Service-users' Experiences of Person-Based Cognitive Therapy for Hearing Voices

Volume I

by

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INTRODUCTION TO THE PORTFOLIO

The following portfolio provides a compilation of work completed during Clinical Training, and submitted for the degree of Doctor of Clinical Psychology (PsychD). This has been divided into two main bodies of work; Volume I and Volume II. The portfolio represents a wide range of work completed during clinical training, spanning academic, clinical, and research-based areas. Within each section, documents have been presented in chronological order. All personal details pertaining to the clients represented have been modified or removed, and pseudonyms used.

Volume I is comprised of three sections; an Academic Dossier, a Clinical Dossier and a Research Dossier. The Academic Dossier contains two essays, three problem-based learning accounts, and two summaries of case discussion group process accounts. The Clinical Dossier contains the summaries of five case reports, and summaries of all clinical placements. The Research Dossier contains a research log checklist (completed prior to submitting the portfolio), a service-related research project, the abstract of a qualitative research project, and finally the major research project. A copy of Volume I will be held by the University of Surrey Library, as well as a further copy being kept by the Psychology Department.

Volume II has been further divided into two parts due to the volume of work it contains. Part 1 contains five full case reports and two case discussion group process accounts. Part 2 contains full placement documents for each clinical placement. A copy of Volume II will be held within the Psychology Department of the University of Surrey.

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Professional Issues Essay

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Adult Mental Health Essay

Can the experience of hearing voices ('auditory hallucinations') be considered an ordinary part of human experience? What implications might such a conceptualisation have on the way that Clinical Psychologists respond to service users who hear voices?

December 2005
Year I
INTRODUCTION
This essay will attempt to evaluate the extent to which auditory hallucinations can be considered 'normal' human experience. I will start by broadening the question to incorporate the normality of psychosis, including delusional beliefs and hallucinations. This will lead to the introduction of the continuum model of psychosis, a theory suggesting that all individuals in the population can be placed on a scale of psychotic symptoms. Alternative perspectives to the continuum model will then be considered, focussing on differences between clinical and 'normal' populations in terms of cognitive functioning.

Once insight into the normality of psychosis has been gained I will narrow the scope of literature to investigate auditory hallucinations. Studies examining this phenomenon in the general population will be cited, and modern psychological perspectives opinion of auditory hallucinations discussed.

Using the information I have gathered I will go on to evaluate how Clinical Psychologists may aid their practice when working with service users who hear voices. To begin this I provide the reader with a personal account of a voice hearing experience in an attempt to understand how service users may relate to the psychological and psychiatric opinion stated so far. Here the stress-vulnerability model will be introduced as a possibly tool in helping service-users explain their experiences. Current clinical practice will be reviewed with additional suggestions stemming from psychological theories.

My conclusion will draw all the research contained in the essay together with additional thoughts of how best practice may be conducted when working with service users within the NHS.
THE 'NORMALITY' OF VOICES

The title of this essay asks us to consider very specifically the 'normality' of auditory hallucinations. This cannot be done, however, before investigating some very basic issues that arise in psychology. These relate to the concepts of both normality and indeed mental illness.

It must be emphasised that normality is an extremely subjective notion and cannot easily be defined in psychology when dealing with anything above the individual level (i.e. what is 'normal' for a specific person). The meaning of 'normal' is dependent on the context in which it is used, varying across cultures, religions and throughout history. It must be highlighted that this essay is written from a 21st Century, Western, Psychological perspective, and therefore contains biases because of this (e.g. voices here are assumed to be a psychological rather than spiritual phenomenon).

I have chosen not to consider in great detail different perspectives on the concept of 'normality' before attempting to produce a relatively solid definition; I do not feel it would be feasible within the confines of the current piece of work to do so. For the purposes of this essay I will make the assumption that the non-clinical populations (i.e. the general public) can be considered a normal sample for comparison with psychiatric populations. With reference to the essay title I will therefore be considering questions such as:

- Can members of the general public experience auditory hallucinations in the absence of mental illness? (If so to what extent, and how do these differ from the experiences of those in clinical populations?)
- Do psychological models of cognitive functioning differ between the general population and psychiatric/voice hearing populations? (If so, how?)

Regarding clinical implications of the above issues, I will contemplate;

- Does accepting auditory hallucinations as 'normal' have benefits for service-users?

The definition I have chosen is not without problems. The assumption of normality in the general population could imply that mental illness is an 'all-or-nothing' trait.
Although this is a viewpoint put forward by some, others have argued in support of a continuum model of symptoms spanning members of the general public as well as psychiatric populations. This debate has particular importance to the title of this essay, and has been outlined in the section below. The chosen definition also assumes that mental illness does not go undetected in the community. Again, this provides a question relevant to the current topic: Does mental illness only occur where it is diagnosed? Throughout the rest of this essay I will attempt to keep these limitations in mind.

THE CONTINUUM MODEL OF PSYCHOSIS

It has long been suggested that psychotic symptoms, as seen in clinical populations, present points on a continuous scale of psychosis. Such variation was investigated by Strauss (1969, as cited in van Os et al., 2000) who put forward a multidimensional model of psychosis. According to his model Strauss argued that, within psychotic populations, individuals vary in the conviction, preoccupation, and implausibility of their delusions.

More recently factor analysis studies have suggested schizophrenia can be categorised into three dimensions; psychotic (or positive), negative, and disorganised. This was shown in a study conducted by Peralta et al. (1997) who provided data confirming previous research relating to this factor structure of psychosis. It is worth noting that the authors acknowledge that factor analysis is possibly affected by the rating measurements used (in this case the Scale for the Assessment of Positive Symptoms- SAPS, and the Scale for the Assessment of Negative Symptoms- SANS).

Although this section appraises in general the continuum model of psychosis, it is worth bearing in mind that auditory hallucinations can be considered a positive form of schizotypy.

Strauss' theory of a continuum of mental illness was re-examined by van Os et al. (2000), this time to examine whether members of the general population could be included on the same original scale as clinical samples. They used delusions and hallucinations sections from the Composite International Diagnostic Interview (CIDI).
to assess individuals in the general population. Experiences resembling the clinical concept of psychosis were reported in 17.5% of the population, and of these 2% received a diagnosis of non-affective psychosis under the DSM-III-R. Van Os et al. (2000) suggest in their conclusion that Strauss' (1969) findings can be extended to non-clinical samples, and that psychosis-like experiences are not uncommon in the general population.

Although not mentioned in van Os et al.'s (2000) paper, I believe there is a potential flaw in assuming that psychosis can occur in the 'normal' population based on this study. It could be argued that those who scored highly on the CIDI for delusions and hallucinations, especially the small number whose scores were high enough to received an actual diagnosis (0.35% of the overall sample population) were actually suffering from mental illness that had thus far gone undetected. This point brings up the issue of whether mental illness is only diagnosed when the symptoms cause high enough levels of distress to interfere with the person's daily functioning and bring them in contact with services.

A later paper by Stefanis et al. (2002) notes that general population studies often measure the symptoms occurring in psychiatric populations. The authors observe this implies that the symptoms of psychosis (i.e. hallucinations and delusions) are not always associated with the disorder. Therefore despite the prevalence of schizophrenia being low, the presence of the symptoms may be significantly higher, possibly associated with personal and cultural factors independent of psychosis. Stefanis et al.'s (2002) study adopted a different approach by measuring psychotic symptoms in non-clinical participants rather than projected experiences from clinical samples. Results again suggested a three-factor model of positive, negative and disorganised schizotypy. These findings for similar multidimensional factors in both schizophrenia and schizotypy suggest a continuum that includes members of the general population through to those showing schizotypy and schizophrenia.

Other studies examining the incidence of psychotic-like symptoms in the general population have focussed on comparisons between risk factors of having psychotic-like symptoms and clinical psychosis. In a review of the continuity of psychotic symptoms within clinical and non-clinical populations, Myin-Germeys et al. (2003) cite many similarities in areas such as demographics, environment, genetics, and
neurocognitive and psychophysiological factors. Such studies support strongly the link between experiences in the general population and those within the mental health system.

**Summary**

The continuum model of psychosis proposes that every member of the population is located on a sliding scale of the severity of psychotic symptoms. Within this, psychosis is proposed to be multimodal and is likely to vary between individuals. One’s position on the continuum is not necessarily fixed, and may shift depending on situational factors. Although auditory hallucinations have not been considered in great detail here, this generalised model of psychosis may be applied to any psychotic symptom, of which auditory hallucinations can be considered a positive schzotypy. Research into the continuum model provides evidence that psychotic symptoms such as auditory hallucinations are present in the general population, and therefore can be considered ‘normal’ according to our chosen definition. This notion raises a problem though; If psychosis is such a continuous trait then how can diagnoses such as ‘schizophrenia’ be made? Are there any objective differences between clinical and non-clinical populations?

**COGNITIVE PERSPECTIVES OF DELUSIONS**

Despite the large evidence base in support a continuum model for psychosis, other theories maintain a dichotomous stance. Some that we will now consider revolve around cognitive differences. These take the perspective that delusions and hallucinations occur when there is a malfunction of normal cognitive processes. It therefore suggests that the process that leads to their manifestation is abnormal. In this section we will examine three such theories highlighted in a paper by Garety and Freeman (1999): probabilistic reasoning, Theory of Mind (ToM) and metarepresentations, and causal attributions.

Although we have no information of whether the ‘normal’ participants in the following studies have ever shown sub-clinical psychotic symptoms, given the studies above supporting the continuum model it may be fair to presume that samples chosen contained similar rates of symptoms found in the general population.
Probabilistic Reasoning
Studies suggest individuals harbouring delusions are more likely to 'jump-to-conclusions' (i.e. make decisions based on less evidence than is required by individuals in non-clinical populations). Huq et al. (1988) demonstrated this using jars of poker chips in a certain colour ratio (e.g. one with 85 green and 15 pink, and the other vice versa). Participants were informed that one of the jars had been selected at random. The task was to guess which jar has been selected, by being shown only chips drawn from the jar. Despite being told that the chips are being selected randomly, all participants are shown a set sequence of chips. Results from Huq et al.'s (1988) study suggest that individuals with schizophrenia require less evidence in making a decision than non-clinical controls, as on average they decide which jar has been chosen after being shown fewer chips. Since this original study, results have been replicated on many occasions (e.g. Fear & Healey, 1997, as cited in Garety & Freeman, 1999).

Implications from such findings suggest individuals in clinical samples may have an impaired ability make logical assumptions when confronted with stimuli. This hypothesis has particular reference when considering voice hearers. Individuals found in clinical populations may be more likely to jump-to-conclusions as to the origins of their voices, thus attributing them to sources producing paranoia or unusual beliefs. This is likely to cause high levels of distress. Voice hearer’s who spend longer in formulating explanations for their experience may produce less anxiety provoking hypotheses. Again this brings us to the concept that levels of distress may provide a 'gateway' that distinguishes between those individuals who hear voices and are know to services from those who aren’t.

Theory of Mind and Metarepresentation
Another cognitive model of delusions relates to Theory of Mind (ToM). This accounts for one's ability to understand that perspectives and thoughts of others may be different to one's own. In his book 'The Cognitive Neuropsychology of Schizophrenia', Frith (1992) proposed that delusions, including auditory hallucinations, stem from a ToM deficit leading to misinterpretation of the behaviours and intentions of others. Frith (1992) relates abnormalities in ToM to those found in autism, with the difference that the onset in schizophrenia is after
the 1st psychotic episode. Indeed studies have shown that individuals with schizophrenia perform poorly on Theory of Mind tasks. Doody et al. (1998) found that a clinical population of those with schizophrenia were less able to complete second order (but not first order) ToM tasks, a phenomenon unexplained merely by the drop in IQ that usually accompanies psychosis.

In an extension of ToM, Frith (1992) introduced the concept of ‘metarepresentation’. This is described as a cognitive mechanism that enables us to be aware of our own goals and intentions, as well as those of other people. Metarepresentation can easily be related to the experience of hearing voices. If a person is unaware of their own intentions, it is understandable that internal self-monitoring may be misattributed to an external ‘voice’. This may lead the hearer to dissociate from their own thoughts. Unlike probabilistic reasoning, deficits in metarepresentation may go some of the way to understanding the cause of auditory hallucinations, both in clinical and non-clinical samples.

Causal Attributions
In this hypothesis put forward by Bentall (Bentall et al. 1991), it is proposed that in schizophrenia negative representations of the self are attributed to external sources in an attempt to maintain a positive self-esteem. Bentall et al. (1991) argue that although this ‘self-serving bias’ is apparent in the general population, in schizophrenia it takes an extreme form that can lead to delusions of persecution. Bentall et al.’s (1991) have shown in a study that schizophrenic populations on average externally attributed negative events at a higher rate than depressed and normal controls, and that these attributions were more likely to be directed at other people. Although not stated by Bentall, this theory could go some of the way to explain auditory hallucinations, as self destructive thoughts may be disowned and therefore perceived as a ‘voice’.

Summary
The above perspectives infer that in schizophrenia, cognitive mechanisms (providing functions such as reasoning, monitoring, planning and maintaining self esteem) are affected, resulting in abnormalities in reasoning, disassociation from one’s own thoughts and increased external causal attributions. This would suggest
schizophrenia involves abnormal cognitions and is separate to psychotic symptoms found in the general population.

AUDITORY HALLUCINATIONS

So far we have investigated perspectives on the normality of delusions and hallucinations in general, making some reference to auditory hallucinations. From this knowledge base I would like to narrow my focus to consider the experience of hearing voices.

General Population Studies

Although many studies report findings of psychotic symptoms in the general population, relatively little data can be found specifically relating to auditory hallucinations. Voices are usually included alongside other psychotic symptoms and reported generally. In a study looking into prevalence rates of psychotic symptoms in the British population (Johns & Cannon, 2004) factors specifically associated with auditory hallucinations were found to be very similar to those of generalised psychotic symptoms. These include victimisation experiences, average and below average IQ, alcohol dependence and female gender. This suggests that the sub population of those who hear voices can be equated to those with other psychotic symptoms in the general population. Johns and Cannon’s (2004) study found an annual prevalence rate (in the absence of psychotic disorder) of 5.5% in their sample. This replicates previously quoted findings by van Os et al.’s (2000), who used their data as evidence for the continuum model of psychosis.

In their service-user orientated book ‘Accepting Voices’, Romme and Escher (1993) refer to a Dutch television appeal they launched in the early 1990’s. This asked anyone who experienced voices to contact them, and received around 450 replies from voice hearers throughout general and clinical populations. Romme and Escher (1993) focussed mainly on the hearer’s ability to cope with their voices, finding that around one-third of respondents had developed successful coping strategies. Those who were able to cope generally felt stronger, experienced more positive voices, were able to set limits and selectively listen to the voices, experienced support and communicated more frequently to others about their voices. Of course those who were able to cope were a lot less likely to be known to services.
Findings of the above investigations allow us to infer that the continuum model for psychosis may be applied specifically to auditory hallucinations. A continuum model for hearing voices would suggest that the experience may be considered 'normal' according to our definition. However, as little information is available to support this it is important to investigate the second part of our definition concerning the cognitive components of auditory hallucinations. We have evidence to suggest that cognitive functioning is 'abnormal' in schizophrenia, but does the same apply for auditory hallucinations?

Modern Psychological Perspectives of 'Hearing Voices'

According to Leudar et al.'s (1997) paper examining the pragmatics of auditory hallucinations, voices can be categorised independently of a psychiatric diagnosis as perceptions without stimulus and/or inner speech. In a longitudinal study spanning four years, Leudar et al. (1997) conducted detailed interviews with voice hearers. Interestingly all of the participants knew when they were hallucinating and never mistook the experience for somebody actually speaking. This highlights a difference between auditory hallucinations and other types of delusion; people with unusual beliefs will rarely acknowledge their thought processes as irrational. Findings from Leudar et al.'s (1997) study indicated that hallucinations took the same structure as ordinary speech, were focussed on the individual experiencing the voice, generally related to daily activities, and the compulsion to comply with the voices was low. Thus the authors suggest that voices can be thought of as inner-speech, although note this type of monologue is unusual as the hearer does not acknowledge them as their own thoughts. Leudar et al. (1997) also refer to differences between psychiatric and non-psychiatric participants in their study. Voice hearers with schizophrenia were less likely to link the voices with family members, usually considered the content of the hallucinations less worthwhile, and more frequently heard voices instigate violence.

The above piece of literature contains elements reminiscent of Frith’s (1992) metarepresentation. It cites similarities between voices and inner speech in that they each appear to have a monitoring function. However, Leudar et al. (1997) extend this by highlighting that auditory hallucinations do not necessarily coincide with a psychiatric diagnosis. Differences between voices experienced in psychiatric
and non-psychiatric samples have been found, although these are few compared to the similarities, in what appears to be a convergence of the continuum and cognitive models. Cognitive abnormalities in self-monitoring are suggested to be the cause of auditory hallucinations, but these may exist on a scale of severity throughout the psychiatric and general populations.

A study produced by Birchwood et al. (2000) has investigated auditory hallucinations from a different perspective, considering the hearers perception of the voice rather than content of the hallucinations. The authors hypothesised that the hearer’s reaction to the experience will vary depending on their perception of the voice as being dominant or passive. Hearers who perceive their voices as dominant or ‘malevolent’ will experience higher levels of distress than those who hear passive or ‘benevolent’ hallucinations. Within their study, Birchwood et al. (2000) found that the hearer’s perceived ‘rank’ difference between themselves and their voice mirrored the difference they believe exist between themselves and other members of society. This creates a separate hypothesis that interpersonal schema, or the beliefs held about oneself, may mediate reactions to auditory hallucinations. As predicted, levels of distress were linked to perceived difference in social rank between the hearer and the voice, with elevated distress occurring when the voice was seen as highly dominant.

Authors of the above study went on to develop possible models explaining the relationship between voices, distress and interpersonal schema (Birchwood et al., 2004). Within these models they included depression as a factor featuring in psychosis. Birchwood et al. (2004) outline three models. In the first depression is proposed to directly cause distress, subordination to voices, and subordination to others. The second views the actual voices as leading to depression and distress as well as subordination to the voices and to others. The final model states that interpersonal schema, including subordination to others, causes depression and distress, as well as subordination to (and delusions about) voices.

In a study testing these three models, findings suggested that voice hearers generally saw the voices as dominant in comparison to themselves. This power imbalance caused high levels of distress, with the majority of voice hearers experiencing at least moderate depression. Finally they found that experiences in terms of relationships with others were mirrored in the self-voice relationship.
Although the paper draws no conclusions as to which model best fits their findings, Birchwood et al. (2004) highlight the importance of interpersonal schema, especially the voice hearer's feelings of subordination in comparison to society.

Taking the findings of these studies together, we can start to get a picture of modern psychological perspectives of hearing voices. It appears that voices stem from an abnormal self-monitoring process that is found throughout clinical and non-clinical populations. Differences between (and within) these populations may be due to individual differences in personal schema, with feelings of distress and subordination important factors in diagnosis or psychosis. Auditory hallucinations under our chosen definitions appear to have both normal and abnormal components, occurring in the general population but featuring abnormal cognitive processes. When working with service users who experience voices is will be important maintain a balanced perspective of how normal their experience is.

INCORPORATING THEORY INTO CLINICAL PRACTICE

So far this essay has focussed on the theory behind auditory hallucinations, neglecting insight into how this information may be implemented practically. I believe this has been necessary to gain a firm and rounded understanding of research before the implications of such findings could be addressed.

Although many different areas in the study of auditory hallucinations have thus far been examined, each with different perspectives as to the 'normality' and origins of voices, one theme has continued throughout. This is the idea that distress is fundamental to the voice hearers' experience, and possibly in clinical diagnosis. It does not seem unreasonable to presume that attempting to reduce a voice hearer's distress should hold precedent when working clinically.

Although psychological perspectives on auditory hallucinations may provide useful explanations as to how auditory hallucinations are originated or maintained, they do not provide insight into how voice-hearers' themselves may understand the experience. Knowledge of this is likely to be extremely valuable in working therapeutically with clients.
A Personal Account of Voice Hearing
Personally I have experienced an auditory hallucination. This single incident came at a point in my life when I felt under a lot of personal stress and emotion. The hallucination took the form of a man's voice saying my name, and came out of my car radio whilst I stuck in traffic and late to an appointment. My instant reaction was shock and confusion, and straight away I tried to make sense of the occurrence. I believe it was due to self-awareness regarding the amount of emotional pressure I was experiencing, that I felt little distress at the paranormal encounter. I immediately decided that the incident had not really occurred. My brain was overloaded with trying to make sense of all that was happening around me, and I was unsurprised that it had 'misfired' slightly. Only later when I stopped to think about the incident did I briefly entertain alternate paranoid hypotheses for the voice, none of which I could take seriously (e.g. 'Somebody must have hijacked the radio waves to contact me!).

My example ties in with research we examined by Birchwood et al. (2000), that a voice hearer's appraisal of the experience determines their reaction over the actual content of the experience. I appraised the voice as a brief brain malfunction, nothing serious; just a misfire that had caused me to hear something that wasn't there. I have often thought when considering hallucinations, that the brain is such a vastly complicated organ it is not surprising it occasionally makes mistakes. Whether this belief buffered my appraisal after experiencing such a hallucination I could not say, but I consider this is a reasonable theory. Certainly I did not view myself as subordinate in comparison to the voice, and so did not find it particularly distressing or threatening.

Without much thought I was able to normalise my experience. I cannot say for certain what allowed me to easily do this, but I believe it may have involved self-awareness and knowledge of how stress may manifest itself as unusual experiences.

The Stress-Vulnerability Model
The most coherent tool I have found in understanding psychosis is the stress-vulnerability model, a generalised concept that can be applied to specific psychotic symptoms (see Zubin & Spring, 1977). In researching this essay I came across this model outlined in an Issue of the Sussex Voice (August 2005), a newsletter
circulated as part of the East Sussex Hearing Voices Group. Stress-vulnerability describes how ‘vulnerability’, resulting from biological factors or past experiences, produces a threshold (in terms of stress) for psychosis. Those with high vulnerability will require relatively low amounts of stress to experience psychotic symptoms. Conversely, the model assumes that there are some extremely stressful situations in which most people will experience psychotic symptoms, independent of their ability to cope.

The stress-vulnerability model is extremely important in considering the normality of auditory hallucinations, as it implies that the psychotic symptoms may be a ‘normal’ reaction to stressful situations. In a book investigating studies of verbal hallucinations, Leudar and Thomas (2000) cite much research indicating that voices may result from trauma and abuse. For example, studies by Ensink (1993, as cited in Leudar & Thomas, 2000) showed that around 43% of women who had been sexually abused in childhood reported hallucinatory experiences.

I believe that the inclusion of the Stress Vulnerability Model in an issue of the Sussex Voice emphasises the therapeutic importance of normalisation. Service-users may find comfort in the thought that they are not ‘crazy’, but experiencing a phenomenon that could occur in any ‘normal’ person. Collaborative work between therapists and service-users in investigating the ‘normality’ of auditory hallucinations would likely prove an important tool in clinical practice.

Current Clinical Practice

Currently cognitive-behavioural therapy (CBT) is a widely used treatment of psychosis, usually in an attempt to reduce the frequency of psychotic episodes. Despite its success in areas such as depression and anxiety, there is strong debate as to whether CBT is effective in psychosis (e.g. Turkington & McKenna, 2003). Sceptics argue that too little research has gone into exploring outcomes of the treatment for psychosis, and (of those studies that do) few show significant data or make comparisons against control groups.

With findings of this essay strongly suggesting that distress plays a central role in a person’s experience of voices, clinical implications can be made regarding the use of CBT. As general population studies suggest, together with findings put forward
by Birchwood et al. (2000), auditory hallucinations themselves are not necessarily the problem. Rather the individual’s interpretation of the experience may lead an adverse reaction. Focussing on coping strategies, improving self-esteem, and using normalisation techniques may not reduce psychotic symptoms, but instead provide the service-user with resources to manage their experience. CBT may therefore be better put to use in helping service user’s deal with their anxiety, depression and distress resulting from auditory hallucinations. As there is a strong evidence base that CBT is effective in these areas, improved outcomes are likely to result. In future research examining the effectiveness of CBT, it would be more interesting to examine the individual’s outcome in terms of quality of life, ability to cope and levels of distress rather than frequency of psychotic episodes.

It is noticeable within this section that cognitive differences between clinical and non-clinical populations have been given little emphasis. When implementing therapies such as CBT it is important not to ignore possible differences, especially given that service-users within the NHS are likely to have a clinical diagnosis. For example, Huq et al.’s (1988) finding that individuals with psychosis ‘jump to conclusions’ has possible implications for the use of behavioural experiments. These are often implemented as ‘homework’ in CBT in helping clients rationalise their assumptions. When using behavioural experiments it might be important for clinicians to spent time designing situations in which concrete conclusions can be drawn, or examining unexpected assumptions resulting from such tasks. Frith’s (1992) observations concerning metarepresentation suggest that voice-hearers with a clinical diagnosis could be less aware of their emotions and intentions. More time may therefore be required on education around emotions and feelings. It is important that service-users are not limited by a clinical diagnosis and treated on their individual merit, although acknowledging any cognitive difficulties is equally important.

CONCLUSION

Auditory hallucinations can be viewed as having both ‘normal’ and ‘abnormal’ components. They are proposed to represent a basic self-monitoring function present in all humans. Usually this is accepted as being part of one’s thoughts,
however in the case of voice-hearing there is dissociation from the consciousness and attribution of the thoughts to external stimuli.

Incidents of auditory hallucinations are well recorded in the general population indicating they are not limited to psychiatric diagnosis, and could therefore be considered normal under our chosen definition. Like the well established continuum model of psychosis, auditory hallucinations may be seen as a continuous scale running throughout both general and clinical populations. Individuals are likely to vary in vulnerability to experiencing voices, and incidents of trauma can result in auditory hallucinations. People with less developed coping mechanisms of dealing with stress are more likely to experience the phenomena.

Viewing voices as a normal part of human experience is likely to have an important therapeutic function for service-users, who draw comfort from the idea they are not ‘abnormal’. Rather than attempting to decrease the frequency a voice-hearers experience it may be more effective to focus on coping strategies, including working to increase self-esteem and decrease distress. As there appear to be large numbers of voice-hearers in the general population who are not disabled by their experiences, it may be worth investigating successful coping strategies that are already being implemented on a daily basis. Encouraging voice-hearers from non-clinical populations to meet and influence those who are less able to cope could be an important step in supporting service-users within the NHS.
REFERENCES


Professional Issues Health Essay

Critically discuss some of the theoretical tensions and dilemmas faced by the clinicians in the treatment of borderline personality disorder in a multidisciplinary team setting.

January 2007
Year II
INTRODUCTION

Having read through the title of this essay several times, I have come to conclude that a level of interpretation is required before generating discussion on this topic. This concerns the tensions and dilemmas that may be faced by members of multidisciplinary teams in the treatment of borderline personality disorder. I have highlighted the latter part of the previous sentence, as I believe there are two main ways in which this can be interpreted.

The first concerns the treatment (or therapy) for borderline personality disorder (BPD); for example the use of dialectical behavioural therapy (DBT), with individuals whom have been given a diagnosis according to formal diagnostic criteria. Examining such an issue may lead to discussion about the validity of this diagnosis, and whether personality disorder should be classified and treated as a mental disorder. Dilemmas and tensions experienced by multidisciplinary teams may involve differing opinions on this area under discussion, and whether diagnosis and treatment of personality disorder is more beneficial for the clients or those professionals working with them.

The second possible interpretation of this essay title may examine treatment (or management) of individuals with BPD within services, who are being treated for other mental health issues that may or may not be related to their diagnosis. In this case, dilemmas and tensions within the multidisciplinary team may involve challenges that are particular to working with individuals with personality disorder, for example working with countertransference. Also of interest here would be potential difficulties and dilemmas faced by multidisciplinary work involving clients with BPD, for example ethical issues including management of self-harm and suicidal behaviour.

For the purposes of this essay I have chosen to focus on my second interpretation of the title. This will allow me to explore different ways in which people with borderline personality disorder may be involved in mental health services, or indeed general health services, rather than the fairly narrow range of treatments for BPD. As people with borderline personality disorder rarely receive direct treatment for this disorder, often presenting to services with issues related to their diagnosis, I believe focusing on these issues will be more relevant to my clinical
work. Likewise, I have chosen to keep discussion about the validity of diagnosis of personality disorder to a minimum, as I feel this is less clinically relevant. However, aspects of whether personality disorder should be treated as a mental disorder may be included to some extent in this discussion.

Borderline Personality Disorder

The International Classification of Mental and Behavioural Disorders, ICD-10 (World Health Organisation, 1992), defines a personality disorder as 'a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (American Psychiatric Association, 1994) has a similar definition, and includes an acknowledgement of cultural influences on the diagnosis, specifying that the behaviour of individuals 'deviates markedly from the expectations of the individual’s culture'. For a formal diagnosis, this behaviour must be stable over time, and have an onset in late childhood or adolescence.

There are several different types of personality disorder that are arranged into three categories, or clusters, according to the DSM-IV criteria. Borderline personality disorder falls within the second of these clusters (cluster b), referred to as the emotional or dramatic types. The diagnosis of borderline personality disorder is regarded by many professionals as highly controversial, and service-users’ have reported experiencing a sense of discrimination and blame for their behaviour within the health service (Mind, 2004).

The National Institute for Mental Health in England (NIMHE, 2003) have proposed ‘the development of a specialist multi-disciplinary personality disorder team’ (p7) as a good practice guideline. The reasons or evidence base behind this recommendation, however, are not clearly stated within their document. The body of this essay will examine borderline personality disorder, exploring the reasons why the importance of multidisciplinary work has been emphasised for this client group, and the tensions and dilemmas working within this model create.
WORKING CLINICALLY WITH BORDERLINE PERSONALITY DISORDER

Within the literature, several main areas are highlighted as salient with regards to working clinically with clients with borderline personality disorder. These are not exclusive to this client group, and indeed important to working with all clients. The issues raised through working clinically with BPD are ones that will present professionals with dilemmas throughout their clinical work. These are possibly more apparent when working with clients with BPD due to the anxiety that working with individuals from this group raises in health care staff, as will be discussed.

Risk Management

Both DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) diagnostic criteria for borderline personality disorder include self-harm and suicidal behaviour as being aspects of diagnosis. Guidelines developed by the National Institute for Clinical Excellence (NICE, 2004) on the management of self-harm emphasise the roles of professionals in reducing short-term risk to clients. However, Krawitz and Batcheler (2006) highlight that overly defensive practice in the management of such issues with clients with BPD may actually increase long-term risk of self-harm or suicide. Interventions such as hospitalisation may act to increase long-term risk to the client, as they do not encourage problem solving around the events that precipitate the suicidal behaviour. In the long-term this may lead clients to believe that they are unable to cope with life, and therefore more likely to use suicidal behaviour in the future when faced with stressful situations.

In reading Krawitz and Batcheler's (2006) journal article, it struck me that there may be two aspects of defensive practice; one in which the professional attempts to minimise the risks of the client self-harming, and one whereby the professional may diminish the likelihood that they will be held accountable if serious self-harm or suicide occurs. Krawitz and Batcheler (2006) focus solely on the first aspect of defensive practice. I feel it is important to emphasise both of these, as each may impact on treatment that the client receives. This second type of defensive practice may be important when working with clients who heighten anxiety in health professionals, as is the case with borderline personality disorder.
This issue presents a particularly relevant dilemma with regards to the management of clients within a multidisciplinary setting. Krawitz and Batcheler (2006) found that professionals who feel well supported were less likely to use defensive practice. Strong multidisciplinary working may therefore lead to better management of risk and self-harm when working with clients with borderline personality disorder. However, any intervention in the management of self-harm must focus on the interest of client’s long-term safety. It could be the case that multidisciplinary working acts to diffuse the sense of responsibility from any particular professional, which in itself is a form of defensive practice. It is important to strike a balance between professionals' taking responsibility for ensuring an appropriate level of support is provided, and the client taking personal responsibility for their self-harming behaviour.

Fine and Sansone (1990) have written about dilemmas in managing suicidal behaviour in people diagnosed with borderline personality disorder. Within this article attention is draw to the distinction between suicide attempts in acute and chronic contexts. Here the chronic context refers to suicide attempts as ‘a mode of adaptation to life’ (p163), i.e. a mechanism that the individual utilises when they feel that they are not able to cope. From this perspective, the individual's suicide attempt does not necessarily occur because of the person wanting to end their life (as with the acute context), but a method of coping with feelings that they are out of control. Fine and Sansone (1990) state that chronic suicide is common in individuals with personality disorder, although both types can occur in the same person simultaneously. The authors also indicate that the role of the therapist, and other professionals, is different in the management of each type of self-harm. In the acute context the therapist takes an active and directive role in ensuring that suicide is not committed. They take responsibility for the suicidal behaviour in the short-term to ensure independence in the long-term once the client has recovered from the acute episode. Conversely, in the chronic context, individuals with personality disorder may relate to others by encouraging them to take responsibility for the suicidal behaviour. By doing so the person avoids taking appropriate levels of personal responsibility for their behaviour, and the professional enforces the individuals' sense of helplessness and lack of autonomy by taking control of the situation. In this incidence, interventions should encourage
the person to accept reasonable levels of responsibility for the self-harm, and look into the meaning behind the suicidal behaviour.

Articles and literature such as those above create a tension with NHS policy. Department of Health implementation guidance for people with personality disorders, produced by NIMHE (2003) does not indicate that suicidal behaviour should be managed differently in these individuals. Similarly, the National Institute for Clinical Excellence (NICE, 2004) guidelines for the management of self-harm make only one reference to borderline personality disorder, saying that dialectical behaviour therapy should be considered for this client group.

