. Agreed to focus on a purely clinical population and to extend supervisors previous research. The primary research question was “in people who hear voices does voice identity affect the style of interpersonal relating to the voice and does it affect the individual’s style of recovery?” | 23/10/03 (Year 2) |
| Write a brief research proposal | 1. Wrote a brief proposal to conduct service related research looking at the validity of a caseload management tool in mental health services, which was used as a means of generating discussion with clinical psychologists and managers. I also used this proposal to inform the course research tutors and the NHS Trust research and development committee (R&D) of the initial aims of the research, which led to a more detailed proposal.  
2. Wrote a proposal for the major research project, to be reviewed by the course research tutors to ensure the project was appropriate, given the course requirements and the available time and resources. | 27/11/02 (Year 1) |
<p>| Write a detailed proposal/protocol | 1. Developed a detailed proposal for the SRRP, which was used to inform NHS Trust R&amp;D and ethics of the rationale, aims and procedure of the study. This also included a timeline for the study, a discussion on possible ethical issues, the method of data analysis, the cost of the study (in terms of finance and time) and the possible implications of the research. | 05/12/02 (Year 1) |</p>
<table>
<thead>
<tr>
<th>Obtain appropriate supervision/collaboration for research</th>
<th>2. Wrote a detailed protocol for the MRP which formed the basis of registering the project with R&amp;D. This protocol was also used to describe the process of the research during the application to the ethics committees that were involved. A flow diagram of the research process was also developed at the request of the ethics committee, describing the procedure of the research and highlighting possible problems or ethical issues that could arise and how these would be managed. The structure of the protocol was revised following R&amp;D approval in preparation for ethics.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>05/04/04</td>
</tr>
<tr>
<td>1. Supervision for the SRRP was obtained from my placement supervisor and research tutor. In order to promote the research individual meetings were held with individual team members and the rationale for the research was presented at one business meeting and one allocation meeting. Flyers were sent to staff reminding them of the study and the research was included on all meeting agendas.</td>
<td>Year 2</td>
</tr>
<tr>
<td>2. Supervision for the qualitative research was provided to the group on an informal basis, during timetabled qualitative research methods teaching sessions and via e-mail. In addition, group members approached the university to utilise the undergraduate credit system in order to recruit suitable participants (psychology undergraduates). The group met on a regular basis to discuss the research and the literature and to share ideas. In addition, provided a forum to discuss the transcripts and the process of conducting interpretive phenomenological analysis (IPA).</td>
<td></td>
</tr>
<tr>
<td>3. Supervision for the MRP was provided by a member of the course team with an interest in hearing voices and recent experience of conducting research in the field. Due to potential difficulties with recruiting individuals who hear voices two individuals were approached to act as field supervisors in different trusts and both agreed. Due to unforeseen circumstances one field supervisor was unable to continue this role and another individual eventually agreed to take on this role. Collaboration</td>
<td></td>
</tr>
</tbody>
</table>
with services was partly facilitated via these field supervisors, although the majority of the collaborative working came about following individual discussions between myself and service managers.

4. Supervisor contracts were circulated to field supervisors, indicating who would be responsible for specific tasks within the research project.

