My faith has helped me through many hard days over the last three years, and I thank God for giving me what I have.

The honesty and openness of the service users and their families that I have worked with during training have made my learning an enjoyable process. I would also like to acknowledge the contribution of my clinical and research supervisors to my development as a clinician.

The Race & Culture Special Interest Group (SIG) has provided me with support in many ways. My appreciation goes to the committee members who have both kept the SIG going (particularly the London region group) and who have had an ear open for me.

To Mum — it seems like those times spent reading together at the kitchen table when I was little, have finally paid off. Just think, all these words have been typed with only three fingers; what could I have achieved if I could type properly! Thank you for your love and encouragement.

To Den — I’m passing the baton to you, so go get ‘em!

To Alex — now I’ll have to find a reason other than ‘The Course’ for being a miserable cow! Over the last three years you have helped me to keep my feet on the ground; my ability to question all that I was learning has undoubtedly been inspired by you and your ‘smarts’! Thank you for your love and support. Now let’s finally get on with life!

This portfolio is dedicated to the memory of my grandmother Miriam Austin (Ma), whose determination throughout life and love of reading is surely the reason I am where I am today.

I wish you were here to see this.
### Contents – Volume I

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACADEMIC DOSSIER</td>
<td>4</td>
</tr>
<tr>
<td>The Academic Dossier</td>
<td></td>
</tr>
<tr>
<td>- Adult Mental Health Essay</td>
<td>6</td>
</tr>
<tr>
<td>- People with Learning Disabilities Essay</td>
<td>20</td>
</tr>
<tr>
<td>- Children &amp; Families Essay</td>
<td>37</td>
</tr>
<tr>
<td>- Older People Essay</td>
<td>52</td>
</tr>
<tr>
<td>CLINICAL DOSSIER</td>
<td>68</td>
</tr>
<tr>
<td>The Clinical Dossier</td>
<td></td>
</tr>
<tr>
<td>- Placement Summaries</td>
<td>70</td>
</tr>
<tr>
<td>- Case Report Summaries</td>
<td>77</td>
</tr>
<tr>
<td>RESEARCH DOSSIER</td>
<td>91</td>
</tr>
<tr>
<td>The Research Dossier</td>
<td></td>
</tr>
<tr>
<td>- Service Related Research Project</td>
<td>93</td>
</tr>
<tr>
<td>- Qualitative Research Project</td>
<td>118</td>
</tr>
<tr>
<td>- Major Research Project</td>
<td>178</td>
</tr>
<tr>
<td>- Research Log Book</td>
<td>321</td>
</tr>
</tbody>
</table>
Academic Dossier
Contents of the Academic Dossier

This section contains four essays related to each of the four core placements.

Page

Adult Mental Health Essay 6
"Critically discuss the role of clinical psychologists in Community Mental Health Teams, with reference to some advantages and limitations of the psychologist's role. To what extent do psychological theories about group and team functioning help us to understand the issue?"

People with Learning Disabilities Essay 20
"Parenting skills can be taught to people with learning disabilities. Discuss"

Children & Families Essay 37
"Do cognitive techniques add therapeutic value to working behaviourally with children with OCD?"

Older People Essay 52
"What theoretical approaches and models can be helpful when addressing issues of diversity in our clinical work with older people and their families?"
Critically discuss the role of clinical psychologists in Community Mental Health Teams, with reference to some advantages and limitations of the psychologist’s role.

To what extent do psychological theories about group and team functioning help us to understand the issue?

Year 1

January 2003

Adult Mental Health Essay
Examining the range of articles in 'Clinical Psychology' (and its predecessor 'Clinical Psychology Forum') suggests that the issue of the role held by clinical psychologists, particularly within a community mental health team (CMHT) is one which the profession has struggled with. In the early 1990s, titles such as "Community mental health teams and the role security of clinical psychologists", "CMHTs and clinical psychology: the death of a profession?" and "Psychologists and teams: has death already occurred?" reveal the insecurities, anxieties and pessimism prevalent in the profession regarding this way of working. So what underlies such apprehension and does it still exist today? New and innovative ways of theoretical working have been a feature of the profession since its inception, with the development of behavioural and cognitive based understandings of behaviour away from the traditional psychodynamic concepts that were initially prevalent. Admittedly some in the profession have been less than pleased by this shift in theoretical "fashion", and battles between various schools of thought appear to continue with as much ferocity as they always have. However, it could be argued that the majority of psychologists have acknowledged and appreciated the value of new methods which challenge stagnant practice and generally enhance the standard of care offered to clients. So perhaps then, this apprehension and tension reflects the resistance of the profession towards change.

This essay will attempt to explore the explicit roles and responsibilities of clinical psychologists working in CMHTs, particularly as identified by policies and guidelines. It will consider the positive benefits of their inclusion in such a team as well as some of the limitations that are commonplace. This essay will then consider some of the psychological theories regarding group and team working that offer a conceptual framework for understanding the more implicit roles that a clinical psychologist may have, beginning with a discussion of work from social psychology and then looking at psychoanalytical theories of team functioning. Before embarking on this, however, the essay will briefly explore the context in which all of this occurs: the community mental health team.

The phenomenon of CMHTs
In the UK, CMHTs are the model most frequently used for the co-ordination of mental health and social care community services (Peck, 1999), providing a more effective service than non-team approaches (Tyrer et al, 1997 in Norman & Peck, 1999). Their creation followed moves away from institutional care towards the local provision of
services resulting in the formation of teams which supported the integrated health care of an adult experiencing serious mental ill health (Whittle & Val Logan, 1990). Although initially this represented local service initiative, the Department of Health standardised this model in 1996 creating a national policy on how mental health care should be delivered (Norman & Peck, 1999). More recently the Department of Health updated this model by joining social and health care agencies to facilitate and increase communication between the different agencies and to represent a more holistic approach to the care of individuals (Department of Health, 1998).

According to the Department of Health, CMHTs function best when staff member's primary responsibility is working within the team and their model of mental health practice, the Care Programme Approach, acknowledges that clinical psychologists amongst other practitioners can provide this co-ordinated care (Department of Health, 1999). Such national directives have therefore encouraged some services to relocate clinical psychologists to CMHTs rather than the external psychology departments within which they are traditionally based. Although CMHTs are a nationally prescribed model, each team is a unique entity with a variety of influences that determine its functioning, such as individual team personnel, the locality of the service and the types of clients seen (McCourt, 2002). Working in a CMHT is therefore likely to be a highly individualised and variable experience which this essay will struggle to critique. It will therefore examine the general professional roles that a clinical psychologist is able to perform whilst employed in a mental health team.

What can a clinical psychologist do in a team?
The aim of a clinical psychologist as identified by the Division of Clinical Psychology is to both encourage psychological well-being and decrease psychological suffering by applying knowledge gained from psychological theory (2001a). The role derived from this aim has an equally broad remit, which can be categorised into three main elements: direct therapeutic work with clients, indirect clinical work such as consultancy and an organisational input (Division of Clinical Psychology, 1998). Each of these will now be discussed in turn.

Direct Clinical Work
One of the most fundamental roles of a clinical psychologist is their involvement in complex cases where their unique understanding of psychological problems is required (DCP, 1998). With access to a range of complex psychological theories,
clinical psychologists are able to pick, choose and even combine evidenced-based theoretical models to provide a psychological framework for understanding a client's difficulties. Whilst other mental health professionals are encouraged to undertake psychological interventions such as cognitive-behaviour therapy (Department of Health, 2002) a clinical psychologist's unique theoretical understanding allows them to develop interventions specific to the client's needs rather than the blanket application of generalised techniques (Division of Clinical Psychology, 1998). The emphasis in training of evaluative skills and reflective practice are particularly suited to the current NHS environment. Compared to the skills of the other disciplines often present in a CMHT, it is these abilities which differentiates the clinical psychologist's contribution (Parry, 1989). As one of the only professions in the CHMT without formal statutory tasks such as administering medication or sectioning (McCourt, 2002) clinical psychologists are also able to develop trusting, non-contingent therapeutic relationships with their clients. Furthermore, by utilising non-diagnostic models of mental illness and by providing interventions that complement or are an alternative to more passive forms of treatment such as medication (Gelsthorpe, 1999) clinical psychologists are in a unique position to help empower clients and increase their independence and authority.

Indirect Clinical Work
Clinical psychologist's distinct understanding of psychological problems is one which they are encouraged to share with others, thereby enhancing the psychological efficacy of the team further (Division of Clinical Psychology, 2001b). This may involve working jointly with colleagues from other disciplines within the team contributing to the planning of clinical programmes where a psychological component is pertinent, or consulting to other teams which fulfil client's needs such as staff groups in care homes (Division of Clinical Psychology, 1998). Supervising more junior psychologists is often undertaken by clinical psychologists (Anciano & Kirkpartick, 1990), thus ensuring the future of the profession and allowing the team to benefit from a wider psychological input. Similarly research and audit are important professional functions which clinical psychologists are encouraged to pursue, both for the teams benefit and the profession's continuing development (Cushion, 1997).

Organisational Involvement
A third way in which clinical psychologists fulfil the Division's aims and participate in CMHTs is by contributing to an understanding of the organisational processes
relevant to the care of clients with mental health problems. This may include the formulation of standards of psychological care and of innovative ways that teams can best serve their clients (Division of Clinical Psychology, 1998). In addition, clinical psychologists are involved in enhancing service quality, not only by training staff in specific skills but also by encouraging the wider use of psychological principles such as increased evaluation of the service and feedback from service users (Division of Clinical Psychology, 1998).

In summary, clinical psychologists are able to combine their skills and expertise in psychological theories and interventions, with an understanding of the ways in which teams and organisations operate, providing a unique contribution to a team. Unlike other clinicians within the team, psychologists have noted that such variety in function offers them scope for creating individualised roles within a team (Peck & Norman, 1999), determined to some extent by the varying theoretical positions that clinical psychologists can take (McCourt, 2002). Such autonomy in determining their role offers the psychologist a degree of power relative to the majority of their CMHT colleagues. However, whilst providing an idyllic view of how a clinical psychologist can operate within a CMHT, the reality seems to offer a dimmer picture, with many experiencing difficulty utilising these unique skills.

The real picture of clinical psychologists in CMHTs?
As identified earlier the Department of Health’s CMHT policy guidelines (2002) advocate that professionals should be committed to the interests of the team. National models of mental health care have also become more business-oriented with the emphasis on reducing waiting lists and seeing as many clients as possible rather than more specific aspects of service quality (Peck, 1999). Consequently, psychologists’ team leaders, who tend to be from other disciplines (Cushion, 1997), may discourage psychologists from utilising their indirect and organisational skills if they are unable to see the direct value of such work (Anciano & Kirkpatrick, 1990).

Where the clinical psychologist’s skills are valued and identified in a team it can result in the psychologist becoming a last resort: seeing those clients who others have failed to reach any improvement in or who have become ‘stuck’ in knowing what to do next. For example, Searle (1991) in an exploration of allocation within a multidisciplinary team found that the team tended to refer or allocate to psychology where there was an unclear diagnosis or where an individual was failing to make
progress with other interventions. Such a ‘filling-the-service-gap’ role within the team places almost unachievable expectations on the clinical psychologist and when they are unable to provide the required answers dissatisfaction from all is inevitable (McCourt, 2002; Brown, Ball & Williams, 1999).

Sharing their clinical skills and psychological knowledge amongst the team may leave colleagues and managers wondering about the specific value of the profession to the team (Anciano & Kirkpatrick, 1990). It is therefore possible that colleagues’ unawareness of the roles that this profession can undertake underlies clinical psychologists’ limited functioning within a team. For example, the roles of other team members such as nurses or psychiatrists are easily identifiable and their professional identity and role appears to be firmly entrenched. Furthermore psychologists have noted that as their role can vary from one team to another, other mental health workers hold a range of images about their professional role (Peck & Norman, 1999). Yet, psychologists’ colleagues do seem to have some awareness of their contribution to a CMHT. Although using a small sample size Cushion (1997) observed that other professions were aware of their positive input within the team and valued their broad psychological knowledge base, analytical thinking and their research and audit skills. However they commented that clinical psychologists were not appropriately used within the team particularly in performing routine mental health work. Similarly, Peck and Norman (1999) identified other disciplines’ perception of clinical psychologists as high status mental health professionals with a considerable degree of autonomy. In addition their colleagues appealed for greater definition of the clinical psychologist’s role and a higher level of commitment for CMHT work. Thus it seems that clinical psychologists need to advocate their tripartite role more proactively which will perhaps allow them to hone the blurred boundary roles and professional identities (Anciano & Kirkpatrick, 1990). There is also a need for psychologists to develop and promote their strengths to demonstrate their distinct contribution to CMHT work other than their generic mental health skills (Ovretveit et al, 1992).

What is responsible for this pessimistic picture?

As acknowledged earlier, a CMHT consists of a group of professionals from different disciplines working collectively to enhance the lives of adults with mental health problems. Yet CMHTs can be a forum for inter-disciplinary conflict unlike that seen in other mental health contexts where better-defined hierarchies result in less ambiguity about roles and fewer professionals aiming for the top (Norman & Peck, 1999).
Within the team, clinical psychologists alongside their colleagues from various professions have to find a way to work collaboratively, generically and respectfully whilst also asserting their own unique contribution and maintaining loyalty to their respective disciplines. In addition each individual, whilst remaining faithful to their profession will also carry with them their own values and opinions (McCourt, 2002) as well as ideas about the nature of mental health problems and how best they can be managed or supported. Inevitably this will lead to disputes and anger, for psychologists envy and frustration may prevail in their battle to make the psychological model prevalent (Gelsthorpe, 1999). Some have argued that disagreements about definitions of mental health problems are fundamental to the poor inter-agency working observed (King’s Fund London Commission, 1997 in Norman & Peck, 1999). Unfortunately this argument is beyond the scope of this essay, however it does hint at the difficulties clinical psychologists may have in negotiating their role in a professional way.

Clinical psychologists are often in the minority in CMHTs (DCP, 1998) compounding their struggle to assert their individuality (McCourt, 2002). Power issues within the team cannot be ignored and it is interesting to consider where clinical psychologists lie in the implicit and explicit power structures that exist within any team. Onyett (1999) identified two types of power influences that can operate within a team: legitimate power derived from skills and knowledge, and illegitimate power originating in social status, education, ethnicity and personality. Clinical psychologists lengthy training compared to other professionals may have given them illegitimate power and status which may be limiting their professional development within a team (Peck & Norman, 1999; Searle, 1991). Such autonomy may have also given them licence to disengage from the mental health system, decreasing the validity of their views and giving others the impression of a non-committed team member (Gelsthorpe, 1999). Thus it may be that clinical psychologists are failing to operate in the interests of the team and some argue that inter-professional work is limited when more powerful professionals exempt themselves from the explicit and implicit work of the CMHT (Norman & Peck, 1999).

How can we understand these issues?

Hosking and Morley’s Team Approach

In developing their theory of group performance Hosking and Morley (1991) acknowledge cognitive and political problems in teams which can inhibit the positive
aspects of group work. Thus politically, clinical psychologist's difficulties may be due to their failure to contribute their skills to the collective effort and success of the team and may also be evidence of their failure to relinquish some of their autonomy (Steiner, 1972 in Hosking & Morley, 1991). Cognitively, clinical psychologists may not have successfully organised their intellectual activity so that they think clearly about the issues and develop a collective understanding with their colleagues about the team process. This failing can extend to other members of the team so that together they engage in a defensive form of information processing (Janis & Mann, 1977, in Hosking & Morley, 1991). This social psychological model offers some suggestions for effective team functioning. Firstly to combat defensive thinking, the team should be organised to receive input from the widest number of sources possible. Thus CMHTs should encourage clinical psychologists to liaise and network with other psychologists as well as other relevant agencies (Onyett, 1999). This also opposes the current top-down approach enforced by national standards, which results in a loss of faith in a system that does not appear to benefit service users (Norman & Peck, 1999). Secondly, teams should be comprised of workers with sufficient and diverse expertise with roles and responsibilities that are clearly identified and differentiated. This supports the involvement of the distinctive skills of a clinical psychologist but highlights the need for the profession to clearly demarcate its function within a team. Thirdly workers should be encouraged to develop open-minded thinking and to test the assumptions that they make (Onyett, 1999), a skill which clinical psychologist's training emphasises but which individual's can relinquish once they have established their professional identity. Gelsthorpe (1999) suggests that if clinical psychologists openly acknowledged their power and status within the team some of the anger and frustration experienced may be reduced. Finally an effective leader is required; who evaluates team processes and ensures that the above criteria are being fulfilled. It has been suggested that CMHT managers that adhere too strongly to national directives and promote a democratic approach, lose the support and respect of their workers and may end up with a team who think they have an equal input to all decisions (Norman & Peck, 1999). This approach thus emphasises the explicit and conscious processes that occur in individuals but it ignores the possibility of underlying unconscious processes and internal conflicts.