These differences in literature are likely to create ethical dilemmas for practitioners working with individuals with BPD. With regards to multidisciplinary teams, clinicians may have differing opinions on whether suicide attempts should be treated the same regardless of a diagnosis of BPD, or whether views in the literature regarding long-term risk should be prioritised. It may be very difficult for a team working with a high-risk client to adopt a non-defensive strategy when NHS guidelines emphasise the minimisation of short-term risk.

**Countertransference**

Within the psychotherapeutic literature there appears to be extensive interest into therapeutic interactions with clients with borderline personality disorder. This is due to the strong countertransferences that people with BPD can illicit within their personal interactions. According to psychodynamic theory, individuals with borderline personality disorder do not have an integrated sense of self, or of others (McHenry, 1994). An individual with BPD may alternate between viewing themselves and others as idealised, or ‘all-good’, and devalued, or ‘all-bad’. This generates intense and unstable relationships, where the individual has a strong sense of need for others, but at the same time does not feel like they can trust them. Similarly, BPD has been described as an abnormality in adult attachment style (Fonagy et al., 1996). This leads people with borderline personality disorder to strive to avoid abandonment by others, and act out in ways that are impulsive or self-destructive to ensure this does not occur. Consequentially individuals with BPD may have little sense of being able to tolerate distress, or comfort themselves during stressful episodes. It is possibly because of these intense and unstable
relationships that those working with BPD are more likely to experience powerful countertransference.

Therapist’s awareness of countertransference whilst working with clients with borderline personality disorder is extremely important. In a paper discussing this subject, McHenry (1994) has written that any therapist who does not do so will ‘recreate repeat, and perpetuate’ (p558) the client’s feelings and insecurities within the therapeutic relationship. Therefore, therapy that does not focus on countertransference will be counterproductive to the client, and reinforce negative beliefs about the self and others which people with borderline personality disorder already harbour.

Kerr (1999) has written an interesting report of cognitive analytic therapy (CAT), and multidisciplinary work with a client with borderline personality disorder. Emphasised are the implications of this work, both on a personal and an organisational level. Kerr (1999) describes strong countertransferences that occurred between the client and himself, the community team, and other services (i.e. police, social services, legal services). He explains his own frustration at this work, and how members of the team projected their annoyance at the client into him. Thus he experienced both roles in the countertransference as being needy and abused, and the angry abuser. Kerr (1999) also describes how, through sharing part of his clinical formulation with members of the team, who were consequentially able to refrain from falling into the reciprocal roles. This was done through him treating the client as a ‘needy child’, thus providing containment and not playing out either of the abused/abuser roles.

This example is used by Kerr (1999) to illustrate the importance of developing a contextual framework within the team supporting the client. He points to literature produced by Walsh (1996) regarding organisations. Here she stresses the importance of teams acknowledging and owning the feelings elicited by some clients, and their anxiety at not being able to provide treatment that improves the client’s wellbeing. Such issues must be overcome if multidisciplinary work with BPD clients is to be successful.
**Multidisciplinary Working**

Nowlis (1990) has drawn attention to the way in which members of teams can experience strong and conflicting reactions to clients with borderline personality disorder, and that this may provide insight into the psychological workings of the team. Teams in which individuals have conflicting opinions, ways of working, and unresolved issues may struggle to cohesively support clients with BPD. Similarly to Walsh (1996), Nowlis (1990) concludes that successful treatment of individuals with borderline personality disorder may involve the team developing, as well as the client.

It is likely that clients with borderline personality disorder will have had a history of difficult relationships, and so may not understand aspects of the therapeutic relationship that are expected within the health service. This may lead to an interaction between the client and the team that is considered inappropriate by some or all of the team members. Because of the likelihood of the person with BPD also splitting team members into 'all-good' and 'all-bad', this may cause further tensions between team members, who may act this out and begin to see some of the team as not providing adequate support for the client.

There has been considerable debate as to the treatability of personality disorders, and rarely do individuals get direct treatment for this mental disorder. Often clients are seen for short-term admissions in times of personal crisis (Langley & Klopper, 2005). Professionals may have different opinions as to whether this is an effective method of support for clients. Some may view the support they are providing the client as successful due to them being able to manage periods in the community with little support. Others may feel that the client frequently coming back to the team proves that their intervention is unsuccessful.

Nowlis (1990) also examined the pitfalls and difficulties of multidisciplinary work with clients with BPD. As people with this diagnosis are usually fearful of rejection, they may experience a referral to another professional as abandonment. He suggests that in this instance professionals must be aware of this issue, as the client may not verbalise their concerns. Reassurance is also recommended to let the client know that they are not being abandoned, but that the professional is
seeking support from their colleagues. In working with people with borderline personality disorder, it may be beneficial to introduce the team early on in the treatment so that the person understands they are being supported by a group of professionals rather than a particular individual. Where this is not possible or practical, the person working directly with the client might stress the importance of multidisciplinary teams within the health services, and describe how this works in practice. These measures may lessen the distress of clients when referrals are made to other professions.

It is concluded by Nowlis (1990) that successful treatment of clients with borderline personality disorder stems from strong multidisciplinary effort, and in turn, successful management of these clients will strengthen multidisciplinary working. This may occur through improved communication, understanding of the way in which the team operates, and sensitivity to clients.

**Burnout**

Working with clients with borderline personality disorder is often associated with high levels of stress. This has been especially highlighted in the nursing literature. Bland & Rossen (2005) have emphasised the importance of clinical supervision when working with this client group. This is due to a combination of the inflated risk of self-harm, but low treatment success that may lead to frustration, and intense interactions with the client causing emotional reactions in the nursing staff. They also indicate that polarisation of staff may occur due to the client projecting ‘all-good’ or ‘all-bad’ feelings, and that this may be acted out within the nursing team.

Bland & Rossen (2005) suggest that staff training and supervision may enhance understanding of clients with BPD as having difficulty expressing intense emotions, rather than attention-seeking and manipulative. Such understanding may help staff understand any emotional reactions or acting-out that they experience in working with the client, and facilitate them supporting clients to develop alternate and less self-destructive coping strategies.

In reality there is a great strain on resources, and from conversations with nursing colleagues I understand that supervision is often limited and hard to arrange. Team
meetings might provide an opportunity for reflection on clients, and clinical psychologists are likely to play a key role in facilitating these discussions.

PERSONAL EXPERIENCE OF WORKING CLINICALLY WITH BORDERLINE PERSONALITY DISORDER

In my first year of training in clinical psychology I worked in a continuing needs service supporting clients with complex needs. I received permission from one of my clients to write up our work as a case report, and for the purposes of this I gave her the alias Sarah. Sarah and I worked together over 10 sessions of CBT for obsessive-compulsive disorder (OCD) and psychosis. She had a long standing psychiatric history and first came into contact with services at the age of 16 following a suicide threat, where she was given a diagnosis of OCD and schizophrenia. During an admission to a psychiatric hospital at the age of 36, Sarah’s diagnosis of schizophrenia was questioned by the clinical psychologist there, and instead borderline personality disorder was suggested. Sarah was extremely resistant to having her diagnosis re-examined, and a formal diagnosis of BPD was not made.

Whilst working with Sarah, I feel there were strong countertransferences within our therapeutic relationship. During our sessions I often felt overwhelmed and helpless, and our meetings were usually unstructured and confused. Discussion about Sarah’s case took up a disproportionate amount of time in supervision, and in the early stages of therapy my supervisor and I became focused on the pragmatic aspects of therapy rather than the therapeutic process. Whilst working with Sarah I was acutely aware of my anxieties about my lack of experience as a first year trainee. Although I considered these a normal feeling common among first year trainees, this experience was certainly enhanced with Sarah compared to working with other clients.

During our sessions Sarah would often talk about a previous experience of therapy she had engaged in. As her current therapist I felt that Sarah idealised this therapy. She would discuss the differences between this and our current therapy, always with the previous therapy in a more positive light. This acted to further increase my sense of helplessness, and feelings that I lacked experience. Towards the end of
therapy I was interested to find out from a community support worker that to her Sarah talked about our therapy sessions in an extremely positive light. This resulted in the support worker feeling that Sarah was not experiencing the help she provided as beneficial. Thinking about this interaction within the context of borderline personality disorder, I believe that the idealisation of other professionals was a way of Sarah expressing her sense of neediness. Doing so encouraged the mental-health professional to do everything they could to help her, as within us it elicited a feeling of wanting to help Sarah as much as others had done.

I believe that this example of working with Sarah illustrates an advantage of working within multidisciplinary teams to support clients with BPD. Had it not been through discussions with Sarah’s support worker I would not have gained insight into the similarities between our experiences of working with her. Doing so allowed me to reflect on this experience as one of countertransference, and this provided a window into Sarah’s feelings of helplessness and the need for support by others. Using this information, within supervision I explored process issues within the therapy and ways of helping Sarah to develop her sense of autonomy. This was particularly useful during one session in which Sarah disclosed that she had suddenly begun self-harming by cutting her arms. Within this session we devised coping strategies that Sarah could put in place when she felt she was going to self-harm. These included distraction techniques, such as phoning a friend, or avoiding situations in which she was able to self-harm, for example going out in public. These strategies were designed to be directly under Sarah’s control, and were successful in stopping the self-harm. Hopefully this method helped Sarah feel a sense of control and improved her chances of coping in the future, as Krawitz and Batcheler (2006) suggested. From a clinician’s point of view, supporting Sarah in controlling her self-harming behaviour felt uncomfortable because of feelings of responsibility I held. I do not feel I would have been able to do this as easily if I had not been receiving the high levels of supervision as a trainee clinical psychologist.

On reflection I feel that a diagnosis of BPD may have been relevant and useful in Sarah’s case. However, it was clear that Sarah was against having her diagnosis of OCD and psychosis reformulated. The benefits of a diagnosis may have included clinicians being more aware of countertransferences between themselves and Sarah. This may have reduced levels of stress, and personal feelings of
helplessness. Also, multidisciplinary agreement as to the management of behaviours such as self-harm may have been considered in a way that helped Sarah feel in control and less reliant on the continuing needs service. Such differences may have resulted in Sarah receiving more effective support from the team. It could be argued, however, that these changes would have been more beneficial in alleviating the team’s anxiety, raising the issue as to whether diagnoses are in the interest of professionals or clients themselves. As discussed in the introduction, this is not an area that I will be addressing directly in this essay, but this issue must be given acknowledgement.

With this in mind I think that it is important for clinicians not to attribute all of the feelings brought out by working with somebody with borderline personality disorder to this diagnosis. In the example of my work with Sarah it is obvious that certain issues that were brought up for me, for example feelings of being inexperienced as a therapist, were important for me to resolve in working with clients. Being aware of this ‘hook’¹ and making sure that I had supervision time dedicated to discussing this issue was important in working, not just with Sarah, but with all my clients. Just as it is important for the person with BPD to take responsibility for their own feelings and behaviour, it is important for clinicians to remain mindful of their own unresolved issues that may interfere with the therapeutic relationship.

DISCUSSION AND REFLECTIONS
This essay has discussed some of the literature relating to working clinically with borderline personality disorder. Issues of risk, staff burnout, and countertransference have been explored, and each of these has been considered in the context of team setting. Multidisciplinary work with clients with BPD has also been examined as a separate issue that may provide dilemmas and tensions when working with this client group. A personal illustration has been discussed of working with a client for whom a diagnosis of borderline personality disorder had been considered, but not formally diagnosed. Within this example, issues of risk, self-harm and multidisciplinary working were examined further.

¹ I have used the word ‘hook’ here from the psychodynamic literature on countertransference (Gabbard, 1999). This describes issues that the person experiencing the countertransference may react strongly to; usually this is due to not personally resolving the issue.
To conclude I would like to bring together the information that has so far been collated, and combine this with personal reflections that I have had during the process of writing. Particular emphasis will be given to issues involving multidisciplinary work.

I singled this essay title from the others partly due to my limited experience with the client group, but mainly because of difficulties I have with the term ‘personality disorder’. The hesitancy I have with diagnostic labels in general is one commonly held in psychology: they tend to point to the client as being the problem, rather than the difficult experience or life event’s that this individual has been exposed to. I believe this obstacle can be addressed to some extent with clients by externalising the difficulties that are being experienced; for example helping a client to regard a lack of motivation as a symptom of depression rather than a personality trait, or that they are ‘useless’. However, with regards to ‘personality disorder’, I feel this technique would be hard to implement. I certainly like to view my personality as being a stable entity, and one that influences almost every aspect of my life. To me, the concept of a disorder in personality infers that global personality traits within the individual are the cause of their problems. Seeing personality as the ‘problem’ seems to me to enforce the idea that the client is responsible for their difficulties.

Researching this essay has enabled me to consider borderline personality disorder as being an adaptive function that attempts to help the client cope with adverse life circumstances. However, it appears this strategy is usually maladaptive within adult relationships. The psychodynamic literature illustrates BPD as a maladaptive coping mechanism, where people are seen as striving to avoid abandonment because of difficulties they have with developing secure adult attachments. When considered in these terms, I find borderline personality disorder easier to conceptualise as a mental disorder.

I have written this essay from the stance that multidisciplinary work is almost always a positive and necessary factor when working with clients who have complex needs. It has therefore been interesting to consider certain negative aspects of working to this model. Nowlis (1990) considered several disadvantages, including the client experiencing a referral being made as rejection by their key worker. If
we are to consider an individual with BPD as having difficulty with forming meaningful and appropriate relationships, it is sensible to expect they will have difficulty adapting to any kind of therapeutic relationship. This is likely to become more difficult when a multitude of professionals are involved. Due to their complex needs, it would not be unusual for a person with BPD to receive support from several teams and disciplines within the NHS. Each of these may have different cultures and expectations that the client has to adhere to in order for the relationship to be considered appropriate. Therefore, multidisciplinary work may in fact provide an obstacle that the client has to overcome.

However, multidisciplinary teams play a crucial role in sharing background information to produce an individualised formulation for the client, including ways that the person forms social relationships. Group working may also help professionals to avoid falling into maladaptive ways of relating to the client, through team members reflecting on their relationship with the client. The peer support that multidisciplinary work provides will be extremely important for clinicians working with high risk clients, or where strong countertransferences are experienced.

In writing this essay I am aware of my assumption that professionals working in mental health services will not themselves have a diagnosis of a personality disorder. With NICE (2004) estimating the proportion of people in the general population with a personality disorder at 10-13%, it is likely that there will be a number of people working within the NHS who have received, or meet the criteria for, diagnosis. I have not come across any literature discussing this issue, and am uncertain whether particular aspects of having a personality disorder might preclude this population from working in the health system, although I consider it unlikely that this is the case.

When this possibility is considered, a new set of tensions and dilemmas surface relevant to working with clients with borderline personality disorder. I think that here it must be acknowledged that personality disorder seems to hold negative connotations. Certainly this is the experience of those who have been given the diagnosis (Mind, 2004). In my reading for this essay I came across an article outlining individual case studies of clients with borderline personality disorder.
Within this the authors' introduced one client with the description: an “overweight, widowed and childless woman with no work history” (Trappler & Backfield, 2001). I am certain that this was not intentionally reported in a derogatory manner, and that the authors thought this information was important in highlighting aspects of the client’s background for the reader. However, I couldn’t help thinking “Was this the only way to describe this person?”. From a reader’s perspective a rather bleak image was portrayed of this client. Possibly this description gives insight into the reactions of professionals to clients with personality disorders, and feelings of hopelessness that they experience. My train of thought led me to wonder how the client would feel about reading this description of themselves, and how others with BPD might experience this. Given that such literature is likely to be read in the health service context, I contemplated how professionals with diagnoses of personality disorder might view the reactions of their colleagues to clients with BPD. This also raises questions about dilemmas that professionals with personality disorders might experience when working with members of this client group. I do not feel in a position to address these questions beyond speculation, but I feel they are important issues to consider and might form the basis of further study into borderline personality disorder.


Problem-Based Learning Account - Year I

The Relationship to Change

March 2006
Year I
In writing the following reflective account of our first problem based learning (PBL) task, I have had to be particularly stringent in terms of content. Consequentially I have decided to place emphasis on what for me has been the most important aspect of this exercise: dynamics and relationships within the group, and my role in this.

One of the things I have been most struck by since completing the PBL task was the discovery of a large disparity between my experience of the group, and the perceptions of certain other group members. Whilst working towards our group goal I felt we operated well as a team, and personally I felt completely at ease with the other members of my group. Until recently I had been unaware that some people were not as comfortable in the group, feeling that others were becoming dominant and overshadowing them. This insight I have since gained from casual conversation outside of the group setting. Our group decided to offer each other personal reflections on how the group process was developing as part of the PBL task, and so I am surprised that these undertones were not made more overt. Feedback was generally positive, and although the subject of members being dominant in the whole year-group was discussed, the same was not said of our case discussion group. With hindsight it is probably naive to think that such a conversation being shared among group members would not have an overly positive slant. However, I was not perceptive to these undercurrents, a fact I find surprising as I would say that I am generally sensitive to such dynamics.

The importance of being aware of team dynamics is well highlighted within my current clinical placement. I work as part of a continuing needs service supporting service-users with complex mental health issues. I was informed early on that there were several complex relationships within the team. These included members of staff being close relatives, members of the team knowing service-users on a personal level, current members of staff having received support from the team in the past, and an ex-member of staff currently being supported by the continuing needs service.

It was vitally important to know details of these interpersonal relationships, especially those between members of staff and service users. Not understanding these dynamics pose a great risk to service-users' rights to confidentiality within
the team, and could potentially jeopardise service users’ confidence in, and relationship with, the service. Policies are in place within the team to protect the above from occurring, relying on team members to act responsibly and indicate that they should not be present to conversations involving those service-users known on a personal level. I was informed, however, that some team members were not very good at making this explicit and so to exercise caution wherever possible. The situation in which a member of staff has come to be supported by the continuing needs service is being managed in a more covert manner. An alias has been assigned to this person so that only certain members of the team are aware of their identity. I believe this is an unfortunate situation that has negative consequences for both the service-user and team. Other than risking a breach in confidentiality, without overt information sharing amongst the team, service-users is likely to miss out on some aspects of multidisciplinary input. Also, not being able to disclose information to one’s colleagues may create tensions within the team if it is not appropriately managed.

Perhaps a partial reason for my lack of awareness of underlying group dynamics during the PBL task was my position within the group; I became the assigned chairperson. This may appear paradoxical, as part of my responsibility was to manage interactions between the group members. However, as chairperson I found I became concerned with much more obvious group exchanges, for example that each member was able to share their opinion, that tasks were allocated evenly, and that we were running consistently with our time-line. In concentrating on these logistical aspects it is possible that I became less aware of the more subtle group interactions. I felt comfortable within the group and mistakenly made the assumption that others felt the same.

After completing the task was able to insight into another’s perspective regarding my position as chair. I am fortunate enough to have a strong relationship with one of the members of my case-discussion group, through which I have gained honest feedback about my role.

“I think you developed more of a leader role than a chair role, and this changed the dynamics. We all conformed to this and therefore the group worked less like a collaborative team. I know that no-one else
volunteered to become the chair, but I wonder whether as a group we were conforming to a gender stereotype. If you were female we might not have accepted you in this leader-like role”

The point of gender stereotypes raises an interesting issue. It is astounding that in every PBL group (apart from one consisting of seven females) males took the role of chair. From my point-of-view this occurred due to the salience of gender in such an environment. I feel no-one particularly wanted the responsibility of being chair, and when assigning this role we all tried to make ourselves as inconspicuous as possible, for example by not speaking or making eye-contact with other group members. The feeling that I already stood out as the lone male made this much harder for me to do, and I believe I felt more pressured to volunteer myself. In a male dominated environment I believe there is much less of a chance that I would have assigned myself to the role.

Regarding the other comments made about my role as chair, I believe they are a fair in that I was much more task- than relationship-orientated. As stated previously I took a greater interest in the practicalities of producing a presentation than I did in the group dynamics. I think it is true that the group easily conformed to having a strong leader rather than a chair who took more of a background role. Within this arrangement there are several positives, and I believe these were apparent in our presentation. Feedback from the audience evaluation of our work described the presentation as well structured and clear, with group members making an equal contribution to the task. However, I feel there was also a negative side to this strong leadership in that some members of the group felt overshadowed and passive to the process. This resulted in some people becoming less comfortable within the group.

This bias towards goals (that I experienced as chairperson) is a danger within multidisciplinary settings, and perhaps partially explains why rifts become apparent between management and other team members. It is important that managers do not focus heavily on targets at the expense of staff dynamics. This is something I have certainly experienced within multidisciplinary working, where team members do not understand the pressures those in different roles are experiencing. When this occurs it is important that individuals are open about difficulties they face in
order to promote mutual understanding. This way, compromises are more likely to be made by all parties to ensure the team functions as efficiently as possible.

Feedback about the leadership traits I brought to being chairperson has led me to reflect on my role as a therapist. I feel that I should be very aware of this part of my personality in my individual with service-users. Although it is important to establish goals with clients and guide them towards achieving these, this must be collaborative process. Clients feeling like they are overshadowed or passive to the therapeutic process are unlikely to gain much benefit from psychological intervention. I hope that this is not the case with any of the clients that I am currently working with, all of whom I feel I have established a firm therapeutic relationship with. However, this is definitely something I will bare in mind.

Although members of my group appear to have had different experiences of our group process, there are certain things that we have discussed where opinions are shared. One of these is that there was a change in dynamics during sessions where our facilitator was present. In the presence of the facilitator, conversations within the group became more of a power struggle. From my perspective the group became harder to chair as members tried to express their ideas all at once, and it was more difficult to devise united goals and move the group forward together. It is likely that part of the reason I found the group hard to chair was possibly because I was also trying to express my own opinion simultaneously. I know that other members of the group found it more intimidating to express opinions in the presence of the facilitator and felt as if they were not being listened to when they did.

Motivation behind our change in behaviour is not obvious. We knew that we were not assessed on an individual basis, and also that the facilitator was there to assist group progress rather than monitor our performance. And yet still individual motivation seemed to be to impress and stand out within the group rather than be a functioning member of a team. Although the expression of different ideas within the group may be functional on one level, it may also hinder the group process due to a reduction in co-operation.
Within our presentation we examined Tuckman’s (1965) ‘Forming, storming, norming and performing’ model of group development. It would seem that in the presence of the facilitator our group aligned more with the ‘storming’ phase, emphasised by power struggles within the group as members compete to establish themselves. This occurred even towards the end of the process, when task-wise we were between the ‘norming’ and ‘performing’ stages. This highlights the limitations of linear models such as Tuckman’s (1965), as these do not necessarily recognise that backward or transient movement between stages is possible.

In summary I have to say that I really enjoyed working as a group towards the completion of our PBL task. I feel we performed well together, producing a presentation I am proud to have been part of. There are, however, certain aspects of my role in the process that I am less comfortable with. My emphasis as chairperson on leadership rather than group cohesion disappoints me, as I would say that the latter is more important in any group task. I know that some members of my case discussion group remain uncomfortable within our regular meetings, and that some members have not felt able to discuss difficulties they have been experiencing. Although I feel that I am not responsible for this, I wonder whether my role as chair was a contributing factor to the current atmosphere. Over the next year I would like to see stronger relationships form within our case discussion group, to develop a supportive environment that each member feels part of. I believe this is an easily achievable goal, as personally I do feel I have strong relationships with the majority of my group and feel supported enough to raise any difficult issues I experience, both personally and professionally.
References

Problem-Based Learning Account - Year II

Children and People with Learning Disabilities

March 2007

Year II
I am starting this reflective account with less enthusiasm than I have the previous reflective and process accounts. This is for several reasons; the most significant for me being that I expected that the topics for our reflective accounts would change this year. This expectation followed a conversation with my buddy last year, who discussed with me a reflective account she had been writing on her experiences of supervision as a trainee. I felt this was an interesting focus for reflection, and one that I think would be extremely useful when working with future supervisors and clients. I feel that this would have allowed a high level of personal reflection and been an important exercise as a trainee clinical psychologist. Although the current exercise will elaborate on a group process and the role I played in this, it feels slightly like going over old ground, being a similar exercise and reflecting on a similar topic as at the beginning of training. I understand that this exercise may have been chosen to show progress over our first two years of training, but I think this would have been apparent regardless of the topic of reflection. The change may also be linked to our year long placements, meaning that some people will only have had one supervisor throughout their first year. However, by the time of writing this account everybody will have had experience of at least two supervisors, and possible experience of supervision prior to training. I feel it is important to put this piece of work in the above context, in case my feelings about the task may be reflected within the writing.

Our problem based learning (PBL) task this year incorporated issues concerning both working with children and people with learning disabilities, as these were the placements current to our training. The scenario illustrated a low income family in which both parents had mild learning disabilities, and the mother was experiencing domestic violence from her husband. The couple had twin girls aged three who were on the child protection register, and the local authority wished to take the children into care. We were asked to represent a child protection court hearing and conduct a risk assessment to help the court decide whether the children should be taken into care. Our group opted to utilise a mixture of role-play and video footage to create a talk-show style presentation. We decided to look at the case retrospectively as though the court hearing had taken place 15 years previously, during which the children had been taken into care. Within this the family members and professionals involved in the case were interviewed to review the decision that had been made. By doing this we were able to look at the scenario from several
different viewpoints, examine the pros and cons of the decision to take the children into care, and highlight the protective factors that might have helped the children cope with their adverse circumstances.

We divided the tasks up so that each person in the group took responsibility for one character within the scenario. I feel that this was an extremely effective way of allocating the work, as it created an individual aspect to the group task. I believe this allowed us to spend our time more effectively in preparing for the presentation compared to a year ago. Developing a particular character ensured that each of us explored the scenario from different viewpoints. Sharing our diverse interpretations of the situation in this manner added substance to the presentation and helped us to maintain interest in the task.

At the beginning of our previous PBL exercise one of the first things that we did was allocate a chairperson to oversee the task. I volunteered myself for this role, as no-one else put themselves forward. This year I missed these initial conversations as I was late to the first case discussion group (CDG), due to a time clash with my placement review meeting. I understand that in the time that I missed, the group made a decision not to allocate a chair to the current task. When I discovered the group had opted for this, I had a sense that the style of chairing that I had adopted in the previous PBL had been rejected, and an initial thought that my group felt this had not been constructive to the task. Considering this further however, I realised that I would have probably agreed to this decision if none of the group had put themselves forward for the chair. I certainly wouldn't have wanted to take this role again, so as to gain experience of the group process from a different role. This experience made me appreciate the ease at which group decisions may be taken personally when some members are not involved and the importance of incorporating all members in decisions where possible.

I feel that our group worked much more cohesively in the producing of this presentation compared to the previous year. Less time and effort went into the actual presentation, and I think that generally more fun was had during the process. Despite less work being put into the task, I do not believe that our end product was a reduced standard compared to last years. Possibly not having a chairperson meant that all members of the group felt on an equal footing to
contribute their ideas. This sense of cohesiveness may have been aided by a sense of rivalry that we created between ourselves and the other groups. Early on in the development of our presentation we discovered that another group had also decided on presenting in a News-night style. Finding this led to light hearted conversations about there being a ‘mole’ in the other group who had leaked our idea, and created a joint goal within the group that our presentation would be of a better standard compared to other groups. I feel that this sense of competition had an impact on our sense of group membership.

Another factor which I believe contributed to increased group cohesiveness was the absence of one of our group members. On recommencing lectures in September we were uncertain about whether one of the members of our group would be part of our PBL process, due to their place on the course being under question. Early on in the exercise we found out that the person would not be coming in for our meetings. Finding this instilled a sense of loss within the group, and we spent time discussing the person within our sessions. Particularly we focussed on what the individual had brought to the group, and how they would be missed. During this several of us commented that we were acting as though we were in mourning having experienced bereavement. This was intended as a joke, although actually I think that the process that we were going through was not dissimilar to an incident when this actually occurred on my adult mental health placement.

In the summer of my first year I ran a recovery group for in- and out-patients of a rehabilitation and recovery unit for adults with psychosis. On the morning of our second session I arrived at the unit to discover that one of the members of the group had died in the unit overnight. This was a gentleman that I had known fairly well through my frequent visits to the unit, and had been part of other therapy groups I had participated in. I was quite shaken and shocked by this sudden death, and it was my first experience of losing a client in this way. The incident caused me to reflect on losses that I had experienced. As this person was someone who had spent a great deal of time at the unit I thought that my feelings of shock and loss would be amplified within the staff team and other service-users who knew him better than I had. I decided to spend the morning at the unit and make myself available to any of the staff or service-users who wanted to talk about the death.
My colleague and I considered whether we should go ahead with the group. We decided that we would probably put the content of our planned session on hold, but still provide a space for any of the group members to come alone and use the time however they wished. My expectation was that the members of the group would spend the time talking about personal feelings related to the death, and engage in discussions about the person who had died. I was therefore surprised to find that those who attended the group wanted to continue with the content of the session after a brief discussion about the death. I observed that during this session the group members appeared to show more empathy towards one another, and feel there was an enhanced sense of closeness within the group. This undertone remained throughout the duration of the group, although the member who had died was not mentioned by the other service-users until our last meeting was coming to an end. I believe that there was a sense that through our regular meetings the memory of the service-user who had died was held closely within the group, and as these sessions came to an end it became more important to talk about the person.

Relating this to the absence of a member of our PBL group, I feel that our initial explicit conversations were replaced by a more subtle feeling of closeness within our group. This effect was possibly enhanced by the fact that the person who left the group was particularly interested in learning disabilities, and the task being particularly centred on issues concerning this topic. I believe that taking time to discuss the assets that one of the members brought to our group increased how valued each of us felt within the group.

As I am currently on my child placement, the above reflections have made me consider the impact that negative life events such as loss and bereavement have on the family system. In psychology we often regard negative life events as having only a detrimental impact on people. Reflecting on this experience has made me consider the positive, and possibly more subtle, effects that may follow such an event. I have experience of a recent bereavement in my immediate family, and can relate well to the effect this has on bringing some members of the family together. Through personal experience I feel that this effect is not constant across all people and situations, and can also have the opposite effect of separating people and enhancing existing conflict.
I feel that our CDG has evolved considerably as a group over the last year. This was particularly apparent through the empathy and closeness generated by the loss of one of our group members. Added to this we worked far more effectively as a team, and were able to produce a presentation of a similar standard to the previous years in a shorter time space and without somebody allocated to oversee the process. We received a positive response to the presentation from both the staff member present during the day and the other trainee’s. Most prominent perhaps was feedback that we gained from a carer who attended following a service-user and carer meeting at the University. They said that we had captured well the personal resources and support that people going through life events may have to draw on in order to cope with difficult situations. I regard this as a strong compliment, as within the scenario of child protection it would might been easy to focus solely on the professional issues and support networks that must be put in place. This comment also made me feel that we had been successful in creating a personal and empathic element to our presentation, which was much needed when dealing with such serious and difficult issues.
Problem-Based Learning Account - Year III

Older Adults

February 2008
Year III
The devising of our final problem-based learning (PBL) presentation has been an interesting and difficult process, which lead to our group making some important reflections about the impact of our perspectives and beliefs on our clinical practice. This reflective account will focus on the main themes that arose in our discussions, and hopefully give some insight into dilemmas and challenges we faced in developing our final PBL task.

In the early stages, our group took a more tentative approach to devising our presentation than we had in previous years. Focus centred primarily on the style our presentation was going to take, rather than the contents of the message we wished to put across. During all of our early meetings the majority of our time was spent reformatting presentation and the roles each of us were going to take within this. Following our second or third non-constructive meeting I decided to spend time considering why we were finding this particular task harder than in previous years.

I reflected that our difficulties were possibly due to the context of the PBL scenario; chiefly the dilemmas it confronted us with in terms of representing a different cultural group. Personally, I was concerned that the lack of cultural diversity within our case discussion group would make the representation of a Muslim family from Pakistan look stereotyped or humorous. Although all of our previous presentations had used elements of humour to illustrate certain points we wished to make, I felt that within this context it would not be appropriate. My idea for our presentation therefore took the perspective of a multidisciplinary team meeting of health professionals working with the family, with an interpreter representing the actual family members. I felt that this would help us to practically think about working in a multidisciplinary setting with families from diverse cultural backgrounds. I also felt more comfortable with this representation, especially due to personal experience of working with a family from a very similar cultural and religious background to that represented within the PBL scenario. I therefore felt it would be useful for me to express the challenges that I encountered in this work, for example working with families through interpreters and incorporating cultural beliefs about disability and mental illness into psychological formulations.
Taking my thoughts about our difficulties with the scenario back to the group, I found that here was agreement as to people's feelings of discomfort related to us white British/Irish representing a Pakistani family. We discussed the difficulties in demonstrating 'difference' whilst experiencing fear of being seen to portray a stereotype. However, one member of our group pointed out that our previous scenario had included a mother with learning disabilities, and we had not shied away from the challenge of representing her in our presentation. This led us to discuss the specific difficulties that we seemed to be having with representing cultural diversity. We wondered whether discussing race was a particular difficulty within the context of a predominantly white society. A member of our group reflected on an article she had come across related to white cultural beliefs in America (Gushue, & Constantine, 2007). This involved discomfort related to personal awareness that one benefits from being a member of a majority racial group, through the unequal privileges that they experience in comparison to minority groups.

We began talking about our difficulties addressing cultural difference in the context of our roles as members of the NHS. One of our group members reflected on an experience she had within a multidisciplinary meeting, whilst a client from an ethnic minority background was discussed. It became apparent to the trainee clinical psychologist that the team were having a lot of difficulty working with this diversity. They had failed to acknowledge that the person was from a minority background, to the extent that the client's lack of fluency in the English language was ignored, and the need for an interpreter overlooked. This example highlights a 'colour-blindness' that can be adopted when people have difficulty acknowledging diversity. This effect is well described by Gushue, & Constantine (2007): where in an attempt to suppress ones' own prejudices related to race, the impact of cultural background is minimised so that it is not considered important. The trainee clinical psychologist in our group described how she had decided to suggest the need for an interpreter within the team meeting. Doing so was able gently open up conversations about the cultural differences between the team and the client, and resulted in the team being more able to work effectively with them.