| Write a participant information sheet and consent form | 1. A participation information sheet and consent form was prepared for the SRRP, which adopted the format suggested by the LREC. This included information regarding the aims of the research, what participation would involve and some indication of ethical issues, with particular reference to confidentiality.  
2. An information sheet and consent form was developed for the MRP, which followed the recommended structure outlined by the COREC website. Amendments were made to these in order to obtain ethical approval. | 19/01/03 (Year 1) |
| Judge ethical issues in research and amend plans accordingly | 1. Ethical issues were considered prior to conducting the SRRP and were assessed by an LREC prior to beginning data collection. These were mainly concerned with issues of confidentiality as there was little deviation from standard clinical practice. Data was not collected by myself and therefore the issue of judging each individual's suitability for participation and their ability to give informed consent was made by the professionals involved. Feedback from the ethics committee supported the notion that there was minimal risk of distress and suggested that minor amendments be made to the patient information form prior to approval being granted. | 13/12/02 (Year 1) |
2. Ethical approval for the MRP was granted by the MREC and University of Surrey, with the application considering issues such as obtaining informed consent, managing and reducing potential distress, exclusion of individuals with learning disabilities or organic psychosis and the limits of confidentiality (i.e. managing risk). During the process of conducting the MRP individuals who did not fit the inclusion criteria were invited to participate by care co-ordinators and had to be informed by myself that they could not be able to participate. In addition, a number of individuals arrived at the interview but had changed their minds and no longer wished to participate. Consequently it was important to highlight their right to not participate and to offer reassurance that their care would not be affected. On two occasions participants became slightly anxious and therefore the interview was terminated. Numerous participants found it difficult to concentrate and I had to ensure that they were offered the opportunity to have a break from the interview.

| Obtain approval from a research ethics committee | 06/10/04 (Year 3) |
|------------------------------------------------|--|---|
| 1. Ethical approval for the SRRP was obtained following minor amendments to the patient information sheet. I did not attend the meeting. | 13/12/02 (Year 1) |
| 2. Ethical approval for the MRP was obtained from the NHS via the central allocation system, whereby a central ethics committee reviewed the project, in addition to site-specific assessments by the two trusts involved. Additional site-specific assessments had to be conducted following a change of field supervisor and the decision to extend the study to include a borough not included in the original application. Approval was granted by the chairman following amendments to the patient information sheet and additional information regarding statistical support for the research. | 06/10/04 (Year 3) |
| 3. The University of Surrey granted approval to the study via a fast track system following approval from the NHS ethics and R&D committees. | 02/02/05 (Year 3) |
| Collect data from research participants | 1. Data collection for the qualitative research study was conducted by each member of the group and consisted of a semi-structured interview lasting approximately fifty minutes, which was audio-taped and transcribed. The semi-structured interview was designed by the group, based on theories relating to the use of IPA.  
2. For the MRP 26 interviews were conducted with service users with experience of voice hearing using a semi-structured interview (the cognitive assessment of voices) and three questionnaires (the recovery style questionnaire (RSQ), the you to voice (YTV) and the psychotic rating scale – hallucinations sub-scale (PSYRATS)) which were administered by myself to prevent missing data. Each interview lasted at least one hour and produced quantitative data (with some additional qualitative and demographic information). | 04/05/04 (Year 2) | 08/02/05 – 04/06/05 (Year 3) |
| Set up a data file | 1. An SPSS data file was set up during the SRRP in order to analyse the data regarding the convergent validity of the caseload management tool with the CORE measure.  
2. An SPSS data file was set up for the MRP, including demographic details (age, years since first episode and gender), identity of voice and scores for the RSQ, the PSYRATS and the YTV. This included defining each of the variables and entering the data. | 12/04/03 (Year 1) | 27/05/05 (Year 3) |
| Analyse quantitative data | 1. Analysis of quantitative data was conducted on numerous occasions as part of the research methods teaching in Year 1, including parametric and non-parametric analysis using SPSS and power analysis using GPower.  
2. Data from the SRRP was analysed using SPSS. A Spearman’s rho correlation was used, as the data was not suitable for parametric analysis. | 30/09/02 (Year 1) | 12/04/03 (Year 1) |
<table>
<thead>
<tr>
<th><strong>Major Research Project</strong></th>
</tr>
</thead>
</table>

| **Analyse qualitative data** | 1. Qualitative data was analysed as part of the qualitative research methods teaching block. In addition, IPA was used to analyse data for the qualitative research project and included individual and group work in this area. | 11/05/04  
(Year 2) |