**Psychoanalytic Approaches - Melanie Klein**

The use of psychoanalytical concepts provides some understanding of what appears to be irrational processes occurring in individuals and teams (Mosse, 1994). Klein's
work is based on fundamental psychoanalytical concepts such as 'the unconscious', the hidden motivating force behind an individual's behaviour, and 'defence mechanisms', which can be employed to protect against internal pain. However, Klein focused primarily on the infant and proposed that an infant 'split' its caregiver into good and bad parts, as a way of coping with the internal conflicts of loving and hating the same person. Additionally she proposed that the child 'projected' unwanted parts of the self into others, again as a defence against inner pain (Halton, 1994). This 'paranoid-schizoid' position, paranoid as all badness is external and schizoid as the individual is splitting, was hypothesised as a normal stage of development. Eventually the individual assimilates these separated feelings and learns to face the disparity between their internal conflicts and external reality. This results in guilt and sadness and the development of the more whole and realistic 'depressive' position (Halton, 1994).

Using this model the conflict within a CMHT could be seen as a failure to manage and contain splits. Clinical psychologists as well as their colleagues from different personal and professional cultures, who may previously have projected anger and frustration to other disciplines, now have to struggle to work with them (Foster, 1998). This, as well as external anxieties from clients, referrers and national policies results in high anxiety causing individuals to resort to a paranoid-schizoid position. Schizoid splitting in the helping professions is unlikely to be located in clients as there is a tendency to deny feelings of hatred about service users (Halton, 1994). Thus all negative aspects of their role such as their insecurities and failures are split off and located in other team members or professions (Foster, 1998) producing fighting separate individuals, rather than an integrated CMHT. For change to occur, the team needs to acknowledge the splitting processes that occur (Heginbotham, 1999) and operate in the more realistic depressive position, where they are secure enough to acknowledge their own and other's strengths, weaknesses and differences and how these contribute to the team's functioning (Foster, 1998). Thus a key issue for mental health professionals is how to manage their unconscious processes in order to relate to their colleagues appropriately (Lawthorn, 2002). However, the team may be working collaboratively to deny the reality of CMHT work as was proposed by Wilfred Bion.
Bion’s Theory of Group Behaviour

Bion's work (1961, in Lawthorn, 2002) identified two coexisting and contradictory group mentalities that can operate to enable workers to both face reality and complete the task: a 'work group mentality', and avoid reality and thus task completion: a 'basic assumption mentality'. This second mode of working may help to explain the experience of clinical psychologists in a team. Teams operating according to this mentality usually do so when facing anxiety about survival (Bion, 1961, in Roberts, 1994) and tend to avoid conflict and psychological distress at all costs. The unconscious desires of the team determine the group's agenda, ignoring the primary task and instead focusing on alleviating the groups underlying anxiety and internal conflicts (Lawthorn, 2002). This occurs according to which of three basic assumptions is the common defence mechanism amongst the members. A team dominated by a basic assumption of dependency operate as if the primary task is to fulfil the needs and wishes of the members. The leader plays an instrumental role in protecting them from the actual task of the group resulting in dependency on him to maintain this status quo. A basic assumption fight-flight group focuses on an enemy or impending danger; their primary task is to await appropriate action from their leader. The final group, basic assumption pairing operates on the unconscious belief that a pairing between two individuals can bring about future change. Thus the focus is entirely on the future allowing a denial of the present situation.

This framework could be used to explain both conflicts within the team and the experiences of clinical psychologists. Within the team the idyllic notion of a CMHT and the illusion of joint working is used both to obscure the difficulties of multidisciplinary working outlined earlier and as a defence against possible conflicts (Stokes, 1994). Individuals experience both relief and displeasure from membership of such groups: relief that they no longer experience anxiety yet discontent because their ability to work effectively and think rationally and independently is compromised (Stokes, 1994). Foster (1998) has argued that in mental health teams the dominant defence is fight or flight. Individuals either continue to battle with their colleagues or they employ one of two 'flight' defensive strategies. They either avoid conflict situations such as team meetings, and continue to work as usual resulting in a fragmented service, or they avoid all team differences and act as if each member of the team is the same, creating little choice of expertise for the client.
Individual professional groups may also each adopt a different basic assumption, based on both professional and personal values, with the interplay between the defence mechanisms increasing the conflict. Stokes hypothesised that the training of clinical psychologists for example, which tends to emphasise the relationship between therapist and client may result in this profession operating from a basic assumption pairing mentality. Thus psychologists may focus on this relationship and how they can alter their client’s future without evaluating how it relates to the achievement of the team’s primary task. Placed with social workers possibly operating from a fight-flight mentality and medical practitioners from a dependency mentality (Stokes, 1994) it seems obvious that conflict arises in a team whereby each profession is concerned more with their group identity than that of the team.

Thus it seems that the sometimes-distressing nature of mental health work can instigate anxiety, pain and confusion, which individuals may unconsciously try to contain (Lawthorn, 2002). Practices within the CMHT and relationships between team leaders and practitioners may also be unconsciously structured to defend against anxiety (Stokes, 1994). Despite their awareness of theoretical frameworks regarding group work clinical psychologists fail to apply them to their own teams (Norman & Peck, 1999). It is likely that membership of a team impedes this ability and psychologists are unable to prevent themselves becoming hindered by the anxieties inherent in the work (Mosse 1994).

Conclusion
The issue of clinical psychologists in mental health teams appears to have many components, which have implications for change at three different levels: the service or organisation, clinical psychology as a profession and the individual. At the service level it seems that although the concept of integrating disciplines is a satisfactory model, many services have failed to implement this concept fully (Norman & Peck, 1999). Success is likely to be evident in teams that acknowledge the diversity individual members have to offer and openly discuss the issues of power and hierarchy (Onyett, 1999). At the second level it seems that the profession needs to decide on the future of clinical psychologists in adult mental health services and not be submissive in accepting full time direct clinical work if this is not how they want to see the profession progress (Overetvit, et al, 1992). This will prove even more pertinent with the proposed changes in the Mental Health Act which advocates the clinical supervisor role for clinical psychologists. Searle (1991) suggests that poorly
resourced professionals such as clinical psychologists should remain in a consultative role where their skills can be appropriately utilised in specialist services. Cushion (1997) further argues that the work of a clinical psychologist should become more proactive and preventative rather than its current reactionary status. Finally improving CMHT work requires active participation from staff, not just government prescriptions and directives (Peck & Norman, 1999) and psychologists need to acknowledge their individual contribution to a team at both a conscious and an unconscious level.
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Parenting skills can be taught to people with learning disabilities. Discuss

Year 1

October 2003

People with Learning Disabilities Essay
People with learning disabilities continue to experience discrimination and inequality when compared to the general population and parents within this group are no exception. Indeed the title of a recent television programme about learning disabled parents: "Unfit Parents?" (ITV – 07.07.03) demonstrates that within wider society this is a contentious issue and one that can stimulate much debate. However, parenting in this population is not a new phenomenon and probably existed to a greater extent than was previously recognised (Booth & Booth, 1994). Despite 'Valuing People' (Department of Health, 2001) noting an increase in learning disabled parents over the last twenty years, it is difficult to identify exact numbers (Booth & Booth, 1994) and popular sampling techniques which rely on referrals to services may be underestimating the extent of parenting (McGaw & Sturmey, 1993). Changes in definition of this group over time and across cultures enhance the difficulty of this. As learning disabled adults report looking forward to normal life experiences such as forming relationships and having children (McGaw & Sturmey, 1993) and with the adoption of ordinary life principles to service provision (Booth & Booth, 1994), it is estimated that numbers of parents with learning disabilities are likely to increase further (Whitman, Graves & Accardo, 1989).

The complexity of services and the varying agendas of professionals involved have resulted in confusion over roles that community teams for people with learning disabilities (CTPLD) should adopt regarding this issue (O'Hara & Martin, 2003). Clinical psychologists are likely to be involved in assessing capacity to parent and have a distinctive role within a CTPLD as their training provides experience with both child and learning disability services. However this is a difficult task and both specialist and generic family service providers report a lack of knowledge (Llewellyn, McConnell, Russo, Mayes, & Honey, 2002). This essay will consider parenting skills assessments and factors which may hinder or help this process. It will then examine approaches used to teach parenting skills. Prior to this, however it is relevant to explore what is understood by "parenting skills". When "parents" are referred to the reference is to parents with a learning disability, unless otherwise specified.

What are parenting skills?
"Parenting skills" is an ambiguous term whose meaning is often dependent on the context in which it is discussed. A consequence of a failure to demonstrate parenting skills is having one's child removed and within a legal framework, The Children Act 1989 specifies that this would only occur if the child is suffering or is likely to suffer
significant harm (McGaw & Sturmey, 1994). "Significant harm" is described as a parent's failure to adapt to their role, however this is equally vague and difficult to quantify. The psychological and sociological fields have also explored definitions of parenting. For example, parenting is arguably influenced by our own experiences as a child and psychological concepts such as self-esteem and self-control (Reder & Lucey, 1995). In addition our conceptions of the role, which in turn are influenced by discourses that exist in our family and cultural representations seen in the media, are also significant (Young, Young & Ford, 1997).

More specifically the skills involved in parenting have also attracted diverse opinions. Sheerin (1998) summarises some definitions of parenting in his review article including the ability to provide child-focused activities, providing adequate physical care, and demonstrable decision-making skills, although some would argue that these are socially constructed (Reder & Lucey, 1995). What is clear then is that any norms of appropriate behaviour for parents needs to be placed within a cultural and historical context (Young et al., 1997), yet as will be discussed it appears that this has not been the case.

Assessing parenting skills
Original thoughts were that it was not possible for people with learning disabilities to be even considered as parents based on concerns about threats to the national gene pool (Booth & Booth, 1993). When they did have children, research documented that they were more likely than other parents to make demands on child welfare services and have their children cared for by the local authority (DOH, 2001) and constituted a disproportionate number of families where child protection issues were relevant (O'Hara & Martin, 2003).

The effects on the child of inadequate parenting have been well documented for this group of parents and most authors have focused on neglect, physical abuse and developmental delay (Sheerin, 1998). Children of parents with a learning disability are thought to be at risk for behaviour disorders, developmental and psychosocial delay (Feldman & Case, 1999) and for depression and concerns regarding their social functioning (McGaw & Sturmey, 1993). Originally without objective measures or agreed standards against which parents could be assessed (Tymchuck & Andron, 1992), assessors based judgements on subjective accounts and unsubstantiated evidence from involved professionals (Booth & Booth, 1994). For example Tymchuck
and Andron (1988) report on one mother referred by involved professionals for parenting interventions due to suspicions of child abuse and neglect, without any physical evidence. In efforts to provide more objective assessments more rigorous assessment procedures were employed (Booth & Booth, 1993).

The Home Observation for Measurement of the Environment (HOME) inventory (Caldwell & Bradley, 1984, cited in McGaw & Sturmey, 1993) was designed to provide a reliable measure of parents' ability to emotionally and physically stimulate their child using language and toys. The findings suggested that parents demonstrated an increased use of punitive approaches and less involvement with their children when compared to the normative population (Feldman et al., 1996 in Dowdney & Skuse, 1993). However, the tool's scope is limited, such as its inability to assess child safety skills (Tymchuck & Feldman, 1991). Observational approaches have been designed to provide a more valid picture of parenting skills.

Bakken, Miltenberger and Schauss (1993) assessed knowledge and skills in parent-child interaction in 5 mothers, with IQ's ranging from 57 to 70. Knowledge was assessed by responses to descriptions of parenting situations and skills were assessed during 15-minute home observations where parents were instructed to first play with their child and then to continue with their usual routines. The parents demonstrated poor knowledge and limited positive interaction with their child. However, with such a small sample size, and without a comparative group it is difficult to attribute their difficulties to their disability alone. This has been rectified to some extent by Feldman, Case, Garrick, Maclntyre-Grande, Carmwell and Sparks (1992), who observed the child care skills of mothers with a mean IQ of 74 and compared them to non-learning disabled mothers who had similar aged children. The skills assessed were those which raised concerns for the referrers and the parents, or were noted to be absent during an informal observation. The findings from this fairly subjective assessment, unsurprisingly demonstrated significant child-care skill deficits such as difficulties in bathing the child or preparing bottles.

Predictably, debates continue within the field and it is questionable whether parenting skills can accurately be assessed in these ways (Booth & Booth, 1994). As is inherent in all studies attempting to follow a scientific method with human participants not all factors could be controlled for (Feldman, 1994) and thus the reliability of the studies is questionable. Feldman et al's (1992) study for example noted that their
comparative sample consisted of mothers earning up to $75,000 (Canadian); an unlikely income for people with learning disabilities and therefore an unsatisfactory control group (Dowdney & Skuse, 1993). In fact it was identified over 30 years ago that once compared to mothers from a similar socio-economic background, few differences could be identified in parents with an IQ of 60 or more (Borgman, 1969). Thus the issue is whether parents can be appropriately assessed once confounding variables have been controlled for (Accardo & Whitman, 1990).

Tymchuck and Andron (1992) attempted to address some of these criticisms by matching participants on a number of variables including socioeconomic status, ethnicity and number of children. Although not a pure measure of parenting with mental and physical ill health affecting 4 of the 15 parents, their study was one of the few to report a culturally diverse sample. Parent-child interactions were observed both at home and in a clinic setting providing a reliable and valid measure of parent and child behaviour, although it is questionable whether a 5-minute observation is sufficient to determine parents’ abilities. The results suggested that parents praised and labelled their child’s behaviour less and their children were more noncompliant at home than non-learning disabled mothers and their children, which the authors cite as evidence for a parenting deficit. However when examined further the parents and their children differed significantly on only 3 out of a possible 19 measures. This skewed focus on difficulties rather than achievements (Sheerin, 1998) blames the individual and further supports the unreliability in assessing parents in this way (Booth & Booth, 1994). In addition to the flaws identified, methods such as these have ignored other factors which arguably influence parenting ability and experience and any assessment that claims to be ascertaining parenting skills should also consider wider influences.

**Influences on parenting skills**

As more individuals are being raised in the community (Booth & Booth, 1993), it will become necessary to assess the effects of childhood experiences and traditions within the parent’s own family as these have been found to affect parenting knowledge and skills in mothers (Llewellyn, 1997). In fact this issue is pertinent for mothers raised in institutional settings too as they would have had poor models of parenting from which to base their own behaviour (Booth & Booth, 1993). The vulnerability and cognitive limitations of people with learning disabilities emphasises further the impact of additional factors which can influence parenting (Whitman et al.,
These include a low-income and employment difficulties (Whitman et al., 1989) and the parent's physical and emotional health (Sheerin, 1998). A recent study identified that stress was a confounding factor in mothers' ability to interact positively with their child (Feldman, Varghese, Ramsey & Rajeska, 2002). Ideally a parenting assessment would consider these variables too, removing the focus and the pressure to achieve from the parents' knowledge and skills alone.

The limitations of the individualistic approach is highlighted with other risk factors associated with poor parenting (Sheerin, 1998) including the size of the family (Accardo & Whitman, 1990), the quality of the relationships and the influence of the extended family (Dowdney & Skuse, 1993). Although social support has been found to enhance parenting skills it can also be limiting. For example Bangladeshi mothers who were more likely to be living with their children than white mothers reported extended family support to be at times disempowering as they struggled to find an autonomous role in caring for their children (O'Hara & Martin, 2003).

The O'Hara and Martin study is rare in its explicit focus on experiences of mothers from different cultural groups and emphasises the necessity of assessments exploring this issue. Overwhelmingly the parenting literature has focused on the parenting of white western mothers and has failed to explore how ethnicity may affect their parenting role. Even where ethnicity has been reported (for example, Tymchuck & Andron, 1992) researchers have failed to make it an independent variable in their subsequent analysis (Cotson, Friend, Hollins & James, 2001). Assessments of parenting skills will only be valid if they remain conscious of the added disadvantage that clients from a minority ethnic group face, where labelling and oppression based on disability and ethnicity may be routine (Baum, Nadirshaw & Newland, 2000). In addition assessments tend to be both based on and measured against the practices of white western culture doubly disadvantaging those for whom this is less relevant. For example assessments that focus on whether hierarchies and boundaries are maintained between parent and child may be judging a family outside of their cultural norm (Maitra, 1995). Fathers with learning disabilities have been largely ignored too (Booth & Booth, 1993) and valid and reliable assessments of their parenting skills remain unexplored.

Child characteristics also affect parenting style and some view a reciprocal relationship between parent and child's temperament and behaviour (McGaw &
Sturmey, 1993). For example, the child's cognitive abilities are thought to impact negatively on parental behaviour if they are demonstrating greater abilities (McGaw & Sturmey, 1993). Furthermore, parenting for these families appears to increase in difficulty once children enter late childhood and early adolescence (Accardo & Whitman, 1990); many of the assessment studies narrowed their focus to infancy and early childhood.