Fortunately I have had more positive experiences of working with cultural differences within the NHS. As mentioned previously, I had the opportunity to gain
experience working with a family whose background was similar to those in the PBL scenario on my learning disability placement. Following our first meeting with the family, my supervisor took time to discuss the session. I was encouraged to reflect on obstacles that are present working with language barriers, such as building and maintaining rapport. Also, having not realised that it was customary to take ones shoes off on entering the family home, I felt extremely disrespectful when we went to leave and I realised my mistake. Through this conversation we decided that in my continued work with the family it would be important for me to gain some understanding of the family’s cultural background. Fortunately the family were keen to help me gain understanding as to their culture. I was also able to arrange a session to meet separately with the interpreter to discuss cultural beliefs about learning disabilities, and community support that might be available to the family.

I believe that acknowledging the cultural differences between myself and my client’s family helped build rapport. In addition to the behavioural work I was conducting with the family, I also took a coordinative role in monitoring and feeding back progress that had been made by the NHS and social services in the client’s care. After a few sessions of working with the family they felt able to express some of the frustration they felt at the NHS, and divulged fears that they may be being marginalised by health care professionals due to their culture and Islamic beliefs. In their article, Gushue, & Constantine (2007) highlight the importance of empathically acknowledging clients’ experiences of marginalisation rather than dismissing the family’s feelings. Fortunately, I feel I was able to take such a stance, and although it felt uncomfortable to believe that the NHS may be experienced as marginalising to some people, I had to acknowledge that it was likely that the family had valid reasons for feeling this way. Certainly I think we need to acknowledge power differentials that exist between health professionals and the service users they support. In psychology we are encouraged to consider these differences, although this may not be so much the case across other professions.

As a result of continued discussions about diversity within our PBL meetings, we decided that the theme of working clinically with diversity and difference would become the main topic of our presentation. Doing this, we acknowledged that we would be giving less attention to equally important themes of the PBL scenario,
such as differential diagnoses of depression and dementia, working with intergenerational families and working with older adults with dementia. However, as our PBL meetings kept circling back to the issues of cultural issues we felt that this focus was justified. In addition we decided that it might be a good idea to include in our presentation a representation of the difficulties we had had in engaging with this exercise, and our reflections on the reasons for this. We were also interested as to whether other groups had the same difficulties, and if not then what made these conversations easier.

A few weeks into devising our presentation I discovered that I had unintentionally booked holiday over the presentation date. This posed a problem as to how we were going to include the aspects of my input without me being present, as well as me feeling that I was letting the rest of the group down. Fortunately, my fellow group members were supportive in formulating ways in which I could retain my contribution to the presentation. Eventually we decided that I would provide a PowerPoint presentation in the style of postcards sent from my holiday destination recounting personal reflections of working clinically with a family from an ethnic minority. We felt that this would add a light-hearted element to our assignment, whilst enabling me to retain a personal aspect within the presentation.

Within one of our later PBL meetings, we had our first experience of having to manage explicit conflict and disagreement within the group. This was possibly due to time constraints and the pressures of extra work generated by our major research projects, and our wanting to spend as little time as possible preparing for the PBL presentation. However, attempting to take shortcuts in terms of our time actually acted to increase the pressure we felt under at points. This was especially noticeable after we had spent an entire study day working on the assignment, but had ultimately spent most of the time continually shifting the content of our presentation. Towards the end of the day two of our group members voiced their unhappiness at the format of the presentation, and suggested that we revised most of the work we had done that day. This was met by frustration by other members of the group who felt that this meant our study day had been wasted, and were reluctant to devote any further time to the task. Possibly due to knowing I would be absent on the day of the presentation, I did not feel a particular need to engage in this debate. Instead I was impressed at the way we were able to mediate this
disagreement, and agree on less drastic changes to improve the presentation without spending extensive amounts of time doing so. In observing this negotiation I was struck that in previous years we had not had such outspoken disagreement between group members. On reflection I felt that conversely this possibly marked positive progress in terms as our cohesion as a group. In the past I’m not sure that we would have been able to manage disagreement in such a constructive manner. Group members being able to voice opposing views and show their own frustration, and at the same time resolve difference with relative ease indicated robustness in our group that I believe has developed over the last year. This incident impressed on me the importance of being able to openly manage disagreement within teams, and reach resolve without ongoing conflict.

Although I was not present during the actual presentations, I understand that we gained favourable feedback from other members of the group and team members who were present. In terms of the presentations made by other groups, I was interested to hear that only one of the groups actually decided to represent the family within the PBL vignette. This made me think that other groups had also had faced dilemmas in terms of not wanting to portray racial stereotypes, as previously all groups have represented individuals within the PBL vignettes in some form. I’m uncertain whether other groups had explicit conversations about these difficulties. I am also unsure how the group who did portray the family in the vignette were able to overcome this dilemma, although interestingly this was the group with the most diversity in terms of national origin which may have facilitated conversations around diversity.

On the whole I found this PBL exercise a good source of both personal and clinical reflection, and despite my absence during the actual presentation I feel that my group were supportive in including my personal contributions. Although we became slightly sidelined by issues of diversity highlighted by the PBL problem, possibly to the detriment of other important issues, I feel we produced a thoughtful and reflective presentation.
References

Summary of Case Discussion Group - Year I

Process Account I

September 2006
Year I
This CDG account discussed my increasing awareness of process issues over the course of my first year of training, including within my clinical practice. This began with reviewing my first reflective account, and the comments that were made by the invigilator on this piece of work. Through doing so I was able to assess the level I was at in terms of understanding group processes at the beginning of the course, and show how I had built on this.

In evaluating our CDG, I reflected that we had not taken a particularly process orientated approach to our meetings throughout the whole of our first year. On the few occasions when process was discussed, as group members we had a tendency to only conform to an overly positive perspective of the group. This was at the expense of sharing our diverse experiences of being in the group, opinions which did not surface until much later on in the development of the group. Instead we took a fairly structured and goal orientated approach to the group, planning the majority of our sessions in advance and not leaving much space of reflections on process. I reflected that our resistance to discuss process issues and orientation towards goals was mirrored in the year group as a whole, for example in our team-trainee meetings where tight agendas were drawn in advance.

Within the CDG account, I reflected on a particular session in which we shared our family trees with other members of the group. I noted that there was unease at the prospect of conducting this exercise, as some group members thought it might breach professional boundaries, and my initial irritation at this. On reflection, however, I felt that group members' concern was possibly less about boundaries, but regarding 'safety' and trust within the group. Conducting the exercise, however we were able to create and maintain a safe atmosphere, aided by our facilitator. I felt that doing so helped to increase cohesion within the group, and opened our group up to conducting further exercises within the CDG where personal reflection and information was shared.
Summary of Case Discussion Group - Year II

Process Account II

February 2008
Year III
Following on from my first year CDG process account, I used this exercise in my second year as a continuation of my developing understanding of process issues. The writing of this account coincided with a psychodynamically orientated placement, within which I was joint facilitating a process based group for people with learning disabilities. Through this placement I had begun to develop my use of process therapeutically with clients, and I reflected that this had altered my perception of process within our CDG, and that over the second year I felt I had adapted my position in the group as a consequence.

With regard to our case discussion group, I contemplated the increased number of conversations concerning gender, for example the impact that gender would have on the therapist role. This led and my emerging feeling of difference from other group members in being the only male, and I felt was possibly influenced by my taking a less directive role in the group.

Within the CDG account I also reflected that we had begun the year in the context of upheaval, with the loss of a group member, a change of facilitator and the potential division of the group. Although I had written that these had a positive effect on group cohesion in other reflective and process accounts, I felt that the group had become less open through the second year in comparison to the end of the first year. Within the CDG I attempted to address this through sharing my personal reflections of being in the group, although I did not feel that this was taken up by other group members. Later I reflected on my feelings of protectiveness of the group, and that my attempt to open up this conversation was possibly driven by an impulse to make the group safer for its members. I also considered my impulse towards protectiveness in my clinical work, for example against feelings of distress, and the unconstructive effects that this might have on psychological work with clients. Through reflecting on this role that I have a tendency to fulfil, I considered the benefit of allowing clients or groups to sit with anxiety occasionally, rather than guard against this.
Case Report Summary

Adult Mental Health Case Report I - Cognitive-behavioural therapy with a 40 year-old woman presenting with symptoms of obsessive-compulsive disorder and psychosis

May 2006
Year I
This case report presents ‘Sarah’, a 40 year-old white British female client. Sarah’s first language was English, and she described herself as holding spiritual beliefs. At the time of engaging with services Sarah was single and living in supported accommodation with several other service users.

Sarah was referred to a rehabilitation and recovery service who work with people who are experiencing symptoms of psychosis. Her presenting difficulties were experiencing frequent intrusive thoughts that were causing her considerable anxiety, which met the DSM-IV criteria for obsessions according to the diagnosis of obsessive-compulsive disorder.

Sarah’s difficulties were formulated with assistance from Wells’ (1997) CBT model for obsessive-compulsive disorder. This described Sarah’s intrusive thoughts as triggering a cycle of beliefs about and appraisals of this intrusion, and related behavioural responses that reinforced these beliefs. Sarah was offered ten sessions of CBT, all of which she attended. During her course of therapy, Sarah began to conceptualise her intrusive thoughts as a ‘bully’ that harassed her into doing things she didn’t want to. Sarah described her behaviours that maintained her OCD as ‘feeding the bully’, and attempted to reduce these as far as she could. Graded exposure techniques were used as part of behavioural experiments to assist this process. Thought challenging was also introduced to demonstrate biases in Sarah’s thinking and appraisals of her intrusive thoughts.

During therapy Sarah began to describe alternative beliefs, for example that she received bad energy from certain spiritual objects. She also began to self harm by cutting herself with scissors. Managing the risk associated with self harm, as well as addressing symptoms of psychosis became the focus of therapy.

Intervention was not completed at the time of writing the report, and further sessions with Sarah were planned following the ten sessions she was offered.
Case Report Summary

*Adult Mental Health Case Report II - Cognitive-behavioural therapy with a 20 year-old man presenting with symptoms of panic disorder and vomit phobia*

September 2006

Year I
This case report presents ‘Andy’, a 20 year-old white British male client. Andy’s first language was English, and he described himself not religious. At the time of engaging with services Andy was single and living with his mother and his younger step-brother and -sister in their family home.

Andy was referred to a primary community mental health team by a crisis recovery team, following an episode in which he had taken two overdoses across on the same weekend. These overdoses were triggered by an argument that Andy had with his mother regarding his frequent use of cannabis. His presenting difficulties were experiencing high levels of anxiety and feelings that he could not cope, related to a fear of vomiting every time he went out in public or after eating food. This met with the DSM-IV criteria for panic disorder.

Andy’s difficulties were formulated with assistance from Wells’ (1997) CBT model for panic disorder. This described Andy’s anxiety as being triggered by perceiving social situations as a threat, due to his concerns of being sick and embarrassing himself. This caused Andy to experience the physical symptoms of anxiety, and misinterpret these as a sign that he was going to vomit. To counteract these beliefs, Andy engaged in safety behaviours to stop him vomiting, which confirmed his beliefs that he would have been sick had he not engaged in them. Andy was offered six sessions of CBT, all of which he attended. Psychoeducation, behavioural experiments and graded exposure were used in conjunction with Socratic dialogue to challenge Andy’s thoughts that he was going to vomit in public. Andy’s risk of self-harm was also managed, including monitoring his use of cannabis and the impact that this had on his family.

Following therapy, Andy showed a marked decrease in anxiety according to the Beck Anxiety Inventory. He had also been able to sit with his family and have a meal, and was not experiencing thoughts of self-harm.
Case Report Summary

Child Case Report - Cognitive-behavioural therapy with a 10 year-old girl presenting with symptoms of separation anxiety

April 2007
Year II
This case report presents 'Jessica', a 10 year-old white British female client. Jessica’s first language was English, and she described as of Christian faith. At the time of engaging with services Jessica was attending junior school, and living in her family home with her mother, father and three older brothers.

Jessica was referred to child and adolescent mental health services by her GP, due to experiencing extreme distress on being separated from her mother, who worked in the school Jessica attended. This had begun eight months prior to her referral and met with the DSM-IV criteria for separation anxiety. This was triggered by a lesson at school that had addressed the issues of death and dying.

Jessica’s difficulties were formulated with assistance from Carr’s (1999) CBT model for separation anxiety. This described Andy’s anxiety as being maintained by Jessica avoiding separation with her mother, and by her beliefs that separation from her family was dangerous. Jessica was offered ten sessions of CBT, part of which would involve meeting with any other members of the family who could attend. Jessica attended all of her sessions, and at various points all members of her household also attended the appointments. Psychoeducation, graded exposure, development of coping strategies and thought challenging were used as techniques to challenge Jessica’s belief that separation from her mother was dangerous. Jessica’s thoughts and beliefs about death and dying were also explored.

Following therapy Jessica did not show a decrease in anxiety according to the Spence Children’s Anxiety Scale. However, qualitatively Jessica showed an increased ability to cope when away from her mother, and had been able to spend a whole day at school whilst her mother had not been working there. She was also sleeping in her own room throughout the night, whereas before she had always gotten into bed with her parents.
Case Report Summary

Learning Disability Case Report - Short-term psychodynamic psychotherapy
with a 69 year-old woman presenting with symptoms of panic disorder

October 2007
Year II
This case report presents ‘Margaret’, a 69 year-old white British female client. Margaret’s first language was English, and she did not describe herself as belonging to a particular faith or religion. At the time of engaging with services Margaret was single and living alone in a warden assisted maisonette.

Margaret was referred to a mental health and learning disability team by her GP, due to experiencing frequent episodes of panic. These had begun seven years prior to her referral, and were triggered by Margaret’s attendance of her mother’s funeral. Margaret had received nine sessions of CBT by a locum clinical psychologist, prior to being seen for further psychological input by the trainee clinical psychologist.

Margaret’s difficulties were formulated using the assistance of Klein’s theory of projective identification, in conjunction with Bicknell’s (1992) theory of ‘secondary handicap’ that is experienced by people with learning disabilities. This described Margaret as projecting her sense of independence into others, and her anxiety emanating from her beliefs that she was helpless and needy. Margaret was offered short-term psychodynamic psychotherapy lasting for 15 weekly sessions, with the potential of longer-term input following this if she wished. Margaret attended all of these sessions, which involved exploring countertransference within the therapeutic relationship to identify and discuss Margaret’s feelings of helplessness and fear of abandonment.

Following therapy Margaret was eager to engage in longer term psychodynamic psychotherapy. Although she was still having frequent panic attacks, Margaret was better able to identify her feelings, and had begun to develop her daily routine to involve increased sociable activities.
Case Report Summary

Older Adult Case Report - Neuropsychological assessment with an 86 year-old man presenting with word finding and short-term memory difficulties

April 2008
Year III
This case report presents Mr ‘Richardson’, an 86 year-old white British male client. Margaret’s first language was English, and described himself as being of Christian faith. At the time of engaging with services John was a widower of 28 years, and was living alone.

Mr Richardson was referred to the clinical psychology department of an older adult assessment and rehabilitation centre by his GP for neuropsychological assessment. This was due to Mr Richardson having developed difficulties with his language and word finding abilities, for example getting stuck with a particular word in the middle of a sentence. The emergence of this difficulty appeared to possibly coincide with two events that Mr Richardson had experienced - a head injury and an operation to replace his hip.

A detailed history of Mr Richardson’s presenting problem was taken, along with his personal history, in order to identify the possible causes for Mr Richardson’s difficulties. Through this process three possible hypotheses were generated. These were that Mr Richardson was experiencing postoperative cognitive dysfunction following his hip operation, that the difficulties were caused by a head injury, or that they were associated Paget’s disease. Dementia was ruled out as a possibility as Mr Richardson was not experiencing any interruption in his activities of daily living and there had not been a gradual onset or decline. Mr Richardson was offered neuropsychological assessment over two two-hour sessions. During these he completed the WTAR, WAIS-III, RBMT, Hayling & Brixton tests, semantic and phonological fluency tests and the HADS.

Mr Richardson was found to be experiencing specific difficulties with his working memory, consistent with the hypothesis of postoperative dysfunction. The use of a memory aid was recommended, although Mr Richardson gained most benefit from the reassurance that his difficulties were unlikely to decline further.
Placement Summary

Adult Mental Health Placement I

October 2005 - March 2006
Year I
During my first year of clinical training I worked within an Assertive Outreach team as part of a service for people experiencing symptoms of psychosis. The team consisted of a variety of professions, including Support, Time and Recovery (STR) Workers, Community Psychiatric Nurses, Approved Social workers and Psychiatrists.

My role as a Trainee Clinical Psychologist involved working as part of a multidisciplinary team to assist clients living in the community, as well as those who at the time were inpatients within a Rehabilitation and Recovery hospital. I was supervised by the Consultant Clinical Psychologist working within the Assertive Outreach team, and placement’s orientation was mainly towards CBT, incorporated systemic theory to formulate clients’ difficulties. I engaged in individual therapy with clients, as well as group work in association with staff at the Rehabilitation and Recovery hospital. Within my individual work I supported clients in a range of presenting difficulties, including intrusive thoughts, dissociative episodes, social anxiety, symptoms of obsessive-compulsive disorder, and alternative beliefs associated with psychosis. Due to the demographics of the local area, I mainly saw clients from a white British cultural background, although individuals varied substantially in their personal histories, including socioeconomic status, religious or spiritual background, family structure, and history of contact with mental health services.

As part of my work with the Rehabilitation and Recovery hospital I worked to set up a Recovery from Psychosis Group for both inpatients and those who had recently returned to community living. With the aid of service-users of the hospital, I helped organise a group consisting of 8 weekly sessions, with the aim of exploring personal strengths and resources among group members. I also supported two of the group members in taking on the role of facilitating the group. Aside from client work, I conducted a teaching session and a workshop with nursing staff addressing psychological approaches to treatment of clients with psychosis.
Placement Summary

Adult Mental Health Placement II

April - September 2006
Year I
During the second part of my first year placement in clinical training I worked within a Primary Community Mental Health Team. This team consisted of several other clinical psychologists, Community Psychiatric Nurses, Social workers and Psychiatrists.

My role as a Trainee Clinical Psychologist involved working as part of a multidisciplinary team to assist clients living in the community, who were experiencing psychological difficulties. I was supervised by one of the Clinical Psychologists working within the PCMHT, and the orientation of the services was mainly towards CBT. My supervisor was also interested in incorporating systemic theory to formulate clients' difficulties, and had experience of working within a Cognitive Analytic Therapy model.

Within this part of the placement I solely engaged in individual therapy with clients. Through this work I supported clients in a range of presenting difficulties, including panic disorder, emotional difficulties associated with receiving a diagnosis of HIV, social anxiety, depression, low self-esteem, phobias and obsessive-compulsive disorder. Due to the demographics of the local area, I primarily saw clients from a white British background, although I experienced some experience of working cultural diversity. Other than this, clients varied substantially in their ages, personal histories, socioeconomic status, religious or spiritual backgrounds, and family structures.

As part of my work within the Primary Community Mental Health team I gained substantial experience in conducting neuropsychological assessment with clients, and sought separate supervision from a Clinical Neuropsychologist within the trust. This included taking on a case for assessment outside the PCMHT.

This placement provided me with a strong grounding in my assessment and formulation skills, along with the ability to write reports including psychological and neuropsychological formulations, and communicate these to clients.
Placement Summary

Child Placement

October 2006 - March 2007
Year II
For my Child placement I worked within a Child and Adolescent Mental Health Service. This formed part of a Tier 2 and 3 service, and was comprised of clinical psychologists, counselling psychologists, psychiatrists, and tier 2 nursing staff. My role as a Trainee Clinical Psychologist mainly involved working with children at a tier 3 level, although I also had the opportunity to engage in some tier 2 support. I was supervised by the Consultant Clinical Psychologist working within the CMHT, and the work was orientated towards a combination of cognitive-behavioural and systemic theories. I also gained experience as forming part of a reflective team, whom worked purely within a systemic model.

Within this part of the placement I engaged in individual therapy with clients, as well as working systemically with their families. I supported children with a range of presenting difficulties, including separation anxiety, low self-esteem, phobias, obsessive compulsive disorder, conduct difficulties within school, difficulties related to Autism and Asperger’s syndrome, and low mood. Despite the demographics of the local area being primarily white British, I gained experience working with clients of diverse cultural origin, as well as children from a wide range of ages (1½ - 15½), religious backgrounds, and family structures.

As part of my work within the Child and Adolescent Mental Health Team I gained substantial experience in working psychologically with children and their family networks. I also had the opportunity to work with and influence children’s wider systems including liaising with schools and nurseries.

This placement provided me with a strong grounding in my ability to adapt psychological methods of therapy to make them accessible to children of different ages and intellectual abilities, as well as to maintain rapport and engagement with children and their families.
Placement Summary

Learning Disability Placement

April - September 2007
Year II
For my Learning disability placement I worked within two services at separate sites; a Mental Health and Learning Disability Team, and an Assessment and Intervention Team. Each of these consisted of multidisciplinary teams, including Clinical Psychologists, Occupational Therapists, Community Nurses, and Psychiatrists.

As a Trainee Clinical Psychologist, my role involved providing psychological assistance to adults with learning disabilities living in the community. I was supervised by the Consultant Clinical Psychologist working across both services. This work mainly orientated towards psychodynamic approaches to formulating clients' difficulties and providing treatment, although I also engaged with clients in administering other psychological therapies including behavioural techniques.

Within this part of the placement I engaged in psychodynamically-orientated individual therapy with clients, as well as co-facilitating a process-focussed experiential group for adults with learning disabilities. I also gained experience working with family's of service-users' with learning disabilities, in helping them support the individual. During the placement I worked with a range of presenting difficulties, including anxiety, self-injurious behaviour, bereavement, challenging behaviour, obsessive- compulsive disorder, and difficulties related to Autistic spectrum disorder. Due to the diverse demographics of the local area, I gained experience working with clients of diverse cultural origin, religious backgrounds, and family structures. This included working with a family who did not speak English as their first language, and therefore working with an interpreter.

This placement provided me with a strong grounding in my ability to work systemically with client's families or support networks, including staff within supported accommodation and day centres. I also gained substantial experience working within a psychodynamic model to assess, formulate and psychologically treat clients in their presenting difficulties.
Placement Summary

Older Adult Placement

October 2007 - March 2008
Year III
For my older adult placement I worked within an Assessment and Rehabilitation Centre located within the day centre of a local hospital. This involved working in a team consisting mainly of nursing staff, with some input from Psychologists, Geriatricians and Physiotherapists.

As a Trainee Clinical Psychologist, my role involved providing psychological assistance to older adults who were living in the community, as well as those who were inpatients on the hospital wards. I was supervised by the Consultant Clinical Psychologist within the service. This work mainly orientated cognitive-behavioural approaches to formulating clients' difficulties with an emphasis on Rational Emotive Behavioural Therapy.

Within this part of the placement I engaged in individual therapy with clients, as well contributing towards an outpatient group for people recovering from fear of falling. I also had the opportunity to set up and run a Reminiscence group for people with Alzheimer’s disease, based at an Alzheimer’s Society community centre. During the placement I worked with a range of presenting difficulties, including fear of falling, emotional difficulties associated with the management of Parkinson’s disease, relationship difficulties, chronic pain, depression, carer strain associated with Alzheimer’s disease, post-traumatic stress, difficulties associated with strokes and bereavement. Due to the demographics of the local area, I mainly experience working with clients from a white British origin, although I worked with clients with a range of religious backgrounds, ages, life experiences, and family structures.

This placement provided me with skills in working with clients who were experiencing physical or terminal difficulties, and aiding them in their ability to understand and psychologically adjust to these. I also gained confidence and proficiency in my teaching and presentation abilities, due to engaging in several teaching sessions with both client groups and within departmental meetings.
Research Log Checklist

Completed July 2008
Year III
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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
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<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
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<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
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<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
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<tr>
<td>11</td>
<td>Collecting data from research participants</td>
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<td>Choosing appropriate design for research questions</td>
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<td>13</td>
<td>Writing patient information and consent forms</td>
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<td>14</td>
<td>Devising and administering questionnaires</td>
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<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
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<tr>
<td>16</td>
<td>Setting up a data file</td>
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<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
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<td>18</td>
<td>Choosing appropriate statistical analyses</td>
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<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
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<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
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<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
</tr>
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<td>28</td>
<td>Defending own research decisions and analyses</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
</tbody>
</table>
I would like to thank all of those who took part in interviews as part of this research project, as well as those who helped develop the interview schedule used. I would also like to thank my research tutor, Vicky Senior, for her guidance throughout the process of writing this report.
ABSTRACT
Within inpatient units, the psychiatric ward round plays an important role in the lives of service-users, where key decisions are made directly affecting their care. A small body of research investigating service-users' perceptions of this process in acute and forensic wards suggest it can be anxiety provoking, leaving users feeling uninvolved in decisions made. No research has thus far examined views of the ward round in rehabilitation settings. This study investigates views of service-users' involved in a ward round at a rehabilitation and recovery unit. Questionnaires were produced based on previous research into acute ward rounds, and semi-structured interviews held with service-users directly following a ward round in which they were present. Thematic analysis on the qualitative data gained suggested some findings in common with research into acute ward rounds, including a minority of service-users feeling unempowered and separate to decisions made. Contrary to previous studies, service-users rated feelings of involvement as being high, and described a wide array of ways in which they were involved in the decision making process, from agreeing with those that had been made to participating in collaborative decision making. Suggestions based on service-user feedback were fed back into the service through a discussion with both service-users and staff, and guidelines for good conduct in ward rounds proposed by Wolf (1997) were presented. Suggested changes resulting from this discussion included service-users meeting with a known health professional prior to the ward round, and producing notes of the meeting to be kept by the service-user.
INTRODUCTION

Department of Health (DoH) policies of acute inpatient mental health-care emphasise the importance of multidisciplinary professional input and care planning in the form of a ward round (DoH, 2002). This is one of the most important aspects in the lives of service-users, within which decisions are made that directly affect their care. A small body of research into ward rounds in acute mental health settings suggest it can be intimidating for service-users who would rather have fewer professionals present (White and Karim, 2005), preferably meeting the Consultant Psychiatrist alone (Foster et al., 1991). Service-users also describe how the experience highlights power differentials between themselves and staff (Baker, 2005). As DoH (2002) guidelines aim for care that is user focused, including user involvement in decision-making, ward rounds play a key role in implementing this philosophy. Insight into service-user perceptions of the ward round is therefore essential in evaluating the extent to which the DoH guidelines are being achieved, and gaining feedback to improve the process.

Several organisations have sought to introduce recommendations and guidelines to improve ward rounds. In 1997 a code of conduct was published by Wolf (1997) in ‘OpenMind’. This set of guidelines makes suggestions for good practice in ward rounds, including ensuring the service-users are prepared for the meeting, that appointment times are given and held, and that seating arrangements should be made so that the service-user is part of a circle. Wolf’s guidelines were adopted by some National Health Service (NHS) mental health trusts operating in central London, and have been recommended by the Department of Health acknowledged the recommendations as good practice.

Those few studies that do examine service-users’ experiences of ward rounds focus mostly on acute psychiatric settings. Likewise, DoH (2002) guidelines refer solely to adult acute inpatient care provision. Other than a recent research paper by Baker (2005) that examined the ward round in a forensic unit, no research studied other inpatient settings, including rehabilitation and recovery units.

Findings associated with service-users’ views of the psychiatric ward round are varied. Wagstaff (2003) reported that the majority of service-users interviewed expressed negative opinions of the process and felt separate to any decisions made,
believing that these had been decided on prior to them entering the room. White and Karim (2005) found that many service users felt unable to express their feelings during ward rounds due to experiencing high levels of anxiety. However, a study conducted by Foster et al. (1991) found that 74% of participants had a favourable view of the process. This research also found a positive correlation between how anxious service-users felt during the ward round and how helpful they perceived it to be. This implies that a certain level of anxiety may be useful in service-users involvement in the ward round.

Perceptions of the ward round in recovery units may differ from those of acute settings, as service-users are more likely to see the process as positively contributing to their recovery. As the recovery model emphasises the importance of user empowerment and involvement, it is essential that service-users feel they are able to make decisions about their own health care within recovery settings.
AIMS

- To obtain service-users' views of a particular ward round, focusing on perceived involvement in decision making, and ways in which the meeting could be improved.
- To compare these findings to other mental health settings, as shown in previous research.
- To use the above information to make recommendations about the structure of the ward round so that it proves less intimidating and more useful to service-users.

METHODS

Semi-structured Interviews were held with those inpatients willing to participate, at rehabilitation/recovery mental health unit consisting of 14 beds. Interviews were conducted on a one-to-one basis, immediately following a ward round in which the service-user was present.

It was important to consider my role in the interviewing process, and the affect that this might have on the responses gained. I decided that being known to the service-users would facilitate rapport within the structured interviews, but it was important that I was considered separate to the ward round in order to increase the likelihood of gaining genuine feedback. I attended only one ward round in order to gain insight into the structure of the meeting, 20 weeks prior to commencing interviews. At the time of conducting this research I was working alongside service-users and staff of the rehabilitation and recovery unit in helping set up and facilitate a recovery group, and a mental health promotion group.

Questionnaires for the structured interviews were developed from previous research into service-user perceptions of ward rounds (Foster et al., 1991; Wagstaff, 2003) and discussions held with the consultant psychiatrist facilitating the ward round. An ex-service-user of the unit was also consulted on the questionnaire to gain insight into any areas that may have been overlooked. Subsequently a further question was added to the structured interview. A copy of the questionnaire can be found in appendix A.
The semi-structured interviews lasted around 30 minutes. Permission to record the conversation on tape was asked of the interviewee, both before and after the interview. Tapes were used as a memory aid in order retain accurate feedback and to ease qualitative analysis of the data, and erased after use. Some service-users declined having their interviews taped. In this situation their responses were written by hand and then fed back to the service-user to ensure they were accurate.

Ten services-users participated in the structured interviews. Eight of these defined themselves as white British, one as Asian British and one as white European. Six of the participants were male and four female, ranging in age from 25 to 65 years (Mean = 40.3 years, SD = 10.99).
The responses to open questions from the questionnaire were analysed using guidelines for thematic analysis according to Joffe and Yardley (2004). Sentences and phrases used as the coding unit, and it was decided that each coding unit had to be coded exclusively into one category.

Coding units were grouped together according to their similarities, forming coding categories. The coding categories were then split to form a hierarchy, with higher categories sub-divided into lower level categories. Modifications were made by further splitting of categories, or splicing sub-categories together, until each coding unit fitted into a discrete coding category.

Code categories were given a code name, a description of the category, and an example of a coding unit that fitted into this category. Together the coding categories formed a coding frame, within which the coding units for each question were categorised.

This method of coding was inductive as categories for coding the data were not decided on prior to coding. However, there was a deductive element to the coding, as previous work was used to guide the formation of a questionnaire through which the data were collected.

Inter-rater reliability was gained by providing a second rater with the coding frame and coding units for one of the research questions to be re-categorised. Through this process the inter-rater reliability was assessed as being high, with all units coded into the same categories coded by both raters.
RESULTS

Key findings of the research are presented for the purposes of this project. Full results of the thematic analysis can be found in appendix B.

Anxiety, helpfulness and involvement in the ward round

Quantitative scales from 0 to 10 (0 being not at all and 10 being very) rated the mean average level of service-users’ anxiety as 3.2 (SD = 2.27), perceived helpfulness at 6.5 (SD = 2.58) and involvement at 8.1 (SD = 1.70).

Decision making

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist -</td>
<td>Psychiatrist made decisions independently</td>
<td>“The Doctor always makes the decisions, to me it always feels like the doctor.”</td>
</tr>
<tr>
<td>independent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist -</td>
<td>Psychiatrist made decisions through reaching an</td>
<td>“I agreed with what she said but feel I should sign an agreement”</td>
</tr>
<tr>
<td>agreement -</td>
<td>agreement with the service-user</td>
<td></td>
</tr>
<tr>
<td>service-user</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist -</td>
<td>Psychiatrist made decisions through reaching an</td>
<td>“The Psychiatrist consulted others and me, then made the decisions.”</td>
</tr>
<tr>
<td>agreement -</td>
<td>agreement with the group</td>
<td></td>
</tr>
<tr>
<td>group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint -</td>
<td>Service user made a joint decision with the</td>
<td>“I discussed it with the doctors and we made a decision.”</td>
</tr>
<tr>
<td>collaboration</td>
<td>psychiatrist based on collaboration</td>
<td></td>
</tr>
<tr>
<td>Group -</td>
<td>Group decision made not involving the service-</td>
<td>“I think they’re foregone conclusions. Staff members jot things down during the week, (the staff nurse) represents you.”</td>
</tr>
<tr>
<td>uninvolved</td>
<td>user</td>
<td></td>
</tr>
<tr>
<td>Group -</td>
<td>Group decision made involving consulting the</td>
<td>“Relevant options were passed to me.”</td>
</tr>
<tr>
<td>involved -</td>
<td>service-user</td>
<td></td>
</tr>
<tr>
<td>consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group -</td>
<td>Group decision made involving questioning the</td>
<td>“They came up with decisions on what questions to ask me.”</td>
</tr>
<tr>
<td>involved -</td>
<td>service-user</td>
<td></td>
</tr>
<tr>
<td>questioned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Showing coding categories for the ways in which decisions were made during the ward round.