| **Summarise results in figures/graphs** | 1. As part of the SRRP report graphs were produced that depicted the correlations that had been carried out, looking at the relationship between ratings on the caseload management tool and the CORE clinical outcome measure. In addition, because additional analysis could not be carried out due to the low N, tables were produced which highlighted some of the non-significant trends that were observed in the data.  
2. Data from the MRP was summarised in graphical form, showing the correlations that had been conducted on the data. In addition, descriptive statistics and mean scores (with standard deviations) were also produced in table form. | 15/04/03  
(Year 1) |

| **Interpret results from data analysis** | 1. Results were interpreted for the SRRP, and indicated a significant relationship between the scores on the CORE outcome measure and the caseload management tool. However, due to the low N, this analysis was under powered and therefore the results had to be interpreted with caution. Analysis could not be carried out on the data to compare ratings of case severity between primary care and specialist mental health services due to the low N and therefore interpretation of the results was made on the basis of trends in the data. The low response rate from professionals was also discussed. | 15/04/03  
(Year 1) |

3. Quantitative analysis was carried out on the data collected for the MRP using SPSS. Data analysis included t-tests and correlations, including analysing the data to ensure it met the criteria for parametric analysis.  

27/05/05  
(Year 3)
2. The results of the qualitative research project were interpreted by the group rather than individually. Important themes that emerged during the interpretation of the results related to issues of upbringing, morality, the relationship between psychology and spirituality / religion and studying psychology as a degree. This included discussion on the literature on psychology and its links with scientific values and the idea that individual’s beliefs are often relatively established by the time they begin undergraduate study.

3. The results of the MRP were interpreted within the cognitive model of voices (Chadwick and Birchwood, 1994) and the previous literature on theories of interpersonal relating (Birchnell, 1996) and recovery style in schizophrenia (McGlashan, 1976).

<table>
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<tr>
<th>Present research findings/plans to an audience</th>
<th>11/05/04 (Year 2)</th>
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<tbody>
<tr>
<td>1. The SRRP was presented to a managers meeting within the NHS trust where it was conducted, approximately 6 months after completion. The research formed part of a wider project within the trust which had experienced poor participation by professionals. This issue formed the wider part of the discussion that followed the presentation and the difficulties associated with the research process seemed to be of particular value to the services involved.</td>
<td>17/06/05 (Year 3)</td>
</tr>
<tr>
<td>2. In order to recruit participants for the MRP professionals had to discuss the research with service users who might be suitable for the study. I conducted presentations to a total of twelve specialist mental health services across two NHS trusts over a four month period. This included a description of previous research, the aims of the study, the data collection process and inclusion/exclusion criteria. Recruitment was prompted via these meetings, in addition to regular contact with specific professionals and via the circulation of memos, e-mails and posters to the teams. Organisations such as the Hearing Voices network and Community Connections were also approached to increase peoples understanding of the aims of the study.</td>
<td>16/01/04 (Year 2)</td>
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<td>26/01/05 – 06/06/05 (Year 3)</td>
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</tbody>
</table>
| Produce a written report on a research project | 1. The SRRP was written up as a research project for inclusion in the portfolio and was examined by internal markers.  
2. A research report was written for the qualitative project, including contributions from all three members of the group. This project was marked by internal examiners but does not form part of the final portfolio.  
3. The MRP hearing voices research was written up as a thesis, including a literature review of research relating to voice hearing, a description of the methodology used in the study, the results of the study (with relevant discussion on the use of specific statistical analyses) and a discussion of the main findings of the study. | 05/03 (Year 1)  
06/04 (Year 2)  
07/05 (Year 3) |
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<td>Defend research project in an oral examination</td>
<td>1. The SRRP and MRP will be discussed as part of the viva examination and will provide me with the opportunity to defend these research projects.</td>
<td>13/09/05 (Year 3)</td>
</tr>
<tr>
<td>Submit research report for publication in a journal/book</td>
<td>1. The MRP will be written for publication following the viva examination in September 2005.</td>
<td>09/05 (Year 3)</td>
</tr>
</tbody>
</table>