Assessment in practice

It seems that more holistic assessments would better capture the myriad of influences on parenting capabilities and provide more valid and reliable assessments of parenting skills. This is particularly pertinent for determining outcomes in parent interventions as some physical and mental health factors are thought to predict slow learning and rapid forgetting in parents (McGaw & Sturmey, 1993). One such approach based on predictors of parental achievements and inadequacies, has been developed to assess parents. The Parental Skills Model (McGaw & Sturmey, 1994) identifies three areas that should be examined for a comprehensive assessment of parenting: parental life skills, family history and available support and resources. Each factor is assessed using a variety of quantitative and qualitative methods and are thought to have a direct and indirect effect on the child's care and emotional and developmental needs. The model emphasises collaboration between disciplines and agencies in assessing and planning services for these parents. Usefully the authors provide a case example using the framework and the literature evidences its use in clinical settings (for example Woodhouse, Green & Davies, 2001), although empirical research is needed to document its reliability. However to support the principles established in Valuing People (DOH, 2001) and as research indicates that IQ does not confound ability to parent perhaps separate assessments are unnecessary (Booth & Booth, 1994). The Framework for the Assessment of Children In Need (Department of Health, Home Office & Department for Education and Employment, 2000) outlines the assessment procedure for all parents including those with learning disabilities (Cotson et al., 2001). This could be implemented with parents with disabilities once multiple life-skill deficits that parents may have are considered take into account (Cotson et al., 2001). Furthermore, to ensure that parents are not being disadvantaged on the basis of their disability a number of questions should be asked prior to assessing capacity. Göpfert, Webster, Pollard and Nelki (1996) suggest asking whose needs the assessment will be meeting: the child's and/or the parent's, or the anxieties of the professional network.
Teaching parenting skills
Wider society appears to value teaching parenting skills and good results have come from individual and group approaches for the general population (McGaw & Lewis, 2002). Accardo and Whitman (1990) present a less than optimistic picture from their own clinical experience of training learning disabled parents. Examples, which include parents inability to recall their children's names or birthdays and putting shoes on the wrong feet demonstrate for them their inevitable failure to learn adequate skills. Parent trainers present a slightly different picture. A survey of their experiences revealed that parents made significant improvements although programmes tended to be of longer duration, more directive and more complex than programmes for parents without a disability (Budd & Greenspan, 1985). Furthermore they reported that long-term support was seen as necessary to maintain and generalise the gains made. However a more rigorous approach is required to determine the learning abilities of this group including the specifics of skills taught and the length and intensity of training (McGaw & Sturmey, 1993).

A number of empirical studies have attempted to answer this. Whitman et al. (1989) trained parents with unborn or preschool children in child-care skills. The intensive instructional training consisted of 4 days a week at a centre with twice-weekly follow-ups in the parents' home over a minimum of 2 years. A range of approaches was used such as role-play and individual and group discussion to train parents. Although each parent was given an individual learning plan, they were not involved in formulating these, which seems like a lost opportunity for collaborating with parents and increasing their empowerment. According to the researchers: "many of the parents made significant improvements in their parenting skills..." (p. 433) although they fail to quantify this figure or expand on how this result was achieved. However, they highlight the many problems they encountered throughout the training. For example some parents were lacking in basic skills such as generalisation, self-organisation and time management. Moreover, many were often in psychological and social crisis with 46 percent of families made homeless during the study. Again queries can be raised as to whether this constitutes a "pure" measure of teaching parenting. Yet, these were the circumstances under which these individuals were attempting to parent and it is a testimony to their perseverance that parenting skills were learned. This study therefore demonstrates that adverse life experiences need not be a barrier to teaching parenting skills. However, this approach was extremely
resource demanding and unlikely to be viable in everyday clinical practice. Additionally, with poor generalisation of newly attained skills, it may be more beneficial if parenting was taught in the environment it is to be practiced in (Tymchuk et al., 1990).

Tymchuck and Andron (1992) offered 2 hours of clinic and home-based training to mothers each week founded on an established evidence base of positive parent-child interactions. Parents demonstrated encouraging changes in some skills such as modelling positive behaviours to their child, although none were able to reach the standards of the comparison mothers. There was little change in parents’ ability to praise their child, although measures taken in their children showed an increase in their positive behaviour, thus increasing the reliability of the approach. Variability in acquisition and maintenance of skills further demonstrates that parents with learning disabilities are not a homogenous group (McGaw & Sturmey, 1993) although some generalities could be made: parents with pre-existing skills were most likely to benefit, a pattern noted by the trainers reported earlier (Budd & Greenspan, 1985).

Home-based training of child-care skills has also produced positive findings. Feldman et al. (1992) trained mothers of young children at home using a variety of methods including modelling and reinforcement. Skills improved in all mothers from a mean percentage correct score of 58 percent in baseline to 90 percent in training and 91 per cent at follow-up. Similar scores were also achieved for the control group of non-learning disabled parents. The superior results obtained in this study suggest that as well as home-based advantages such as convenience and increased rates of attendance (Llewellyn et al., 2002), parents perhaps find acquisition of more concrete, knowledge-based skills easier. This has been supported by Llewellyn et al. (2002) whose child health and safety issues training occurred over 10 weekly visits of 60 to 90 minute duration; useful information for clinical practice. The training identified a number of components for success including the use of pictures, positive reinforcement and the importance of individual programmes to meet parent’s varying needs. However, the reality of home training where interruptions are likely means that trainers may not have parents’ full attention. In addition, all training was conducted by a trained educator which, although identified as an important component for success (Llewellyn, 1997), tend to be unlikely in resource-stretched CTPLDs. Thus the development of low-cost approaches is ideal.
Feldman and Case (1999) developed one such approach based on a self-instructional manual, allowing the parents to have the advice on-hand at all times. The authors used best practice child-care guidelines to identify child-care skills and focused on skills needed for children less than two years old, which is useful in considering preventative or early intervention measures. Parents were taught to use the materials by a community support worker and were then assessed at home at one-week intervals until a score of 80 percent was achieved. Results suggested that the majority of parents not only benefited from the training, but also maintained gains over a mean follow-up of 4 months. In addition the 5 parents for whom satisfaction data was collated gave mostly positive feedback for the approach. An important factor for future use of this approach is that the one parent who reported disliking the manual was the least successful, although this was not a significant finding. Additionally there were no significant correlations between skills attainment and reading ability or motivation to use the materials, which further increases its use amongst parents. It is encouraging to note that both mothers and fathers volunteered to participate in the study, although two-thirds of the parents were under court-ordered supervision and may have felt that participation was obligatory rather than voluntary. One could argue that the power relationship so evident here accompanied by the severe consequences of failing might also inhibit parents performance. All participants were described as having a mild learning disability but diagnostic criteria were not provided. This is unfortunate particularly as earlier in the paper the authors refer to "IQs less than 80" being indicative of an intellectual disability (p. 27) which differs to populations eligible for services in the UK.

This approach meets some of the factors identified to be relevant in successfully training parents with learning disabilities, such as requiring mastery in a specific skill (McGaw & Sturmey, 1994). In addition self-instructional approaches may be more empowering for parents than traditional approaches and may assist in generalising and maintaining taught skills throughout the child's development (Feldman & Case, 1999). Although Feldman and Case argue that self-learning may be effective for behaviour management and parent-child interactions the more abstract nature of these concepts may necessitate additional training. It also remains unclear what techniques might be suitable for more complex behaviours or parenting of older children whose caring requires more elaborate problem-solving techniques (Whitman et al., 1989). Teaching problem-solving skills would be useful for the mostly novel situations that parenting provides, particularly as the typical life experiences of people
with learning disabilities leaves few opportunities for decision-making (Llewellyn, 1997). Tymchuck et al. (1988, cited in Sheerin, 1998), using a multiple baseline design reported that parents were able to learn and apply basic problem-solving steps. However, as others have found, gains for some aspects of problem solving were not generalised or maintained at one-month follow-up.

Ensuring that parenting is successful for all
It seems that much of what parents learn is context and time specific (Young et al., 1990) with pessimistic implications for generalisations beyond the training environment and the child's current age. Thus it is important that programmes teach parents to generalise learned skills across settings and over time (McGaw & Sturmey, 1993) and that future research identifies ways in which generalisations of taught skills is more likely in these parents (Sheerin, 1998). There is some question as to whether this group of parents can be taught skills quickly enough to surpass or even keep up with their child's progress (Accardo & Whitman, 1990). The development of longitudinal studies may help to determine this as well as examining the impact on the child and parent of teaching parenting skills (Whitman et al., 1989).

A number of variables associated with poor compliance to training programmes have been recognised including social isolation, maternal mental health, family conflict, socio-economic status and single parenting (McGaw & Sturmey, 1993). Acknowledgement of these other variables may help to identify those parents who are likely to struggle with any training approach. In these instances of multiple identified risks the intervention's timing is crucial; intervening within the first three years of the child's life has been identified as most relevant in preventing developmental delay (Martin, 1990 cited in McGaw & Sturmey, 1994). Even when children do have developmental delay, training can still produce positive results as evidence by Tymchuck and Andron's single case study of a learning disabled parent with three children with developmental delay (1988). Providing extra support may make learning parenting skills an easier and more successful task (Llewellyn et al., 2002). For example Arnold (2003) describes the development of a service for people with learning disabilities that also addresses skills relevant to parenting such as increasing self-esteem and assertiveness training. Other factors associated with successful outcomes include the use of staff with professional attitudes who can offer continued support (Tymchuck 1992, cited in McGaw & Sturmey, 1994). Identifying who in the wider social network relates best to the child including older siblings, and
involving them in aspects of teaching (McGaw & Sturmey, 1993) would help to combat the necessity of prolonged staff involvement.

Overall it seems that mothers can be taught adequate skills although different parameters for defining parenting skills make comparison of different research studies difficult (Sheerin, 1998). Concerns have been raised regarding the reliability of the studies with some arguing that if more stringent IQ criteria were used a different picture may emerge (Accardo & Whitman, 1990). Similarly the use of sampling is not necessarily reliable as information regarding the prevalence of all learning disabled parents and their parenting abilities or strengths are not known (Llewellyn, 1997). Ignoring this aspect momentarily, few studies considered issues of diversity such as including fathers in training or training parents from minority ethnic groups, which limits the reliability of the findings further. Fantuzzo, Wray, Hall, Goins and Azar (1986) reports training three black mothers with positive results although, as with assessment approaches, any possible effects of ethnicity were not examined. Indeed a focus on training the individual may further disadvantage those cultural groups for whom community family life is more the norm (Maitra, 1995) and without social support, regardless of cultural identity, any gains made during training will not be maintained (Llewellyn, 1995; Guinea, 2001).

Teaching in practice
The above provides useful information for a practising clinical psychologist in a CTPLD although it is debateable whether separate teaching from the general population is an honest recognition of the differing needs of this client group or merely a reflection of societal views. Clinicians within the field have argued that general parent training programmes would be unable to meet the needs of people with learning disabilities without some adaptation (McGaw & Sturmey, 1993). Within wider parenting populations parenting training can result in individuals feeling deskilled and lacking in confidence in their own abilities (McGaw & Lewis, 2002) which would most likely be amplified in a population who are frequently undermined as learning disabled adults are and practitioners would need to be aware of this. In addition, the effects of institutional racism and discrimination would need to be reflected upon when considering parents for training as such issues could lead to exclusions from appropriate interventions within mainstream service provision (Baum et al., 2000).
Placing parent training within a political arena, the aim of educating parents could be seen as making the poor and disadvantaged less of a problem rather than increasing support to those most in need (McGaw & Lewis, 2002). In this respect it would be useful to consider ways other than formal teaching programmes, that parents could acquire skills. The role of informal learning, as often assumed in the general population, should not be ignored for learning-disabled parents. Llewellyn (1997) looked at the parenting of eight learning-disabled parents who were parenting adequately. There were no socioeconomic difficulties so generalisations are limited. Using interviews and information collated from time spent with the couples she identified a number of common themes for learning parenting skills including learning from examples set by others, learning from making mistakes and using family traditions remembered from their own experience of being parented. When this revoked negative memories parents often used opposing strategies to those used when they were children. Acknowledgement of such prior learning which is less passive than “being taught” implies, may help to combat the culture of dependency which currently exists whereby people with learning disabilities are continually in the passive role of receiver of services (Young et al., 1997). Where formal teaching is required practitioners need to consider issues of consent in relation to parenting assessment and training and the psychosocial implications of having a child (O’ Hara & Martin, 2003).

Conclusions
The rights of the child should outweigh the parents within the context of abuse and neglect (Accardo & Whitman, 1990). However this essay has shown that where abuse is not the main agenda the rights of parents with learning disabilities must be equally prevalent. Although there are few integrated teams (O’Hara & Martin, 2003), where assessments are required, these should be conducted jointly between children and adult learning disability services to ensure the needs of both parties are met (Cotson et al., 2001). To complement parent training, children may also benefit from psychological intervention (Tymchuck & Feldman, 1991).

The traditional focus of the individual in psychology does not seem to benefit parents with learning disabilities and perhaps we need to consider the family’s context, the availability of services, the community and the current political context as equally important in providing the right environment for raising a child (Göpfert et al., 1996). Perhaps approaches such as community psychology should be employed (Orford,
1992) allowing the development of more creative practices. For example, parenting and related topics such as sexuality and relationships could be taught to students in special education (McGaw & Sturmey, 1993) to help compensate for the poverty of experiences they may have had in the past or in the future. In addition antenatal services could be trained to be aware of the differing needs of all clients and to promote accessible services (Arnold, 2003) so that enforced separation does not continue and opportunities are made for networking within the wider community. Woodhouse et al., (2001) describe their service which aims to identify parents at an earlier stage where preventative interventions can be used such as providing support, training and consultation to professionals involved with parents. It is encouraging that such approaches can be incorporated into CTPLDs where specialist service provision is unavailable.
References


Do cognitive techniques add therapeutic value to working behaviourally with children with OCD?

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Obsessive-compulsive disorder (OCD) is a debilitating anxiety disorder which can be identified by intrusive thoughts or images that interfere with functioning and cause distress (Shafran, 1998). These are often accompanied by ritualised, repetitive behaviour which function to reduce this distress (Benazon, Ager & Rosenberg, 2002). Prevalence rates of childhood OCD resulting in clinical impairment have been estimated at between 2 and 3 per cent (Grados & Riddle, 1999). However accurate diagnosis of childhood OCD is difficult as children are often secretive about the condition and parental reports probably underestimate the severity (Rapoport, & Inoff-Germain, 2000). This, accompanied by a lack of insight that a child might have into the disorder (Shafran, 2001) complicates assessment and identification of the disorder. For example some reports state that compulsive behaviours without obsessional thoughts are more common in children than in adults but this may more reflect the child's cognitive developmental stage and their inability to identify and report such phenomena (Shafran, 1998). What is clear is that the condition can have far-reaching affects on academic, social and family functioning (Piaccentini & Bergman, 2001, in Benazon et al., 2002). Furthermore it is estimated that between 30 and 80 per cent of adults with OCD developed the disorder in childhood (Shafran, 2001) so early intervention is not only important for reducing the child's suffering but also for preventing this debilitating condition from affecting adult life (March, 2001).

The gender and age disparities which exist in child OCD populations are significant and require consideration when evaluating intervention approaches. Boys are more likely to develop the condition (Shafran, 1998) and tend to develop the condition in middle childhood, whereas girls' symptoms are more likely to occur during the pre-pubertal periods (Grados & Riddle, 1999). It is rare that OCD will present in isolation and co-morbidity rates have been estimated at approximately 70% (Grados & Riddle, 1999) with children also presenting with other anxiety, mood or psychiatric disorders. These also need to be considered as they can affect compliance with treatment (Rapoport, & Inoff-Germain, 2000). In fact the similarities between OCD and other neurodevelopmental disorders (Grados & Riddle, 1999) such as tic disorders and pervasive developmental disorders results in confusion in diagnosis (Shafran, 1998). However these stereotypies do not have the accompanying intent or purpose as in OCD (Shafran, 1998) nor do they appear to cause the same level of distress (Grados & Riddle, 1999). Similarly OCD in children can appear analogous to the superstitions and 'magical thinking' that can occur in childhood. However the intensity and content
of the thoughts and behaviours differ significantly in OCD and tend not to involve the frequently shared beliefs in superstitions (Shafran, 1998).

The value of exploring the usefulness of therapeutic approaches is pertinent in child populations as parents are often reluctant to consent to medication and require independent evidence to validate the use of an alternative intervention (Benazon et al., 2002). Thus this essay will begin by examining the behavioural model and the efficacy of behavioural approaches with the paediatric OCD population whilst considering the different ways that "therapeutic value" has been conceptualised. It will then use a similar framework for cognitive techniques and will finally explore other therapeutic adjuncts that could be considered with this population. Throughout, children will be understood as any young person who might access a child and adolescent mental health service (CAMHS); usually those under 18.

**Behavioural approaches**

The behavioural model of OCD in adult populations uses the principles of learning theory to explain how obsessions are acquired. Thus neutral stimuli, by being paired with aversive stimuli come to elicit intrusive, obsessive thoughts (Carr, 1999). To prevent anxiety caused by the obsession, the individual engages in escape strategies or rituals which function to prevent the feared thought from occurring. These actions, which occur as covert compulsions such as thought suppression or overt behaviours like checking reduce anxiety and thus negatively reinforce the compulsion (Basco, Glickman, Weatherford & Ryser, 2000). The aims of behaviour therapy are twofold. Firstly it aims to break the cycle between the obsessional fear and the resulting anxiety through exposure to the feared stimulus. Secondly it attempts to break the cycle between compulsions and decreasing anxiety by preventing the individual's usual response. During exposure the client imagines or faces anxiety-inducing stimuli from a hierarchical list (Lam & Steketee, 2001). Their usual response is prevented and without this act, anxiety levels eventually decrease by a process of habituation (McLeod, 1997). In addition to exposure and response prevention (ERP) the behavioural approach typically begins with relaxation skills to help reduce anxiety during exposure (Rapoport & Inoff-Germain, 2000) and skills training to learn more adaptive stress-relieving behaviours (Basco, et al., 2000). ERP is regarded as an efficacious, efficient treatment for adults with OCD (Hollander, 1997, in Francis & Gregg, 1996), whereby 65 to 80 per cent of adults demonstrate and maintain significant improvement compared to other interventions, including using the separate
components of exposure and response prevention in isolation (Lam & Steketee, 2001).