Service-users provided an array of ways in which decisions were made during the ward round. The three main themes of the coding categories emerged within the
data: the psychiatrist making decisions, the service-user making joint decisions
with the psychiatrist, and the group as a whole making decisions. Of these, two of
the sub-categories indicated that the service-user was uninvolved in the decision
making process; that the psychiatrist made decisions independently, and that a
group decision was made without involving the service-user.

Views being taken into account

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - medication</td>
<td>Service-users felt their views were taken into account due to compliance with medication</td>
<td>“My views were only taken into account because I’m taking medication now.”</td>
</tr>
<tr>
<td>Yes - listening</td>
<td>Service-users felt their views were taken into account due to staff listening to them</td>
<td>“They were listening to me so my point of view was taken into account.”</td>
</tr>
<tr>
<td>Yes - opinion</td>
<td>Service-users felt their views were taken into account due to providing personal opinions</td>
<td>“I shared my opinions, my goals and my aims.”</td>
</tr>
<tr>
<td>Yes - decision</td>
<td>Service-users felt their views were taken into account due to influencing decisions</td>
<td>“They were thinking about increasing antipsychotic medication. I said I was experiencing side-effects and they decided to leave it.”</td>
</tr>
<tr>
<td>Yes - discussion</td>
<td>Service-users felt their views were taken into account due to holding discussion</td>
<td>“We discussed everything and when I asked questions they answered them.”</td>
</tr>
<tr>
<td>Uncertain - opinion</td>
<td>Service-user was uncertain whether their views were taken into account.</td>
<td>“Hopefully they were. I did give my point of view. If they listened I don’t know.”</td>
</tr>
</tbody>
</table>

Table 2: Showing coding categories for service-users’ views being taken into account during the ward round

Eight out of the ten service-users interviewed felt that their opinions were taken into account during the ward-round. Two of the service-users were uncertain about this. Service-users felt their opinions were taken into account in several ways, including being listened to, expressing an opinion, and having their questions answered. One coding category indicated that service-users sometimes felt that their opinion being taken into account was dependent on compliance with medication.
Changes to the ward round

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same - fulfilling - function</td>
<td>Service-user would not change the ward round due to it fulfilling its function</td>
<td>“It’s functional, it serves its purpose very well”</td>
</tr>
<tr>
<td>Same - fulfilling - necessity</td>
<td>Service-user would not change the ward round due to its necessity</td>
<td>“You have to see all the people and the doctor.”</td>
</tr>
<tr>
<td>Same - fulfilling - positive</td>
<td>Service-user would not change the ward round due to a positive opinion of it</td>
<td>“I think it’s ok, I can’t see any problems.”</td>
</tr>
<tr>
<td>Same - powerlessness</td>
<td>Service-user would not change the ward round due to not having power to change it</td>
<td>“Who am I to say it should be different?”</td>
</tr>
<tr>
<td>Change - environment - people</td>
<td>Service-user would change the environment of the ward round by having fewer people there</td>
<td>“Have less people there you don’t know- the doctor, a member of staff and the pharmacist. The rest are not necessary to me.”</td>
</tr>
<tr>
<td>Change - environment - room</td>
<td>Service-user would change the environment of the ward round by having a more comfortable room</td>
<td>“More comfortable room- not as claustrophobic”</td>
</tr>
<tr>
<td>Change - communication - notes</td>
<td>Service-user would change the communication of the ward round by having meeting notes</td>
<td>“There were no meeting notes, I don’t know when they’re coming back again. I would like an agenda with their names on- I didn’t know who I was speaking to.”</td>
</tr>
<tr>
<td>Change - communication - meeting</td>
<td>Service-user would change the communication of the ward round by having a prior meeting</td>
<td>“More communication before you go in to say what it was going to be about”</td>
</tr>
<tr>
<td>Change - communication - questions</td>
<td>Service-user would change the communication of the ward round by being supported in asking difficult questions</td>
<td>“I would have asked questions about whether there was a cover-up within the NHS and strange deaths linked to travelling people.”</td>
</tr>
<tr>
<td>Change - personal - pressure</td>
<td>Service-user would change their personal feelings ward round by reducing the pressure</td>
<td>“Less pressure”</td>
</tr>
</tbody>
</table>

Table 3: Showing coding categories of ways in which service-users would like to change the ward round.

Statements about changes to the ward round were categorised into two main themes depending on whether or not changes were proposed. Within those sub-categories where changes were not suggested, three of these related to the current ward round fulfilling its purpose. The final sub-theme in this category indicated
that some service-users did not feel that making changes to the ward round was within their power or control.

Suggested changes fell into three categories; changes to the ward round environment, changes to communication within or before the ward round, and changes to personal feelings held about the ward round.
DISCUSSION

Information gained in this study regarding service-users' views of the ward round reflect some aspects of previous research in other mental health settings. The importance of improving communication within the ward round was one of the key themes that emerged from service-user feedback. This is similar to Baker's (2005) finding in a forensic setting that inpatients wished for improved communication between themselves and the psychiatrist. As in White and Karim's (2005) study, one of the suggested changes was having fewer staff present during the meeting. This has also been a recommendation made in Wolf's (1997) good practice guidelines for ward rounds. There was an element of anxiety associated with the ward round, a common finding in previous research (Wagstaff, 2003; Foster et al., 1991), although this appeared much less than these studies would predict.

With regard to decision making within the ward round, findings of this study did not appear to replicate those of previous research. Wagstaff (2003) reported that the most service-users interviewed believed that decisions had already been made prior to entering the room. In the present study, service-users revealed a number of ways in which they felt involved in making decisions, from approving decision through to actively participating in collaborative decision making. Feelings of involvement and perceptions about how helpful the meeting was were rated highly. Also, the majority of service-users felt that their views were taken into account during the ward round. A small proportion of the data indicated some feelings of not having a role in the decision making process or uncertainty about their views being incorporated. This suggests a minority of services-users agreed with elements of Wagstaff's (2003) finding. Discrepancies in the findings of this study compared to previous research may reflect the different settings in which the research was conducted; no previous data exists relating to rehabilitation and recovery hospitals. Due to research in this field predominantly being conducted through small scale studies, individual differences between different ward rounds may also have an effect on the data.

Results of this study are positive in relation to guidelines set out by the DoH (2002). Service-users rated their feelings of involvement very highly, most were certain that their views were taken into account, and a variety of ways in which they were involved in decisions were described. This suggests that the DoH (2002) philosophy
of increasing service-user involvement in decision making is being implemented in this service.

Despite positive findings about the level of involvement experienced by service-users, an underlying theme of powerlessness emerged when obtaining information on changes to improve the meeting. Some feedback also indicated that service-users felt their point-of-view being heard was dependent on compliance with medication. These findings suggest that a power imbalance is perceived within the ward round, weighted against service-users. This is an important aspect of the research as empowerment is a key philosophy of the recovery model, within which rehabilitation and recovery units operate. This highlights the importance of incorporate service-user feedback into service provision to assess whether guidelines and philosophies are being met. In this incidence, including service-users in the process of service development will hopefully have positive effects of service-user’s feelings of involvement, empowerment and beliefs about abilities to improve services. Regularly consulting service-users on ways of improving the services they are involved in should go some way to address the power imbalance they experience.

A limitation of the data collected in this study is that the ward round examined follows guidelines that the psychiatrist meet separately and service-users who do not want to be seen in the ward round. Although this is good practice, and recommended by Wolf (1997), it may have skewed the results towards positive feedback. Feedback from those service-users who feel more negatively about the ward round and do not wish to participate in it may able to provide valuable feedback about changes and improvements that can be made. These service-users were not included in this current study, and further research would be useful in gaining information from this population.

A presentation based on these research findings was fed-back to service-users and staff involved with the rehabilitation and recovery unit (see appendix C). Within this, recommendations for the service were discussed. Guidelines proposed by Wolf (1997) were also presented. Proposed changes to improve the ward round included ensuring that service-users meet with their community psychiatric nurse (CPN) prior to the ward round, producing a record of the meeting for the service-user of
decisions made, and changing the room to a more comfortable environment. Also discussed was the importance of subjecting the ward round to regular evaluation to ensure that objectives are being met from both the staff and service-users' perspectives.
REFERENCES


APPENDICES

Appendix 1

Copy of the questionnaire used.
Interview schedule

Who was present during the ward round?

Were they introduced?

Were there trainees or people you didn’t recognise present in the ward round?

How did you feel about this?

How anxious did you feel on entering the ward round?
Not at all anxious
anxious
0 1 2 3 4 5 6 7 8

How helpful did you feel the meeting was?
Not at all helpful
helpful
0 1 2 3 4 5 6 7 8

How involved in the meeting did you feel?
Not at all involved
involved
0 1 2 3 4 5 6 7 8

What do you think the purpose of the ward round was?

How were decisions made during the ward round?

Were your views taken into account? If so, how?

How would you change the ward round?

In what way would these changes make you feel differently about the ward round?

Have you experienced ward rounds in other locations, and if so how does this one compare?
Appendix 2

Results of thematic analysis
Were there trainees or people you didn’t recognise in the ward round? How did you feel about this?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>No - positive</td>
<td>Service-user recognised all staff present and felt positively about this</td>
<td>“I felt quite happy that I knew everybody”</td>
</tr>
<tr>
<td>Unsure - ambivalent</td>
<td>Service-user was unsure whether they recognised staff or trainees present and felt ambivalent about this</td>
<td>“I didn’t look at them all, but think there were It’s ok... They’re all doing a job.”</td>
</tr>
<tr>
<td>Yes - staff - ambivalent</td>
<td>Service-user did not recognise all staff present and felt ambivalent about this</td>
<td>“Didn’t mind really. The ones I knew did most of the talking.”</td>
</tr>
<tr>
<td>Yes - staff - negative</td>
<td>Service-user did not recognise all staff present and felt negative about this</td>
<td>“It’s a bit uneasy”</td>
</tr>
<tr>
<td>Yes - unsure - ambivalent</td>
<td>Service-user did not recognise staff, were unsure if these were trainees, and felt ambivalent about this.</td>
<td>They could have been trainees... I didn’t mind really. The ones I knew did most of the talking.”</td>
</tr>
<tr>
<td>Yes - trainees - ambivalent</td>
<td>Service-user recognised trainees and felt ambivalent about this</td>
<td>“It’s immaterial. It doesn’t matter if there are other people in the room. I look at it as a shared experience. It doesn’t worry me.”</td>
</tr>
<tr>
<td>Yes - trainees - negative</td>
<td>Service-user recognised trainees and felt negative about this</td>
<td>“I was a bit reserved that there were students there as I thought they looked terrorised.”</td>
</tr>
</tbody>
</table>
What do you think the purpose of the ward round was?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical - diagnosis</td>
<td>The ward round had a medical purpose to do with diagnosis</td>
<td>“To see about diagnosis. I think this is wrong on their records, and is just due to stress.”</td>
</tr>
<tr>
<td>Medical - medication</td>
<td>The ward round had a medical purpose to do with medication</td>
<td>“To see if medication is working.”</td>
</tr>
<tr>
<td>Medical - sectioning</td>
<td>The ward round had a medical purpose to do with conditions of being sectioned</td>
<td>“To make me aware that my section has been lifted.”</td>
</tr>
<tr>
<td>Personal - wellbeing</td>
<td>The ward round had a personal purpose to do with the service-user’s general wellbeing.</td>
<td>“Check up to see if I’m doing ok. Regular talk with doctor— it’s rewarding.”</td>
</tr>
<tr>
<td>Personal - housing</td>
<td>The ward round had a personal purpose to do with housing needs</td>
<td>“It’s about housing”</td>
</tr>
<tr>
<td>Personal - multidisciplinary</td>
<td>The ward round had a personal purpose to do with multidisciplinary working</td>
<td>“When people who are involved with one come together so there is a co-ordination of results.”</td>
</tr>
<tr>
<td>Personal - opinion</td>
<td>The ward round had a personal purpose to do with the service-user expressing their opinion</td>
<td>“I get to tell them my point of view.”</td>
</tr>
</tbody>
</table>
How were decisions made in the ward round?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist - independent</td>
<td>Psychiatrist made decisions independently</td>
<td>“The Doctor always makes the decisions, to me it always feels like the doctor- you don’t hear the others talking.”</td>
</tr>
<tr>
<td>Psychiatrist - agreement -</td>
<td>Psychiatrist made decisions through reaching an</td>
<td>“I agreed with what she said but feel I should sign an agreement”</td>
</tr>
<tr>
<td>service-user</td>
<td>agreement with the service-user</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist - agreement -</td>
<td>Psychiatrist made decisions through reaching an</td>
<td>“The Psychiatrist consulted others and me, then made the decisions.”</td>
</tr>
<tr>
<td>group</td>
<td>agreement with the group</td>
<td></td>
</tr>
<tr>
<td>Joint - collaboration</td>
<td>Service user made a joint decision with the</td>
<td>“I discussed it with the doctors and we made a decision.”</td>
</tr>
<tr>
<td></td>
<td>psychiatrist based on collaboration</td>
<td></td>
</tr>
<tr>
<td>Group - uninvolved</td>
<td>Group decision made not involving the service-user</td>
<td>“I think they’re foregone conclusions. Staff members jot things down during the week, (the staff nurse) represents you, foregone conclusions.”</td>
</tr>
<tr>
<td>Group - involved -</td>
<td>Group decision made involving consulting the</td>
<td>“Relevant options were passed to me.”</td>
</tr>
<tr>
<td>consultation</td>
<td>service-user</td>
<td></td>
</tr>
<tr>
<td>Group - involved -</td>
<td>Group decision made involving questioning the</td>
<td>“They came up with decisions on what questions to ask me.”</td>
</tr>
<tr>
<td>questioned</td>
<td>service-user</td>
<td></td>
</tr>
</tbody>
</table>
Were your view taken into account, and if so how?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - medication</td>
<td>Service-users felt their views were taken into account due to compliance with medication</td>
<td>“My views were only taken into account because I’m taking medication now—luckily that’s right.”</td>
</tr>
<tr>
<td>Yes - listening</td>
<td>Service-users felt their views were taken into account due to staff listening to them</td>
<td>“They were listening to me so my point of view was taken into account.”</td>
</tr>
<tr>
<td>Yes - opinion</td>
<td>Service-users felt their views were taken into account due to providing personal opinions</td>
<td>“I shared my opinions, my goals and my aims.”</td>
</tr>
<tr>
<td>Yes - decision</td>
<td>Service-users felt their views were taken into account due to influencing decisions</td>
<td>“They were thinking about increasing antipsychotic medication. I said I was experiencing side-effects and they decided to leave it.”</td>
</tr>
<tr>
<td>Yes - discussion</td>
<td>Service-users felt their views were taken into account due to holding discussion</td>
<td>“We discussed everything and when I asked questions they answered them.”</td>
</tr>
<tr>
<td>Uncertain - opinion</td>
<td>Service-user was uncertain whether their views were taken into account</td>
<td>“Hopefully they were. I did give my point of view. If they listened I don’t know.”</td>
</tr>
</tbody>
</table>
## How would you change the ward round?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same - fulfilling - function</td>
<td>Service-user would not change the ward round due to it fulfilling its function</td>
<td>“It’s functional, it serves its purpose very well”</td>
</tr>
<tr>
<td>Same - fulfilling - necessity</td>
<td>Service-user would not change the ward round due to its necessity</td>
<td>“You have to see all the people and the doctor.”</td>
</tr>
<tr>
<td>Same - fulfilling - positive</td>
<td>Service-user would not change the ward round due to holding a positive opinion of it</td>
<td>“I think it’s ok, I can’t see any problems.”</td>
</tr>
<tr>
<td>Same - powerlessness</td>
<td>Service-user would not change the ward round due to not having power to change it</td>
<td>“Who am I to say it should be different?”</td>
</tr>
<tr>
<td>Change - environment - people</td>
<td>Service-user would change the environment of the ward round by having less people there</td>
<td>“Have less people there you don’t know- the doctor, a member of staff and the pharmacist. The rest are not necessary to me.”</td>
</tr>
<tr>
<td>Change - environment - room</td>
<td>Service-user would change the environment of the ward round by having a more comfortable room</td>
<td>“More comfortable room- not as claustrophobic”</td>
</tr>
<tr>
<td>Change - communication - notes</td>
<td>Service-user would change the communication of the ward round by having meeting notes</td>
<td>“There were no meeting notes, I don’t know when they’re coming back again. I would like an agenda with their names on- I didn’t know who I was speaking to.”</td>
</tr>
<tr>
<td>Change - communication - meeting</td>
<td>Service-user would change the communication of the ward round by having a prior meeting</td>
<td>“More communication before you go in to say what it was going to be about”</td>
</tr>
<tr>
<td>Change - communication - questions</td>
<td>Service-user would change the communication of the ward round by being supported in asking difficult questions</td>
<td>“I would have asked questions about whether there was a cover-up within the NHS and strange deaths linked to travelling people.”</td>
</tr>
<tr>
<td>Change - personal - pressure</td>
<td>Service-user would change their personal feelings ward round by reducing the pressure</td>
<td>“Less pressure”</td>
</tr>
</tbody>
</table>
In what way would these changes make you feel differently about the ward round?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same - fulfilling - positive</td>
<td>Service-user did not feel changes would make any difference with positive feelings about the meeting</td>
<td>“They’re nice to me and help me. I can’t see any problems. It’s all set out well. I wouldn’t want it changed.”</td>
</tr>
<tr>
<td>Same - powerlessness</td>
<td>Service-user did not feel changes would make any difference with ambivalent feelings about the meeting</td>
<td>“I don’t think it would change anything.”</td>
</tr>
<tr>
<td>Change - environment - comfort</td>
<td>Service-user felt that changes would improve the environment by making them feel more comfortable</td>
<td>“I would feel more at ease.”</td>
</tr>
<tr>
<td>Change - communication - administration</td>
<td>Service-user felt that changes would improve communication by having better administration</td>
<td>“The administration would be tightened. The doctor would get more engagement time for conversation.”</td>
</tr>
<tr>
<td>Change - communication - rehearsal</td>
<td>Service-user felt that changes would improve communication by giving them an opportunity to rehearse their thoughts</td>
<td>“An opportunity to voice thoughts beforehand as a type of rehearsal.”</td>
</tr>
<tr>
<td>Change - personal - understanding</td>
<td>Service-user felt that changes would give them more understanding about the meeting</td>
<td>“So I know what’s going on, to help out with my private situation.”</td>
</tr>
<tr>
<td>Change - personal - involvement</td>
<td>Service-user felt that changes would make them feel more involved</td>
<td>“I might feel more involved.”</td>
</tr>
</tbody>
</table>
Have you experienced ward rounds in other locations, and if so how does this compare?

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - positive</td>
<td>Service-user had experienced previous ward rounds and felt this was more positive</td>
<td>“This is much better.”</td>
</tr>
<tr>
<td>Yes - positive -</td>
<td>Service-user had experienced previous ward rounds and felt this was more positive due to knowing staff</td>
<td>“In some I have felt like they don’t know me. Here they know me, and it’s better if they know me.”</td>
</tr>
<tr>
<td>staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - positive -</td>
<td>Service-user had experienced previous ward rounds and felt this was more positive due to feeling more comfortable</td>
<td>“This is more placid and peaceful, I felt comfortable with it.”</td>
</tr>
<tr>
<td>comfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - positive -</td>
<td>Service-user had experienced previous ward rounds and felt this was more positive due to being more involved</td>
<td>“The psychiatrist used other people’s views more. Felt more included”</td>
</tr>
<tr>
<td>involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - positive -</td>
<td>Service-user had experienced previous ward rounds and felt this was more positive due improved organisation</td>
<td>“This is more organised. Others had too many clients to get through in a short space of time- it exceeds practicality.”</td>
</tr>
<tr>
<td>organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - similar -</td>
<td>Service-user had experienced previous ward rounds and felt this was similar for positive reasons</td>
<td>“Very similar. I seem to get on with the doctors and psychiatrists. I talk to them and I think they help me, and I do ok.”</td>
</tr>
<tr>
<td>positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - similar -</td>
<td>Service-user had experienced previous ward rounds and felt this was similar for negative reasons</td>
<td>Still very tense</td>
</tr>
<tr>
<td>negative</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Letter sent via e-mail from the consultant clinical psychologist involved with the rehabilitation and recovery unit, regarding the presentation of research findings to a group of staff and service-users.
28th June 2006

XXXXXX XXXXXXXXXX
Trainee Clinical Psychologist

Dear XXXXXX

Thank you for coming and presenting the results of the service evaluation that you completed at XXXXXXXX: “Service User View of Ward Round in our Rehab & Recovery Unit”.

It was useful to present to both service users and staff. The feedback from the session was particularly interesting and we hope to incorporate some of the following ideas:

1. Service users to keep their own record of decisions made at the meeting
2. Changing the room and possibly using the art room as it has more space and feels less claustrophobic
3. Care co-ordinators to be asked to meet the service user prior to the ward round to discuss content and questions they may wish to ask
4. Dr XXXXXXXX having someone else to take written notes so she can concentrate on the discussion more effectively

We look forward to receiving your written report shortly.

Best wishes.

Yours sincerely

XXXXXXX XXXXXXXX
Consultant Clinical Psychologist

cc: XXXXXXXXXX, Acting Manager, MLH
XXXXXXX XXXXXXXX, Consultant Psychiatrist
XXXXXXX XXXXXXXX, Manager CNS
XXXXXXX XXXXXXXX, Operational Manager
Qualitative Research Project

Dr Stereotype: An Interpretive Phenomenological Analysis Investigating Perspectives of Psychologists in Films

May 2006
Year I
**Title:**
Dr Stereotype: An Interpretive Phenomenological Analysis Investigating Perspectives of Psychologists in Films.

**Aim:**
The aim of this current study was to examine people's perceptions and thinking about psychologists in films, particularly whether they viewed psychologists as being stereotyped.

**Method:**

**Participants:**
Five participants (2 male, 3 female, aged between 20-32 years) took part in a focus group. Selection criteria: participants were non-psychologists and had not studied psychology at degree level.

**Focus Group:**
The five participants met together with two facilitators to talk about their experience of psychologists in film, within a private, distraction-free room at the university. The focus group aimed to elicit the subjective experience of the participants, and a semi-structured schedule was used. The interview style was based around the principles of the counselling interview (Coyle, 1998). The focus group was recorded using audiotapes, and lasted approximately 60 minutes. The tape was then transcribed verbatim.

**Analytic Strategy:**
An interpretive phenomenological analysis (IPA) approach (Smith et al., 1999) was used to analyse the data. This approach captured participants' perceptions as opposed to empirically 'perfect' data. The content of transcript was analysed using the method described by Smith et al. (1999), which involves examining the transcript for master themes and sub themes.
Analysis:

Five master themes were identified following analysis of the transcript:

- General stereotype of the shrink;
- Movies vs. Reality (themes relating to participants’ awareness that the portrayal of psychologists in film is not realistic);
- Therapeutic Relationship;
- Difficulty identifying psychologists in films;
- Performance anxiety of participants.

Limitations:

There were some limitations to our study. A number of assumptions were made by the researchers on conducting this research e.g. that psychologists are stereotyped in films, and that this is an opinion shared by other psychologists, and this assumption may have affected how the research was conducted. One methodological limitation was that the study used a small, convenience sample.

Further research:

To determine whether psychologists in films shape people’s views of real-life psychologists and how this may influence the likelihood of people seeking psychological help. To investigate representations of psychologists in other forms of media, for example, books, television programmes, newspapers.

References


Major Research Project

Service-users' Experiences of Person-Based Cognitive Therapy for Hearing Voices

Word Count: 20,000

July 2008
Year III
ACKNOWLEDGEMENTS

I would like to thank all of those service-users who took part in focus groups that provide the foundation for this research project. I extend my gratitude to all of the health professionals who were supportive in organising and helping to facilitate the gathering of data for this project, namely Paul Chadwick, Laura Dannahy, Caroline Gashe, Emma Harding, Mark Hayward, and Wendy Turton. In addition I would like to thank my tutors at the University of Surrey, Dora Brown and Mark Hayward for their guidance throughout the process of writing this report.
ABSTRACT

Title
Service-users' Experiences of Person-Based Cognitive Therapy for Hearing Voices

Objective
To gain an insight into service-users' experiences of group therapy for voices, and explore their relationship with the voices following the therapeutic process.

Design
Data was gathered during a series of five post-therapy focus-groups based on a semi-structured interview schedule.

Setting
Six therapy groups were held consisting of individuals experiencing voices.

Participants
Participants were aged 16 years and over. Inclusion criteria stipulated that the participants had been experiencing drug resistant and distressing voices and had an ICD 10 diagnosis of schizophrenia or schizo-affective disorder.

Method of Analysis
Grounded Theory was used to categorise the data.

Results
Four categories emerged that represented common experiences of those participants engaging in the study: the impact of hearing voices, learning to cope with voices, developing a group identity, and development of sense of self.

Conclusions
Participants' experiences of therapy for hearing voices occurred within the context of their prior experiences of hearing voices. The group context of therapy was also powerful in normalising the experience of voices. Within such contexts therapy for voices helped build participants' ability to cope with voices, and develop their sense-of-self.
INTRODUCTION

The Phenomenon of Hearing Voices

Historically the experience of hearing voices has been viewed exclusively within the model of mental illness, located as a common symptom of the diagnostic category schizophrenia. Medical theories of schizophrenia suggest that voice hearing experiences are directly related to distress, and therefore clinicians' goals when working with voice hearers have traditionally sought to decrease or eradicate the voices. This has led to a reliance on pharmacological treatment, shown to diminish 'positive symptoms' (including voices) associated with schizophrenia in some clients. However, so far medication has been unsuccessful in treating 20-30% of those affected by such experiences (Conley & Kelly, 2001).

The notion of a multidimensional approach to schizophrenia, with variation among clinical populations in terms of symptom severity, is certainly not a novel one, and can be traced at least back to the 1960's with Strauss' continuum model of psychosis (van Os et al. 2000). It has only been relatively recently, however, that practitioners have taken an interest in extending this theory beyond the confines of clinical diagnosis, to examine the occurrence of symptoms of schizophrenia within the general population. With respect to hearing voices, this process became popular through the work of Romme and Escher (1993), whom investigated the prevalence of individuals who heard voices in Holland (although similar studies existed prior to this; see Bentall & Slade, 1985). Romme and Escher (1993) found that individuals spanning both clinical and non-clinical populations varied in the amount of distress they experienced from voice hearing episodes. Around a third of people had developed successful ways of coping with their voices, felt more in control of their voices, and were more likely to have positive voices.

Such findings challenge the original diagnostic approach to treating psychosis. These propose 'recovery' based model of managing symptoms, and suggest that people should be treated according to their presenting difficulties (Bentall, 1990) or the ways in which the person's life is affected (Boyle, 2002). More recently, psychological approaches have moved further still from the medical perspective of psychosis, to examine the individual meaning that service-users' construct from their experiences of hearing voices, as will be discussed.
Present Research

The following research project examines service-users' perspectives of a new form of group-based cognitive-behavioural therapy (CBT) for hearing voices. I have already begun by introducing the phenomenon of hearing voices, and its links with the diagnostic category schizophrenia. I will go on to discuss the use of terminology within this project, before presenting current research in the treatment of hearing voices, and the development of psychological theories of voice hearing. This field of literature will be narrowed to specifically examine findings from previous group-based approaches to treating voices. I will conclude my introduction by outlining the treatment protocol on which this study was based, before going on to introduce the objectives of the current study the analytical methods used to examine this.

Use of Terminology within this Study

Within this research project, the term 'psychosis' will be preferred over use of the diagnostic category 'schizophrenia'. Psychosis in not classified as a form of mental illness in its own right. It therefore acknowledges that unusual experiences may occur outside the realms of the schizophrenia, and even in the absence of mental distress. Within this study I will only be referring to the term 'schizophrenia' when examining literature in the field of hearing voices. This is because most research specifies this diagnosis as inclusion criteria when working with service-users from clinical populations, including the therapy groups examined in the current study.

I will also be refraining from using the term 'auditory hallucinations', commonly used in literature as an explanation for voices. As this study seeks to examine service-users' own perceptions of hearing voices, referring to voices as hallucinations would show a clear bias in my research towards a medical model of voice hearing. It must be acknowledged that the service-users interviewed in this study had already been through the mental health system, and therefore were likely to have already been socialised into a medical perspective of voices. However, it has been important not to reinforce this potential bias through accepting such a perspective as taken-for-granted. Instead priority has been given to service-users own explanations for voices.
It could be argued that even using the term ‘psychosis’, as outlined above, shows bias towards a psychologically-orientated approach to hearing voices, implying that voices occur through a disruption to the normal process of thought. Rather than trying to completely eradicate this perspective, which would be almost impossible within the scope of psychological research, I will be attempting to limit (and make transparent) my potential biases towards this approach.

**Psychological Treatment for Voices**

As has been the general trend in psychological treatment, recent evidence-based approaches of managing psychosis have moved towards the use of CBT. This form of therapy has evolved from the integration of behavioural and cognitive methods of psychological therapy. Early behavioural methods of managing voices centred on using operant reinforcement or conditioning techniques, such as aversion therapy (e.g. Alford and Turner, 1976) and thought stopping (e.g. Allen *et al.*, 1985). Such techniques were associated with decreased frequency of voices, although ethical issues involved in techniques such as electrical aversion therapy mean that it is not favoured in current practice.

Methods of treatment evolved with the introduction of early cognitive perspectives of psychosis. These were based on the assumption that voices resulted from abnormal processing of information within the brain. For example, Frith (1992) used the concept of ‘theory of mind’, i.e. the ability to surmise the thoughts and perspectives of others, to understand psychosis. He suggested that people who experience psychosis have an impaired ability to understand their own thoughts and actions, a concept which Frith (1992) refers to as ‘metarepresentation’. According to this theory, voice hearing is viewed as a form of inner speech that is not recognised by the individual as stemming from their own thoughts. These representations of psychosis led to treatments that involved interfering with the process of inner speech, for example humming (Green & Kinsbourne, 1989) or distraction strategies using auditory and motor stimuli (Gallagher *et al.*, 1995).

As may be apparent in the descriptions above, both behavioural and cognitive methods of treatment have aimed to reduce the frequency of voice hearing episodes. Findings of general population studies, suggesting that voice hearing is
not directly related to distress, have lead to a modification in the goals of treating voices. Psychological treatment has therefore begun to concentrate on reducing distress associated with voices, rather than attempting to reduce the frequency of voice hearing episodes. This has primarily been achieved through using cognitive-behavioural methods to challenge the beliefs held by the hearer about their voices. Chadwick et al. (1996) have proposed an ABC model for experiences of psychosis, based on the work of Ellis (1962). This assumes that unusual experiences (A) are not directly related to distress (C), but mediated by the beliefs (B) of the individual undergoing the experience. This theory was based on their earlier research examining the meaning that service-users construct from their experiences of hearing voices (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994, 1995), findings of which suggest that the voice hearers' beliefs about the identity, intent, omnipotence and perceived control over the voices mediate their distress and the coping strategies they employ. Specifically, voices perceived to be malevolent and/or omnipotent are associated with high distress and resistance, in comparison to those that are perceived as benevolent.

More recently, psychological research into voice hearing has begun to examine the experience of social interaction that occurs between the hearer and their voices. Benjamin (1989) was the first to suggest that hearers may be viewed as having a relationship with their voices, a theory which received support through subsequent research. Birchwood et al. (2000) proposed that voice hearers make social comparisons between themselves and their voices, and that this may account for the distress that is experienced. This research used 'social rank theory' to hypothesise that depression and distress ensue from life events that impinge an individual's status or role within society. When applied to the experience of voice hearing, the theory proposes that voice hearers who perceive themselves to be of lower rank than their voices will experience elevated distress compared to those who do not. In testing this theory, Birchwood et al. (2000; 2004) have found evidence to support their hypothesis. Voice hearer's who perceived their voices to be of higher social rank also felt more subordinate to the voice, attributed the voices as having a greater capacity to cause them shame, and experienced higher levels of distress and depression. Based on these findings, Birchwood et al. (2004) suggest that therapy for hearing voices should target the power differentials that exist between the voice and the hearer. Thus therapists should move beyond
cognitive-behavioural techniques of challenging hearers' beliefs about their voices, towards focusing on the voices ability to dominate and cause shame to the individual.

Hayward (2003) has investigated the addition of a second dimension that may influence distress within the voice hearing relationship. This work is based on ‘relating theory’, as proposed by Birtchnell (1999), which states that social relating occurs along two axes: power and proximity. Here, the dimension of proximity refers to the degree of intimacy one seeks from others. Birtchnell (1999) distinguishes between positive and negative forms of relating, and argues that elements of both closeness and distance are required for positive relating, for example integrating with cohesive groups as well as maintaining personal boundaries. Failure to competently assimilate a range of positive behaviours, along with the ability to appropriately move between these dependent on the social situation, will result in negative relating and therefore distress, according to Birtchnell’s (1999) model. Hayward (2003) found evidence that ‘closeness’ to the voices was positively correlated to closeness within social relationships. Subsequent studies have shown that voice hearers do show a tendency to behave in a manner that puts distance between themselves and their voices, and associations between this coping style and distress (Vaughan & Fowler, 2004; Hayward et al. 2008).

Together the above studies suggest that voice hearers have a relationship with their voices that is comparable to relationships within their social environment. This includes differentials in perceived social rank, as well as the proximity that the person seeks with their voice or others.

**CBT for Voices**

Research into the use of CBT for voices rose from findings citing the effectiveness of this approach in treating psychosis (e.g. Tarrier et al., 1998), along with some promising findings of its use in group contexts (Gledhill et al., 1998). This body of research suggest that CBT is effective in conjunction with medication for reducing ‘positive symptoms’ of psychosis (i.e. disordered thoughts, and unusual beliefs and experiences). A randomised and controlled evidence base exists for the use of individual CBT for hearing voices. Trower et al. (2004) divided a population of service-users who were at high risk of complying with ‘command hallucinations’
(i.e. orders from voices that are usually violent in nature) into either a continued ‘treatment as usual’ condition or with added individualised CBT. Treatment as usual was delivered by community mental health teams providing a wide range of multidisciplinary input, from supported accommodation services to psychological intervention for anxiety. Trower et al. (2004) found statistically significant different effect sizes between the two groups, in that compliance with voices, level of distress, and perceived power, omniscience and controllability of the voice were reduced within the CBT group. They also provided evidence to support the theory presented above - that voice hearer’s relationship with their voices (specifically in terms of power differentials) was the key independent variable contributing to this difference.

Group Therapy for Voices

Although CBT has been developed as a form of individual therapy, recently it has been adapted to be administered as a group programme. Group based cognitive-behavioural therapy has been shown to be as effective as individual therapy, with the added benefit that it reduces feelings of isolation and improves social support among people who hear voices (Wykes, 2004). Group therapy is also a more economic alternative to individual therapy, as more people can be offered therapy, thus increasing the likelihood that requirements set out by governing bodies can be met.

To date there have been several studies examining the effectiveness of group therapy for voices, including a randomised control trial. Wykes et al. (1999) conducted one of the first exploratory studies into group treatment for voices. Participants in this study attended a 6 week CBT programme with a follow-up session 12 weeks later. Results showed that this treatment was successful in improving voice hearers perceived power over their voices, and their ability to engage in coping strategies. This effect was found to be comparable to research into individual CBT for voices.

Chadwick et al. (2000) later published a study on group CBT, based on their earlier research examining the meaning that service-users construct from their experiences of hearing voices (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994, 1995), as has been presented above. Within their study, Chadwick
et al. (2000) aimed to weaken participants' beliefs about the omnipotence of their voices and increase their perceived levels of control using cognitive-behavioural techniques. They also introduced their participants to a psychological model of voices, suggesting that voices originate from the mind in a similar manner to intrusive thoughts. The results of this study varied substantially between individuals, although overall there was a statistically significant reduction post-therapy in participants' convictions in their beliefs about their voices level of control and omnipotence. In addition, a small amount of qualitative data was gathered. As well as supporting the quantitative findings, this indicated that group members especially valued having a space in which to discuss their voices without fear of being misunderstood or judged. Sharing their experiences with others was ranked by participants as being the most useful aspect of the group process.

Following on from these earlier studies, Pinkham et al. (2004) conducted research in the United States, based on the protocol developed by Wykes et al. (1999). Their study comprised of a comparison between two inpatient groups; one 7 week CBT programme, as used originally by Wykes et al. (1999), and an expanded 20 week CBT programme based on the same content. Findings from this study revealed that both groups showed significant decreases in distress associated with voices, and contrary to the authors predictions, this effect was not related to the length of the programme.

As described above, studies examining the effectiveness of CBT for hearing voices suggest positive results with respect to service users' beliefs about their voices, and the distress associated with this experience. However, other than Wykes et al.'s (1999) study which used a waiting list control group, none of these studies set adequate controls for comparison. Only one randomised controlled trial could be found specifically examining the effectiveness of group CBT for hearing voices. Wykes et al. (2005) randomly assigned participants to either a CBT group (focusing on engagement, collaborative discussion, cognitive restructuring and negative self-evaluation over 7 sessions) or 'treatment as usual' condition, although the specifics of this "usual" treatment were not outlined. Findings were modest, indicating an improvement in social behaviour within the CBT group, but no reduction in distress, voice frequency or topography of the voices. There was some evidence that groups run by more experienced CBT therapists created larger effect sizes, although these
differences were not found to be statistically significant. Wykes et al. (2005) conclude that although their results were generally disappointing, improvement in social functioning in the CBT group was extremely important given the high levels of social isolation experienced in this population. They suggest that engaging in CBT for voices specifically is likely to have caused this improvement, rather the effects of the being in a group per-se, although this proposal is anecdotal.

Studies Examining Service-users' Perspectives of Therapy

Only a very limited number of studies exploring group CBT for voices use qualitative methods to analyse service-users' perspectives on the process of therapy. Of these, only one could be found that employed rigorous qualitative techniques to analyse their data. Martin (2000) reported on a hearing voices group based on Romme and Escher's (1993) suggested principles of working with voice hearers. This did not seek to provide psychological intervention to group members, but rather provided a space for hearers to speak about their experiences with the aim of increasing group members' understanding of their experiences. Attendance at these groups was non-compulsory, and a session every three months was allocated to reviewing the outcomes of the group. Reoccurring themes from these evaluations were compiled; increased confidence and self esteem, the benefits of sharing experiences, the value of shared understanding among group members, and recognising differences among group members. Martin (2000) acknowledges the lack of qualitative rigour used to analyse participants' feedback, but concludes that the study provides useful insight into the potential benefits of the group context in working with voice hearers.

Jones et al. (2001) also reported on an ongoing hearing voices group based on the sharing of experiences among group members and increasing understanding. This time data was collected in a focus-group format comprising of all members of the group, and guided by use of a semi-structured interview schedule. Jones et al. (2001) are not explicit about their methods used to analyse the data, but report that two themes emerged through this process. The first of these was safety, within which group members emphasised the importance of confidentiality in providing an environment where they could speak openly. The second theme was sharing, whereby group members explained the benefits of discussing their common experiences, including increased confidence and self-acceptance, release of

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emotional tension, and normalisation. Jones et al. (2001) use their findings to support their hypothesis that group environment can have an effect on normalising the experiences of voice hearers.

By far the most comprehensive study so far produced into service users' perspectives of group therapy was conducted by Newton et al. (2007). This piece of research used the qualitative method of Interpretive Phenomenological Analysis to explore the experiences of young people who had taken part in a 7-week early intervention group for voices. Again this was based on the group CBT protocol set out by Wykes et al. (1999). Semi-structured individual interviews were conducted with eight participants across four groups, and the resulting transcripts analysed according to guidelines set out by Smith et al. (1999). Using this method, two superordinate themes emerged from the data. The first of these was a place to explore shared experiences, consisting of four subthemes; a safe place to talk, normalising and destigmatising, learning from and helping others, and role of the facilitators. In general this first theme depicts the support that participants gained through the group process of meeting other with similar difficulties and being able to assist one another in their difficulties (for example by sharing coping strategies or providing emotional support), resulting in group members feeling less alone. The group also provided an experience of empowerment for the participants, enforced by the facilitators positioning group members as experts in their own experiences, which resulted in an increased sense of self-esteem among group members.

Newton et al.'s (2007) second superordinate theme provided an inductive account of coping with auditory hallucinations, which aimed to make sense of participants' accounts of hearing voices within a psychological framework. This incorporates previous literature in the field of hearing voices. Newton et al. (2007) illustrate their participants' experiences as consisting of interacting patterns between the content of the voices, the person's beliefs about the source of their voices, the voices perceived power, their emotional reactions, and their coping strategies. Using these aspects of service-users' experiences, Newton et al. (2007) were able to divide their sample into two 'types', dependent on their beliefs about the source of their voices, and their ability to control them based on this explanation. Thus the groups comprised of those who felt that they had agency over the voice (i.e. the voices are caused through stress or an illness), and those who did not (i.e.
voices are caused by other people or supernatural forces). Despite this division, the authors stress that this illness-spiritual divide that was apparent in their study could work in the opposite way depending on the belief system of the hearer. For example someone may believe they are more able to control spiritual entities through prayer, or feel helpless in the face of a medical condition. Newton et al. (2007) link this finding with Chadwick and Birchwood's (1994, 1996) model, that hearers distress and ability to cope are mediated by their beliefs about the intentions and omnipotence of voices. Rather than suggesting that therapy should focus on adapting voice hearers' beliefs when unwavering external explanations for their voices, Newton et al. (2007) advocate therapists working within clients' sociocultural contexts. The aim of this work would be to develop a sense of agency within the client's already constructed beliefs. The authors suggest that this process should be explored in individual therapy if hearers still hold strong external explanations following group therapy. Also, that client's social network should be involved due to their potential influence over the person's social context.

Several limitations can be identified from Newton et al.'s (2007) study. Participants were only selected from two of the four groups that ran, and inclusion was dependent on whether they attended the final therapy session. This meant the interview sample may not have been representative of all four groups, and that those whose attendance was more erratic were less likely to have their opinions included.

The Current Study

Treatment for Voices

Participants in the present study had participated in new group-based cognitive-behavioural therapy for voices. This was based on the protocol set out by Chadwick et al. (2000) to challenge hearers' beliefs about their voices, but integrated the model of Person-Based Cognitive Therapy (PBCT; Chadwick, 2006) to explore the hearer's relationship with their voice. The aims of this therapeutic approach were to weaken hearer beliefs about the omnipotence of voices, and increase a sense of personal control within the client's relationship with their voice, with the ultimate goal to decrease their distress on hearing the voices.
PBCT has evolved from the symptom-focused approach to treating psychosis. It focuses on the meaning that clients derive from their unusual experiences, rather than the symptoms themselves. The therapeutic goals therefore are to decrease the impact of the voice hearing experience, rather than alter the voices themselves. PBCT uses an adapted version of Vygotsky’s (1978) process-based framework for therapy, the Zone of Proximal Development. The framework is based on the assumption that personal development and change occurs through a collaborative process between the client and therapist. The therapist aims towards aiding the client to increase their insight into their thoughts and feelings, and achieve self-acceptance. Mindfulness plays a central role in PBCT, with the aim of encouraging the individual to accept their unpleasant experiences associated with voice hearing. Acceptance was presented as an alternative way of relating to voices, with emphasis placed on learning to live with the voices rather than attempting to resist them.

The therapeutic use of acceptance as a way of relating to voices is a new concept, and builds on the cognitive-behavioural and relational-based frameworks of voices. Investigations into psychosis have shown that voice hearers experience their voices as an entity separate from themselves, and judge themselves on derogatory nature of the voices (Birchwood & Chadwick, 1997). Hearers also show a tendency to react to their voices in a manner that perpetuates their distress and low self-worth (Chadwick, 2006). Acceptance-based therapy therefore seeks to teach clients to experience their voices without reacting to them. Chadwick (2006) emphasises that their voices are likely to remain unpleasant, although the distress that accompanies the experience will be reduced.

Objectives
The current study aimed to examine voice hearers’ perspectives of PBCT for voices. Included in this study were adults who had been experiencing chronic, drug resistant voices. As has been outlined in the literature above, no previous study has used in-depth qualitative methods of analysis to investigate the views of this population.

Qualitative methods were chosen to guide this study as they provide a method of investigating people’s subjective experiences, focusing on the quality of such
experiences and the discrepancies between contradictory viewpoints (Willig, 2001). For the current study, the research team chose to use data collected from focus groups. This decision was guided by the motivation to include the opinions of all group members who wished to contribute. Individual interviews would not have been feasible within the context of the current study, due to the high number of potential participants. Focus groups were also chosen due to the therapy for hearing voices occurring in a group setting, and the interest gaining contextual information of the group on its individual members. Specifically the way in which group members interacted throughout therapy, as well as within the focus-group, was of interest to the research team. Conducting focus groups would yield both explicit and contextual information regarding this.

The selected method of analysis for this study was Grounded Theory (GT), due to the focus of research being on participants' subjective perspectives of group therapy. GT is one of the more generalised forms of qualitative analysis, meaning that it makes fewer specialised assumptions in comparison to other methods of qualitative analysis (Henwood & Pidgeon, 2003). It is rooted in positivism, and therefore assumes that systematic techniques can be used to study the external world (Charmaz, 2003). However, the particular methodology of Grounded Theory chosen to analyse the data incorporated interpretive methods and social constructionist philosophy, with place emphasis on how people construct actions, meanings and intentions (Charmaz, 1990). The epistemological stance of this method of analysis is 'critical realist', which assumes that a physical reality exists, however the representations of this reality are influenced by experience (e.g. culture and language).

One of the key elements of GT is the use of concurrent data collection, coding, and analysis, referred to as 'theoretical sampling' (Glaser & Strauss, 1967). This means that the focus of analysis and subsequent data collection may be shaped by the data itself. The ultimate aim of GT is to reach saturation with the data. This refers to reaching the point in research where further data collection does not result in an expansion to the theory already developed in the particular area of interest. This method of data analysis was ideal for the present study, as focus groups were arranged to be spread out over 12 months. The finite number of focus-groups available for this study reduced the likelihood that saturation would be reached.
However, further hearing voices groups based on the same therapy protocol were planned, providing the opportunity to expand the data gathered in the present study.

Interpretive phenomenological analysis (IPA) was considered as a method of analysing the data, as this approach holds a similar 'critical realist' epistemology to GT, also acknowledges the impact of the researcher on the data, and can be used to gain insight into people's subjective experiences. However, this method would not have been appropriate for the analysis of focus groups data, due to IPA's emphasis on the individual rather than the collective (Creswell, 2007). IPA is usually used to construct a series of case studies to analyse several individual accounts of an experience. With regard to this study, using IPA would have entailed separating the meanings that each individual derived from the group experience from the group context in which the data was collected. Such a methodology which would have presented as problematic due to impact the focus group may have had on the aspects of therapy the participants chose to discuss. GT, however, is an appropriate and frequently used method for analysing data gathered within focus groups as it does not place emphasis uniquely on the individual discourses (Webb & Kevern, 2001). Rather, GT focuses on data comparisons, both between different individuals as well as within individual accounts. Other qualitative methods of analysis (i.e. discourse analysis) were not chosen as they moved away from the critical realist epistemological position adopted to guide this study. It was hoped that GT analysis of the focus group data would build a general theory of how participants experienced group therapy for hearing voices.
METHOD

Participants
Participants in the study attended a closed therapy group for hearing voices. Six therapy groups were held across two National Health Service (NHS) Trusts within the South of England. Each group consisted of seven members prior to any drop out, and ran over eight sessions. This provided a sample population of forty-two service-users across the six groups prior to drop out. Data from one of the focus groups could not be used due to participants withdrawing their consent for the data to be used following the group. In total 18 service-users chose to participate in the research. Participants ranged in age from 30 to 59 years (mean = 44.6). Participants attended 7.3 sessions average (mean; mode = 8). The vast majority of the participants were white British, with one group member defining themselves as white European, and one as Latin American.

Recruitment of participants for this study was in accordance with Smith’s (Smith & Osborn, 2003; Smith & Eatough, 2008) recommendations for ‘homogeneous sampling’. These suggest that participants should be selected from a particular subgroup that share similar experiences, in order to gain in-depth information regarding the experience of this group.

Recruitment for the Therapy Groups
Prior to the focus-groups, participants were recruited for group therapy at three mental health centres spanning two NHS mental health trusts. Referrals for the groups were received from consultant psychiatrists and care co-ordinators. The research team then contacted them to discuss the project and provide an information sheet (Appendix 1). Informed written consent was obtained, and emphasis was made to the participant that neither participation nor non-participation would affect care. Participants were aged 16 years and over. Inclusion criteria stipulated that the person had been experiencing drug resistant and distressing voices for the proceeding two year period and had an ICD 10 diagnosis of schizophrenia or schizo-affective disorder. People were excluded on the grounds of organic illness and a primary diagnosis of substance misuse.
Recruitment for the Focus Group Study

Following the final therapy session, participants were invited to take part in a focus-group. This was held within one month of the final session of group therapy, and all members were invited to participate who had attended at least one therapy session. Separate consent forms were provided for the focus groups (Appendix 2), and information on the gathering of data in the focus group was reiterated from the original participant information sheet (Appendix 1).

Ethical Considerations

Ethical approval was sought and gained from the Central Office of Research Ethics Committees (COREC), including both the Multi Centre Research Ethics Committee (MREC) and site specific assessments (see Appendix 4). Approval was also gained from the Research and Development departments within each of the two NHS mental health trusts. In addition the project was approved by the Faculty of Arts and Human Sciences Committee at the University of Surrey (Appendix 5).

It was anticipated that some of those taking part in focus groups to discuss their voices might experience temporary distress. Several steps were taken to ensure that this risk was minimised. This included having two facilitators present during the focus-groups so that one would be able to make themselves available to anyone experiencing distress, whilst the other remained with the rest of the group. Both facilitators were trainee clinical psychologists, and therefore trained in the assessment of risk and counselling techniques.

Procedures

Interview Schedule

A semi-structured interview-schedule was designed to guide the focus-groups (Appendix 3), based on McGowan et al. (2005). This was adapted by the research team, drawing on extensive experience of working with clients who hear voices, as well as first-hand experiences of hearing voices within the team. Consultation was also gained with researchers at the University of Surrey to ensure that methodologically the interview-schedule remained congruent with the GT approach chosen to analyse the data.
The interview-schedule was designed to illicit participants’ views on five main areas; the circumstances that prompted them to join the therapy group, their expectations of therapy and how this contrasted with their actual experience, their understanding of the therapeutic process, their perspectives of the formation of relationships among group members and with the facilitators, and their current wellbeing following therapy. Questions within the semi-structured interviews were open-ended, allowing participants to relay their own experiences. The focus-group facilitators took a stance of inquisitiveness, and reacted to the feedback of the participants. The focus-group facilitators ran all of the focus-groups and were independent to the therapy group facilitators. Focus groups were tape recorded, and subsequently transcribed for analysis. All collected data were anonymised, and tapes of the focus groups were destroyed following transcription.

Analysis

The chosen method of data coding followed Charmaz’s (2003) approach to Grounded Theory analysis. This form of GT is based in Glaser & Strauss’ (1967) method of data coding, in that it focuses on participant views and data over existing literature, and examines discrepancies within the data through ‘constant comparative methods’ (i.e. comparing related aspects of the data through comparisons of one participant’s dialogue at different times, as well as with the dialogue of other participants). However, Charmaz (2003) differs from Glaser’s (1992) methods by acknowledging the way in which the researcher may shape the data through their interaction with the participants. This method of GT therefore takes a social constructionist perspective that is absent in traditional GT methods, which adopt a positivist philosophy. These assumptions were in keeping with the interests of the research team, in attempting to understand the experiences of service-users’ experiences of group therapy.

Coding of the data occurred in three stages, following the methods of Charmaz (2003). The first stage, ‘line-by-line coding’ (Charmaz, 2003), involved converting each individual line of the transcripts into short, focused codes. The task of this stage was to “make analytic sense of the material” (Charmaz, 2003; p94). Line-by-line coding ensured that subsequent analysis remained close to the data and provided the foundations for later development of theoretical categories.
Line-by-line coding was followed by a ‘focused coding’. This was used to explain larger sections of data, through analysing the most common and significant codes produced during line-by-line coding. Within this stage decisions were made about which codes best explain and categorise the data. Focused coding also established the relationships between these categories.

The third stage of GT analysis involved transforming the focused codes into conceptual categories. Focused codes were developed to produce a definition of the category in the form of memo writing. Such memos explained the properties of the category, the circumstances around which the category arose, and the relationships between categories. Conceptual categories therefore produced a definition of the data containing an element of theoretical understanding alongside information grounded in the text.

Through the above process of analysis, limitations and gaps in the data were exposed. This was addressed by amending the structure of further data collection within subsequent focus groups. Data gathered in these focus groups followed all of the above stages. This subsequent data build further on existing conceptual categories, as well as defining new categories.

**Evaluating Quality**
To date there remains no standardised method of evaluating qualitative research. However, guidelines exist to ensure the quality of such research is maintained. Charmaz (2006) sets out criteria against which GT studies can be evaluated, spanning four areas, summarised below. These criteria were followed in the current study to certify that quality was achieved.

- **Credibility:** Data should be sufficient to warrant the claims of the analysis, with strong, logical links between the data and categories. This should allow the reader to form an independent assessment of the claims. Credibility was achieved through including participant quotes to endorse the categories and subcategories emerging through GT. A sample transcript has also been provided (Appendix 6).

- **Originality:** GT should emphasise the social and theoretical significance of the findings, and provide links to current theory and practices. The
Discussion section of this research compares the finding of the current study to modern literature, and the implications of such findings.

- **Resonance:** Categories should portray the richness of the clients' experiences, and reveal the meaning of taken-for-granted aspects of the data. Personal reflections are provided (below) discussing my attempt to reduce potential bias in the gathering and analysis of data. Definitions of concepts that were taken-for-granted by participants have also been provided within the results section (e.g. 'madness' - see p.139).

- **Usefulness:** The contribution of the analysis to current knowledge, and its practical implications should be provided. This has been addressed within the Discussion section of this report.

**Reflections**

In conducting this piece of qualitative research into service users' perspectives of group therapy, I became a member of a larger research team who were interested in studying the effectiveness of PBCT. Qualitative and quantitative methods of analysis were implemented to study whether there were any therapeutic benefits for the participants. The gathering and analysis of qualitative data was my sole responsibility, and in this sense I remained separate to the rest of the team. My aim in conducting the qualitative aspect of this research was to gain insight into participants' experiences of the therapy, rather than evaluate the therapy itself.

I have no personal experience of diagnosed mental illness or psychosis. My personal stance on the experience of voice hearing is not in itself pathological, as has been shown in studies of the general population. In fact I count myself among those who have had an unusual voice-related experience. Notably, in my case this experience was not accompanied by distress. As is probably apparent, I favour a less medical or diagnostic approach to categorising peoples' experiences of voices, however I acknowledge the benefit that some service-users may draw from gaining medical explanation of their difficulties. To a certain extent I accept that it is useful for mental health professionals to use diagnosis in researching treatments to ameliorate their clients' causes of distress, although as a psychologist I favour a formulation-based model of defining individual experiences and difficulties.
In conducting and analysing this piece of research I was careful to avoid literature as far as possible concerning the theoretical models of voice hearing, and clinicians' perspectives on the experience of voice hearing. However, to a certain degree creating this distance from psychological literature was not possible, due to my theoretical background in psychological perspectives, as well as my experience working clinically with clients with psychosis. It was important for me to remain mindful of these potential biases in my perspective when interviewing clients and analysing the data collected in this project. In doing so I feel I was able to successfully maintain an interpretive stance of 'not knowing', and interest in the individual perspectives of those who participated in the study.
RESULTS

Although all participants involved in this study came from a variety of diverse backgrounds, four common categories emerged from the data. Within this section I provide an in-depth account of these categories. A visual representation of the relationships between these categories can be seen in figure 1 at the end of this results section (p.157) together with general theory of how the categories interrelate.

- Characteristics of Hearing Voices

This category provides context to the group members' experiences of living with voices. All those participating in this study found it important to share the widespread emotional, psychological and social difficulties they experienced on a daily basis as a consequence of their voices. Of these, possibly the most significantly affected aspects of the lives of participants involved the loss of social support networks and concerns that they were descending into ‘madness’, as summarised by Patricia:

“When I first started getting voices [...]2 I felt so isolated because there was no-one I could talk to. I didn’t know what was happening to me, and I thought I was going crazy.”

This category has been divided into six subcategories which have been presented in more detail below.

Emotional reactions to hearing voices

Group members described ways in which they were emotionally affected by voices, and the impact this had on their social and familial relationships. Most group members described hearing voices as causing immediate distress, and viewed the experience as catastrophic. Although some described early positive voices (for example Patricia explained they had diminished her loneliness through childhood), fear was most commonly associated with episodes of voice hearing. This was

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2 Symbol reference:

[...] indicates a section of text has been removed for the purpose of the quotation.

... indicates a pause in the dialogue.

[text] indicates text has been added to make the quote understandable to the reader.
especially apparent when group members were faced with violent commands towards themselves or others. During these episodes violent imagery and anxious thoughts of complying with the voices were commonly experienced simultaneous to the voices.

Harbouring feelings of blame, either towards the self or others (usually family members), was described as a consequence of ongoing distress caused by voices. Blame commonly resulted from participants attributing the onset of voices to life events or early experiences, and considering the contributions that others had made towards these. For example Liam explained:

"I blame my daughter a bit, and I know that's a terrible thing to do. If I hadn't have had her, I might not have [the voices]."

As portrayed in this example, feelings of guilt and a sense of conflict arose out of such blame towards others, which had an impact on the individual’s personal relationships. Fatigue and reduced concentration resulting from voices was also described as contributing to family tensions and arguments, causing the hearer increased stress.

The Power of Voices

Most group members described feelings of powerlessness in the face of their voices. Voices were described as having a controlling influence over the person, and in some cases were seen as in control of their actions. For example, Helen said:

"They allowed me to come to these groups and the reason for that was that they could laugh at me and what I was doing here [...] I should be grateful to them for allowing me to come."

Some participants showed a tendency to comply with any demands that were made of them in an attempt to appease their voices. This strategy of compliance with the voices aimed to prevent the voice from getting any worse and hope that it would eventually subside. Other group members described living with voices as a struggle for survival, as they were often faced with suicidal commands. Having to fight with voices was associated with fatigue and exhaustion. Whether they engaged in power
struggles with voices or assumed passive strategies to alleviate their voices, most participants experienced feelings of having lost control, as is described in the subcategory below.

*Feelings of Having Lost Control*

Thoughts of being controlled by voices, and therefore being powerless, led group members to experience feelings of having lost control. For some participants, uncertainty related to not knowing how the voices would react to new situations caused feelings of anxiety, and therefore hearers were unwilling to engage in new or previously enjoyed activities. Employment opportunities also suffered as a consequence of feeling unable to control the voices. In most cases group members were unable to continue working, or not capable of gaining employment, as a direct result of their voices.

Some group members described determining whether their day was going to be ‘good’ or ‘bad’, depending on the activity levels of their voices on waking. Such prejudgement of the day ahead culminated in feelings of inevitability and dread. Dependence on ineffective coping strategies was also cited as being a large aspect of feelings of having lost control. Increasing distress led group members to rely on a narrow set of coping strategies rather than considering alternatives. For example Catherine described making several attempts to drowning out her voices:

> "I used to [...] put the telly on to try and stop them getting into my head even more... And if that wouldn't work I'd put some music on to see if that would help. Different methods, you know. Nothing at the end of the day really helps."

As can be seen in this example, although Catherine felt she was trying different methods of coping, she actually only considered one type of strategy (i.e. using sound as a distraction) which had already proved ineffective. Through doing this Catherine reinforced her belief of being unable to alleviate her distress. Such beliefs led group members to have ‘all-or-nothing’ views of their voices, and conclude that the only solution to their difficulties would be the absence of voices. Thus each episode of voice hearing resulted in increased anxiety, and desperation to find a ‘cure’ to eradicate the voices.
However, for most it was feelings of having lost control that provided the motivating factor in joining the therapy group. Helen described this as:

“I just thought ‘well anything might help, anything. Any type of therapy or psychology or talk might help’. And that’s why I wanted to come.”

*Being Judged by Others*

Group members described experiences of feeling judged by others who did not share their experiences of hearing voices. This sometimes occurred in the context of the participant trying to cope with their voices, whilst at the same time dealing with the demands of social interaction, as highlighted within the excerpt below:

Patricia  “[…] you’re looking blank, and they think you’re stupid, because you’ve missed half their conversation.”

Andrew  “I’m sure people think I’m thick most of the time, because...”

Janet  “I think they think I’m rude.”

Andrew  “Because I’m just looking at them, you know, because I can’t understand what they’re saying.”

In addition to feeling judged owing to their difficulties in social situations, several group members described being directly laughed at, or having jokes made about them because of their experiences of voices. Such encounters left individuals feeling upset, tormented, and misunderstood. Voices were also described as directly contributing towards feelings of being judged through derogatory name calling. Feeling judged by others led members of the group to want to *isolate* themselves from the rest of society, as is described in the subcategory below.
Isolation

Most group members discussed their feelings of isolation resulting from reduced social support. Several causes for isolation were discussed; not having others to talk with about their difficulties and experiences, increased avoidance of social interaction due to feeling judged, increased social difficulties as a direct affect of voices (i.e. increased paranoia or difficulty maintaining conversation), and attempting to avoid disclosure of their voices.

Reduced social contact resulted in people feeling abnormal, or like a "freak" or a "loner" as described by Brian and Helen respectively, and contributed towards feelings of madness, as described in the category below. This also resulted in a loss of social confidence, further increasing avoidance of social activities and thus resulting in a cycle of increasing isolation. Helen succinctly described this situation:

"[The voices] make me lose self esteem and self confidence, and I even get to the point sometimes when I don't want to walk out of the front of the flats, be anywhere near any people."

Group members described facing a dilemma of finding social contact increasingly stressful, whilst at the same time knowing that isolation will make their situation worse.

The Concept of 'Madness'

Most group members described feelings of uncertainty and incoherence resulting from having difficulty understanding their experiences of hearing voices. This was also strongly related to the distress they experienced, as described in emotional reactions to voices, and feelings of having lost control. In attempting to seek an explanation for their voices, some people described comparing themselves to friends or family, who did not share their experiences. Others went on to seek comparisons with people they knew to be users of mental health services, but did not have similar experiences. Such comparisons inevitably produced discrepancies between the person's own experiences and those around them, thus confirming beliefs that they were 'not normal' or 'mad'.

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Confusion regarding the differences between the person's own experiences, and those of others often culminated in participants viewing their experiences of hearing voices as a prominent aspect of their personal identity (as is described in the category development of sense-of-self). An example of this was found in the manner in which Catherine introduced herself:

“I'm schizophrenic, that's it basically.”

As well as defining themselves by their experiences of voice hearing, some group members described their wanting to distance themselves from the concept of madness. For example Andrew explained:

“I'd never ever met anyone else who is a schizophrenic. You just think they're mad and don't want to be associated with them anyway.”

By distancing themselves from other people with similar experiences, group members were unable to challenge their beliefs that other people in similar situations were ‘mad’. Such avoidance also served to enforce personal beliefs about being mad, through not having their experiences validated by others.

- Developing a Group Identity
This category describes the process by which members of the therapy group developed a shared sense of identity. For some, being in this environment provided their first experience of being part of what they perceived as a homogenous group. It was also the first time most people were able to discuss their experiences in a non-judgmental environment with others who understood and shared their difficulties. The group environment therefore had a powerful impact on the group members, and provided a strong therapeutic element of the treatment, for example the normalisation and validation of their experiences. As Janet explained to her fellow group members:

“That's what I found the most helpful, was you lot being the same as me. That's what I found most comforting”.
The category *developing of a group identity* can be broken down into five subcategories, as described below.

**Social Inclusion**

Most participants described their initial reasons for joining the therapy group as being to meet others with whom they shared similar experiences, with the hope of developing their social network. Through joining the therapy group these expectations were satisfied. Group members described a strong sense of empathy and understanding within the group, and valued having the space to share their experiences without social judgement or societal constraints on what 'should' or 'shouldn't' be discussed. Although the feelings of social inclusion mainly arose from the collective group members, facilitators also played a significant role in the development of this process. Several participants felt that, while understanding of their experience could only be shared between voice hearers, the facilitators contributed strongly to the understanding and non-judgemental environment. Group members also described the facilitators as prioritising their views over the 'expert' information that they brought to the group. This made participants feel their opinion and observations were supported and valued within the group.

Becoming a valued member of a social group and holding a feeling of responsibility towards other group members resulted in increased self-esteem and optimism regarding future social functioning. The therapy group also provided participants with an experience of having their feelings and thoughts validated, leading to comfort, relief, and reduced their sense of being isolated or 'mad'. Martin explained:

"It was good because you didn't feel isolated. Which I had been for years - I felt really isolated [...]. I had no idea of other people's suffering, and it made it better for me because I would, sort of relate to them."

Within therapy sessions, group members described acknowledging shared personal attributes within the group, strengthening their sense of group identity, as well as *reevaluating perspectives of the self*. However, most participants explicitly stated
that their feelings of social inclusion did not extend beyond the bounds of the therapy group. Despite this, some members used the group as a base to increase their engagement in social activities, as described in the subcategory support.

**Normalisation**

Discovering common experiences with others had a powerful normalising effect on the members of the group. Although several participants said that they had been informed that there were also other people living in the community who had similar experiences to them, they had not believed this until they actually met the other group members. Hearing the experiences of others was attributed as reducing group members' sense of fear, and influential in reducing the behaviours that they engaged in as a reaction to the voices (for example carrying a knife for personal protection or publically arguing with the voices). Group members explained that they felt they were treated as 'normal' within the group, which contrasted previous experiences of being judged by others and labelled within mental health services and society more generally. They also found comfort in learning that other people also experienced symptoms of depression as a result of the voices, which increased their perceived ability to cope.

Normalisation also occurred on a physical level. Several people described the surprise they experienced on meeting other members of the group due to their 'normal' appearances. Martin described the effect that this had on his view of himself:

"I’m just surprised that everyone was so normal [...] I thought if they seemed alright, they looked, you know, normal, perhaps I did as well."

Such comparison of the self with other members of the group, both physically and in their behaviours and experiences, resulted in a greater feeling of 'normality'. It also helped participants develop the concept that they could blend into society without being noticed, or as Patricia described it, being "anonymous".

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The use of Humour

Several group members highlighted the important role that humour played within the therapy group. For most people humour was seen as being used very differently outside the group, in terms of providing ridicule and insults. Patricia explained this difference:

“We can have a laugh as well, can’t we? Because we’re not laughing at them, but with them. And yet other people outside who don’t understand what’s going on are laughing at us. You know, these people are judging us. And it’s nice not to be judged for a change.”

Group members experiences of having humour used against them, or voices inspiring paranoia about others laughing at them, had created a perspective that humour was threatening prior to joining the group.