The behavioural approach has been employed with children with OCD. Piacentini, Grrow, Jaffer, Graae, & Whitaker (1994) presented case studies where each child received 10 sessions of ERP implemented in both the clinic and the client's home to ensure generalisation of the approach. Unlike adult approaches where the client is often treated in isolation, the family's role in maintaining the disorder was considered and family members were also involved in the intervention. All of the children described were Caucasian females potentially limiting generalisations. However, they presented with a range of OCD symptoms and histories and varied in age and co-morbid difficulties suggesting that the intervention would be applicable to most clients presenting with OCD. The value of this approach was predominantly assessed by symptom reduction. For example a 9 year old girl with co-morbid behavioural problems received non-clinical ratings on the Child Yale-Brown Obsessive Compulsive Scale (CYBOCS; Goodman, Price, Rasmusseen, Mazure, Fleischman, Hill, Heninger & Charney, 1989, in Piacentini et al., 1994) following a combination of ERP and behaviour management techniques which her family were taught to target her oppositional behaviour. Similarly a 12 year old girl who had received an unsuccessful prior treatment of medication, demonstrated habituation to all feared stimuli and achieved non-clinical ratings on the CYBOCS, although this finding was not subjected to statistical analysis. This followed a package of ERP accompanied by family work focusing on psychoeducation and strategies for disengaging in OCD rituals. In this case therapeutic value was also assessed by the impact of OCD on the family, which reportedly decreased considerably, and positive self-reports from the child and her family 1 year after the intervention.

More rigorous evidence for behaviour therapy was obtained in Scahill, Vitulano, Brenner, Lynch and King's (1996) repeated-measures pilot study. 7 children ranging from 9 to 16 years were given an average of 14 sessions of ERP, with additional family interventions which included positive reinforcement for completing tasks. The majority of children had persistent OCD symptoms despite being on medication for 4 weeks, suggesting severity of the disorder and in an effort to diminish any confounding effects, dosage levels remained constant throughout the intervention. Following the trial all participants demonstrated at least a 30% reduction on CYBOCS scores. The benefits of the approach were not just focused on symptom reduction
but also on the wider system and the authors reported a return to school and an improvement in social functioning and peer relationships for two of the participants. Thus the behavioural approach appears valid in its conceptualisation of OCD and appears to provide reliable results when applied to children with the disorder. In addition, children report that they believe exposure and response prevention to be helpful in decreasing their symptoms (Flament, Koby, Rapoport, Berg, Zahn, Cox, Denckla, Lenane, 1991 in Wolff & Wolff, 1991) thus giving further validity to the approach. However, limitations exist with the approach as evidenced by Piacentini et al.'s (1994) third case study. The authors reported ERP with a 13 year old girl whose OCD had persisted despite 2 years of psychotherapy and medication trials. Previous therapeutic experiences had resulted in an ambivalence and scepticism towards engaging in ERP. Thus the majority of sessions were spent exploring emotions regarding the disorder and its treatment, as well as associated family issues which included a parental history of OCD and alcohol abuse and separation anxiety. Little impact was made on achieving goals related to her hierarchy of feared stimuli as the authors reported that she would only engage in exposures she perceived to be achievable. Furthermore the family had difficulty in applying taught techniques and continued to display a blaming attitude towards the child and her difficulties despite the provision of family interventions. Ratings at the end of treatment completed by the clinician, the family and the adolescent suggested only minimal improvement. Thus difficulties with the behavioural approach include overcoming the child’s resistance to treatment as well as ensuring that behavioural programmes are indeed carried out (Wolff & Wolff, 1991). This essay will therefore consider the role cognitive techniques might have when working therapeutically with children with OCD. In doing so, reference will be made to this latter case study presented by Piacentini et al.

Theoretical rationale for cognitive techniques
A number of cognitive models have been identified which explain the onset and maintenance of OCD, highlighting the role that cognitions have in mediating between obsessive thoughts and compulsive behaviour. Salkovskis' (1985) theory, which is widely accepted and has supporting empirical evidence in the adult population (Barrett, Shortt & Healy, 2002), postulates that the individual's interpretation of their intrusive thought determines the amount of distress this will cause them. Thus the person who is likely to experience OCD will be characterised by cognitions which overestimate personal responsibility for preventing harm to themselves or others and
overestimate the severity and likelihood of harm occurring (Salkovskis, 1985). Such cognitions result in hyper-vigilance for intrusive images and thoughts, greater distress when they do arise and behavioural actions which function to either suppress or neutralise the intrusions and avoid responsibility (Barrett & Healy, 2003). Furthermore, completion of the ritual reinforces belief in the appraisal because of the resulting decrease in anxiety thus maintaining the compulsions. Additional cognitive models have been proposed by O'Kearney (1998, in Barrett & Healy, 2003) and Rachman (1997). O'Kearney hypothesised that poor cognitive control increased the frequency of intrusive thoughts and that self-doubt was responsible for the indecisiveness and motivation to repeat behaviours that is evident in OCD. In contrast Rachman proposed a dysfunctional cognitive process where people with OCD confuse thoughts and actions associated with harm and view them as equivalent; a process he termed thought-action fusion (TAF).

Evidence of faulty cognitive processes was recently identified in a sample of children with OCD. Barrett & Healy (2003) designed assessments which they proposed to tap into the cognitive constructs described earlier. For example to assess cognitions regarding responsibility the authors designed personally relevant sentences involving OCD threats which children had to rate on a 7-point scale. The study employed an appropriate range of measures with good reliability and validity to assess OCD including objective questions and more subjective parent and child reports. In addition the cognitive assessments tasks demonstrated good face validity. The majority of children recruited to the study had co-morbid difficulties thus demonstrating clinical relevance. Furthermore the sample had a spread of ages (7-13) and mix of genders which reflects OCD symptom presentation and the development of cognitions in children although the social and cultural backgrounds of participants was not specified so applicability of the results is limited. The results suggested that children with OCD reported significantly higher ratings of Rachman's (1997) construct TAF and responsibility for OCD-threats than non-clinic children but could not be discriminated on measures of O'Kearney's theory of self-doubt. In addition poor cognitive control was the only measure that additionally discriminated OCD children from children with other anxiety disorders suggesting that this process may be most pertinent in childhood OCD. However the development of some cognitive processes may not have occurred in the younger participants and this may be responsible for the lack of differentiation from children with anxiety. The small sample size would have additionally impeded attainment of significant findings.
Nevertheless this provides a theoretical rational to add cognitive techniques to behavioural approaches and the outcomes obtained following cognitive-behavioural therapy (CBT) for childhood OCD shall now be examined.

The contribution of cognitive techniques
The protocol designed and evaluated by March and colleagues (March, Mulle & Herbel, 1994; March & Mulle, 1995 and 1998) is widely reported as integrating cognitive and behavioural approaches in the treatment of OCD. In addition they employed a narrative approach to externalise OCD. Clients were therefore encouraged to form an alliance with the therapist, family and friends to work together against “the enemy” OCD using ERP, anxiety management training and cognitive strategies. These consisted of constructive self-talk and cognitive coping strategies to help the child withstand the exposure and increase their sense of control over the disorder. Efficacy of the approach has been provided by both treatment trials and case studies. March et al. (1994) employed a within-subjects design using 15 children with OCD between the ages of 8 and 18. Both genders were represented in the study and the sample, who mostly presented with co-morbid difficulties, represented two ethnic groups, thus extending the generalisations that can be made. OCD severity was assessed using a variety of measures validated for use with children including CYBOCS (Shafran, 1998), although not all of the sample was assessed on the same scales. Statistical analysis revealed a significant improvement following a mean of 10 sessions which was sustained at follow-up for 80 per cent of clients. The authors acknowledged the limitations of their design; namely that most children received concurrent treatments of medication, making it difficult to isolate the effects of the protocol (Benazon et al., 2002) and consequently the cognitive contribution. Similarly the protocol had not yet been standardised and so participants received various versions of the intervention. These limitations were remedied to some extent with the results of a case study where a medication-free child was treated successfully using the protocol (March & Mulle, 1995).

This approach is useful in providing a standardised intervention which can be easily transferred to clinical settings. Furthermore the cognitive techniques are likely to have helped participants to understand the intervention and withstand exposure (Rapoport & Inoff-Germain, 2000). Such an approach may have benefited Piacentini et al.'s (1994) unsuccessful case whereby cognitive techniques may have provided her with additional coping strategies prior to facing her most feared stimuli. In fact
Academic Dossier – Children & Families Essay

some would argue that a behavioural approach implicitly challenges dysfunctional OCD cognitions (Shafran, 1998) and in some respects is equivalent to behavioural experiments used in the cognitive approach. However this implicit approach was insufficient in instigating change in the above example and others have argued that the function of behavioural experiments within a cognitive framework is to test the validity of OCD appraisals which have been made explicit during therapy (Whittal & McLean, 1999). It seems that within March's approach the cognitive techniques function to facilitate exposure, particularly as there is no assessment of cognitive processes which may be maintaining the disorder. Indeed the authors suggest that ERP forms the core of their treatment which may explain the difficulty in identifying the cognitive theoretical rational on which this form of CBT is based. The authors' placing of OCD within a narrative context suggests that adding this technique may enhance a behavioural approach with children. For example it might have discouraged the blaming attitude seen in Piacentini et al.'s (1994) case and may also have united the client and her family by encouraging the formation of an alliance against a common enemy OCD. It is therefore necessary to explore whether a more overt cognitive approach might provide a supplement to standard behavioural approaches with children.

A more explicit cognitive technique that has been used and reported to be useful is that of cognitive restructuring, following identification of dysfunctional OCD appraisals. Using Rachman's (1997) cognitive model, Shafran and Somers (1998) described a simple technique, which helped 2 adolescents to reframe their cognitions regarding the significance of intrusive thoughts. By asking clients to try not to think about a white bear (with the result that they typically find this impossible) they were able to learn a strategy which challenged and weakened the strength of their beliefs. Cognitive restructuring such as this is thought to be useful for those who are resistant to ERP (Rapoport & Inoff-Germain, 2000) and would therefore provide a useful addition to behavioural approaches. Further evidence for the value of including cognitive techniques has been provided by a recent open trial. Benazon, et al., (2002) implemented a combination of cognitive and behavioural therapies which were grounded in established theoretical frameworks. Thus the behavioural approach was based on March & Mulle's (1998) protocol and the cognitive approach on an adult model of OCD (Schwartz, 1996, in Benazon et al., 2002). The intervention therefore consisted of both ERP and training in cognitive techniques which aimed to provide insight into the use of more adaptive coping skills. The cognitive training was not
only provided by the therapist but also supplemented with an audiotape, which probably helped to consolidate the skills taught. In addition psychoeducation was provided to help children and families re-conceptualise OCD as a neuropsychiatric illness. The participants included both genders and a good spread of ages so the approach's effectiveness can be evaluated for both younger children (8 years) and adolescents. All patients were described as Caucasian and details were not given regarding the social backgrounds of the children so generalisations in these areas cannot be explored. However 50% of the sample had co-morbid difficulties, which reflects the presentation of OCD in the community and none of the participants had received any prior interventions including medication. As with other studies families were included in the intervention, thus ensuring that strategies were implemented outside of the clinic and representing the typical way that CBT occurs in CAMHS (Ronen, 1998). Uniquely however, the degree of parental involvement was determined by the extent to which parents affected and were distressed by their child's OCD. Therapeutic value in this study appeared to be measured by symptom reduction and the same tools were used as in the March et al. (1994) study to assess severity of OCD, anxiety, depression and overall health. In addition all clients were seen for 12 hourly sessions so the approach is valuable in terms of cost-effectiveness. It would, however have been interesting to note how the clients and their families determined a successful outcome in addition to symptom reduction. Results suggested a minimum 50% reduction on CYBOCS for 10 out of the 16 participants and non-clinical anxiety and depression scores for half of the sample. However psychotherapy was less successful with those with more significant difficulties and the addition of medication was required to increase outcome. Unfortunately the study did not follow-up the participants and due to the open nature of the study is unable to determine whether the effects are solely attributable to the therapy. Furthermore it is unclear whether the additional cognitive techniques enhanced the standard ERP approach. In fact a closer examination of the scores obtained in this study reveal that they appear remarkably similar to those obtained by March et al. (1994) although this finding would need to be subjected to statistical analysis. Thus on the evidence provided by this study, the addition of a theoretically valid cognitive component does not appear to enhance a behavioural approach, but nor does it produce worse outcomes which is also an important clinical finding and replicating March et al.'s findings using a more standardised approach is an important development in the field. It therefore seems that the identified theoretical rational for implementing cognitive approaches (Barrett & Healy, 2003) has not been endorsed
by experimental evidence. Nonetheless guidelines suggest that both behavioural and cognitive behavioural approaches should be considered for children with OCD (Wolpert, Fuggle, Cottrell, Fonagy, Phillips, Pilling, Stein & Target, 2002) so it is useful to consider the clinical implications of doing so.

Clinical considerations
Some ethical dilemmas exist when applying an adult-based model of CBT to a child and families setting (Doe, Elsworth, Tingay & Wolpert, 2002). For example, client-determined goals is a basic principle in CBT but it is unclear who the client is in CAMHS settings – with the child, the family or some other external agency all as potential contenders. In addition child-centred approaches may reinforce scapegoating in the family and collude with the view that the child is to ‘blame’ (Doe et al., 2002) as occurred in Piacentini et al.’s case. However all of the studies examined in this essay considered the child’s system and involved the family in the intervention to help combat this. Should CBT be selected as an appropriate tool, particular sensitivity is required when questioning beliefs where the family and clinician differ socially and/or culturally (Fatimilehin, Raval & Banks, 2000). Any effect this may have had on the therapeutic relationship was not explored in the above studies, possibly because of the lack of diversity in the samples. Developmental considerations such as the child’s cognitive stage (Ronen, 1998) and cognitive abilities (March, 2001) also need to be considered when pondering the addition of cognitive techniques. Younger children may not be able to cope with the cognitive demands of CBT (March, 2001) and some concepts such as appraisal have been difficult even for some adults to grasp (Whittal & McLean, 1999). Such issues would be compounded for the child with developmental delay and whilst these approaches are thought to be of use for children with OCD and a pervasive developmental disorder (Grados & Riddle, 1999) these assertions are yet to be supported with evidence. It may be that other techniques may also enhance behavioural approaches and may prove to be of therapeutic value for children who might not benefit from a cognitive approach.

Alternative adjuncts to a behavioural approach
An increased prevalence rate of OCD in the families of children with the disorder raises questions about a role for the family in the aetiology and/or maintenance of the condition (Barrett et al., 2002) and as discussed the studies examined here included the family in their interventions. However, Barrett et al. also identified a theoretical
rational in their study which looked at the behaviour of the family of children with OCD. They found that parents of children who have OCD behave differently to parents of children with other anxiety disorders and parents of children without any difficulties. For example they demonstrated poorer problem-solving skills, and were less rewarding of their child's independence. These parents also reported higher levels of anxiety and depression than other parents. Therefore an added therapeutic value may be gained by involving the family in clinical interventions where the purpose is not just to generalise treatment effects outside of the clinic setting but also to address the wider ramifications of OCD on the family (Barrett et al., 2002) and any family psychopathology. Such an approach has supporting literature whereby a combination of behaviour therapy and family therapy resulted in participants being symptom free and no longer taking medication (Bolton, Luckie, Steinberg, 1995, in Shafran, 1998). Maintaining and generalising treatment effects is nevertheless important and where OCD has permeated the school setting this system has been incorporated into a behavioural intervention with good outcomes (March & Mulle, 1998). In fact the importance of peer relationships to young people has lead some to question whether group interventions would be beneficial to this client group (Drinkwater & Stewart, 2002).

Psychodynamic approaches represent another alternative to cognitive techniques. Within this model is the suggestion that psychotherapy may be useful in breaking down the defence mechanisms the child uses to reinforce OCD symptoms and may also help increase engagement in the behavioural component of therapy (Grados & Riddle, 1999). Furthermore for adolescents the secondary effects of OCD such as lowered self-esteem may be appropriately targeted by long-term psychotherapy (Wolff & Wolff, 1991). However as with the adult literature (Lam & Steketee, 2001) there have been no controlled outcome studies for dynamic interventions. It seems that alternative conceptualisations such as this become caught in a vicious cycle whereby insufficient published evidence leads to clinicians using approaches like CBT, which in turn builds up a greater evidence base.

Although not within the remit of a clinical psychologist’s role it is important to consider the effects of medication in alleviating children from OCD particularly within a CAHMS setting where medical colleagues are easily accessible. The evidence appears mixed however. For example following implementation of March & Mulle’s (1998) protocol no differences in outcome could be identified between those taking
medication and those not (Franklin, Kozak, Coles, Rheingold & Foa, 1998, in Shafran 2001). Yet evidence-based intervention guidelines suggest that medication should be considered when CBT has been ineffective in abating OCD symptoms (Wolpert et al., 2002). The studies examined here suggest a role for medication where chronicity is evident and it may have a role in encouraging the initial exposure where high anxiety is interrupting engagement (Lam & Steketee, 2001).