Humour provided a function of increasing group cohesiveness and a shared understanding, with ‘in-jokes’ described among group members. It helped to raise energy levels and enthusiasm, as well as allowing group members to describe their difficulties in a light hearted manner. This use of humour enforced the process of normalisation within the group.

Containment

Structure and consistency provided an important element of the group environment. Several group members described finding previous groups difficult due to not having a fixed session plan, and different people attending each week. For example, of a separate group Sophie said:

“Sometimes there might only be two or three of you, and other times there would be lots of you, and it’s very difficult because you don’t know how many. Whereas with this group you know how many there is all the time. And you get to know each other as well.”

Group members thought that a structured group was more likely to be therapeutic in comparison to one that was less structured. They also felt that the group was taken seriously and therefore regarded it as important. Participants found
consistency and familiarity comforting and easier to cope with than less structured groups, and felt safe to share their experiences. Several group members also voiced the importance of having explicit rules regarding confidentiality, and felt that this enabled them to disclose more personal information, and discuss sensitive issues.

Support
As well as providing an environment of social inclusion, participants described being supported, both by the facilitators and other members of the group. Such support provided group members with the encouragement and motivation to pursue their goals, as described in the goal setting and graded exposure subcategory. Some group members met up in the community to go out socially, and in doing so extended this support to outside the group. Liam described going out to a club with one of his fellow group members:

“We went to a club, for the first time in about ten years [...] I wouldn’t have done that had I not come to this group.”

Participants also found that the group provided a gateway to other means of support, through providing information about other groups and services.

After the final group session almost all group members described strong feelings of loss, and felt as though the group had come to a premature ending. Some indicated that they had considered not attending the final group due to knowing that the group was coming to an end. Such emotions were attributed to feeling the end of the group would mark a loss of support, and a fear that any progress would be reverted back to their previous circumstances. A minority of group members did not view the end of the group as a loss, but felt they wished to view the group as having been a positive experience from which they could continue to develop their ability to cope with voices.

• Learning to Cope with Voices
This category describes the process by which group members developed a concept that they were able to cope with voices, and begin developing their strategies to do so. This began with a shift in group members’ expectations, perspectives,
and/or an acceptance of their experiences of voice hearing. Doing so allowed them to move from an ‘all-or-nothing’ view of their voices to a more coping-based perspective. Kimberly described the ways in which her view of living with voices shifted over the course of the group:

“I wasn’t expecting to be able to cope with the voice still there. I wasn’t expecting to, just be in control. I was expecting to either have the voice or not have the voice.”

Once group members have achieved this alteration in their perspectives of voices, they were able to begin implementing strategies that allowed them to cope with voices on a daily basis. These involved psychological techniques used in cognitive-behavioural therapy, such as thought challenging, relaxation, mindfulness strategies, and graded exposure. Liam described this two-staged process:

“I didn’t really look at it as accepting, but that’s probably what it was - accepting. And I suppose once you accept it it’s easier for you to look at ways of coping. Because when you’re fighting it, you’re just scared.”

The category *learning to cope with voices* can be broken down into six categories, as outlined below.

*Altered Expectations*

Prior to joining the therapy group, participants described their views of the future involving either being ‘cured’ or living in misery as a result of the voices, as described by Kimberly in the section above. This view was related to group members’ internal models of the concept of illness, and influenced by their experiences of medical services. Medication was seen by most people as being the only solution to alleviating voices, leading them to focus on and monitor their voices in order to assess whether they were ‘getting better’. This was explained by Liam:
"For a long time with my illness it was more what symptoms I've got. I thought the only solution was more medication, more medication, more medication."

Such reliance on medication, especially when it is not effective, enforces people's belief that they have a severe illness and increases their feelings of hopelessness relating to finding a 'cure'. Later Liam described the way in which his views of the voices were changed over the course of the group, and the impact this had on his management of the symptoms:

"By coming to the course I've been back to my consultant and said 'let's keep the medication as we are' because I've learnt that the voices [...] can trick me into believing that I'm more ill that I actually am. So I've been able to break that cycle of symptoms".

The process of group members' perspectives of voices shifting from a 'cure' to a 'coping' model was assisted by the group facilitators' transparency regarding the aims of therapy not being to eradicate voices. Although this was described as initially causing widespread feelings of disappointment, in the longer term it increased their hopefulness that they would be able to manage their voices.

Acceptance and Understanding of the Experience of Voices

For some group members, beginning a process of accepting their experience of voices was important in developing their ability to cope. This concept of accepting the voices was strongly linked to self acceptance. As described in the emotional reactions to voices category, several group members described feelings of resentment and self blame for the voices. Participants' acceptance of their experiences appeared to begin with confronting their thoughts that they were responsible for their voices, or the attribution to an 'evil' personality trait. Doing so led to increased confidence and self-esteem. Of this process, Rachel said:

"[I have] more confidence. I said to myself, I'm different, though I've got voices. I said to my voices 'I've got to live my life' [...] and this for me is very important."
However, the process of acceptance was not experienced by all group members. Some explained that, although they had not come round to accepting the voices, they felt that their understanding of the voices had increased. The development of understanding regarding the experience of hearing voices appeared to have a similar affect as those who described their feelings of acceptance towards the voices. For example Patricia explained

"I found it very hard to understand why I couldn't stop them if it was me doing them. And the group's helped me understand that yes, it is me, but also it's not really me, it's my mind."

Again the key element to this process appears to be addressing feelings of responsibility for the voices, resulting in increased confidence and ability to cope. Increased understanding was aided by facilitators using accessible information and language to describe the experiences of hearing voices, rather than medical jargon.

In the cases of both developing understanding and acceptance of voices, group members felt that they were only in the early stages of the process, and that this would continue on after the group. Some felt that it would provide the basis for further therapy.

*Reflecting on the Power of Voices*

During the course of therapy, most group members described a change in the way they perceived the voices, and themselves in relation to the voices. One of the main ways in which this was done was the revaluation of the power that the voices commanded. Kimberly provided a very clear example of this process, saying:

"I learnt that [...] it was still my will that overcame the voice that was extremely powerful. I still was more powerful than the voice at the end of the day. Although I'd burn myself, or cut myself, or something like that... But I wouldn’t actually do what he's telling me to do, and I’m more powerful."
As highlighted in the *power of voices* subcategory, group members described their views of the voices prior to the group as being completely powerful, and themselves as submissive.

This process of changing perceptions began with group members starting to notice changes in their voices depending on their environment or the activity they were engaging in. Also, by listening to other group members and making their opinions a priority (as described in the subcategory *social inclusion*, above), authority was shifted away from the voices. Therefore, for most group members actually being in the group environment had a beneficial effect of decreasing the power of the voices. This, however, was followed by a sudden increase in the power of the voices directly after the session. Several group members reported that their voices in general increased in frequency over the course of the therapy, although their ability to cope with the voices improved and the perceived power of the voice was reduced.

Some participants discussed their developing beliefs and realisations that voices did not have the capacity to cause them physical harm. Isabel, for example, explained:

"You realise that the voices, even though they're bad, they're not going to kill you. They're not going to suddenly come up behind you and head-butt you, sort of thing."

Isabel described part of her process of recovery was making the voices realise that they could not hurt her. She acknowledged, however, that this belief was not absolute, and that the voices still maintained the ability to cause emotional harm.

*Increased use of Coping Strategies*

Most group members described an increased ability to cope with their voices over the course of the group programme. As described in the introduction to this category, the development of coping strategies followed on from the process of *acceptance and understanding of the voices*, and *altered expectations* of the participants. Through the group, participants extended their range of available coping strategies, as well as increased confidence in the ability to implement these to control their voices. The development of coping strategies occurred through
information imparted by the group facilitators, as well as gaining ideas from other members of the group. Isabel described her improved ability to cope with voices as:

"You’re trying not to do what they’re telling you to do, but you don’t know what to do. That’s why the group has been so good, because there is a bit of [...] ‘this is what you can try, or you can do’, whereas before you’re on your own.”

Some group members also described having their current coping strategies validated within the group. This support from other group members made them feel less self conscious about their methods of coping and giving them increased confidence in using these strategies.

Previous to the group, the main forms of coping strategy described involved using music or other loud noise to drown out the voices, or altering activity levels as a form of distraction. However, the problems of these strategies were also highlighted, for example exhaustion resulting from having to remain active for long periods. Within the focus groups, participants described implementing an array of coping strategies following the group. These included the use of positive self statements, setting limits on stressful activities, using mindfulness techniques and relaxation, reminding themselves of the voices limitations, engaging in enjoyable activities, and increased support seeking behaviour. As well as improving the person’s ability to cope when experiencing voices, the majority of these techniques also gave them confidence in their ability to cope.

Although group members described the importance of focusing on their increasing ability to cope with voices, Helen highlighted the danger of facilitators putting too much emphasis on this:

"I felt like I was being a bit manipulated into saying that I had learnt how to tackle the voices. It was like we were expected to say something, and if we said it that it was full marks. And there were a lot of times that I felt it wasn’t getting any better."
Helen’s comment stresses the difficult role that facilitators play in maintaining a balance between listening and empathising with clients who feel they are not coping well with voices, whilst acknowledging the progress of those who are coping well. Not adequately maintaining this balance may lead to group members feeling isolated and hopeless, or conversely that their achievements have not been recognised.

Goal Setting and Graded Exposure
Once group members had achieved altered expectations of receiving a ‘cure’ and experienced an increased use of coping strategies, they started to set themselves goals for increasing their daily activities. As discussed within the category characteristics of hearing voices, most group members had become increasingly isolated over time due to their avoidance of social interactions in an attempt to reduce the voices. By setting achievable goals, group members were able to gradually increase their determination and confidence with engaging in daily activities, as well as focus on longer term aims rather than their present difficulties. Janet described the process by which she was increasing her confidence in using public transport:

“The other day I got a taxi down to my doctors and got a taxi back. I can’t get a bus yet, but I got a taxi - that’s the first step. And this week I’m going to go on a bus trip. I don’t know where but I thought I’d just get on the bus and go somewhere. Catch a bus and then go back.”

Actually coming along to the group was also described as providing exposure to an activity which would have previously avoided. Therefore attendance of the group provided sense of achievement for most participants.

As well as increasing confidence, however, such exposure also resulted in feelings of exhaustion. Some group members described getting home from the group and crying due to overwhelming emotion and fatigue. In some cases this was also due to experiencing increased voices directly after the group, and feeling more vulnerable. Other members described increasing anxiety that accompanied their increasing ability to cope with voices. Group members described using similar
strategies to cope with this anxiety to those they used to cope with voices. For example, Isabel described the importance of not letting her anxiety stop her from attending the group:

"If I don’t do it, it will be easy for me to say ‘no no, I won’t do it then’ again next week, and before you know it you’re going backwards, not forwards."

As outlined in the paragraphs above, the experiences of participants appears to be similar to using exposure techniques, as described in behavioural psychology and cognitive-behavioural therapy. As participants increased in their ability to cope with voices, and therefore increased their exposure to previously avoided situations, anxiety became a limiting factor in their progress. Combating the obstacle of anxiety became the next stage in achieving increased daily activities.

Another form of exposure that occurred within the groups involved listening to the voices of the facilitators. Several group members commented on their experiences of the facilitators' voices. Some described the positive effects of the facilitators' voices, for example their relaxing qualities during mindfulness exercises. Others, however, found the experience of listening to the voices of the facilitators more challenging. Kimberly described her experience of not being able to understand the facilitator, as if they were "talking scribble". This was a similar property to that of the voices. Over time this improved until she was able to listen to and understand the facilitator. Again, Kimberly’s experience could be viewed as exposure to attending to an external voice that mimicked the incoherence of her internal voice.

**Challenging Negative Beliefs and the Voices**

Over the group programme, participants began to challenge their ways of thinking about the voices. This has been highlighted in previous sections, for example revaluing the power of voices, and increased use of coping strategies. Some members also described going on to directly challenge their voices. This involved using techniques such as examining evidence for and against their negative thoughts and voices, as commonly used in cognitive therapy. Sophie gave an example of the ways in which she had begun challenging her voices:
"Last week the voices said that when I go to bed to sleep my family were going to kill me [...]. And then I woke up and thought ‘no they didn’t kill me, the voices were wrong’. So it proved a point that the voices can be wrong at times.”

Another group member described challenging paranoid voices saying that people were continually watching and laughing at her. Using techniques to challenge the voices developed group members’ feelings of being able to control their voices, thus also challenging thoughts that they were out of control, or going ‘mad’. As mentioned above, thought challenging is a commonly used technique in cognitive-behavioural therapy that can be used for a wide range of psychological difficulties.

**Development of Sense-of-Self**

This category describes the development of group members’ understanding of the experience of hearing voices. This coincided with the process of revaluating their sense of personal identity as separate to their voices. This process of externalisation was explained by Martin:

“I am not the illness. I am a person with a certain illness.”

The group environment in which therapy sessions were conducted had an impact on group members’ perception of their abilities to interact socially with others, as well as altering their views of how they are perceived by other members of society. This category can be further divided into five subcategories, as portrayed below.

*Revaluing the Concept of ‘Illness’*

Being within the group and meeting other people who hear voices had an impact on group member’s beliefs about mental illness, about other people who experience voices, and consequentially themselves. As described in *The Concept of ‘Madness’* subcategory, prior to the group several participants expressed their wish to distance themselves from the concept of madness, and others they perceived to be mad. For some this was based on previous experiences of being hospitalised, for example Martin described his experiences of other voice hearers as being “noisy and unpredictable” when he was first admitted to hospital. Attending the group
challenged beliefs that all people diagnosed with schizophrenia were ‘mad’. Individual differences between group members were highlighted, both in personal qualities and the symptoms they experienced.

Meeting other voice hearers also had the effect of reevaluate perspectives of the self, i.e. that they were evil or had done something bad to deserve having voices. Isabel explained the impact that listening to others expressing similar feelings about themselves had on these beliefs:

“It wasn’t until we were in the group that we started to realise that you haven’t done anything bad. You know? But all of them were saying ‘Yeah, well I must have done something to make me have these voices’. You know, and then you’re sort of in your mind thinking ‘that’s exactly how I feel’ [...] We can’t all be evil. We can’t all be wrong.”

Group members were also able to begin to alter their perspectives that their voices directly affected their mental health. This involved adjusting their views on ‘relapse’ (i.e. feelings of not being able to cope) and the process of recovery. For example, for some, feeling overwhelmed by voices became to be viewed as part of the process of recovery, rather than a sign of impending relapse. Having other group members and facilitators as an external frame of reference also helped individuals to gain an outside perspective on their progress and ability to manage their voices.

Separating Voices from Identity
One of the main benefits that participants described gaining from the group was the recognition their voices were separate to their personality. Several group members indicated that when they had first entered the mental health system, they had not been given information regarding possible associated features that people with their respective diagnoses might experience, such as hearing voices and feelings of depression. This resulted in people becoming confused as to the reasons for their unusual experiences, due to not being able to relate these occurrences to common experiences among people who access services. For example, Martin described experiencing a severe loss of motivation to the extent
that he had great difficulty getting out of bed in the mornings. Finding out that this was a common feature of depression was influential in helping him to manage this situation, and increase his understanding of himself (i.e. that he wasn't just being lazy). Similarly, Gina explained the ways in which the therapy group helped to address her understanding of her difficulties:

“Things were happening to me and I didn’t know whether it was normal or not. But with the group they sort of explained to us this is why you’re like this and this is how you can deal with that.”

The externalisation of the voices as a symptom of an illness was aided by being given information within the groups, and provided with psychological theory by facilitators. Being informed about, and subsequently noticing, the links between stress and voices was noted to be a powerful tool in viewing voices as a symptom of mental illness. This gave group members hope that they were able to control their voices through alterations in their lifestyle, as mentioned in the category increased use of coping strategies. It also decreased group members’ reliance on medication as being the only ‘cure’ for their difficulties, as has been mentioned previously. Through these processes group members were able to develop the concept of their voices as interacting with the self, rather than being an integral part of it.

Making Sense of Voices

Over the process of the group, some participants described a change in the ways in which they viewed the reasons behind their voice hearing experiences. As is apparent in the introduction section of this category, several members of the group described adopting an ‘illness’ model of their voices. Within this voices were viewed as being a symptom of mental illness or a trick of the mind, and therefore separate to their identity. One group member, Brian, related his power struggles with the voices to previous relationships, and felt that his voices were related to being too compliant as a child, and his family having too much authority over him. Other participants described building up alternate explanations for their voices that were not related to them being a symptom of a mental health problem, for example Isabel explained:
“Well I think that the voices realised that they were up against some more voices. Not just trying to get at me, voices trying to get at other people in the room, [...] there are other voices that... other voices that aren’t evil.”

The above explanation for voices does not appear to coincide with psychological or medical views of voices. It is possible that this explanation had spiritual significance for Isabel, although this belief was not explored. Others participants, however, did not feel that they received adequate explanations for voices within the group, and suggested that this should be included as a focus of future therapeutic groups.

Whatever the explanation that was adopted to make sense of their voices, it appears that participants needed to reach this conclusion by themselves, rather than having the explanation for voices imposed on them. Frances described the way in which her family explained her difficulties:

“[My family] kept saying to me ‘you’re going through what your mother went through’ [...] and I thought I was going crazy, you know? I couldn’t figure out what was wrong with me.”

Despite this, it was important for group members to be given information regarding possible psychological reasons for the voices, and common experiences that may be associated with these, as explained in the separating voices from identity subcategory.

Revaluating Perspectives of the Self
As well as having negative beliefs challenged within the group (for example regarding being evil), group members described having their positive qualities reinforced. Within sessions, group members described sharing their positive opinions of one another. Some expressed surprise and scepticism at the feedback they were given, and were able to express their self-doubt. This was validated by other group members who felt the same. Others gained reinforcement by people outside the group, who substantiated the feedback they had been given. Receiving this feedback provided group members with an alternate perspective on
themselves, which had a positive effect of increasing self-esteem. Nigel felt that receiving positive messages within sessions had an effect on his relationships outside the group, for example his ability to manage conflict with his son. Listening to other people’s experiences was also effective in reinforcing the idea that the way in which group members perceived their difficulties was not the only way of interpreting the situation.

Some group members also described having altered their perspectives of themselves through revaluating their ability to cope with voices. Danielle explained how she had developed the concept that she was uncovering resources that she had always had:

"You learn new things about yourself. That you’ve got resources and assets to call on to help you deal with your illness. I never thought I was going to be working on something that I’ve already got."

Reevaluating Capacity for Social Functioning

As has been mentioned in the developing a group identity category, participants expressed many benefits of engaging in therapy as a group. One such advantage was that the group environment allowed for a revaluation of group members beliefs about their social functioning. Kimberly explained the change she had experienced in her social confidence and how this had challenged her expectations:

"I think that I’m better at groups now than I was at the beginning of the group, [...] I never thought I’d say anything today!"

Because of feeling less anxious, group members felt that they were better able to concentrate on conversations, and focus on their social skills.

Some group members also felt that their ability to communicate their difficulties with friends and family members had increased since joining the group. This had been aided by being able to take resources used in the group home to help explain their situation. Group members reported feeling more understood within their personal relationships, and were more able to discuss their problems.
Theory of Participants' Experiences
Throughout the results section there has been explanation of the ways in which the various and subcategories are interrelated. Figure 1, below, represents a general theory of the participants’ experiences of group therapy for hearing voices, portraying the relationships between the four categories.

Figure 1: Showing the relationships between categories, as produced through qualitative analysis.

As can be seen in the outer shell of this diagram, the category Characteristics of Hearing Voices provides the overarching context that surrounded participants' experiences of therapy for voices. This describes group members' experiences of living with voices on a daily basis, including social isolation, loss of control and fear of a descent into madness. Therapy for hearing voices provided individuals with a group environment consisting of others whom shared similar experiences. This led to a powerful group process, within which members of the group began Developing a Group Identity. Such a group environment also provided the context within which the therapy for hearing voices took place, as represented by the second shell within the above figure. Therapy for hearing voices helped group members to begin
Learning to Cope with Voices, whereby they began to accept or understand their voices, and went on to develop their coping strategies. Therapy also aided individuals to revaluate themselves in comparison to their voices, and in relation to other members of society, as described in the category Development of Sense-of-Self.

The diagram above highlights the strong relationships between the four categories. It portrays the way in which these categories Learning to Cope with Voices and Development of Sense-of-Self were influenced by the group context within which the therapy took place. For example, meeting other members of the group and going through a process of normalisation helped individuals to revaluate some of the negative beliefs about the self. The diagram also shows the links between the categories Learning to Cope with Voices and Development of Sense-of-Self. An example of this was that increased confidence with using coping strategies helped develop group members' perceptions that they could control voices, which were therefore perceived as being separate to their identity.
DISCUSSION

This study sought to gain insight into service-users' experiences of group therapy for hearing voices. A constructivist GT methodology was used to examine personal accounts of service-users' experiences of therapy for voices. Through analysis four themes emerged that represented common experiences of those participants engaging in the study. Each category and its relation to current literature will now be described, along with the implications of these findings and suggestions for further research. Guidelines produced by the British Psychological Society (2000) emphasise the need for research to include literature on functioning in 'normal' populations, and where possible such literature has been examined.

The Characteristics of Hearing Voices

Social isolation, and its effect on recovery from psychosis, is well documented in psychological literature. In general, two schools of thought emerge from links between psychotic symptoms and social isolation. The first of these views reduced capacity for maintaining social relationships as a direct effect of disorder on the individual, coming under a general category of 'negative symptoms'. This stance is in accordance with DSM-IV (American Psychiatric Association, 1994) guidelines, which include 'social dysfunction' as one of the main characteristic symptoms in the diagnosis of schizophrenia. In a longitudinal outcome study of schizophrenia, Breier et al., (1991) concluded that negative symptoms showed a strong positive correlation with poor social and vocational functioning. They suggest that medication to target negative symptoms should lead to improved outcomes.

Davidson and Stayner (1997) portray an alternate viewpoint; social isolation is secondary to the impact that psychotic experiences, and the resultant labelling of these difficulties, have on the lives of individuals. In a study on the phenomenology of social functioning in schizophrenia, Davidson and Stayner (1997) found that people cited their main reasons for reduced social contact as stigma associated with mental health services, loss of employment, reduction in expendable income for leisure activities, reduced capacity for attention, and hypersensitivity to environmental an interpersonal stimuli.
Results from the current study support Davidson and Stayner’s (1997) views of social isolation in psychosis. Certainly there was little evidence within the data to suggest that participants were incapable of forming meaningful relationships, or lacked insight into social interaction. In fact, the group context in which the data was gathered highlighted social bonds that had been formed over the course of therapy. Rather than being unaware of their social difficulties, participants described anxiety at the complexities of social interaction, and showed an awareness of the impact of voices on their ability to interact and communicate with others.

Several studies have addressed the importance of socialisation in the recovery from schizophrenia. Erickson et al. (1998) showed that improvement in adaptive functioning five years after first-episode schizophrenia was correlated with higher numbers of non-kin relationships prior to the onset of their illness. Macdonald et al. (2005) found that young people with psychosis placed value on the support gained from family members. They also report that young people described the forming of new social networks as influential on their recovery, rather than the maintenance of previously forged friendships.

This literature shows a general consensus that individuals experiencing psychosis are at risk of becoming isolated. Also, social support plays an important role in recovery, and should be facilitated where possible. Findings of the current study support this view, and emphasise the benefits of bringing people together as part of a therapeutic group. This issue will be discussed further, when considering the development of a group identity among group members.

For many of the participants in this study, becoming isolated combined with feelings of having lost control over their lives led them to develop the concept that they were descending into ‘madness’. Exploration into the meaning of ‘madness’, as experienced by individuals with psychosis, has been largely neglected by researchers, although there is an emerging body of literature describing first hand experiences of psychosis. For example, in an autobiographical case study, Kiser (2004) describes his personal definition of madness as having lost touch with reality, accompanied by a feeling that his mind was disintegrating through having
lost concept of his past, present and future. He describes this state as being "lost in an internal hell that I could not understand, communicate, or escape" (p437).

As in the definition produced in this study, Kiser's (2004) experience of 'madness' involves a discrepancy between the person's perspective of reality and that of those around them, along with an alteration in one's sense-of-self. Within the current study, participant's concept of madness was defined by having lost understanding of themselves and the world around them, together with a widening gap of inconsistency between their own experiences and those of their family and friends. This culminated in individuals experiencing distress and incorporating this concept of madness into their sense-of-self, thus defining themselves as 'mad'. Further research is warranted to explore the concept of madness, as experienced by people with psychosis. Such information might be used therapeutically to provide comfort and a sense of normalisation to those who feel isolated by their experiences.

**Developing Group Identity**

As discussed in the above section, increased socialisation has been linked to better outcomes in terms of recovery from psychosis. This phenomenon has been widely researched by Davidson et al. (2001), who have studied the impact of supported socialisation with people experiencing psychosis. Doing so appeared to have an impact on the quality of life experienced by these individuals, including expanding social networks and enhancing self-esteem and social confidence. In analysing young people's experiences of group therapy for first-episode psychosis, Macdonald et al. (2005) found that meeting others with similar experiences, feeling understood, and developing trust were key elements that were gained by participants of group therapy.

The group context of therapy that participants in the current study underwent provided an experience of supported socialisation, and allowed the formation of social relationships. Group members described feelings of belonging within the group, and developed a sense of shared understanding and identity. Such cohesiveness is commonly described within psychotherapeutic work with groups, and therefore by no means individual to hearing voices. Yalom and Molyn (2005) highlight the importance of individual members of a group sharing their personal
experiences, and receiving acceptance from others. For many of the participants in this study, the group therapy for voices was their first encounter of meeting others with similar experiences, and finding acceptance within a social environment.

One important aspect of the group, cited by several participants, was the use of humour and 'in-jokes'. Humour was used to enhance feelings of cohesiveness in the group, as well as to increase energy levels and create a sense of 'normality'. This appeared to be a marked contrast from participants' encounters with humour outside the therapy group, where jokes were experienced as being used with the intent of causing ridicule. Dziegielewski et al. (2003) have studied the use of humour as a communication tool in therapy, which aids the reduction of tension as well as assisting group cohesion and the attainment of shared goals. They also discuss the obstacles that may arise in the use of humour, including previous negative personal experience. In the case of participants in the current study, humour had previously been interpreted as threatening due to its utilisation by voices, family members or others to cause humiliation. Part of the function of humour in therapy, according to Dziegielewski et al. (2003) is to allow the client to experience upsetting events in a more benign manner. This was implemented within the current study, as participants described being able to laugh about their difficulties with other group members. Doing so would have helped group members to view difficult situations as less threatening. In studying humour across a range of adults in the general population, Solomon (1996) found a positive relationship between use of humour and people's perceived level of control within situations. It is therefore possible that the use of humour within the group influenced participant's perceptions of themselves as having greater self-efficacy and control. In turn, greater self-control enhances emotional wellbeing and ability to cope with stress (Kuiper et al., 1993). Several other beneficial elements of humour have emerged within psychological literature, for example, stimulating change in thoughts and perceptions, and enhancing problem solving (Gladding, 1995), promoting positive self-concept (Gelkopf & Kreitler, 1996), and promotion of social skills (Bloch et al, 1983).

To date there has been little research into the use of humour among groups of clients who share voice-hearing experiences. The small amount of literature that does exist focuses on the apparent impairment that such individuals have in the
ability to appreciate humour (e.g. Mitchell & Crow, 2005; Stratta et al., 2007). Despite these seemingly negative findings, some researchers have found that humour can be therapeutic when used with people with symptoms of psychosis (Felices, 2005) and studies suggest that the apparent reduced ability to utilise humour may be accounted for by co-morbid symptoms of depression (Falcenberg et al., 2007). None of the above research, however, took into account the findings of this study; that humour was seen as having a malevolent or threatening function by individuals who hear voices. The literature also appears to place emphasis on the role of the therapist in providing a humorous environment for the client to engage in, rather than the development of humour amongst groups of service-users. The finding of this study suggest that humour generated within the group is likely to have a more cathartic effect in comparison to that ‘imposed’ by facilitators, due to previous experiences of humour used as a form of stigma.

The current study provides a novel perspective on the use of humour among of voice hearers brought together within therapy groups. Humour provides an important aspect of the therapeutic process, which may be especially effective when used in conjunction with cognitive-behavioural based group therapy. This is due to the function of humour in promoting group cohesiveness, stimulating change of thought, positively influencing perceived ability to cope and promoting positive self-esteem. Findings of the current study also place unique emphasis on the importance of this humour being generated organically within the group, rather than being imposed by external sources. Further research might focus on helping groups use humour therapeutically, whilst facilitators remain separate to the development of this process.

Overall, the group context in which therapy was conducted had a substantial impact on participants, many of whom had not experienced such a peer group previously. However, the group context in which the data was collected must be taken into consideration when evaluating this finding. Within the field of qualitative research, focus groups are usually composed of members who do not have previously formed relationships. In the case of the present study, group members had become familiar within each other over the course of therapy. This meant that the data was at risk of overemphasising the group process and positive aspects of the group, as group members may have found it hard to speak critically
within such an environment. Despite this, there is evidence in the data to suggest that people were able to voice negative aspects of the group, for example Helen's feedback that she felt 'manipulated' into saying that she was learning to cope with voices (p.148). Given the levels of isolation and prejudice that this population had encountered prior to joining the group, it is also possible that the group context had a positive and facilitative effect of aiding participants in sharing their experiences. It was apparent through analysis that participants felt safe within the group, and it may therefore have been easier for them to express their opinions than had they been among strangers. Considering these points, it is important to bare in mind the group context of the data collection method. However, the strength of these findings, together with their similarity to group processes as studied in the general population (i.e. Yalom & Molyn, 2005) suggest that the group environment strongly impacted on group members' experiences of therapy.

Often within the NHS, group therapy is seen as being a cost-effective way of managing long waiting lists or large case-loads. Findings of the current study suggest that there may be substantial therapeutic benefits to treating voice hearers within a group context. This was mainly due to the powerful effect that meeting others had on normalising the experience of hearing voices, which far overshadowed clients being told that they were not alone in their difficulties by health professionals. Findings of the present study therefore suggest that group therapy may provide specific benefits in terms of normalising the experience of hearing voices, and should be considered in addition to individual CBT and family interventions, as set out by the National Institute for Clinical Excellence (NICE; 2002).

**Learning to Cope with Voices**

Participants described a process by which they developed the notion that they could cope with voices over the course of therapy. This involved a change in expectations of therapy providing a cure for voices, and developing an understanding or acceptance of their voices. Through achieving this, group members went on to build existing coping strategies (or acquire new ones), as well as challenging their beliefs about voices.
Altered Expectations of Therapy

Most participants described experiencing a shift in their expectations regarding the outcome of therapy. This began during the first session, when participants were directly informed that therapy would not aim to cure the voices, but enable them to engage in a lifestyle that was not limited by voices. Initially this was met with disappointment by several group members, although ultimately it helped develop the belief that they could cope. This standpoint bares resemblance to the 'recovery model' of psychosis, which came into being in the early 1990's (Anthony, 1993). At the time this model provided a radical new perspective for services treating individuals with severe symptoms of psychosis. The recovery perspective points out that people experience wider disability than their symptoms alone, acknowledging the social impact of stigma and isolation. It also asserts that recovery can take place without the amelioration of symptoms. The therapeutic aims of this approach are to empower service-users in taking an active role in their recovery, rather than becoming reliant on medical treatment to control their symptoms (Thornhill et al., 2004).

Early papers on recovery preceded therapeutic protocols to achieve these aims, for example Anthony (1993) stated “we are nowhere near understanding the recovery concept nor routinely able to help people achieve it” (p20). Findings of the current study suggest that participants were able to accept the recovery model through the process of person-based cognitive therapy. They were also able to use this as a foundation to improve the quality of their lives, through acknowledgement that they could live with voices. Although the absence of a cure was met with disappointment, there was no evidence to suggest that participants were disheartened by this perspective. Rather, the recovery model appeared to provide voice hearers with increased confidence in implementing coping strategies and increasing their engagement within the local community. This conclusion, however, must be made with caution. Most of those individuals who attended the focus groups had also attended all 8 therapy sessions. It is therefore possible that those who did not attend as many sessions were discouraged by the recovery model, although their perspectives were not represented within the focus groups.

It is possibly surprising that there is very little reference to clients discussing their spirituality in conjunction with recovery from psychosis. This is an area that has
been highlighted as important by some investigations, for example in helping clients to cope and providing a supportive network (Chadwick, 1997; Nicholas & Russell, 2003). It is possible that the group context in which data was collected was constrictive for some clients, preventing them from discussing sensitive issues, including divulging their religious or spiritual beliefs. Another possible explanation might be the mental health context in which the focus groups were held. It is noticeable that participants in the current study mainly discussed psychologically oriented explanations for hearing voices following therapy. Possibly clients felt that expressing their personal beliefs about religion or spirituality were not relevant to the context. This might have been overcome by interviewing participants separately, or introducing the subject of spirituality within the interview schedule.

**Acceptance and Understanding of Voices**

Acceptance-based treatment for voices is a relatively new concept in psychological literature, and has evolved from cognitive-behavioural methods of treatment. Findings of some CBT studies show that distraction and suppression techniques to control voices can be associated with poor coping and increased distress in some individuals (Romme & Escher, 1993). The aim of therapies based on acceptance is to promote 'second-order' change, meaning that the individual's functioning changes without altering the actual symptoms (Veiga-Martínez et al., 2008). Participants are taught to notice and accept their distressing symptoms without attempting to change them. Psychological therapies that involve acceptance include mindfulness-based cognitive-therapy, as was used by the groups examined in the current study (Chadwick et al. 2005), and acceptance and commitment therapy (ACT; Bach & Hayes, 2002). Early studies into the use of such therapies have shown some promising results. For example, a randomised controlled trial investigating the use of brief ACT showed a 50% reduction in rates of hospitalisation compared to a treatment as usual group over a four month period. Although this study was conducted with a relatively small number of participants (35 in each group) and most outcome measures relied on self-reported scales rather than validated questionnaires, rehospitalisation rates showed a statistically significant reduction in the ACT group, and the results have been replicated in a subsequent study (Guadiano & Herbert, 2006). However, despite these promising findings, Batch and Hayes (2002) note that the effects of this brief therapy decreased substantially over time. They suggest that incorporating acceptance into lengthier,
evidence-based treatment approaches for psychosis should be examined to enhance this benefit.

As highlighted in the introduction, acceptance of the experience of hearing voices is one of the goals of Person-Based Cognitive Therapy. This is driven by a mindfulness-based understanding of distress, suggesting that 'decentred awareness' (i.e. being open to an experience without emotionally reacting to it) is directly related to reduced distress (Chadwick, 2006). The current study found some evidence to support the mindfulness formulation of distress; findings that participants who were able to accept their experience felt less responsible for their voices, and described increased confidence and self-esteem. However, findings of the current study also suggest that achieving acceptance of voices provided the basis for individuals to adapt or implement coping strategies, and it was the use of such strategies (along with an increased sense of control) which led to decreased distress. This model is partially in keeping with mindfulness-based theories of distress, although the goal of mindfulness is to move away from attempting to control distressing stimuli. This study therefore offers a further benefit of acceptance, whereby hearers were empowered to take an active role in coping. In a recently published GT analysis of a mindfulness group (Abba et al., 2008) described a model of coping whereby participants were able to step back from their experiences of psychosis, and achieve acceptance of the voices and themselves. The current study portrays a process of self-acceptance, although participants’ definitions of coping involved increased feelings of control over the voices. Ultimately, both models result in participants feeling an increased sense of control in their daily lives due to being able to cope with voices, and differ only subtly in the mechanisms by which this is achieved.

Although acceptance was an important foundation in coping with voices for some group members, not all were able to achieve this. For those who could not accept the voices, understanding their experience provided the basis of recovery. This involved solidifying their beliefs around the meaning of voices (as described in the making sense of voices category) whereby participants externalised voices from their sense of identity, thus alleviating their feelings of responsibility for their difficulties. Doing so seemed to allow some group members to attribute less authority and importance to the voices’ opinions and commands, in a similar
manner to those who described accepting their voices. It is possible that the processes of understanding and acceptance of voices found in this study were essentially the same, in that both resulted in hearers feeling less responsible for their voices. The difference may primarily lay in the language used by different participants. Some did not appear comfortable with the term ‘acceptance’, possibly due to harbouring a sense of injustice related to their voices.

Use of Coping Strategies
In a recent study, Farhall et al. (2007) conducted a meta-analysis of coping strategies used by people who hear voices. Within this they distinguished ‘natural coping’ (i.e. strategies implemented independently from the advice of others) from coping strategies endorsed within a therapeutic environment. Studies of natural coping showed that the vast majority of voice hearers independently make attempts to cope with or control their voices. With regard to therapeutic interventions for hearing voices, Farhall et al. (2007) highlight that assessing the effectiveness of coping-focused treatment in isolation is problematic, as most studies examine symptoms as a measure of outcome. This is especially apparent in recent cognitive-behavioural research, where interest has moved towards belief systems rather than factors that influence coping. Despite this, coping remains an integral component of CBT for voices, as has been highlighted in the current study.

In spite of this difficulty, Farhall et al. (2007) found that ‘resistant’ methods of coping (e.g. drowning out voices) were associated with increased distress compared to ‘acceptance’ strategies (i.e. the voices presence is acknowledged without resistance). Acceptance has also been associated with greater perceived control of voices (Farhall & Gehrke, 1997).

Within the current study, coping strategies were cited as being a key aspect of the recovery process. Participants felt that the group context of therapy was an ideal environment for sharing coping strategies, as well as having their existing methods of coping validated. Over the course of the group, some participants voiced increased confidence in coping with voices, and improved effectiveness in their use of these. One of the most commonly used ‘natural’ strategies of coping was music to drown out the voices. This ‘resistance’ strategy was also described by some as being ineffective and causing distress, as depicted by Catherine in the subcategory feelings of having lost control.
Revaluating the Power of Voices

Participants in this study described the process by which they came to reevaluate their beliefs regarding the power voices held over them. This involved a change in the voices perceived ability to control their actions, as well as its capacity to inflict physical harm.

There has been considerable interest in recent years in voice hearers’ feelings of inferiority in relation to their voices. This work is based on literature examining subordinate behaviour as an evolutionary, survival-orientated response to perceived threat (Gilbert, et al., 2001). This adaptive strategy provides a defence mechanism against conflict with a dominant other, through behaviours such as compliance with their demands, submission and avoidance (Dixon, 1998). Such threats are not always physical in nature, and may come from others of higher social status, where the intention may be to cause feelings of shame rather than physical harm. This biological theory of subordination has been applied to the area of mental health, including investigations into its role in depression and psychosis. This literature is based on the assumption that the dominant-subordinate interaction may be represented internally, as well as within social relationships. For example, depressive thoughts may be seen as having intent to cause shame (Allen & Gilbert, 1997). Researchers examining service-users’ experiences of voices have shown that people often feel a strong sense of inferiority in comparison to their voices. Furthermore, studies have shown that voice-hearers’ perceptions of their social status in comparison to their voices is significantly related to their perceived status in comparison to other members of society (Chadwick et al., 1996).

In the current study there was evidence to suggest that voice hearers related to their voices as a dominant other. There is also suggestion within the analysis to support the theory that the voice hearers’ relationships with voices reflected their perceived social status; several participants described feeling negatively labelled, judged and laughed at, by both members of the public and their voices. Over the process of therapy participants worked to address this power imbalance.

There was less evidence in the current study to support the notion of proximity as a dimension of voice hearing, as proposed by Hayward (2003). However, some of the
coping strategies described by participants (i.e. trying to drown out their voices) could be seen as an attempt to place distance between themselves and their voice. More noticeable, however, was the impulse of service-users to distance themselves from the concept of 'madness'. This involved not wishing to associate themselves with others whom they regarded as 'mad'. In addition, due to not wanting to be labelled as mad by other people, most of the participants in this study described putting distance between themselves and others within their social sphere. This might be seen by Birtchnell (1999) as a form of negative relating, due to the maladaptive nature of the strategy. Increasing distance between the self and others resulted in the person becoming isolated, and unable to challenge their negative associations between the experience of voice hearing and madness.

Attending the group, however, provided participants with an experience of 'closeness', within which they were able to build up an experience of positive relating. It is therefore possible that voice hearers, rather than attempting to put distance between themselves and their voices, strive to dissociate themselves from their internal representations of abnormality and madness. Doing so, however, is a maladaptive coping strategy, as it prevents the individual from sharing and normalising their experiences.

In general, themes of relating to voices along axes of power and proximity were less evident within the data than might have been expected, given the literature in this area as presented in the introduction. A recent study examining service-user perspectives on the relevance of a 'relationship' between the person and their voices (Chin et al., in press) found that, although participants showed evidence of relating to voices within their dialogue, most were reluctant to accept themselves as having a relationship with their voices. Within the study many participants explicitly refuted the relational model in favour of an illness or symptom-based model as an explanation of voices. This finding appears to be consistent with the current study. Chin et al. (in press) conclude that the relational framework may not be meaningful to voice hearers due to the absence of positive, intimate experiences usually associated with relationships. However, as highlighted in the current study, this remains a useful framework for clinicians to hold when working with voice hearers.
Development of Personal Identity

The category development of personal identity described the process by which participants' built their self-concept as being independent from voices. Several aspects of this process have already been addressed, for example in describing the subcategories of altered expectations of therapy and acceptance and understanding of voices. This section will therefore more generally examine the concept of sense-of-self and its relationship to hearing voices.

Within the fields of both psychology and psychiatry there has been a long standing interest in the relationship between alterations in 'sense-of-self', and experiences of psychosis. Neurobiological theories on the etiology of schizophrenia have sought to establish links to abnormalities of memory functioning or information processing systems in the brain (Hemsley, 1998). Developmental and psychoanalytically orientated theories examine loss of self-concept as a disruption of normal development, or a defence against unbearable emotion (Lysaker & Lysaker, 2002). More recently, psychological approaches to investigating experiences of psychosis have shown service-users are able to articulate a developed self-concept, with awareness of the impact of their symptoms on their sense-of-self. However, the experience of perceived loss of self-control, along with incorporating a sense of social stigma into their personal identity, results in individuals struggling to redefine themselves within the context of their experiences (Korman, 2003).

Over the last 10 years there has been an increased interest in the role of development of self-concept in recovery from psychosis. McCay et al. (2006) highlight the obstacle that having to cope with social stigma represents in recovery. They present the concept of 'engulfment', whereby one's sense of personal identity may be replaced by being defined solely by their symptoms. This alteration in self-concept resulting from stigmatised views of psychosis often results in a withdrawal from society and loss of valued social roles. In a pilot study examining recovery in first-incidence schizophrenia, McCay et al. (2006) found that group therapy had an impact on reducing participants' feelings of engulfment, and the maintenance of a healthy sense-of-self. They conclude that therapeutic groups play a vital role in reducing stigma, whilst increasing social support, and therefore facilitate recovery from psychosis. Tooth et al. (2003) conducted interviews with services-users who defined themselves as in recovery for schizophrenia, and found that the most
frequently identified factors important in recovery related to possessing an active sense-of-self. This included viewing oneself as an active agent in the process of recovery, and the acceptance of their symptoms. Tooth et al. (2003) suggest these factors are comparable to recovery outside the field of psychosis, for example having an internal locus of control has been found to be an important factor in recovery from somatic illnesses, disability and chronic illness (Rodin, 1989).

In a review of qualitative studies on recovery of self in schizophrenia, Sells et al. (2004) defined a potential mechanism in the recovery from schizophrenia. This is referred to as ‘positive withdrawal’, whereby individuals intentionally distance themselves from others whilst simultaneously exposing themselves to public environments. Doing so allows people to remain in the company of others without the demands of social interaction being imposed upon them. Positive withdrawal helps individuals to redefine themselves as distinct from their symptoms, through nurturing ones personal interests. It also allows the person to reengage with society, and revaluate the roles that are available to them. Sells et al. (2004) emphasise that this mechanism of recovery is not limited to individuals recovering from schizophrenia. However, this observation is based on the author's subjective opinions of strategies used in the general population, rather than empirical evidence.

Within the current study there was some evidence of participants using strategies that could be classified as ‘positive withdrawal’. For example, Liam commented on gaining support from another group member in going out to a nightclub. By doing so Liam was able to engage in a social environment, whilst remaining distant from others within that context. Such outings in the community allowed reengagement with society without the challenge of being judged. It could also be argued that attending the therapy group was also a form of positive withdrawal, whereby group members were exposed to a social context whilst at the same time remaining a safe distance from the social constraints of general society.

Through conducting semi-structured interviews with service-users, Davidson and Strauss (1992) identified a four stage process model of recovery involving a developing of sense-of-self. Their first stage, discovering a more active self, involved discovering personal strengths and resources, acceptance of one's
difficulties and hopefulness of recovery. Individuals then go through a stage of *taking stock of the self*, during which they reflect on their capabilities for change prior to engaging in activity. The third stage of the process involves *putting the self into action*, through setting achievable goals and reflecting on the outcome of these. Finally individuals *appeal to the self*, by coping with their symptoms and compensating for their resulting difficulties. This involves coping with stigma, separating their symptoms from personal identity, and an increased sense of personal agency. Davidson and Strauss (1992) acknowledge that this is not a linear model, and that individuals may simultaneously involved in more than one stage.

All aspects of Davidson and Strauss’ (1992) model were covered in the *development of sense-of-self* category produced through GT analysis. The above stage model also shows links to the category *learning to cope with voices* category of the current study, whereby individuals alter their perspectives on hearing voice, begin to accept their symptoms, and implement strategies to help them cope. It is therefore possible that the process by which participants experienced a development in sense-of-self was in accordance with Davidson and Strauss’ (1992) model.
LIMITATIONS

The aim of GT, as was used in the present study, is ultimately to reach 'saturation' in the data, whereby further data collection does not lead to new information or categories. There is a strong possibility that saturation was not achieved due to the confines of this research project, in terms of limited time and the finite sample population. However, as future therapy groups have been planned based on the same protocol of those examined in this study, there remains further scope to extend the analysis produced here.

A further limitation of this study was the group context in which the data was collected. In addition, the way in which the groups were designed, i.e. being made of members who already knew one-another, is atypical for qualitative research. As mentioned in the Discussion section, it is likely that this had the impact of over-representing the group process within the data. Indeed, this was one of the first categories to emerge within the data analysis, and continued to be a strong theme throughout the gathering of qualitative data. The bias towards the group process may also in part be due to my initial biases as a researcher. Certainly I was surprised at the strength of the category Developing a Group Identity, and had not expected the group process to have had such an impact on peoples' experiences of therapy. This initially influenced theoretical sampling, and therefore further collection of data, meaning that it wasn't until later in the analysis that the categories Learning to Cope with Voices and Development of Individual Identity emerged. However, this initial bias is not thought to have had a substantial impact on the overall results of analysis, as later theoretical sampling prioritised these newly emerging categories.

Due to the sampling method, the majority of people who took part in the focus groups had attended all eight sessions of therapy. By inviting all those who had attended at least one therapy session, it was hoped that this bias would be overcome. However, in practice this was not the case. Although it is a general disadvantage in collecting data that only those motivated to give their opinion will be represented, it may have been possible to gain feedback from individuals who attended fewer groups had individual interviews been used.
CONCLUSION

The present study is among the first of its kind to provide an in-depth analysis of clients' perspectives of group therapy for voices, and the first with respects to adults' experiencing chronic, drug-resistant voices. The data gathered amalgamated easily into current literature, to build on psychological understanding of coping and recovery from hearing voices. According to the current research, participants' experiences of therapy for hearing voices can be viewed as occurring within four interrelated areas. Participants' experiences of isolation and stigma outside the group had an impact on their overall experiences within the group, as described the contextual category *the characteristics of hearing voices*. The group context of therapy also had a powerful impact on normalising participants' perceptions of voices, assisting in *developing a group identity*. Within these contexts, therapy occurred within two interrelated areas; participants *learning to cope with voices* and their *development of sense-of-self* in relation to their voices and society.
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APPENDICES

Appendix 1

Participant information sheet
Study title

Group CBT for voices: Enhancing effectiveness through the integration of an interpersonal theory

Invitation paragraph

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 would involve. Please take time to read the following information carefully and discuss it with friends, relatives, care team and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This study is trying to explore ways of helping people who are distressed by the voices they hear. In particular, it is interested in the meanings that people attribute to their voices, and whether these meanings can be modified and become less distressing following some therapy with a group of other people who hear voices.

This study will run from April 2006 until March 2008.

Why have I been chosen?

We are interested in speaking with you because: 1) We understand you have heard voices for at least two years; and 2) a member of your care team thought you might be interested in participating.

In total, approximately 40 people will participate in the study, across a number of different groups.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet and asked to sign a consent form. If you decide to take part you are free to withhold any personal information or to withdraw at any time,
without giving a reason. This will not affect the care you receive. Neither will a decision not to participate.

What would taking part entail?

How much time would it take?

First you would meet with a research assistant on two occasions to complete some questionnaires together. These would be about your experience of hearing voices and your general sense of well-being. After that you would be asked to meet on eight occasions with a therapy group that would consist of approximately seven people who hear voices and two therapists. The group would consist of the same people each week. These meetings would each last for approximately one hour and would involve you sharing information about your voice hearing experience and ways of coping.

When all the therapy meetings have finished you would be asked to meet with the research assistant to complete the questionnaires again. You the other members of the group would then be invited to join a one-off discussion meeting. This meeting would last for approximately one hour and provide an opportunity to talk about your views of the group. The meeting would be tape recorded to allow the discussions to be fully remembered. The person leading the discussion would be a member of the research team who has personal experience of attending therapy group meetings as a participant. You would not have to attend this discussion meeting. If you decided not to attend this would have no effect on any other aspect of your participation in the study.

Following the discussion meeting you would be invited to meet with the research assistant on two further occasions to complete the questionnaires. These would show whether there have been any changes since the beginning of the study. The meetings would be one month and three months after the end of the therapy.

Where would I have to go?

The meetings with the research assistant would take place at a convenient location like the place where your care team work or at your GP surgery. The therapy meetings and the discussion meeting would take place at one of the facilities of your local mental health service. The cost of travelling to these places would be repaid.

What would happen?

Initially, the therapy meetings would involve yourself and the other group members getting to know each other and learning about each other’s experiences of hearing voices and the impact they have. Subsequent sessions would focus upon the meanings given to the voice hearing experience and how people cope with their voices. Differing meanings would be explored and the group members would consider alternative ways of responding to their voices. The therapy meetings could be a safe place to try out these new possibilities. All discussions would be at a pace that felt comfortable for you and would be within your control. You would not be required to do anything with which you did not agree.
What are the advantages and disadvantages of taking part?

It is hoped that the study would result in you having greater control over your voice hearing experience. The knowledge gained from this process would also contribute to a greater understanding of voices and improved treatment for other people who hear them. If you found this approach particularly useful and you felt you needed some more therapy at the end of the study, the research assistant would discuss this with you and your Care Co-ordinator. Depending on the local services, you could be referred onto another therapist or it might be possible to continue the approach with another worker. There would, however, be no guarantee how quickly this could start.

It is possible that talking about your voices, the content of what they say, and the events connected with your voice hearing experience could cause you some distress in the short term. This is common when working towards changes in the long term. The therapists and research assistant would be skilled mental health practitioners experienced in helping people cope with voices. They would assist you to find ways of coping with any temporary increases in distress, should this occur. You would also be free to access help from your care team, should you wish. If you wanted to stop a meeting or discontinue the therapy for any reason, you would be free to do so immediately.

Confidentiality

With regard to your Consultant Psychiatrist and care team

Your care team including your GP and Consultant Psychiatrist/ Care Co-ordinator would know that you were taking part in the study. The research assistant would write to inform them of your participation at the beginning of the study and again after the therapy. The research assistant would agree the content of any correspondence with you before writing, and you would receive copies of any letters and reports that were sent.

The research assistant and therapists would have no other contact with your Consultant Psychiatrist or care team, with one exception: if you said something that led the research assistant or therapists to believe that the safety of yourself or someone else was at risk, this information would need to be passed on. Before this happened you would be asked about the best way to do this.

With regard to writing about the study
All information that is written during the course of assessment and therapy meetings would be kept strictly confidential and stored securely. Only members of the research team would have access to these records. This information would be coded and have your name and address removed so that you would not be recognised from it. The study has been checked to ensure it complies with data protection laws.

**What will happen to the results of the study?**

The results of this study will be written-up by March 2008 and submitted to a national psychology journal. You could receive feedback on the results of the study if you wanted to. No participant will be identified in any part of the write-up or article.

**Who has reviewed the study?**

The study has been reviewed and approved by the Research and Development Department within your local NHS Trust. It has also been reviewed by a NHS Research Ethics Committee which has raised no objection to it.

This information sheet has been written in collaboration with individuals who either hear voices or have previously taken part in group therapy meetings.

**Contact for further information**

If you have any questions or concerns about this study, you should discuss them with the researchers leading the study:

Dr. Mark Hayward  
Clinical Psychologist  
C/o Department of Psychology  
University of Surrey  
Guildford GU2 7XH  
Tel: 01483 689441

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed by someone's negligence, then you may have grounds for a legal action, but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you. You may also wish to seek advice from the Patient Advice and Liaison Service (insert contact details for appropriate PALS).

If you decide to participate in the study you will be given a copy of this information sheet and a signed consent form to keep.
Appendix 2

Consent form for participation in the focus groups
CONSENT FORM

Title of Project: Group CBT for voices – discussion meeting

Name of Researchers leading the study: & Mark Hayward

1. I agree to participate in a one-off discussion meeting to explore my views of the therapy group. I have read the information sheet dated ____________ and have had the opportunity to ask questions.

2. I understand that my participation in the discussion meeting is voluntary and that I am free to withhold personal information or to withdraw at any time. I do not have to give any reason for withdrawing, and my medical care or legal rights will not be affected.

3. I understand that the discussion meeting will be tape recorded for the purposes of this research project. A transcript of the discussion meeting will be written from the recording, in which all information will be reported anonymously. Only members of the research team will have access to the original tape recordings, and these will be erased once they have been used. I retain the right to ask for the tape to be destroyed if I so wish.

4. I understand that (Trainee Clinical Psychologist) will be using the themes from the conversations at the discussion meeting for his coursework at the University of Surrey.

5. I agree to take part in the discussion meeting.

Name of participant Date Signature

Name of person taking consent (if different from researcher) Date Signature

Researcher Date Signature
Appendix 3

Interview schedule used to guide focus-groups
Group Therapy for Voices

Focus Group Interview Schedule

• Thank you for coming along today
• I would like to establish some ground rules before we start - everything that is discussed here today will remain confidential (within usual limits) and any findings in the final report will be anonymous. If anyone wants to stop because they feel distressed, please feel free to leave the room (the second facilitator should go and chat with them if this happens).
• Today’s discussion will aim to get your personal views on the voice hearing groups you attended
• Session will be approximately 60 minutes long
• Session will be tape recorded
• You can leave the conversation or not answer a question at any time without giving a reason or your care being affected
• We will ask about your experiences before and during the groups and then what you thought of the therapy.
• Emphasise separateness from therapy process.
• Before we start this discussion group, please could all participants introduce themselves briefly and explain why they are here today (this acts as a good ice breaker and also helps identify participants for transcribing purposes and is worth doing even if members of the group know each other previously).

Circumstances leading to therapy

1. What do you feel prompted you to join the therapy group?
   Prompt: goals / aims
   problems to overcome
   curiosity
   loss / gaining independence
   if someone else’s idea - why did they want you to participate

2. Prior to the group, how had your voices affected your wellbeing?
   Prompt: positively or negatively?
   impact on activities
   (social) confidence
   type of voice / relating / intrusion / dominance
   work life, family life, personal life. how did you think that hearing voices impacted on your life in general.

Expectations about therapy / what took place

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3. Would you say that you had expectations about what therapy would involve prior to joining the group?
   
   **Prompt:** optimism / pessimism about whether it would be useful therapy vs counselling, changing relating vs getting support
   
   What was the source of this understanding - previous experience / colleagues / participant information / team

4. Would you say these expectations were confirmed? In what way?
   
   **Prompt:** yes / no why

**Understanding of the therapy process**

5. Did you learn anything about yourselves and the voices during the group?
   
   (The prompts below are only to be used if mentioned by the participants)
   
   **Prompt:** balance of power / control personal strengths and resilience accepting the voice presence of and two-way nature of relationship potential for change

**Relationships within the group**

6. How would you describe your relationship with other group members?
   
   **Prompt:** support / trust / confidence / empathy / feeling understood / accepting
   
   shared goals / common ground developing social skills
   
   did the presence of other group members in the process facilitate or hinder?

7. How would you describe your relationship with the therapists?
   
   **Prompt:** support / trust / confidence / empathy / feeling understood / accepting
   
   shared goals / common ground developing social skills
   
   What particular skills did you like / dislike in your therapist? What would you have wanted?

**Current wellbeing**

8. Would you say that your voices have affected your wellbeing since the group finished? If so, how?
   
   **Prompt:** positively or negatively? impact on activities (social) confidence type of voice experience - relating / intrusion / dominance

9. How have you felt since the group finished?
   
   socially efficacy outlook work and family

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End of session

- Is there anything else you particularly wanted to say?
- Thanks for your time
- Articles will be written up - written summary sent to you when study ends in the summer of 2007
- If any one feels the need to speak to the researchers about any aspect of the study - give a contact number for Caroline

*Schedule based on McGowan et al (2005)*
Appendix 4

MREC and site specific R & D ethical approval letters
Dear Mark

Group CBT for voices: Enhancing effectiveness through the integration of interpersonal theory

Thank you for your letter dated 18 April 2006 in response to the Committee’s comments on the above research.

Confirmation of ethical opinion

Your response has been considered on behalf of the Committee by the Vice-Chairman and, as a result, I am pleased to confirm a favourable ethical opinion for the study on the basis described in the application form, protocol and revised documentation.

Ethical review of research sites

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.

Approved documents

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

i) NHS REC Application Form, Version 5.0, dated 14 February 2006
ii) Your curriculum vitae, dated 14 February 2006
iii) Research Protocol (version undated)

An advisory committee to Surrey and Sussex Strategic Health Authority
Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance 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: Sussex NHS Research Consortium

An advisory committee to Surrey and Sussex Strategic Health Authority
South West Surrey Local Research Ethics Committee  

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION  

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

<table>
<thead>
<tr>
<th>REC reference number:</th>
<th>08/Q1909/24</th>
<th>Issue number:</th>
<th>1</th>
<th>Date of issue:</th>
<th>05 May 2006</th>
</tr>
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<tr>
<td>Chief Investigator:</td>
<td>Dr Mark Ian Hayward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full title of study:</td>
<td>Group CBT for voices: Enhancing effectiveness through the integration of Interpersonal theory</td>
<td></td>
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</table>

This study was given a favourable ethical opinion by South West Surrey Local Research Ethics Committee on 4 May 2006. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Post</th>
<th>Research site</th>
<th>Site assessor</th>
<th>Date of favourable opinion for this site</th>
<th>Notes (?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hampshire Partnership Trust</td>
<td>Southampton &amp; South West Hampshire REC (A)</td>
<td>04/05/2006</td>
<td></td>
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<tr>
<td>Dr Mark Hayward</td>
<td>Clinical Psychologist</td>
<td>West Sussex Health &amp; Social Care NHS Trust</td>
<td>West Sussex Local Research Ethics Committee</td>
<td>04/05/2006</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical lead - Psychosocial Interventions for Psychosis Service</td>
<td>Hampshire Partnership NHS Trust Parkway Centre 51 Leigh Road Havant Hampshire PO9 2HU</td>
<td>Isle of Wight, Portsmouth &amp; South East Hampshire Local Research Ethics Committee</td>
<td>04/05/2006</td>
<td></td>
</tr>
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</tbody>
</table>

Approved by the Chair on behalf of the REC:

[Signature of Chair/Administrator]

(delete as applicable) /\  

[Name]  

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.
Dear Mark

Research Project – WHC 642 Group CBT for voices: Enhancing effectiveness through the integration of interpersonal theory Ethics No (LREC): 06/Q1909/24

This letter provides the formal Hampshire Partnership Trust approval required for your project to commence. Overleaf are a list are details of information that the R & D Office will require during the period of your research. Your project is now registered on the R&D database with identification number WHC 642 .... It would be helpful if you could use this number on all correspondence with the R & D Office.

Please note that this trust approval (and your ethics approval) only applies to the current protocol. Any changes to the protocol can only be initiated following further approval from the ethics committee via a protocol amendment; the R&D office should be informed of these changes. We understand that local investigators are to be employed who will require Honorary contracts before they can commence data collection.

The conditions of this approval require you as Principal Investigator to ensure that the study is conducted within the Research Governance framework and I encourage you to become fully conversant with the Research Governance Framework (RGF) on Health and Social Care document, which is available from the following link: www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/ Any breaches of the RGF constitute non-compliance with the RGF and as a result Trust approval may be withdrawn and the project suspended until such issues are resolved.

During the course of your study we will contact you regularly for self completed audits of the study. In addition we are required to site monitor 30% of projects and yours may be selected. Attached is a suggested format for the study/project file which will help to ensure that all the necessary documentation is in place and readily available.
Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

With best wishes

Yours sincerely

[Redacted]

Research & Development Manager
Southampton City PCT (and Hampshire Partnership Trust)

Cc [Redacted]
Dr Mark Hayward
West Sussex Health and Social Care NHS Trust
C/O Psychology Department
University of Surrey
Guildford
Surrey
GU2 7XH

15 May 2006

Dear Dr Hayward

ID: 0666/WSHS/2006 Group CBT for voices: Enhancing effectiveness through the integration of interpersonal theory.

Further to my letter of the 20th February 2006, the Chairman on behalf of the RAMC has considered your response to the issues raised by the committee's initial review. The documents considered were as follows:

* Outline of overarching research plan (no version control undated)
* Research agreement between The Sussex Partnership NHS Trust and Hampshire Partnership Trust (signed and dated 07/04/06 and 14/04/06)
* Surrey REC approval letter (signed and dated 05/05/06)

I am pleased to inform you that this study has now been approved by 'Chairman's action', and so may proceed. This approval is valid in the following Organisations:

* Sussex Partnership NHS Trust

Your RAMC approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make any changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within five working days.

Please note that if your work involves South Downs Health NHS Trust, this approval means that you now have your Research Passport.

Good luck with your work.

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Yours sincerely,

[Redacted]

Research Governance Assistant
Appendix 5

University of Surrey Faculty of Arts and Human Sciences ethical approval
29th October 2007

Dear [Name],

Reference: 179-SE-07
Title of Project: Exploring service-users experiences of integrative therapy for hearing voices

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely,

[Name]
Appendix 6

Example transcript from a focus-group

N.B. This transcript has been anonymised so that all personal data pertaining to the clients has been removed or replaced. Pseudonyms have been used which correspond to the excerpts used in the research project. Facilitator 1 represents the author of this research project. During this interview, Facilitator 2 has to leave half way through due to a personal commitment. However, there were two members of the team on site who were available to manage any potential issues of risk or distress resulting from the focus-group if required.
Facilitator 1 - Ok, so as [facilitator 2] said there we’re going to start off with a round of introductions just to start the process off. Just to let you know that this group is supposed to run for an hour, we’re starting a little bit late, but maybe if we finish at about twenty to three, will that be ok for everybody.

Yeah that’s fine.

Facilitator 1 - Is that ok? And as [facilitator 2] said at the beginning she’s going to have to leave at about twenty past in about half an hour, but we’ll carry on running the group if that’s ok with everybody. So has anybody got any questions that they’d like to ask... no? Ok, so if we start off with a round of introductions, I’ll start. My name’s [facilitator 1] and I’m a trainee clinical psychologist, and I’m studying at the University of Surrey in Guildford, and I’ve come along today because I’m part of the project that’s interested in hearing all of your personal views of the therapy that you’ve been attending in the last, I think it was eight weeks, was it?

Yeah.

Facilitator 1 - So I’m interested in hearing your experiences of that group. Would you like to go next - just a brief introduction about what’s brought you along here today.

Patricia - Sorry?

Facilitator 1 - What’s... just a brief introduction about yourself, and why you are here today.

Patricia - Ok, I am Patricia, I live in [European Country]. I came here for the eight sessions for the voices group. I am [nationality] and I came here three years ago. I am here because I am interested to learn something to research group, to the research group.

Facilitator 1 - Ok, excellent, thanks.

Martin - I am Martin. I live in [town]. I come to the group to help with hearing voices, and the fact that there are other people as well that have voices. So share my experiences with other people. That’s about it really.

Facilitator 2 - Ok, I was a bit over-keen and introduced myself a bit too early before. So I’ll just, kind of... I’m [facilitator 2] and I’m also a trainee clinical psychologist at the same university as [facilitator 1] and I’m really interested in this research and this subject area, and I was saying to everyone else, I have personal experience of mental health problems which is kind of what has made me really interested in this study, in this research. But it doesn’t mean I know how you feel or what
Rachel - My name is Rachel. I'm from [country], I'm living in [place]. I have got voices, all my life, and I came here because I'm bipolar and I want to know about the voices, I want to share my experience and want to learn about the voices, control the voices because it is very difficult with voices. Thank-you.

Sophie - I'm Sophie and I come to the group to see if I can sort some of my voices out because I have them nearly all the time, and I thought that the group would help, which I think it has helped. And I thought I could give something back to the group.

Facilitator 2 - Thank you. Ok, we've got a few questions for you that are really just to promote discussion. The first question is really quite similar question to the introduction really, which is what do you feel prompted you to join the therapy group in the first place. Anyone can kind of... what do you think made you keen to join the group in the first place? What inspired you?

Rachel - Because it's very positive. I normally am one person who hears voices. I come to find support, somebody can listening to me.

Facilitator 2 - So it sounds like other people having similar experiences was useful for you, so that you weren't on your own.

Rachel - Yes.

Facilitator 2 - Ok.

Sophie - I found it quite daunting to think of coming. But I was told that they'd actually be able to help me with understanding why I hear voices. And also I had a thing about policemen, or I have got a think about policemen, and I talked to my CPN and she said that other people have the same experience, but I didn't actually believe her until I came to this group, but now I do. So it makes it easier to understand.

Facilitator 2 - So it sounds like other people understanding has been quite important, and I wondered about Martin and Patricia your experiences.

Patricia - Me, I don't hear one voice, I used to go to another voices group at [place], and I was thinking that a research group would cure me better.

Facilitator 1 - So you were quite interested because you knew it was a study that was going on, and you thought that it might be something that would help.
Patricia - More therapeutic.

Facilitator 1 - More therapeutic, right. So was it something about it being structured, or a certain amount of...

Patricia - Of sessions.

Facilitator 1 - Was there anything else about the fact that it was part of a study that you felt...

Patricia - I was interested to look, to meet other people from my other voices group. Because sometimes we were only two persons, sometimes eleven persons, it depends. There it was, it's always the same amount of persons, they come here for each session wanting to know more about voices.

Facilitator 1 - So it sounds like the structure, and the way that each group was quite consistent and had the same number of people was quite important.

Patricia - Yes because sometimes whichever person comes, or doesn't come. Because one lady, she's doesn't come any more because she has a German lesson, a German course, so she doesn't come any more. Most of the time we were two persons actually. At the end the groups stopped, and we got together - I don't know why. And Sophie used to come as well.