**Conclusions**

The standards of research evident in the adult literature have not been replicated with this population (Rapoport & Inoff-Germain, 2000) and there are no randomised controlled trials comparing the benefits of CBT for childhood OCD with other interventions (March, 2001). The treatment trials that were reviewed here had a number of limitations including small sample sizes based on one ethnic group, which restricts the reliability and validity of the approaches once exported to clinical NHS settings. In addition the studies employed predominantly quantitative research methodologies when evaluating the usefulness of behavioural and cognitive approaches. It would be useful to evaluate the experience of, and interventions for OCD using qualitative techniques as such methods may provide a richer understanding of how the condition impacts on client's lives. However a more fundamental limitation evident in the studies was the lack of theoretical underpinnings for the models proposed and to date a developmentally appropriate model of OCD has not been proposed. Despite Barrett and Healy's important work (2003), which identified the presence of faulty cognitive processes, gaps in the knowledge base remain regarding the aetiology and maintenance of childhood OCD. For example questions such as “when do children develop ‘responsibility cognitions’?” remain unanswered and without an underlying theoretical basis one questions how appropriate interventions can be devised. It is equally concerning that researchers in the field recommend the use of cognitive interventions despite the unsupported theoretical foundations. For example in a discussion on using CBT for children with OCD one author stated that it had a “sound rationale based on theory-driven, empirical and outcome data...” (Shafran, 1998, p. 63) and later conceded that the evidence for CBT was poor. Such practices are dangerous in promoting a “halo-effect” of the efficacy of CBT, possibly to the detriment of other approaches. Indeed other approaches such as narrative techniques and family interventions seem to have a role in supplementing behavioural therapy.
Thus there is insufficient experimental evidence to determine whether cognitive techniques would be a useful addition, although the preliminary findings in this essay suggest the types of presentation where it may be of most use. Positive factors in these studies such as the inclusion of children with co-morbid difficulties increase the validity of these approaches for clinical practice. Practitioners therefore appear to have two options when choosing an intervention for childhood OCD (Shafran, 2001). They can either follow the protocols developed specifically for children with OCD (e.g. March & Mulle, 1998) or they can adapt the cognitive models developed for adults with the condition. More appropriately would be the option to intervene using an evidence- and theory-based model specifically for children, which explored the development, content and distortions of cognitions (Drinkwater & Stewart, 2002) and the idiosyncrasies of behaviour. Even then clinicians are encouraged to find an appropriate balance between systematic research and clinical experience (Wolpert et al., 2002) based on the needs of a particular child at that particular time.
References


What theoretical approaches and models can be helpful when addressing issues of diversity in our clinical work with older people and their families?

Year 2

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Older People Essay
In order to meet the particular needs of a growing ageing population, specialised community services for older people were formed in the UK. A contrary view would argue that it is perhaps a reflection of attitudes in British society that people identified as “older” and usually above the age of 65, require separate services to their younger counterparts. Nevertheless both perspectives recognise that psychological needs do not diminish after a specified age, rather that older people may have distinct psychological needs as well as possibly experiencing the additional effects of neurological decline. Clinical work with this client group reflects this and generally encompasses two main areas of need, which will be explored throughout this essay. Organic issues consider the assessment and impact of cognitive decline and the contribution this can make to disorders such as Dementia and Alzheimer’s. Functional issues take into account the commonly termed “mood disorders” such as anxiety and depression.

Recent developments within individual clinical training courses and at a wider policy level within the British Psychological Society and the Department of Health have resulted in “issues of diversity” becoming prominent in our clinical thinking (Patel, Bennett, Dennis, Dosanjh, Mahtani, Miller & Nadirshaw, 2000). This is perhaps due in part to increased awareness that individuals belonging to certain groups are likely to suffer discrimination and can be disadvantaged within services (Ndoro & Marimirofa, 2004). With older people specifically, the National Service Framework for Older People signals a consideration of distinct issues that apply to this community and explicates how their specific needs should be met. However rather than viewing older people as a homogenous group (Crowther & Zeiss, 2003) there are further calls to ensure that older people from a range of cultural backgrounds receive an equally proficient service. For example it recommends that the needs of minority ethnic elders be taken into consideration when planning services (Ndoro & Marimirofa, 2004). Thus there is an implicit understanding that traditional clinical work requires modification in order to meet the needs of people from all backgrounds.

The essay question as it stands seems to imply that “issues of diversity” will present as specific concerns during an intervention that need to be confronted in order for therapeutic work to progress. My own clinical experience would support this stance and I can recall an instance where the age disparity between a client and myself had

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1 I have chosen to write this essay in the first person to facilitate an integration of my clinical experience.
a negative impact on the therapeutic process, with considerable time spent exploring "age" and its meaning before clinical work could begin. However even within older people services, which are designed to deal specifically with problems occurring in later life, potential clients tend not to be identified with "issues of diversity" as the presenting problem. Rather, in my experience, individuals will present with difficulties that ostensibly, can be met by the service such as the functional or organic issues identified earlier. It is therefore necessary to explore what might be understood by the term "issues of diversity" to examine the likelihood of them presenting as distinct issues that can be individually addressed.

What does "issues of diversity" look like?
As with many concepts in psychology "issues of diversity" can be seen as a construct consisting of whichever factors are deemed relevant by the clinician. To some extent both personal and professional interests may determine this. For example, I am aware of my own focus on the ethnicity and socio-economic status of clients, possibly reflecting my self-identity and the importance these factors have had on my life, but nonetheless to the exclusion of several other potentially significant aspects of social being. "Diversity" as defined in a standard dictionary is "the condition of being different or having differences" (The Penguin English Dictionary, 2002). Within the systemic field in the UK, the acronym GRACCES encompasses a number of "differences" which can be considered in relation to clients: gender, race, ability, class, culture, ethnicity and sexuality (Senn, 2002). A slightly more comprehensive framework has been developed by Hays (1996). Forming the acronym ADRESSING it includes a consideration of "age and generational influences, disability, religion, ethnicity, social status (by income, occupation, education, rural or urban origin), sexual orientation, indigenous heritage, national origin and gender" (Hays, 1996, pp. 188). The ADRESSING framework is a useful reminder of the many influences on an individual client’s presentation beyond intra-psychic or organic factors and demonstrates the unlikelihood of tackling "issues of diversity" as a separate issue. To further highlight this latter point, the intricacies of some of these social categories shall be examined in relation to older people and their families.

Within each of the social categories covered in the ADRESSING framework, exists further diversity and "conditions of difference". For example, variability within the concept of age is demonstrated by acknowledging that at least two generations exist within the client group, each subject to their own generational differences and varying
health and social problems (Crother & Zeiss, 2003) which influence their psychological functioning. In addition each category could be understood as another social construct. For example, the process of ageing can be constructed differently in various societies, which is important to recognise when considering the life experiences of older people. Roles and expectations of older people can vary across cultures as can the value, power and status bestowed on them (Gibson, Lokare & Tress, 2000). Within western society it is widely accepted that ageing is devalued (Seltzer, 1993), possibly due to a societal emphasis on a productive work force, which has been defined as ending at retirement age by those in a position of power (Henrad, 1996). Often coupled with devaluation is discrimination; older people are therefore likely to have experienced ageism and social marginalisation in this society (Crowther & Zeiss, 2003). As a result of being in a relatively powerless group older people may experience low self-esteem and low self-worth in addition to their presenting problem. By societal definition an older person is unlikely to encounter a therapist who is a similar or older age than them, which will have the likely outcome of replicating wider contextual power relationships.

Social marginalisation is also generated by poverty of which old age is a major cause in the UK (Kearney, 1996). The effects of socio-economic disadvantage are wide-ranging, impinging on an individual's physical, psychological and social well-being (Kearney, 1996). Thus in addition to the practical implications which accompany poverty such as financing travel to clinical appointments, the effects of membership of a disadvantaged and probably oppressed group, should not be discounted in a clinical work (Edge, Kagen & Stewart, 2004). Experiences of oppression are also likely for older people from a minority ethnic group (Crowther & Zeiss, 2003) although again they represent a heterogeneous group (Hays, 1996) and so specific individual needs will need to be explored with the client. Nevertheless some commonalities do exist and with regard to issues of ethnicity, heritage and nationality the stress of living in one society in a position without power with memories of a different cultural expectation for old age can manifest itself as psychological distress (Gibson et al., 2000). This in turn can have an impact on the client's expectations of what can be discussed with a psychologist (Gibson et al., 2000).

Similar arguments about the deleterious effects of oppression on an individual's well-being exist for women who are regarded as the gender with the least power in society (Urry, 1990) and as older service users are more likely to be female (Quall, 1996) it is
particularly pertinent. Equal concerns are being raised by those concerned about older people from the gay and lesbian community (Ward, 2000), yet these are arbitrary divisions, as the interplay between these different factors in any one individual cannot be ignored.

Acknowledging such heterogeneity makes it difficult to imagine how a client would present with a specific "diversity issue" that could be tackled by a particular psychological approach. Furthermore, having deconstructed "issues of diversity" working clinically from any theoretical perspective without consideration of such issues appears inconceivable and it is pertinent that clinicians accept that social characteristics will always influence the therapeutic process (Kearney, 1996). Thus a more useful approach is to acknowledge that "issues of diversity" are in fact integral to clinical work and therefore thinking. Indeed in order to practice within an anti-discriminatory framework an important question is whether we should work clinically without addressing issues of diversity.

Having gained some understanding of what might be understood by the term "issues of diversity" this essay will now explore the models and approaches commonly used with older people to ascertain their usefulness in working with diverse populations.

**Considering the theoretical models and approaches**

Replicating the younger adult model, a number of theoretical approaches have been considered for use with older people and some of these will be considered here in relation to their usefulness in addressing diversity. Prior to this several underlying features of traditional psychological models will be explored.

Rather than assuming that academic psychology is universally applicable and culture-free (Patel et al., 2000) the development of psychological theories and practice can be understood as a product of its time and place (Kearney, 1996) making it difficult to disregard the sociological, historical, economic or ideological context (Jones, 1990). The models most commonly taught on clinical training courses such as psychodynamic therapy and cognitive-behavioural therapy (CBT) are therefore reflective of and embedded in the worldview prevalent at their time of conception in Europe and North America (Toukmanian & Brouwers, 1998). Consequently the philosophies and values, which are privileged in our understanding
of mental health are those inextricably linked to a white Western economic and political ideology (Holland, 1990).

Examining more closely the dominant groups in society and their likely influence over clinical psychology’s knowledge base reveals not only Eurocentric supremacy but also masculine and middle-class prevalence (Hays, 1995) as well as a dominance of youth. Thus the definition of psychological problems and their solution can be seen as a social and political act influenced by those who have been accorded the power to construe “normality” and “abnormality” (Jones, 1990). For example if one considered the privileging of the individual in Western ideology an underlying ethic of individualism becomes apparent in many traditional therapeutic encounters (Kearney, 1996) as does a tendency to focus on internal events and observable behaviour. As a consequence distress and the alleviation of this distress is located in the individual (Smail, 2004) and the importance of social constraints and inequality in psychological suffering is denied. The many diversity issues outlined earlier and their relationship to oppression are therefore not explored in relation to a client’s presenting needs.

By ignoring issues of diversity, traditional psychological approaches and their proponents are arguably maintaining existing power inequalities and the disempowerment and oppression of clients (Jones, 1990) thus serving their interests and maintaining the status quo. Poverty and disadvantage for example, which is the experience of many older people in the UK have been ignored in psychological theory and practice reflecting the field’s middle-class standpoint (Edge, Kagen & Stewart, 2004). In addition many of the theories used in clinical psychology and specifically older people services were generated by and for people at an earlier life stage than many of the clients and we are left wondering whether older people’s voices have been heard in relation to the interventions that are commonly applied to them. It is also important to question the impact a devaluation of ageing in Western society has had on eurocentric psychological models and the influence this may have on older people encountering psychotherapy in the UK, from societies or cultures where ageing is valued. Feminist writers have argued that gender-based power differences in society also need to be explicitly addressed in therapy in order to avoid reinforcing the inequalities that may have initiated women’s distress (Perelberg, 1990).
Having set the context in which psychological theories and models exist in, this essay will now focus on some individual theories and examine their usefulness in addressing wider contextual influences.

**Diagnostic models**

Although traditionally the domain of psychiatry colleagues, my experience thus far suggests that clinical psychologists increasingly use diagnostic categories such as in their evaluation of specific therapeutic techniques like CBT for depression. However such categories were devised from work with Euro-American patients within the context described earlier, so their applicability to people from different cultures is questionable (Robinson, 1995). Despite evidence suggestive of the existence of broad similarities across cultures in the pattern of psychological difficulties such as depression, there are also differences in the expression and experience of distress across cultures (Richards & Abas, 1999). It could also be argued that diagnostic models serve the interests of certain groups by reinforcing the view that the individual is solely responsible for the difficulties rather than acknowledging environmental factors or the impact of inequality and oppression. Thus a more useful approach would be for clinical psychologists to use case formulation to understand their clients' difficulties, and perhaps begin to use these formulations in evaluating therapeutic methods (Tarrier & Calam, 2002). This would allow for wider diversity issues to be considered in the origin and maintenance of a client's difficulties.

**Organic issues**

As described earlier organic issues encompasses the assessment and impact of cognitive decline in older people. The Mini Mental State Examination is frequently used in the service I have joined, as an initial assessment tool in identifying whether someone has a dementing illness. However it has been argued that some questions are culturally biased, potentially putting some elders such as those from minority ethnic groups at a disadvantage (Rawaf & Bahl, 1998). The questions do not allow for variations in education or literacy, aside from the important point that it has no legitimacy in other languages (Ndoro & Marimirofa, 2004). Such limitations would need to be made explicit when communicating test results (Murphy, 2000).

Similar arguments exists for other neuropsychological tools used. All are based on the assumption that individuals will freely display their intellectual skills to strangers and are familiar with the abstract, educationally biased way of eliciting information
Academic Dossier – Older People Essay

(Richards & Abas, 1999). In many tests concentration (Hays, 1996) speed and manual dexterity skills are significant which may put many older people at a disadvantage. Although standardised test norms are expected to account for such age-related differences, my experience has highlighted that these are not always available. In addition test norms are often validated on English-speaking individuals (Robinson, 1995) and so caution is required in interpreting the results. For example in an assessment of an elder whose first language was Urdu, I had to exercise considerable care when ascertaining whether his deficits were due to cognitive decline or unfamiliarity with English, using the client and his family to help determine "normal" functioning. In fact gathering qualitative information has an important role in assessing older people and family members and significant others should be consulted to help ascertain the influences of cultural norms and general beliefs and attitudes (Murphy, 2000). To illustrate this point further, referral information for the gentleman described earlier revealed that he had poor skills in activities of daily living, demonstrating reliance on his daughters for meals. However clinical interview identified that this skill had never developed due to his gendered role in the family.

As well as cultural specificity in the assessment of cognitive decline, the final diagnosis given may also have less relevance for some clients. For example some West African communities believe that dementia is caused by evil spirits and would use religious interventions to relieve associated distress (Ndoro & Marimirofa, 2004). This it would be important to acknowledge the labelling of dementia symptoms across cultures (Richards & Abas, 1999) and incorporate client beliefs into clinical work. Furthermore the power imbalances that are prevalent in neuropsychological settings need to be recognised, particularly given older peoples’ cohort expectations of professionals (Murphy, 2000).

Functional issues
Screening for functional difficulties in this client group is also problematic. For example the Geriatric Depression Scale (Yesavage, 1988) has not been validated for minority ethnic elders (Richards & Abas, 1999), which is of concern given its frequent use in screening emotional distress. In fact many of the issues discussed in the previous section also apply to the assessment of functional difficulties and so the focus here will primarily be on intervention and, because of space constraints, the use of CBT and Family Therapy.
Cognitive behavioural approaches

Having eradicated the youth bias prevalent in the younger adult literature, CBT has been identified as an efficacious treatment for many acute mental health problems in older people (Gatz, Fiske, Fox, Kaskie, Kasl-Godley, McCallum & Wetherall, 1998). However, at the foundation of this finding are the randomised treatment trials which have tended not to take diversity issues into account at either the level of the clinical difficulty being examined, for example by excluding co-morbidity (Gatz et al., 1998) or at a more macro level by, for example, failing to account for the sexual preferences of the sample (Hays, 1995). Thus applicability of this model to diverse people is questionable. At a more theoretical level, feminists have argued that the approach is based on a set of assumptions about personality development which are predominantly male and which may not accurately reflect how women think and reason (Worrell & Remer, 1992). Furthermore it attributes responses to external societal factors as “internal psychological errors” (Cromby, 2004; pp.15). Thus concepts such as ‘faulty thinking’ and ‘distortion’ may be disadvantageous to older women whose perceptions may be an accurate reflection of an oppressive environment (Worrell & Remer, 1992). In spite of this others have argued that there is nothing intrinsic about CBT that would imply that it would not be of use with diverse groups, and in fact many aspects of the model suggest that it might be beneficial (Hays, 1995; Worrell & Remer, 1992).

Hays (1995) identified four strengths of CBT that make it particularly helpful to working with diverse populations. To begin with its emphasis on tailoring therapy to the client's particular circumstance is useful because it recognises the individuality of clients and acknowledges the situational element of difficulties. Secondly, its focus on observable process is advantageous particularly where there may be communication issues. Another strength of CBT is the multiplicity of assessment measures used throughout therapy, which allows the inclusion of a range of evaluative sources and tools again adapted to suit the individual. Finally, the context of CBT is of client empowerment and the model acknowledges the client’s own expertise regarding their difficulties which is likely to further endorse a collaborative relationship where power imbalances are evident. Worrel and Remer (1992) argue that the usefulness of CBT is further expanded if concepts from social role theory are integrated into the cognitive model. When considering the position of women for example, they argue that an integrative approach would permit behaviour to be interpreted in terms of gender socialisation and would facilitate an exploration of the
effects of patriarchy and discrimination allowing older women to reframe their position more positively. Laidlaw, Thompson, Gallagher-Thompson & Dick-Siskin (2003) provide a comprehensive approach to CBT with older people which considers particular influences on the formation of cognitions such as the effect of cohort beliefs. Explicitly acknowledging such socio-cultural (Laidlaw et al., 2003) and political (Hays, 1995) influences is vital if CBT is to be viewed as a useful approach.

Family therapy approaches

Family therapy originated from systems theory and dynamic theory, which as discussed earlier cannot be divorced from its Eurocentric, masculine underpinnings and normative concepts of the traditional family (Perelberg, 1990). In addition they were developed for families at a child-rearing stage of the life cycle and so adaptations have to be made to the older family. The aim of family therapy is to modify the function or structure of the family for the advantage of individual members (Qualls, 1996). So identified problems in the elder are viewed as residing in the family and its inability to adapt to meet the older person’s needs (Qualls, 1996). It is a useful approach considering the centrality of and reliance on family for some older people. However there are implications for power imbalances considering older peoples position in society and the likelihood of the elder being “identified” as the patient by a younger family member.

One role of the family therapist is to identify family themes or unspoken rules by which the family operate. However such an approach requires viewing the family as one unit, which excludes the likelihood of cross-cohort differences. For example levels of acculturation across generations in my own family have resulted in a number of differences in beliefs and values, aside from those that can be attributed to age. Furthermore assuming a common goal for the family ignores the possibility of exploitation and inequality within the family, reflecting the wider social context (Perelberg, 1990). Thus individual values and experiences as well as family values would need to be explored, if this approach were to be beneficial.

Underlying traditional family therapy approaches is an assumption of therapist expertise (Perelberg, 1990); therapists are seen as separate entities from the family they are treating and objectivity and neutrality are obtainable. Considering the socio-political context from which therapy derives and exists, concepts such as neutrality become meaningless. Critical approaches such as social constructionism have also
become influential in the field resulting in an acknowledgement of the role of the therapist in the system and attempts to establish a less expert and truth-seeking position (Campbell, 1999). Thus the therapist would acknowledge that she is seeing the family through her own worldview (Campbell, 1999), which is a more non-discriminatory way of working with the range of diversity issues identified earlier than assumptions of neutrality. The relevance of social constructionist approaches within family therapy has further advantages as it takes into account the way that meanings of events are co-constructed in conversation and through language. Language is not a socially neutral form of communicating, being influenced as it is by a number of contextual factors such as class (Kearney, 1996) and gender. Within this society the literature has documented the different ways in which men and women express themselves and respond in conversations when in same-sex and mixed gender company. For example men interrupt women more frequently than other women (Zimmerman, 1977 in Vetere & Dallos, 2003). Such power differentials are further compounded by other societal inequalities such as ethnicity and age. In practice a clinician would therefore need to be mindful of how their language may be subtly reinforcing power inequalities by alienating the client and how a client may be taken more or less seriously dependent on how they speak. In my own practice I endeavour to reflect the words and descriptive terms that clients use rather than translating them into psychological terminology. However as a young therapist undoubtedly my youth biases creep in when working with elders.

A model for working with diversity issues

It seems then that an awareness of the politics of therapy and its influence on client work is imperative when working with older clients. What becomes important is bringing into therapeutic conversations issues that people sometimes are not able to talk about whilst retaining a general sensitivity of social inequalities throughout clinical work (Vetere & Dallos, 2003). For example Holland (1990) discusses a model of psychotherapy for African-Caribbean women that considers the effect of imperialism and colonialism on their depression, thus addressing both intrapsychic and social issues. Without consideration of a client's social and political backgrounds, clinicians are unable to provide culturally sensitive services (Ndoro & Marimirofa, 2004) and are arguable creating and maintaining discriminative practice.

The ADDRESSING acronym is a useful starting point to help a therapist consider their client in their own context. However, Hays argues that her framework was developed
not only to consider client work but also to assist psychologists in the exploration of the influence of a range of cultural factors on their own identity and worldview (1996). Health professionals are likely to share the attitudes and prejudices of the wider society (Ndoro & Marimirofa, 2004) and it is difficult to separate personal values from professional practices particularly where these are pervasively and implicitly held by society at large. Any implicit or explicit prejudiced attitudes or biases are likely to affect clinical work, which considering the positions of power clinicians' hold would be detrimental to clients (Daniel, Roysircar, Abeles & Boyd, 2004). Thus a clinician would need to consider their own personhood within the ADRESSING framework before examining how it influences clients (Hays, 1996). Examining ones own values and prejudices regarding social inequalities and differences could occur within supervision as an important step in developing reflective-practice skills (Daniels et al., 2004). Professional resources such as the reflecting team in systemic practice can also assist in achieving a meta-position as can remaining mindful of ones own experiences of power and powerlessness (Williams & Watson, 1994, in Vetere & Dallos, 2003). Finally gaining feedback from clients would be invaluable in identifying their experience of the therapeutic process (Daniels et al., 2004).

If examining personal attitudes and values is the first step in providing a more helpful approach to working with diverse elders, then incorporating models into clinical practice where awareness of social injustice is integral to the approach is the next step. Community psychology approaches move away from problematising the individual (or the family) and considers the importance of social context in understanding psychological distress (Orford, 1992). Thus for older people their experiences in relation to the labour market and housing, for example, would be considered fundamental to their presentation of distress (Orford, 1992) thereby recognising the impact of discrimination and social inequality on their lives. Rather than focusing on individual treatment approaches this model advocates preventative social action within the community. Orford's example for working with older people encapsulates both an individual approach as well as the clinician “attempting to influence local authority housing policy regarding low-cost housing for older people” (p. 7, 1992). Establishment of mental health teams within the community and away from institutions represents a basic level of a community psychology approach, which has already been incorporated into many older people services. However, the model has much more to contribute towards more effective work with diverse elders.
Conclusion
Having considered the pertinent issues with regards to working with the diverse needs of elders there appears to be a number of implications for clinical psychology training. An integrative model would appear to be more useful than stand-alone teaching on issues of diversity, which only serves to further marginalize these issues, and encourages them to be only considered when they become detrimental to clinical change. In this way all clients can be considered "diverse" allowing a broader range of factors to be explored. Integrating such issues into general teaching would also encourage practitioners to more readily include the impact of social inequality and discrimination into client formulations. Promoting reflective-practice skills would also help trainees to increase self-awareness and develop an understanding of their own worldviews as well as the role the profession can have in maintaining existing power inequalities. Helpful if clinical psychology diversifies its own composition to help bring these issues to the fore.

Final thoughts
I chose to write this essay because it is an area of personal relevance and concern. My predominant interests in ethnicity and socio-economic status have been privileged in this essay, although this was somewhat reflective of the available literature. However it was a noticeable struggle to make this essay specific to the older population as many of the issues, as I viewed them, had relevance across the age range. It was equally difficult to cover the range of themes, which emanated from this title in sufficient detail and I have been left feeling as if I have merely scrapped the surface of the relevant issues. Trying to move away from a problem-saturated story of how theoretical approaches are not helpful was possibly the biggest challenge and hopefully some of the dilemmas raised have accompanying solutions.

This was an appropriate time in my stage of training to think about these issues and I wonder whether I would have been able to deconstruct that which I was eagerly trying to learn if I had approached it at an earlier stage. It has nevertheless been a learning experience about my developing clinician-identity and the impact of a wider range of contextual factors on my own personhood and on my work with clients.
References


Clinical Dossier – Volume I

Please note that details have been changed to preserve the client’s anonymity and confidentiality.
Contents of the Clinical Dossier
Volume I

Contents

Placement Summaries 70
An overview of the clinical experience gained during training

- Adult Mental Health 71
- People with Learning Disabilities Placement 72
- Children & Families Placement 73
- Older People Placement 74
- Specialist Adult Mental Health Placement 75
- Specialist Children & Families Systemic Placement 76

Case Report Summaries\(^1\) 77

- Adult Mental Health 78
- People with Learning Disabilities Placement 81
- Children & Families Placement 84
- Older People Placement 87
- Specialist Adult Mental Health Placement 89

\(^1\) The case reports are submitted in full in Volume II
Placement Summaries
Adult Mental Health Placement Summary

*Richmond East Community Mental Health Team, Surrey*

*with Fiona Stiedl*

October 2002 – March 2003

I saw adults ranging from 23 to 62 years presenting with various psychological difficulties. Clients were of mixed gender, ethnicity and faith. Most clients presented with 'severe and enduring' difficulties, including managing emotions following a traumatic event, personality issues, chronic fatigue syndrome and psychosis. The predominant model used was CBT, although I was also influenced by my supervisor's psychoanalytic orientation. I also completed a neuropsychological assessment for memory problems following a traumatic head injury.

The work was conducted within a multi-disciplinary setting and as such liaison with other professionals was frequently required. In addition visits to other services occurred including a daycentre, an in-patient ward and the local CAMHS to discuss transfer of clients between services. I participated in a presentation with another trainee on the role of a clinical psychologist in a CMHT, and conducted an audit on the implementation of the care programme approach in the team. I also attended a number of conferences including a presentation on anxiety and CBT by Paul Salkovskis.
People with Learning Disabilities Placement Summary

Richmond Community Team for People with Learning Disabilities and the Psychology & Challenging Needs Department, Surrey

with Dr. Helen Quigley

April 2003 – September 2003

This placement was split between a CMHT and a challenging needs service as well as liaison with a range of services. As such co-working with other professionals was predominant. I worked with clients, their families and their carers with various presenting difficulties including, cognitive decline, challenging behaviour, eating difficulties and bereavement issues. Cognitive assessments were undertaken with clients utilising a range of assessment tools. In addition I acted as part of a reflecting team for a new family therapy service which had just been set up.

Theoretical orientations used included systemic, behavioural and community psychology, resulting in a presentation in the latter approach to the team. I have since carried much of these ideas into other placements. I participated in a group intervention based on an Intensive Interaction approach. I also participated in systemic supervision groups where team members received a consultation service for clients and systems they were working with.
Children and Families Placement Summary

_Lewisham Neurodevelopmental Team (NDT) & Lewisham Paediatric Service, London_

_with Dr. Sarah Helps_

_October 2003 – March 2004_

I joined two teams during this placement based in both community and hospital settings. I saw children, adolescents and their families with either developmental disorders (e.g. autistic spectrum disorders) or health difficulties (e.g. sickle cell disease) with co-existing emotional and behavioural difficulties. Work involved individual interventions and family work. I co-ran a social skills group in a primary school and I also conducted a cognitive assessment with a teenager seeking refuge in the UK, using interpreting services. Within the NDT service I also participated in the pervasive developmental disorders clinic run by paediatricians, psychiatrists and clinical psychologists and observed ADHD clinics run by a similar mix of professionals. The young people ranged from 3 – 17 years and reflected this diverse London borough in terms of ethnicity and social background. I mainly worked within systemic and cognitive-behavioural orientations.
Older People Placement Summary

Twickenham Community Mental Health Team for Older People, Surrey

with Dr. Kate Spencer

April 2004 – September 2005

During this placement I worked with older women and men, and their families presenting with functional and organic difficulties. These included anxiety and depression across the mild – severe spectrum, as well as assessments for cognitive decline such as dementia. The main orientations used were neuropsychological, cognitive-behavioural and psychoanalytic. There was a wide range of economic and social backgrounds amongst the clients and it was interesting to note the impact this had on experiences of old age.

I took the opportunity to observe different professionals and different services including the Day Hospital, in-patient occupational therapy services and psychiatry-led review clinics. I also participated in monthly psychology meetings, presenting a paper on working with transference and countertransference, and its application to work with older people.
Clinical Dossier – Specialist Adult Mental Health Placement

Specialist Adult Mental Health Placement Summary

Mother & Baby Inpatient Unit, South West London
with Dr. Jyothi Shenoy

Early Intervention Service for Psychosis, South West London
with Ian Petch

October 2004 – March 2005

This specialist placement was split between two services both based in Springfield Hospital, Wandsworth. In both of these services a mixture of men and women from a range of cultural, social and religious backgrounds were seen.

Mother & Baby Inpatient Unit

This 4-bedded unit catered for women and their babies experiencing post-partum mental health difficulties. The clients I worked with presented with psychosis, depression and anxiety both as first episodes and as relapses to existing problems following the birth of their child. For many, associated social and family issues were also highly relevant. The main model utilised was cognitive-behavioural therapy. My work involved individual work with the mothers, indirect work with the staff team devising a care programme and attendance at the weekly ward round as the sole representative of psychology. I also completed an observation of the women’s only in-patient ward and the day hospital.

Early Intervention Service for Psychosis

This multi-disciplinary outreach service worked with people aged 17-35 undergoing their first episode of psychosis. Most therapeutic work was conducted in client’s homes. The clients I saw individually presented with co-morbid OCD, and anxiety, ‘negative symptoms’ of psychosis such as social withdrawal and voice hearing. I also worked with a family in their adjustment of a family member presenting with psychosis. Liaison with other team members was necessary and there was a role for psycho-education amongst the mostly medical staff. I attended a London Early Intervention Network meeting, which considered the provision of services for Black and Minority Ethnic Groups.
Specialist Children & Families Systemic Placement Summary

Richmond Child & Family Consultation Centre, Richmond, Surrey
with Dr Annika Clark & Gloria Martin
April 2005 – September 2005

To date I have worked with children and their families ranging from 7 – 14 presenting with a range of difficulties such as elective mutism, anxiety, school refusal, behaviour difficulties trauma and parenting skills. The main orientation utilised has been systemic using specific models such as structural approaches and narrative therapy. Cognitive-behavioural principles are also employed. I have participated in weekly team consultation meetings where cases are reflected on and have been part of the reflecting team commenting on the process of the meetings. I also join weekly multi-disciplinary ‘starter’ clinics where new families are presented and seen. A family therapy clinic has recently begun which I observe on a weekly basis behind a one-way screen.
Case Report Summaries
Adult Mental Health Case Report Summary

Cognitive – behavioural therapy with a 36-year-old woman presenting with chronic fatigue syndrome

Year 1 – April 2003

Presenting Problem
Jane Captain, a White British 36-year-old woman, was referred to the Community Mental Health Team (CMHT) by her GP. The referral letter stated that Jane had been suffering from a post-viral fatigue-like condition or myalgic encephalitis (ME) for the past 3 years and was requesting referral to a specialist chronic fatigue syndrome (CFS) unit. Jane was initially seen by the team psychiatrist and was then referred on to the clinical psychologist for further assessment. Jane’s first language was English.

Assessment
Based on existing evidence of the efficacy of cognitive-behavioural therapy (CBT) for CFS, a cognitive-behavioural assessment was conducted during unstructured interviews with the client. Throughout these sessions Jane presented as sleepy and lethargic but was able to give a comprehensive and thoughtful account of her difficulties. This was supplemented by additional information obtained by the team clinical psychologist and psychiatrist.

The assessment gathered information regarding Jane’s patterns of activity and rest as well as associated behaviours, cognitions, moods and physical complaints. Prior to therapy, Jane had kept diaries of her activity levels and her symptoms and these contributed to the baseline measures collated. Information was also gathered regarding Jane’s family, personal and occupational history and current support networks.

Jane reported that she “just wanted to get her life back” and hoped that therapy would help her “be more active”.

Formulation
Jane’s presentation was conceptualised within the cognitive-behavioural model for chronic fatigue syndrome postulated by Sharpe (1997). In this model individuals are
characterised by perfectionist attitudes about coping and performance which are thought to compensate for a low self-esteem. These core beliefs may have been formed during Jane's early difficult experiences with parents who abused alcohol and may have initiated the development of more intermediate beliefs about how she should behave. Her stressful work history, additional family stresses and a viral infection appeared to precipitate the onset of her symptoms which included fatigue and muscle ache. These difficulties were hypothesised to be maintained by an inability to sustain performance in activities due to an increase in fatigue and an interpretation of this as catastrophic, resulting in her avoiding activities altogether. However Jane also attempted to behave normally and fluctuated between sporadic bursts of activity and complete inactivity resulting in frustration.

Intervention
The formulation was discussed with Jane and her hopes for therapy were redefined into measurable goals. For example "being more active" was measured by increasing the time spent in engaged in tasks. The scheduled and graduated activity was introduced as this was hypothesised to alter maladaptive behaviour patterns and subsequently influence her cognitions, mood and symptoms. To prevent Jane's pattern of "overdoing it" she was also encouraged to rest briefly when the symptoms occurred and then resume the activity. Cognitive strategies included monitoring and challenging the unhelpful thoughts that Jane had about her illness using cognitive restructuring and behavioural experiments. Jane appeared to quickly adapt her thinking to the cognitive-behavioural model and she demonstrated a good understanding of how it might be applied to her situation. The therapy was truly collaborative and Jane often assigned herself and completed homework tasks consistent with the cognitive-behavioural model. Throughout most sessions Jane would engage in safety behaviours such as walking very slowly to the consulting room. These were not directly challenged, as the therapist was concerned with protecting the therapeutic relationship. However it was considered important that a balance be found between colluding with the client and complying with the approach.