Sophie - Yeah, I stopped about three months ago. It's just that, because they start and then they do five weeks, then they stop for a period of three weeks, and it never got going after the three weeks.

Facilitator 1 - So it sounds like some people had had previous experiences of being in groups, and talking to other people in the group about hearing voices, and thought "well that might be quite helpful to do something quite structured, and it's a therapy group rather than something that is less structured".

Sophie - I found the research group much better and much easier to cope with than I did at [place].

Facilitator 1 - Right. And at [place] was it people talking about their own experiences or was it...

Sophie - Yeah it was people talking about their voices and things, and how they'd been in that week, and sometimes they had a psychologist, trainee psychiatrist in. And they had psychiatrists going in to explain the sections and things, and they have other people going in. They had [researcher] in a couple of times.
Facilitator 2 - So it sounds like they were giving you lots of information, and talking to you a lot about lots of different areas relating to it.

Sophie - But as Patricia said, sometimes there might only be two or three of you, and other times there would be lots of you, and it's very difficult because you don't know how many, whereas with this group you know how many there is all the time. And you get to know each other as well.

Facilitator 1 - And it sound like that was something that was quite interesting for you Martin, you said that you wanted to get an understanding and also share experiences with other people.

Martin - Yeah. I've been hearing voices for years now, and I've got three, I haven't got just one. I've got two men and a woman, and they talk amongst themselves. It's really hard. I just thought I could do with really understanding about hearing voices and share my experiences with other people, so I came to the group.

Facilitator 1 - So you wanted to get a bit more information about the things that you were experiencing, but also share what you were experiencing with other people in the group.

Martin - Yeah, that's right.

Facilitator 1 - OK, excellent. So before joining this group, I was wondering about how hearing voices affected people's lives and affecting their wellbeing before...

Rachel - I have got one all my life. My family, they don't believe me because when I had got three years, my brother who got seven years and my parents said that "you are naught, you want attention" because I was listening to voices - somebody wanted to kill me, so I used to go to my brother. But my parent's smack me all the time. It was very nasty, and my parent's. I don't want to... I said to my parent's it was psychiatric. Never seen as an illness. It was only when coming to England, in a hospital psychiatric. They said it was bipolar, when I was 32 years old, all my life... For me it is very important coming to this group because I learn about my limit. I can say no, and I can say yes. Because I am a very vulnerable person and always under control at work, I say yes for everything, but sometimes I need to protect myself. It is very important for me.

Facilitator 2 - So it sounds like it was quite a difficult experience you not being believed by your parents.

Rachel - No, they only used to smack me, tell me that I was naught, "you want attention", "you are not my daughter", "you no
Facilitator 1 - You've had a harsh experience of not being believed, and actually reprimanded and hit for trying to tell people about...

Rachel - Like I said, somebody wanted to kill me, someone is outside, and my parent's said it is attention.

Facilitator 1 - So that sounds really difficult.

Facilitator 2 - You also said something about at work and things having to protect yourself, saying yes to people...

Rachel - Yes, because last time... I work in the cleaning department, but someone in there asked me for cleaning her house and look after the cat, and me moved to her house. And [name] the neighbour, talking about me in the house. She's not liking me staying in the house because there is so much cleaning. But coming to this group I learn that I need protection, I learning that I'm more strong than my voices. That I can control voices, and not play games with the voices, say "I'm ok, I'm ok, I'm ok". Because the voice still come a little but not so strong.

Facilitator 1 - So before coming to the group it sounded like you had difficulty saying no, not only to the voices, and trying to control the voices, but also to other people, and people who you worked for. And so something that you've learnt is to start protecting yourself and be a bit more forceful and say no to other people, but also try and control the voices a little.

Rachel - Yes, and this group has helped.

Facilitator 2 - And how did the group help you to do that? What was it about the group that helped that to happen.

Rachel - Because I... the limit, you know? Put limits, protect yourself. Thinking about something positive experiences, and controlling voices. You know, "I feel ok, I feel ok". Voices is not more important, thinking about the voices. In this group I can feel so many support, and I don't know, but I learn about the limit. It's something that happens, magic, in this group. It's very important for me. I'm more important than the voices, and I'll put limits.

Facilitator 1 - So seeing yourself as... it sounds like you're not entirely sure exactly what it is, but you feel that you're able to set some kind of limit and say "I'm more important and I can decide... There's a limit as to what I'm going to let the voices take over".
Rachel - Exactly, and the voices all the time, they are “you need to be more help, you need to be in therapy, you can’t finish your work, you are naughty, you are attention seeking” and I say, “no, I am ok, it’s too much work, but I can support, and it two weeks more I can say, no more of this job. For me it is no more of this job. Limits. I learn this limit. Because this job - look after the cat, and cleaning the house, and everything perfect. It’s too much for me. And I’ve learnt about my limits, control my limits. No for me, this job will make me ill.

Facilitator 2 - I guess I think it sounds more manageable because you can break things up into different areas, it’s not limitless, and... so you can put boundaries around things.

Rachel - Exactly, yes.

Facilitator 1 - And how about other people? How were other people’s voices affecting them before coming to the group?

Patricia - Me, in Easter, I had a big crisis. It was very powerful voices in my head. I went to Milan, even in the plane they were there, in Milan they were there, come back they were there, all the time. Saying things to me. Then my best friend told me to see the psychiatrist, and I took 30 milligrams instead of 15 milligrams. And month after month from Easter they were reduced, and now I don’t have any more voices almost. The voices are very far, far far away, so I can hear them sometimes only. And they keep on repeating the same things anyway, so I’m happy without that any more. They always say that... they always say the same thing, that’s how it feels. It’s a bit bizarre, but it’s voices. And the voices group, this group, this voices group, it gives me a lot of support because I’m taking 30 milligrams now and I’m very scared that when I will reduce my medicine it will come back again. So I keep on going with 30 milligrams now, and there are some side effects to it.

Facilitator 2 - So it sounds like you were saying that the voices had been quite difficult and had been saying some bizarre things to you, but they haven’t... since Easter they seem further away and as if they’re bothering you less, and I wondered how that had happened, what had lead to the voices leaving you alone a bit more?

Patricia - What did the voices...?

Facilitator 2 - What helped the voices to go away?

Patricia - Oh, the medicine, because I took double the dose. 30 milligrams instead of 15 milligrams.
Facilitator 1 - So you've been taking a stronger medication at the same time as doing the group, and now you feel that the voices have backed off a little bit.

Patricia - Yes, and when I decided to go in this group I still had this voices, and it was saying, it was next month you will start this voices group, this special voices group. And during this month the voices have reduced.

Facilitator 1 - Have gone right down? That's great. How about anyone else? What were your experiences of voices before starting this group?

Sophie - Well I've had voices for about 15 years and I've even had ECT treatment. And that's why I'm coming because I had a five minute seizure, when you're only supposed to have a five second seizure. So they were like headless chickens. And it took about 7 years to work out that I've got schizo-affective disorder. And my mum didn't understand, my husband was hopeless because he didn't understand what voices were. And he doesn't really, well I don't sit back and talk to each other because I have six separate groups, and he found it... he thought I'd be agitated and found it really difficult. And now he understands how I feel when I hear voices, and when my daughter keeps telling me to tell them to go away in not such polite terms. But she sometimes gets cross with me because when I hear voices I have fits, and I find it very difficult to concentrate on things. Or she'll say something to me and I'll forget what she said, or I'll only hear half of what she said. Or she'll say something and it doesn't register for a while.

Facilitator 2 - It sounds like the voices were kind of getting in the way of your personal relationships.

Sophie - And seeing as I can't concentrate anymore because I can't cook things at the same time. We'll have starters of potatoes and a main course of sausages and peas for afters. It's things like that, I can't really... I couldn't fry an egg because I kept dropping it and burning myself, so I gave up doing that. And there's lots of things that I had to give up.

Facilitator 1 - So was it that you couldn't concentrate on more than one thing at a time?

Sophie - Yeah, because the voices would talk to me all the time. Then they'd start shouting at me, then they'd start screaming at me, and when they're screaming at me I can't take anything in. I can't watch television, I can't listen to music, I can't listen to what people are saying or anything. And I find it really frustrating.

Facilitator 1 - Yes, It sounds frustrating.
Facilitator 2 - Well I was wondering, before the group started what your expectations about what you thought it might involve were? What you thought might happen in the group.

Sophie - I thought it would be something that would help me concentrate on getting rid of voices. I've found that mindfulness was quite a good idea. It's something I've never come across before. I've come across lateral thinking, which I put into practice which works sometimes, but not all the time. And then mindfulness when you listen to a noise, I can cope with. But listening to... concentrating on your breathing I couldn't do because I can't concentrate on my breathing, like it will speed it up.

Facilitator 2 - So it sounds like...

Sophie - I'd be hyperventilating, so I'd go with noise.

Facilitator 2 - Ok, so it sounds like you wanted to be able to concentrate a bit better, and you'd come across some techniques that you'd used before, but the mindfulness was something that was quite new. And some of it worked, and some of it not quite so much.

Sophie - Yeah.

Patricia - I was hoping for some tricks to cope better to cope better with the voices.

Facilitator 1 - So some strategies, some ways in which to cope? Ok.

Rachel - I found it very good.

Facilitator 2 - And what did people think that the group would involve before they started, what they thought might happen in it. Sorry, just to find out from other people what they expected.

Rachel - Give more confidence. I said to myself, I'm different, though I've got voices I said to my voices I've got to live my life. It doesn't matter... it can't make a difference to other people because I'm different. And this for me is very important. I said to myself, I'll share this with someone who has the same problem as me, someone who can listen. And I'm not the only person.

Facilitator 2 - So it sounds like you're saying that you've become a bit more confident and accept yourself, and it's through other people listening and understanding.

Sophie - I find I'm more able to cope with my voices because before I thought I was going mad, because I just thought it was my
Facilitator 1 - I was thinking quite a few people now have talked about being listened to by other people, and having an expectation that other people will listen to them, and thinking that that would be quite helpful. And I was wondering, what is it that's useful about being listened to by other people?

Patricia - Because they can understand the experience we have.

Facilitator 1 - So when you...

Patricia - Another point of view of our experience.

Facilitator 1 - Ok.

Facilitator 2 - And also from what Sophie was saying, it sounded like you were saying that other people listening and knowing what it felt like was...

Sophie - Yes.

Facilitator 2 - And not feeling like you're going mad because other people having...

Sophie - The same experience. And I find that I used to cry all the time, because the voices would reduce me to tears. I still cry, but if I cry now and people say to me “what's the matter?” I say “nothing”, and they say “oh it's the voices again - we know”. And they know that I'm hearing... well the voices are really bad because I'm crying. And I know that I don't have to say that it's the voices bugging me again.

Facilitator 1 - So it sounds like it's not only other people having an understanding of what it's like to have voices, it's also other people having an understanding of you, and that if you're upset that it could be due to the voices, rather than wondering why.

Sophie - Yeah.

Facilitator 2 - And it sounds like having a bit of empathy, and a glimpse of what it might feel like.

Sophie - Yeah, because he doesn't... because sometimes I'll tell him something, and he says “no, now I'm having a break”. Because the CPN said that he should have a break when he comes home before I tell him these things. But I want to tell him while I remember because I can't write it down, because by the time I've found some paper to write it on I've forgotten what I was going to say in the first place. So he's
Facilitator 1 - So it’s about being accepted, as I think that... or sorry, accepting yourself, and also being accepted by other people. And maybe for example your husband accepting that sometimes you don’t do it exactly right, the way that you’ve agreed, and that being ok sometimes.

Sophie - For me it’s important for people to accept me, because I find I don’t accept myself. That sounds odd, but I don’t accept myself, and I don’t think I’m a very nice person. And yet everybody else says that I am. But the voices tell me I’m not. So it’s trying to get control of the voices so I can change my attitude towards myself, and the fact that I think other people love me. Because I find that when I hear voices and they say “your daughter doesn’t love you” and “your son doesn’t love you”. I can’t count my son because he’s disabled. But my daughter saying “I do love you”, but I think “well she doesn’t love me really because the voices tell me that she doesn’t love me, she’s just saying it to shut me up”.

Facilitator 1 - So has the group helped at all in helping people accepting themselves or accept other people...

Sophie - It’s helped me because I’ve got more ability to control them now. I’m nowhere near as tearful as I was eight weeks ago. And for my husband it’s worked quite well, it’s just having had that talk before and just being able to talk about it.

Facilitator 2 - So it sounds like similar things that people have talked about expecting from the group, about confidence and self acceptance, have actually happened to a degree. That similar things have been confirmed, something you’ve thought about or hoped for has been possible. Would people agree with that?

Patricia - Yes.

Facilitator 2 - And how has that happened? What kind of things has the group done that’s lead to those things working out?

Rachel - Because you are more important than the voices. When you accept that I’ve got voices and I’m sad, I can live more happy. Because for years I know I’m ill, I’m listening to voice, but the voices are not more important. I am more important. I can control a little better.
Sophie - I find that the ABC system works, if you think about your problem in the first place then what it’s going to be and what the outcome is.

Facilitator 2 - So it sounds like taking a different perspective, looking at the voices from a different point of view has helped to change things.

Sophie - I never thought my voices would change. I thought I would always have them. They would always be really really strong.

Facilitator 1 - And how about now? Has that view changed at all?

Sophie - Yes it has. I think I can control them a bit. Not a lot but a little bit. But they don't shout at me so often. They just talk about me and say horrible things. The things they say make me feel bad, but I don't increase my medication as well. And every time I came to the group, when I went home I cried, because I found the group quite difficult. Well, it's wasn't difficult, it was just emotional. So I waited until I got home and then I'd burst into tears. Accept for one time I'd burst into tears after the group.

Facilitator 1 - So it sounds like the group was actually quite emotionally difficult to be part of. I don’t know whether other people experienced that?

Patricia - No.

Facilitator 1 - You didn’t?

Patricia - No it was so interesting and positive, [the therapists], that it was relevant to us, and it was easy to follow.

Facilitator 1 - So maybe some people found it quite difficult, but for some the actual group was a positive process.

Rachel - Yes, for me as well. Exciting, because every day you learn about the voices, and about yourself, and the life - how to be happy. You can control a little bit, and say “I’m ok, I’m ok”. The voices say “no, you’re not ok, you’re not ok”. But I think “no, I can finish this work, I can finish this work, I’m going to manage it”. Next time I’m not going to take a job that's difficult for me, because I've learnt.

Sophie - I've found now I can, how can I put it, that I can put things in proportion more. My voices were in my head before I just couldn't.

Facilitator 1 - Perspective. I think that’s actually what I was thinking when Rachel was saying there that it sounds like people are looking at things in a different way and putting things in perspective a bit.
Facilitator 2 - Thank you very much for sharing everything so far, unfortunately I’m not able to stay, but thank you for letting me listen to your views. It’s been really helpful.

Facilitator 1 - Can you tell [therapist] that we’ll probably go on till about quarter to, if that’s ok for everyone.

Facilitator 2 - Ok, thank you.

Facilitator 1 - Ok, so I was just wanting to continue. Was there anything that people learnt about themselves or their voices during the course of the groups?

Rachel - Unlimited!

Facilitator 1 - So lots and lots of things. So we’ve talked a bit about accepting, and I was wondering if there was anything that you learnt in particular over the course of the...

Martin - I liked the fact that in the group we weren’t being labelled, we were just treated as human beings rather than ‘he’s schizo’ or something like that. I had an experience in Australia with that, but in the group they don’t label you as anything. It’s easier to talk. I found it easier to talk.

Facilitator 1 - So being seen primarily as a person, and not the fact that you hear voices as the first thing that people see in terms of being given a label.

Martin - But since one of the reasons why I didn’t really want to come to this place is because I thought they were just going to label me as something. And never once have we been labelled as anything, so I’ve benefited from that.

Facilitator 1 - And has that shown you anything about yourself?

Martin - Well basically I’m a good person, I’ve just got an illness, basically.

Facilitator 1 - So maybe that your illness isn’t a defining feature about who you are.

Martin - I am not the illness. I am a person with a certain illness.

Sophie - I found it very helpful when we went round and said what the rest of the group thought about each person. And they came out with all different answers, and now we’ve had it sent home. Because I wasn’t actually sure because of the voices what people had said. So I read it to my family, my one, and they all agreed with it, and said it was true. And it gob-smacked me a bit because I thought, “perhaps it is true”. And they were all really nice things that people had said.
Embarrassing at the time, all the really nice things that people had said, so I thought that was nice.

Facilitator 1 - So again I think we're talking about getting a different perspective on yourself and getting other people's opinions on what you are like. It's interesting that when you read them you thought, "no, that's not me", but when you read it to other people they agreed with it.

Rachel - And limit our distress. When I've got a lot of stress, I've got voices. When less stress, less voices. And coming here my stress went down, and my voices, it hasn't gone. But when I said to my doctors, but for me my voices are too much the medication is not working because the stress is too high. And coming here, and explaining my problem here - my problem is too much work. It's a worry when the work is too too much, too much stress I need to protect myself. Go for a walk, or take life easy - an easy life.

Facilitator 1 - So is that something that you'd realised before coming to the group? That the more stress you had the worse your voices were. So, I was just wondering whether coming to the group clarified that for you, and made you think "actually that's right, when I have a lot of stress maybe I need to do other things as well like go for a walk".

Sophie - Also medication has a lot to do with it. I mean to get through it, if you've got the right medication it makes it easier to contend with. Because I found it quite hard because last year I had visual hallucinations, and I went to [place] to the hearing voices group, and there was eight of us and nobody else had experienced it. So I thought it was one of my freak experiences. Even thought other people experienced it I didn't believe people. And then as it came back to policemen again I thought it was just me. And I didn't think that other people think the same. But when we came here there were three of us out of the five of us who had the same experience, so it made everything seem alright again.

Facilitator 1 - So it was helpful for you to explain things to other people that you thought might be individual to you, and actually other people...

Sophie - Because also, with [person] he has one thing about when he goes out he takes a knife out with him. And I thought it was just me that did it. And [person] I think he felt the same as me. But then he said that he put a knife down his sock.

Facilitator 1 - Right, and was the reason you were doing that because you were worried about protection?

Sophie - Because I thought that there were people trying to kill me.
Facilitator 1 - Right, because of what the voices were telling you?

Sophie - Because of what the voices said. Last week the voices said that when I go to bed to sleep my daughter and her husband, and my husband were going to kill me when I’m asleep. So it took me ages to go to sleep, and when I did go to sleep I had bad dreams. And then I woke up and thought “no they didn’t kill me. The voices were wrong”. So it proved a point that the voices can be wrong at times. Not all the time but sometimes. And when I went down to get my diabetes prescription they said I was going to have eye problems and that I was going to go blind. My legs were going to drop off, and all the things that can happen with diabetes. And I think it’s lateral thinking because it was a true statement, it could happen, and the voices, I couldn’t reason with the voices there because what they were saying was true in a way. But as time has gone by I think they were wrong because it hasn’t happened and I haven’t gone blind and my legs haven’t dropped off.

Facilitator 1 - So it sounds like now you’re looking for evidence that the voices are wrong, rather than accepting them as being right. And you said something interesting there about medication there as well, and I think it links back to something that Rachel was just saying, weren’t you about having the right medication helps as well.

Sophie - Because there’s my depot injection and then I have voices and visual hallucination, and so I say “I’ve been waiting for this”. And then he gave me my depot injection but a different one, and it worked. And he increased it because I was still having quite a lot of voices and it helped me quite a lot. Because the voices used to scream at me all the time. I used to wake up in the night and the voices would be there. I don’t know if the voices woke me up or whether I woke up and had the voices straight away. I couldn’t work it out.

Facilitator 1 - So having the right medication is helpful for reducing the voices and helping you with that...

Sophie - And it helps you talk about them as well.

Facilitator 1 - Ok, and it actually helps you talk about the voices within the group.

Rachel - For me good medication, you have got too much stress as well. You need medication and an easy life. Not too much problems.

Facilitator 1 - So it sounds like medication is useful, but it’s not the whole solution because there are other things that you need to do to help.
Rachel - Yes because you have got a little stress, it is most important to take an easy life. You need to know your limit. I can't be a top model, I can't be a manager. I can be a cleaner, that's ok, but not cleaning the whole... no that's my limit. This job for me is 10 hours a week. More of an easy life, go for a walk, go to the shopping centre, or a place for people with mental problems. Go to an easy life. And talk about your problems, it's nice when someone listens to you. If I can talk to psychiatrist... psychologist, it's nice.

Facilitator 1 - So it's important for you to remember that you have to take things slowly and it doesn't necessarily what job you do, just as long as you take things easy and make sure you look after yourself.

Rachel - Yes.

Facilitator 1 - I was wondering whether there was anything else that anyone learnt from coming along to the therapy groups.

Sophie - I learnt that if you fail a task that you wanted to do you can go back and try again. And it gave me the courage to try and cook a meal again. So now I have to get it so that it all comes together more or less at the same time. And that's an achievement in itself, because as I say I used to do it in three or four courses. So it gives you the ability to do something wrong, or if the voices make you do something wrong then you can redo it and it doesn't matter. You can always try again.

Facilitator 1 - So how did you learn that?

Sophie - To try and keep the voices at the back of my mind when I'm trying to concentrate really hard. And the voices will be fighting amongst themselves to get to the front, because some of them are in my head, but some of them are at the side of the head, so I can't get rid of them. And if I play music the ones that are in my head will argue, and the ones outside my head shut up because you can't hear them because you've plugged your ears in. But if I take them out I can't hear what's happening on television. And because of the voices at night I will try and think "who was that on television?". Really silly things that used to bug me about who it was or somebody I'd seen that day and I couldn't remember who they were and I'd get really frustrated.

Facilitator 1 - So it sounds like, were there certain techniques within the groups that helped you put the voices to the back of your head?

Sophie - Yeah, mindfulness I found really helpful.
Facilitator 1 - So how would you describe your relationships with the other group members within the group? How were things between you?

Sophie - I think that they were really good. We've become friends.

Rachel - She's my best friend. I'm coming here because she told me about it, before this group. But I think everybody in it [name], Martin and Sophie is very nice and I enjoy.

Facilitator 1 - And I can remember at the beginning that people were saying... some people were saying that it was important to meet other people and share experience with other people.

Patricia - Yes because individually I find it hard to talk. But with people around me I do actually talk better. I don't know if it's my personal problem I guess, but I feel more confident to talk when there is people with me. I don't know why.

Facilitator 1 - And would that be anybody, or does it help to... Sorry I'm just going to swap theses over. Sorry about that. We were just saying about talking in groups and you find it easier to talk in a large group of people rather than maybe one-on-one with somebody.

Patricia - Yes, because we can share our points of view as well.

Facilitator 1 - And does it help that everybody's got the same experience, or could it be anyone?

Patricia - Yes.

Facilitator 1 - So we've talked a lot about perspective and getting other peoples perspective on the things that you experience and maybe other peoples perspectives on what you're like, maybe things that you don't believe about yourself or the things that other people see about you that you don't necessarily recognise.

Rachel - Yes, coming here I was very scared. I was scared because I don't know who is... why. But later it was fantastic.

Sophie - I was sick before I came. Physically sick. The first time I came I thought I was the only one here because everybody else had gone in because the taxi brought me here late as usual. So I had to walk into a room full of people that I didn't know. Well, I knew Patricia, that was the only one who I did know.

Facilitator 1 - So it sounds like the group took a little bit of getting used to before you were full comfortable.

Sophie - I think I was comfortable by about the third week.
So that was quite quickly. How about you, Martin, what was it like being within the group?

It was good because you didn't feel isolated. Which I had been for years - I felt really isolated. I was... like Sophie said, she felt really isolated as well. It's just, I had no idea of other people's suffering, and it made it better for me because I would, sort of relate to them. That's about it really.

So not feeling like you're the only person.

Yeah, it must be years I've felt like that. I've been in hospital with all of these really sick people, and I thought "I'm not that bad".

So maybe before it sounds like you compared yourself to other people who were very very ill, and coming along here has made you compare yourself to other people who...

I'm just surprised that everyone was so normal. Because half the time you speak to people who are foaming at the mouth, you know. It was just nice to see other people that were just sort of everyday people. It made me feel better.

So how did that make you feel better?

I thought they were... if they seemed alright, they looked, you know, normal, perhaps I did as well.

So again, maybe getting another perspective on yourself that you didn't have before that you thought that people might look at you and see somebody who is foaming at the mouth. But now you think "actually because I've met people who look like they'd blend into a crowd..."

Well I was in university in [country] and I was in shared accommodation and I got really ill. And the guy I shared with, a horrible man, he said "they're going to come and put you in a straitjacket and take you off to hospital". You know, that fuelled my anxieties, and I was terrified about what was going to happen. Since then I've heard that they don't use straitjackets anymore, so that's the main thing.

So you'd had a bad experience of what might happen to you if you hear voices that was never actually realised.

Yeah, he said "there are places we send people like you", just horrible things, you know. And when I was unwell at the same time, you know, it really put you through it. I ended up getting my degree but I was going to do a masters and I got so ill that I just couldn't do it. So I brought it back to here. I
Facilitator 1 - So it sounds like coming along to the group has given you another perspective on the way people view you, the way other members of the public may view you.

Martin - What Patricia said when we were making lists about people, the qualities of people, I couldn’t believe it. You know, I got somebody else’s feedback. I don’t know whether that’s part of my illness. I just thought “oh they’re just being nice, it’s not true”. But I’m not the only one who felt like that.

Facilitator 1 - And has that changed at all or is that still the way you feel?

Martin - I still feel like it. I still feel like shit half the time. But I’m getting there. The group’s been really good. It’s been run really well, and like I say, I’ve never experienced it before. People usually get labelled, and to me that was the one thing I was a bit worried about, that people were going to label me and treat me in a certain way, but they just treated me like a human. You know, like any other normal person, which I appreciated.

Facilitator 1 - And linking on from that I was wondering how people would describe their relationship with the therapists, so with [names of therapists]?

Sophie - I thought they were really good. Really understanding. Helped if I was sad.

Patricia - Good sense of humour.

Facilitator 1 - How did having a good sense of humour... did that help at all?

Patricia - Yes because it was contagious to us, it was really positive.

Martin - They used to joke about my socks.

Sophie - You haven’t got your socks on today Martin!

Facilitator 1 - So it sounds like you had jokes within the group, and that humour was used quite a lot.

Martin - Well it wasn’t stale, you know. It was very fresh.

Sophie - We had a competition, didn’t we?

Rachel - It was all fantastic.

Sophie - I just wanted it to be longer.
Rachel - I think we need more time, more group. For sure. It's fantastic. Maybe one week or two weeks.

Facilitator 1 - So it seems like it was too short and you would have liked to keep going on and keep meeting up.

Rachel - Yes, because next one it was “oh no, no group!”.

Martin - I used to dread every Sunday night. But I’ve got used to it. I’m quite happy to come.

Facilitator 1 - So that links into what Sophie was saying that at the beginning it was sometimes it was quite hard to actually force yourself to come along to the group.

Patricia - For me not at all. I was very engaged to come here. It is the very one thing the week which is very interesting for me. Otherwise I don’t do anything. I just cook for myself and that’s all. It’s very encouraging for me.

Facilitator 1 - So you felt it was quite motivating to come, knowing that you had the group on the Monday to come it.

Patricia - Yes, because I’d think “oh Wednesday, but next Monday I will go to the voices group, I will learn something interesting. I will meet nice people, all nice people - very kind. And I might learn more and more to help cope with the voices”.

Rachel - It’s the feeling... that some mornings everything is positive, you know. When coming here things are positive and exciting.

Patricia - And it’s funny because all of our voices are different. Me, I have voices from four years ago in 2003, summer 2003 in [place], and after it disappeared because I have strong medication and I went to psychiatric hospital for one month. Disappeared completely almost, I would hear it sometimes but rarely. And it came back when two weeks after my marriage, my wedding. It was in September I started hearing the voices, one month after my first job, I was working five months with the voices in my head, and they said “we cannot keep you”, I was too sick. And they fired me because I was too sick with powerful voices in my head and I didn’t take any of my medication at first because... I don’t know. And then the doctor, GP from [place] he sent me to the psychiatrist who prescribed me some medication. And then we tried so many different medications which didn’t work, because it was always the same.

Facilitator 1 - We’re coming to the end, so I’d better move on. How would you say that your voices have affected your wellbeing since the group finished? I know it’s only been one week, but how have things been since you’ve been attending the group?
Rachel - I can live with my voices. And I said, my personality, I will carry on. I am more important than my voices. Keep going, keep going, and share the experience. Say ‘no’ to the voice. ‘no no no no’.

Facilitator 1 - So it sounds like it’s given you some motivation and some drive to move forward, and be positive about things.

Patricia - For me the same. Positive.

Sophie - I’ve found that my self esteem has grown a little bit.

Facilitator 1 - So the things you think about yourself...

Sophie - Have got a little bit better.

Facilitator 1 - It sounds like some of that has been getting a bit of a different perspective on yourself, like reading out the words that the group said about you to your family, and accepting that. I was wondering if it had had any impact on people’s lives outside the group.

Rachel - Monumental. I go to the gym, to my work, tidy my room, I’ve decided to take my new job - easy job. Not hard work.

Facilitator 1 - So for you it’s had quite a wide impact on lots of different areas, on your motivation generally.

Sophie - I find I go to the cinema now. I go for a walk on the beach. I don’t like [place], it depresses me, but that’s beside the point. I’ll go along the beach now for a walk, and if people look at me I will just think “well they’re just having a look”. And I’ll go to the cinema without feeling paranoid.

Facilitator 1 - So are these things that you wouldn’t have done before?

Sophie - I wouldn’t go I used to find excuses for not going. If a film came out I really wanted to see, I’d think “I’ll get it on dvd when it comes out” instead of actually going to see it. And if I did go to see it I would have my daughter sitting with me. We’d have to sit right at the front in a wheelchair, and I’d make her sit with me because I’m too frightened to sit on my own.

Facilitator 1 - And that’s changed slightly?

Sophie - That’s changed slightly, she doesn’t have to sit with me now, she can sit a couple of rows back.

Facilitator 1 - Are there any other things that people have noticed about changes? Martin, I was wondering if there are anything that you’ve noticed that have changed since attending the group.
Rachel - You have changed personally, of course you have! Before you had hair like this. But now you're a happy person. Before sort of scared. No, a change personally in the group.

Martin - Yes, I have.

Facilitator 1 - So you've had a change, and in terms of your appearance over the group.

Martin - Yeah, I've changed my appearance a bit.

Facilitator 1 - And was that because of the group, or was that something you wanted to do?

Martin - It was something I wanted to do. I find I'm not so frightened of police any more. I used to carry knives on me and now I don't do that anymore. You know, I feel a lot better about myself. I think it's hearing other people's experiences has made me feel better. I'm taking that away with me. I mean it's only been one week since the end of the group but I think I've made a lot out of it. I'm not so scared to be seen.

Facilitator 1 - Well we're running over a bit so we'd better finish, but has anybody got any other things that they'd like to say about the group, or about since the group has finished.

Rachel - Thank you very much for me! Very kind, excellent doctors here, fantastic.

Patricia - For me, I need more!

(laughter)

Facilitator 1 - So it sounds like people are really grateful for the time that they had, but thinking, "actually it would be nice for this to go on for a bit longer".

Patricia - Something very serious for me, they are there each Monday afternoon. We know... they told us the times they went on holiday or something, before they go on holiday we know everything about how it works and it's very serious, and that's very important.

Facilitator 1 - I think that's what you were talking about before, that it's been quite structured and people take it very seriously, it hasn't been... although it's been relaxed and jokey, it's been taken very seriously. That's what's been positive.

Patricia - That's what we need actually, because at [place] three months ago I didn't know what was happening. No voices group any more. It's quite sad actually. We've got to take care, I'll see the psychiatrist every five months only, so
nobody to talk about my problems any more except Rachel sometimes, but she's not a psychologist so if I talk to her about this all the time she's going to be tired after.

Facilitator 1 - So it sounds like you're wondering where the support is going to come from once the group finishes. What's going to happen.

Patricia - Yes, that's really important.

Sophie - I must say, because I have my community nurse I have a great big gap, even though I see my CPN every week, there is a great big gap, and there was nothing to do. And then this group came along to fill that gap, and now it's coming to the end I've got a great big gap left again.

Facilitator 1 - So it's looking for ways to fill...

Sophie - I found that quite hard. There was a psychologist supposed to be working through my childhood, but we got waylaid with my visual hallucinations instead, so we never did got to my childhood.

Rachel - I think it's ok for me. I want more, but I'm feeling anyway happy because I've learnt. I know my limits. I know that I've got voices. But she's got voices and she can cook now, she's ok, she is fine and good. And I've got voices, I just need to keep going with my life. No stress, when I have too much stress it is not good for me. What is not good for me - job... work very much. Stress, too much for me. Maybe I need to protect myself, keep going. Easy life, and enjoy my life. I'm different but I'm happy.

Patricia - It is a very positive experience. I will remember all my life about these eight weeks because it's a step in my illness, you know. A step. And I'm going a little bit higher. So it's very positive and I don't want to be negative, you know. To say "oh, everything is wrong. How am I going to finish? How and I going to live, what can I do?". It's a little bit like that actually, but this experience, if I remember sometimes about my illness or something, I'll think about the group. But most of the time I've forgotten actually, I don't think all of the time about this group, but I think that it's better that later on that I think about this positive experience. It was important to make effort for us and very important to remember this group.

Facilitator 1 - So even though leaving the group feels difficult, it's important to remember it as being a positive experience.

Patricia - Yes.

Facilitator 1 - Well we'd better stop, but thank you. I'll stop this recording.