Outcome
Throughout the five sessions attended, Jane's ability to attribute a greater proportion of her difficulties to psychological causes was instrumental in producing the changes seen, and allowed Jane to reappraise her instinctive cognitions about her symptoms. Behavioural changes were more gradual than had been anticipated but nevertheless
demonstrated Jane’s commitment to change. Jane reported that her husband had commented on how different she was, which appeared to boost her confidence.

Despite the reported shifts, Jane continued to demonstrate entrenchment in an “illness” model, which had an impact on her ability to complete her activity regime. Her difficulty in preventing herself from “doing too much” also remained with some activities and fears of relapse remained evident.

Reformulation
Although the clinical work and outcomes appeared to support the initial formulation the possibility of additional maintenance factors emerged from the process. For example Jane admitted that her fatigue quite suited her marital relationship, as her husband preferred a quieter lifestyle, suggesting social reinforcement of her illness. In addition the discovery of possible underlying schemas related to passivity and a need to please others were useful in considering predisposing factors.

Evaluation
Jane’s commitment to attend therapy undoubtedly contributed to the positive changes observed. In addition Jane’s willingness to work within the model was particularly useful. The cognitive-behavioural approach appeared to suit her perfectionist qualities and her diligence in completing tasks benefited her progress.

A briefer intervention was offered to Jane contrary to the evidence base (Sharpe, 1997). This decision was based on the therapist’s availability and the standards promoted in the CMHT for brief interventions. As a consequence changes to many of Jane’s behaviours were attempted which may have been confusing for her. However a brief intervention was beneficial in terms of promoting Jane’s autonomy and an internal locus of control.
People with Learning Disabilities Case Report Summary

An extended assessment to consider the suitability of psychotherapy for a 50-year-old White British woman with a learning disability, presenting with bereavement issues and low mood

Year 1 – September 2003

Presenting Problem
Rose Lyle, a 50-year-old White British woman with a learning disability, was referred to the psychology and challenging needs service by her day centre key worker. The referral stated that Rose required assistance in working through issues of loss and might benefit from “frustration-reducing strategies” that could be used when she became angry. An additional concern was a deterioration in Rose’s general functioning over the last year. She had reportedly lost confidence and gained an “almost institutionalised appearance”, requiring more direction and prompting than previously. Rose’s first language was English.

Initial Assessment
Assessment information was gathered by case file review, meeting with the referrer separately and Rose and the referrer together. It was hypothesised that seeing them jointly would ensure Rose’s consent, facilitate engagement and clarify the therapist’s involvement.

During a previous referral to psychology where residential staff reported struggling with Rose’s challenging behaviour, interventions involved individual sessions with Rose, and the provision of staff training. Strategies designed to decrease the aggressive behaviour of another resident also had positive secondary effects on Rose.

Rose was reported to have been born with a severe learning disability and cognitive assessments completed when Rose was 17 identified her IQ score to be 38, although her communication and social skills were reported to be above that level. Rose’s mother and father had died 29 and 19 years ago respectively. Her brother had died 2 years previously. He was described as having a close relationship with Rose.
Initial Formulation
It was hypothesised that Rose's early experiences contributed to a general psychological vulnerability and her current presentation. Her learning disability may also have inhibited her understanding of life events that had occurred such as the death of her parents. The challenging behaviour of co-residents was considered to be a maintaining factor to Rose's difficulties. It was decided that an assessment to consider Rose's suitability for psychotherapy would be most beneficial, determining her ability to cope with therapy and access her feelings within sessions and provide a clearer formulation of the presenting difficulty. An exploration of the differences between the client and therapist was also planned. Sessions were observed by the clinical supervisor.

Extended Assessment
i. Context Rose was seen for 6 sessions over 11 weeks, at her day centre. Rose seemed to form a good relationship with both therapists and her involvement of the supervisor instigated the sessions to be run jointly. As the sessions progressed Rose's body language became increasingly friendly and open. Rose appeared keen to attend sessions and seemed able to discuss positive emotions and aspects of her life freely. Rose increasingly demonstrated autonomy and appeared able to voice her opinions.

ii. Process Verbal communication was adapted to suit Rose's developmental level by using simple language and frequently checking her understanding. Blank-faced stick figures were also drawn and Rose was prompted to suggest appropriate facial expressions for herself and others. A cognitive-behavioural was considered inappropriate due to the level of abstraction required. Most questioning was based on family therapy approaches. The therapist's subjective experience of being with Rose was also explored during supervision (Tillet, 1996) and helped the therapist to understand Rose's difficulties further.

iii. Content Rose had some understanding of death and dying by stating that her family were having a party in heaven that she could not yet join. It was not clear whether some aspects of our discussion represented religious beliefs or misunderstanding such as her ability to 'see' her family. Discussions regarding Rose's life before her current residence were limited; when raised Rose ignored the question or talked about something else. Rose appeared unable to discriminate her
co-residents on the basis of positive and negative traits, and at times her body language suggested this was a difficult topic to talk about. Over time it became clear that the referral appeared to be prompted not only by the identified issues but also because of the referrer's attachment to Rose. Attempts were therefore made to explore this.

*iv. Difference & Power* The disparity in cognitive ability and language was noticeable and attempts were made to minimise this. Rose would question both therapists, and honest answers were given to help redress the power imbalance, which, with the presence of two therapists, may have made it doubly difficult for Rose to assert her views. Furthermore, to ensure that Rose maintained some control over sessions she was not pushed to answer questions she found difficult.

Additional information was collated using established measures, an analysis of Rose's network and consultation with a psychiatrist.

**Extended Formulation**
Rose's willingness and ability to discuss her losses without significant distress suggested that she was not experiencing a pathological grief reaction. It was hypothesised that adequate bereavement support in the network may have been a protective factor. Rose's reticence in discussing her home life was thought to be indicative of the level of distress this caused and this was considered in light of the referral from the day centre rather than staff at her residence.

**Recommendations**
Offering supervision and/or consultation to the day centre staff was proposed as well as working systemically with Rose and her co-residents in order to avoid stigmatising and isolating Rose as problematic.

**Evaluation**
Evaluation of the work considered co-working, the assessment of affect, other issues relevant to assessing suitability for psychotherapy and power issues.
Presenting Problem
Thomas Trent, a four-year-old boy with a diagnosis of autism, was referred to the neurodevelopmental team. The family was allocated to Dr. Shauna West, a clinical psychologist, and I was invited to co-work. Thomas’ parents described his ethnicity as mixed white British and white Spanish. Although English was the predominant language spoken at home, Thomas was reported to have a good understanding of Spanish.

The main concerns centered on Thomas’ fear of using toilets; on his first day at nursery, Thomas had become distressed by the noise made by the flush and had since avoided using the toilets there or at home. Thomas told his parents that the "toilets will eat me" and had described seeing "teeth" on the underside of the toilet seat. With parental encouragement, he had started to use the toilet at home, although he would leave before the toilet was flushed and avoided looking into the toilet bowl. Parents reported being reluctant to put him back in nappies but were feeling the burden of frequently washing soiled clothes.

Parents and nursery shared an understanding that the nursery flush had frightened Thomas. In addition, parents thought that Thomas’ support worker was unwilling to be involved in assisting Thomas, hence the lack of progress at nursery. Our initial thoughts were that Thomas had developed a specific fear of the nursery toilet flush, which had then generalised, although parents had developed strategies to prevent it becoming entrenched at home.

Assessment
Semi-structured interviews, observations, and paediatric reports were used to obtain information relevant to the assessment, although this process continued throughout.

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2 From this point, "us/our/we" refers to Dr. Shauna West and I.
the intervention. The family were seen jointly with nursery staff as well as individually. In addition I conducted a nursery visit where his support worker provided additional information.

Limited information was obtained from Mrs Trent as she was mostly occupied with managing the children's behaviour. Our preliminary observations of Mr Trent suggested that he had a thinking style similar to Thomas. Our immediate discussions therefore focused on how to present the intervention plan to the family but also with an awareness that the intervention needed to begin quickly to prevent his fear becoming entrenched.

Parents described Thomas as a late developer as regard toileting, showing reluctance to be independent. The family reported that income support met some of their financial needs. There was limited social support.

Initial Formulation
Predisposing factors were hypothesised to have included his autism, his age and the difficulty his parents had in toilet training him initially. Precipitants included starting nursery where the toilets differed to those at home, and where he was required to separate from his parents. The maintenance of Thomas' fear was viewed within a behavioural model of escape and avoidance. Wider contextual factors were also deemed relevant. It was thought that his parent's reported diligence in following a behavioural programme was a positive sign for future positive change. In light of this a tailored behavioural approach was planned, using solution-focused questioning to combat discomfort with a directive therapeutic style.

Intervention
The intervention consisted of five family sessions and three nursery visits supplemented with telephone calls. As planned family sessions were conducted jointly and I conducted all nursery visits independently.

i. Family intervention Observations of the family considered Thomas' behaviour and the parent's ability to manage him. The content of the intervention focused on helping the parents to remain consistent in their application of the behavioural approach such as employing the use of monitoring charts. Modelling was also used in the clinic toilet to provide parents with alternative ways of allaying Thomas' fears.
ii. Nursery intervention Monitoring of the staff's implementation of the programme was undertaken. Observations showed that they appropriately used empathy and reassurance whilst assisting Thomas through the hierarchy. As with the home programme nursery staff were encouraged to use picture symbols to assist with communication.

iii. Integrating both programmes Integrating both programmes proved difficult and was considered in the context of Thomas' and the intervention considered how to help both systems to work together. For example the family were given feedback that Thomas' progress at nursery was in line with our expectations, thus reassuring them of the nursery's abilities.

Outcome Twelve weeks after meeting with Thomas he willingly went into the clinic toilet and with modelling and play was able to flush. Similar changes were also recorded at nursery, although the presence of Thomas' father appeared to medicate this. At home parental report ascertained that Thomas was able to use the toilets and could withstand the toilet being flushed. Thomas was wetting himself less, which decreased washing and consequently parental stress. Parents did however raise additional concerns about a perceived negative effect overall of the programme on Thomas' well-being.

Critical Evaluation The original formulation was considered useful in understanding Thomas' difficulties. Additional maintenance factors such as fluid intake and parental consistency were also considered. It also seems that Thomas' association of his father and the toilet at nursery was an important factor that we overlooked, and Thomas had difficulty habituating without him. Management of the sessions was also considered in terms of balances of power between clinicians and clients.
Older People Case Report Summary

Neuropsychological assessment of a 68-year-old man presenting with memory difficulties

Year 2 – September 2004

Presenting problem
Mr Andrew Mullins, was a 68-year-old White British man, whose first language was English. He was referred to the psychology service by the team’s consultant psychogeriatrician following concerns raised by his family about his memory and fluctuating mood. The referrer was interested to know whether the reported difficulties were the result of organic change.

Presenting problem
Mr Mullins first presented to his GP in October 2002 following concerns that he was having difficulty with his memory. Despite acknowledging changes in functioning, Mr Mullins initially denied any interference to his everyday life. His wife described a picture of general forgetfulness, repetitiveness and variable mood.

History
Mr Mullins reported that despite being a bright student, he left school at 15 without qualifications and began to work in his father’s garage. He eventually developed and owned a number of successful businesses and retired aged 57. Mr Mullins had a family history of cardiac arrests and strokes.

Mr Mullins completion of the mini-mental state examination in October 2002 indicated no significant concerns.

The information obtained at this point suggested that he had experienced changes in memory and possibly personality. A literature review was undertaken to consider memory, executive function, and 4 different forms of dementia: vascular, Alzheimer’s, fronto-temporal and dementia caused by depression.

The assessment
The assessment occurred over 3 sessions. Considerations of Mr Mullin’s observable behaviour was described. The meaning of the assessment for Mr Mullins and his
wife was also considered, and some reflection of my own anxieties in working with an older couple on their relationship was described.

The assessment was then considered under a series of hypotheses regarding his likely presentation in different cognitive domains in light of his history and described difficulties. A range of neuropsychological tests were employed, comparing Mr Mullin’s scores to norms established in the general population. His scores were also considered against estimates of his pre-morbid abilities. Hypothesis were then accepted or refuted.

**Summary**
The profile of scores obtained in the neuropsychological assessment led to a hypothesis that Mr Mullins was at the early stages of dementia of the Alzheimer’s type whereby memory tends to show the most neuropsychological impairment followed by deficits in other domains including executive skills. For example there were significant deficits in immediate and delayed recall of verbal material as well as visual memory after a delay, which could not be accounted for by his age or premorbid functioning. In addition his profile suggested initial changes to executive functioning. Other types of dementia such as vascular dementia and fronto-temporal dementia were not considered likely.

Additional qualitative information supported the pattern of results obtained from the quantitative assessment. For example the verbal memory was thought to account for the forgetfulness described and the lack of insight, which is a general feature of DAT and executive difficulties, was thought to explain some discrepancies in his results.

Recommendations included repeating the neuroimaging immediately and the neuropsychological assessment in 12 months time, as well as the provision of further support for the client and his family.

**Critical Evaluation**
Consideration of other tests that could have been used to supplement the assessment and conclusions were described. In addition issues of engagement were also briefly explored.
Specialist Early Intervention Service Case Report Summary

Cognitive – behavioural therapy with a 24-year-old Asian British woman recovering from her first episode of psychosis and presenting with a recurrence of obsessional thoughts and compulsive behaviour

Year 3 – April 2005

Presenting problem
Ayesha Syed, a 24-year-old Asian British woman was referred by her community psychiatric nurse (CPN) to see a psychologist. Ayesha was recovering from her first episode of psychosis and was no longer reporting any psychotic symptoms. However her long-standing difficulties with obsessional thinking and compulsive behaviour were causing her difficulty at home and at work. This surrounded cleaning herself excessively, to prepare herself for prayer as part of her Islamic faith, and avoidance of 'spiritually unclean' substances. If not carried out, Ayesha feared that she would go to hell and be deemed a bad Muslim by Allah. Ayesha was fluent in English although this was not her first language.

Assessment
Most information was obtained through face-to-face interviews and from her previous mental health records. The family’s attempts to solve the difficulty were explored including plans to take Ayesha on a pilgrimage to be “cured”. A developmental history was obtained revealing that Ayesha first developed obsessional difficulties aged 13. Her last therapeutic involvement with a psychologist in 2001 had resulted in some behavioural change which had been sustained. The content of her first episode of psychosis in 2004 was seemingly unrelated to her obsessions and during this time her obsessional difficulties remitted, returning as her psychosis subsided. Her family history also revealed that her father had a long-standing diagnosis of OCD. Co-morbid difficulties of body image and eating difficulties were also evident.

Established and individualised OCD measures contributed to the assessment process, identifying relevant cognitions and providing a baseline of the extent of her behaviour.

Formulation
Relevant aspects of Ayesha’s history were considered including her own 10-year history of psychological difficulties and her father’s struggle with OCD; each likely to
have rendered her psychologically vulnerable. Precipitating and maintaining factors were also explored with a cognitive-behavioural framework, which considered the reciprocity between her cognitions and behaviour. For example her interpretation of her intrusive thoughts were considered to be integral to the maintenance of her distress. A cognitive-behavioural intervention was therefore planned and, with agreement from Ayesha focused on enhancing her understanding.

**Intervention**

8 sessions were conducted in total. The early sessions focused on helping Ayesha to see that her approach to religion was not commonplace amongst other Muslims, using the experiences of her mother as a comparison to explore interpretation of cognitions resulted in different behaviour, and also on normalising intrusive thoughts. A thoughts record was introduced but her difficulty in completing it suggested that understanding of the model had not been gained. At this stage of the intervention, the value of supervision was highlighted in helping me to obtain clarity and focus. Ayesha's mother was invited to one session and this proved useful in helping to elicit the discrepancies in their understanding of Islam. Ayesha chose to attend the remainder of the sessions alone and these continued to explore aspects of her life where she managed contradictions to her religion such as friendships she maintained with people she believed to be spiritual unclean and therefore forbidden. The efficacy of the guided 'discovery technique', given Ayesha's response, were discussed.

**Outcome**

Behavioural change was evident throughout the intervention and her washing behaviours reportedly decreased. In contrast reports of obsessive thoughts increased according to the repeated measures. This was understood as perhaps enhanced awareness of her cognitions. The work in the context of a multi-disciplinary setting was discussed. In a reformulation, Ayesha's difficulties were considered on an OCD - psychosis continuum, although the original formulation was also considered valuable.

**Critical Evaluation**

Evaluation of the work considered the assessment measures utilised, the role of the therapist as either colluding or developing a therapeutic relationship, and the value of other models in promoting change.
Research Dossier
Contents of the Research Dossier

This section contains three research projects and a logbook of research experience.

Contents

Service Related Research Project 93
“Evaluating Implementation of the Care Programme Approach”

Qualitative Research Project 118
“More than the Score: The Role of Football in Everyday Emotional Expression”

Major Research Project 178
“Relationships with Voices: Does This Make Any Sense to the Hearers? An Interpretative Phenomenological Analysis”

Research Log Book 310
The Research Logbook details skills developed in addition to those evident in the above reports.
Evaluating Implementation of the Care Programme Approach

Year 1

June 2003

Service Related Research Project (SRRP)
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>95</td>
</tr>
<tr>
<td>Introduction</td>
<td>96</td>
</tr>
<tr>
<td>Method</td>
<td>98</td>
</tr>
<tr>
<td>Results</td>
<td>100</td>
</tr>
<tr>
<td>Discussion</td>
<td>104</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>106</td>
</tr>
<tr>
<td>References</td>
<td>107</td>
</tr>
<tr>
<td>Appendix 1: The audit questionnaire</td>
<td>109</td>
</tr>
<tr>
<td>Appendix 2: Additional demographic variables</td>
<td>111</td>
</tr>
<tr>
<td>Appendix 3: Rationale for the demographic variables</td>
<td>112</td>
</tr>
<tr>
<td>Appendix 4: Standards and criteria for measurement</td>
<td>113</td>
</tr>
<tr>
<td>Appendix 5: Evidence of feedback to service</td>
<td>116</td>
</tr>
<tr>
<td>Appendix 6: Ethics Sheet</td>
<td>117</td>
</tr>
</tbody>
</table>
Objectives Amongst the goals for the Care Programme Approach (CPA) are an emphasis on co-ordinated care and increased service user involvement. This study aimed to evaluate the implementation of CPA in the files of service users identified as requiring “enhanced” care. It was hoped that the data would provide the team with baseline data of their working practices and comprise the first stage of the audit cycle (Barker, Pistrang & Elliot, 2002).

Design The study utilised descriptive and quasi-experimental designs.

Method The audit tool was adapted from those designed by the Department of Health and incorporated standards for working practices recently introduced by the Trust. The files of 60 service users who had been on an enhanced CPA for at least 6 months were randomly selected and assessed against a checklist of standards identified as essential criteria for the implementation of CPA. Frequencies were recorded and files were also coded against three demographic variables to detect any differences in implementation.

Results CPA implementation as measured by each standard varied from 18 to 90 per cent. The service user's diagnosis, risk history or length of time using the service did not impact on the level of CPA implementation. An exploratory analysis revealed that when service user involvement was required there was less implementation of CPA standards.

Conclusion Possible reasons for the varied pattern of implementation are explored and implications for improving practices are discussed. The implications of limited service user involvement are also discussed.
INTRODUCTION

A model of care

The Care Programme Approach (CPA) policy framework was introduced by the Department of Health in 1990, emphasising the value of a comprehensive care system for people with severe mental health problems. Underlying the policy was an emphasis on inter-agency teamwork and the involvement of patients and carers (Schneider, Carpenter and Brandon, 1999). In meeting its objectives of ensuring that individuals were not lost to services, and that hospital readmissions were reduced, the policy highlighted four key aspects. Firstly it identified a need for a systematic approach in assessing the health and social needs of people accepted into specialist mental health services. Secondly it recognised the need for a care plan, which met both the health and social care requirements of the individual. This would be formed with the agreement of all involved providers of care including multidisciplinary team members, the GP and the service user. It also proposed the appointment of a keyworker to offer an on-going supportive relationship to the service user (Downing and Hatfield, 1999) and to monitor and co-ordinate care. Lastly, regular reviews and monitoring of the care plan were deemed important to ensure its progress and delivery. Although most individuals with a severe and enduring mental illness are cared for using this approach (Holloway, Carson & Davis, 2002), the model did not appear to be based on any evidence for effectiveness (Marshall, 1996), but rather a retrospective analysis of factors associated with the occurrence of critical incidents (Rose, 2003). Research and reviews have documented both strengths (e.g. Schneider, Carpenter & Brandon, 1999) and weakness (e.g. Johnson, Prosser, Bindman & Szmukler, 1997 in Rose, 2003) of the approach.

National standards for mental health care were made more explicit in 1999, with the publication of the Mental Health National Service Framework and new standards for joint working (Department of Health, 1999a; 1999b). To support services in meeting these goals, the Department of Health updated their CPA policy guidelines, outlining a number of key changes. These included the introduction of a joint health and social care secondary service with a single point of entry, two levels of CPA differentiating between clients requiring "enhanced" and "standard" care, a single care planning process which included regular review and risk management and specific audit requirements. The policy emphasised that successful implementation of CPA was dependent on the commitment of all involved in providing and commissioning mental
health services (Holloway et al., 2002). Again it is unclear whether there was any evidence other than criticisms made by professionals and service users of the original CPA to suggest that these changes would provide a better standard of care. Some have continued to find it bureaucratic and difficult to operate (Villeau, Hill, Hancock & Wolf, 2001).

**Auditing the CPA**

The updated CPA policy highlights the importance of audit in ensuring that the approach is successfully implemented. To assist services in this monitoring process, the NHS Executive published an audit tool (Department of Health, 1999c), which met the requirements of the updated CPA policy and allowed for an audit from the perspective of service users, professionals and independent agents. It provided a checklist of standards for each key area of the CPA and encouraged NHS Mental Health Trusts to adapt the professional audit tool for their own use to demonstrate how CPA was being implemented.

The team who had commissioned the audit reported here comprised a multidisciplinary community mental health team (CMHT). The Mental Health Trust had recently introduced changes to practice based on the Department of Health directives. The team had envisaged that the project would represent the first stage of the audit cycle: evaluating, feeding back, making changes and re-evaluating (Barker et al., 2002). Overall the team was interested in the degree of implementation of CPA as evidenced by the case files of their service users. They proposed to use the collated data to quantify local standards and agree on optimal levels of performance against some of the statements (Department of Health, 1999). They were keen to identify areas for improving practice and if necessary, guidance on simplifying methods for record keeping. It was also hoped that the audit would generate indicators to the service’s strengths and weaknesses which enhanced or hindered CPA implementation (Department of Health, 1999c).
METHOD

An outer London CMHT was evaluated. The team included representatives from nursing, occupational therapy, psychiatry, psychology and social work and at the time of the audit, provided care to over 300 clients defined as having a complex mental health problem. Each service user had been provided a "standard" or "enhanced" care programme and had a named keyworker who was responsible for maintaining the multidisciplinary file and ensuring CPA delivery.

Sample
Agreement was reached with the service manager and team psychologist regarding the sample population. As multidisciplinary input was less likely with service users on standard care plans these were excluded from the evaluation. In addition, only those service users who had received input from the team for at least 6 months were considered. This ensured that the keyworker would have had sufficient opportunity to meet the file audit statements. From the remaining 166 files, 60 (approximately 1/3) were randomly sampled from the team's database. As the team were keen to receive a third of the data from their database a cycle of random sampling was introduced. Thus missing files were noted for the interest of the service but excluded from the study and replacement files were randomly drawn from the sample population. Similarly files that had been booked out were searched for on three separate occasions and if not found, replacements were randomly selected from the sampling pool.

Measures
As recommended by the Department of Health the CMHT had adapted the audit tool incorporating the standards that were most relevant to their working practices and which also reflected the Trust's interests in service development. The audit questionnaire consisted mostly of questions requiring a "yes/no" response (see Appendix 1). These questions covered standards such as whether the file contained a care plan, a risk assessment and the views of the service user. Items also questioned the presence of particular documents in the file such as the Carers' and Users' Expectations of Services (CUES) questionnaire. In addition a further three questions were included to help the team evaluate whether they managed the files of some service users better than others. Three demographic variables were recorded: the service user's diagnosis, their risk history and the length of time they had been
involved in the service (see Appendix 2). Appendix 3 highlights the rationale for selecting these variables.

Procedure
The team psychologist assisted in completing a pilot study with 6 files to determine acceptable standards and criteria for measurement (see Appendix 4). For example, it was decided that if a care plan was more than one year old the file was counted as not having a care plan. Practicality also determined some of the criteria. For example one of the criteria questioned whether involved professionals had signed all entries made in the file. The team acknowledged that it would be impractical to examine all entries, particularly where files had more than one volume. They therefore agreed that adherence for this standard would only be checked in the preceding six months of entries.

Each of the 60 files were then checked against the service’s audit tool. Frequencies were recorded and each file was also given a total CPA implementation score to allow for comparison. The maximum score obtainable was 16 (see Appendix 4 for criteria to obtain a total score). Information for the three demographic variables was also collated. Risk history was determined using the risk assessment documentation that the Trust required all clinicians to complete.

Agreement was reached that the practice of team members would remain confidential between the researcher and the individual clinician, although the general results would be fed back to the team as a whole.
RESULTS

Diagnosis

ICD-10 (World Health Organization, 1992) classifications were used to categorise the diagnostic labels (see table 1 for frequencies). This information was missing in 6 files. Only the two largest groups (schizophrenia and mood disorders) were subject to statistical analysis.

Table 1 – Frequencies for diagnostic classifications

<table>
<thead>
<tr>
<th>Diagnostic classification</th>
<th>Raw frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia and delusional disorders</td>
<td>24</td>
<td>40</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Disorders of adult personality</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Neurotic disorders</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>“Other” e.g. autism, body dysmorphic disorder</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Mental and behavioural disorders due to substance misuse</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Risk

Files were categorised into those with or without risk histories as displayed in table 2. This information was missing in 12 files.

Table 2 – Frequencies for risk

<table>
<thead>
<tr>
<th>Risk history?</th>
<th>Raw frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32</td>
<td>53</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12</td>
<td>20</td>
</tr>
</tbody>
</table>

Length of time in service

The length of time in the service ranged from 6 to 396 months (mean = 68.25, sd = 68.77). A median-split was performed (median = 60) and files were categorised as “old” or “new” files.
CPA implementation

Figure 1 shows the extent to which files were implementing CPA criteria overall. The mean score achieved was 9.3 (sd = 3.5).

Table 3 shows CPA implementation for each individual criterion. As it seemed that lower scores were achieved for criteria that involved service user or carer involvement an exploratory analysis was performed. Each criterion was coded to determine whether it required the professional's involvement alone or additional active participation from the service user/carer. The codes were validated by an expert reference group of multidisciplinary team members and agreement was reached. Items requiring service user/carer involvement are indicated with a "#" in table 3 below. A t-test indicated that scores for items requiring service user/carer involvement were significantly lower than those needing professional involvement alone (t(17) = 5.9, p<0.01, 2-tailed test). Items requiring service user/carer involvement obtained a mean score of 33.57 (sd = 9.69, range 18 - 45) and items entailing professional involvement alone obtained a mean of 72.50 (sd = 15.69, range 53 - 90).
Table 3 - CPA implementation for each criterion

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Raw frequencies of files which met this criteria</th>
<th>Percentage of files which met this criteria in rank order *</th>
</tr>
</thead>
<tbody>
<tr>
<td>The GP was sent a letter within 10 days</td>
<td>26</td>
<td>90</td>
</tr>
<tr>
<td>The &quot;copying correspondence&quot; consent form was filed at the front of the file</td>
<td>23</td>
<td>85</td>
</tr>
<tr>
<td>Demographic data was collated</td>
<td>50</td>
<td>83</td>
</tr>
<tr>
<td>The signature and discipline of the clinician was evident in the notes after each entry</td>
<td>48</td>
<td>82</td>
</tr>
<tr>
<td>A risk assessment had been completed</td>
<td>48</td>
<td>80</td>
</tr>
<tr>
<td>A care plan on file</td>
<td>46</td>
<td>77</td>
</tr>
<tr>
<td>ICD 10 coding was completed</td>
<td>46</td>
<td>77</td>
</tr>
<tr>
<td>A risk management plan had been compiled</td>
<td>45</td>
<td>75</td>
</tr>
<tr>
<td>An assessment on file</td>
<td>43</td>
<td>73</td>
</tr>
<tr>
<td>A meaningful occupation was identified</td>
<td>36</td>
<td>60</td>
</tr>
<tr>
<td>Financial situation was identified</td>
<td>32</td>
<td>53</td>
</tr>
<tr>
<td>The service user was informed about the copying correspondence policy</td>
<td>27</td>
<td>45#</td>
</tr>
<tr>
<td>The carer's view was identified</td>
<td>9</td>
<td>43#</td>
</tr>
<tr>
<td>The service user's view was identified</td>
<td>23</td>
<td>38#</td>
</tr>
<tr>
<td>The care plan was signed by the service user</td>
<td>21</td>
<td>35#</td>
</tr>
<tr>
<td>A care plan review date was arranged</td>
<td>21</td>
<td>35</td>
</tr>
<tr>
<td>The carer's assessment had occurred</td>
<td>5</td>
<td>31#</td>
</tr>
<tr>
<td>The carer was offered an assessment</td>
<td>4</td>
<td>25#</td>
</tr>
<tr>
<td>A CUES (Carers’ and Users’ Expectations of Services) questionnaire was completed</td>
<td>11</td>
<td>18#</td>
</tr>
</tbody>
</table>

*(Adjusted to exclude missing or non-applicable data)

# = items requiring service user/carer involvement.

Comparative data
T-tests indicated that there was no significant difference in the degree of implementation between the two largest diagnostic categories (schizophrenia and
mood disorders, $t(42) = -0.626, p>0.05$, 2-tailed test), those with or without risk histories ($t(46) = 0.380, p>0.05$, 2-tailed test), or those who were "older" or "newer" to the service $t(59) = 0.911, p>0.05$, 2-tailed test). Table 4 shows the mean scores obtained for each group.

Table 4 – Mean scores obtained for each group

<table>
<thead>
<tr>
<th>Diagnostic categories</th>
<th>Mean score</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>schizophrenia</td>
<td>10.04</td>
<td>2.56</td>
</tr>
<tr>
<td>mood disorders</td>
<td>10.55</td>
<td>2.81</td>
</tr>
<tr>
<td>disorders of adult personality*</td>
<td>8</td>
<td>2.94</td>
</tr>
<tr>
<td>neurotic disorders*</td>
<td>7.67</td>
<td>3.79</td>
</tr>
<tr>
<td>&quot;other&quot; disorders*</td>
<td>4.5</td>
<td>2.12</td>
</tr>
<tr>
<td>disorders due to substance misuse*</td>
<td>15</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk history</th>
<th>Mean score</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>9.81</td>
<td>2.75</td>
</tr>
<tr>
<td>no</td>
<td>10.56</td>
<td>2.78</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time in service</th>
<th>Mean score</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>old</td>
<td>9.65</td>
<td>3.40</td>
</tr>
<tr>
<td>new</td>
<td>9.23</td>
<td>3.50</td>
</tr>
</tbody>
</table>

NB categories marked with * were excluded from the statistical analysis as the samples were too small.
DISCUSSION

CPA implementation
This study attempted to quantify CPA implementation in one CMHT. A summary report, including recommendations will be sent to the team. Although only looking at a sample of their files these revealed a varied pattern of CPA implementation. Some elements of CPA were achieved with more success. For example communicating with GPs, conducting a comprehensive assessment and completing a risk assessment and management plan were evident in over 73% of files. However other elements appeared more of a challenge to achieve. Thus although 77% of files had a care plan not all of these documented the financial or occupational status of the service user. In addition only 35% of files contained a care plan signed by the service user and stated a date for review. Of course it may be that elements of CPA have been obtained but not recorded. For example Rose (2003) noted that some CMHTs do not set the next review date in order to be flexible. However without documentation the team are unable to evaluate working practices. In addition, co-ordinated care is compromised if other team members are unable to locate information in the keyworker’s absence.

The results obtained were independent of the service user’s diagnosis, risk history or length of time in the service. A larger sample size may have resulted in more significant findings. In addition the researcher’s coding system may have also influenced the result, as some judgement was required despite the use of the marking criteria. Lastly the appropriateness of a median-split to categorise “length of time in the service” is questionable, as the mean of 5 years obtained is not representative of the time-limited work advocated by the CMHT.

It remains unknown which specific factors hinder CPA implementation and whether they are issues that the team could address directly. For example it may be that limited resources are preventing staff from obtaining and recording 100% on each standard (Schneider et al., 1999; Lawson, Strickland & Wolfson, 1999). Staff may instead be devoting time to other aspects of CPA, which were not audited in this study, such as engaging with clients directly. In this instance the team might wish to employ techniques that would assist staff in documenting their adherence to the approach. For example, care plans pre-printed with sections for occupational and financial status might serve as a memory aid that this information needs to be
obtained and recorded, as without it the team are failing to provide evidence of meeting the social care needs of their service users. Or it may be that information technology could be employed as with “eCPAs”, a method designed to facilitate comprehensive completion of care plans (Howells and Thompsell, 2002).

Service user involvement
The preliminary findings suggest that when service user involvement is required the files show less implementation of CPA standards. Thus for this service, user involvement in the care process is not occurring. Although confirmation of this finding is required, possible explanations might include staff’s reluctance to involve service users in administrative tasks such as signing care plans, or a resistance to involve service users in their care. A local users forum has noted that most service users in the area are unaware of the review date for their care plan (May, 2002).

Variables associated with the service user may be more pertinent and their ignorance of the approach may be influencing the outcomes observed. For example Rose (2003) found that the majority of service users are unaware of the co-ordinated way that their care is managed and tend not to be involved in the process. However the literature suggests that service users want to be more involved in their care (Lawson et al., 1999) so this is also an issue that the service could become responsible for. Perhaps sending prospective service users an information sheet explaining CPA and ways they can become involved in their care may increase their knowledge about the process. Furthermore informing users that advocates are encouraged or providing details of an advocacy service might increase service users empowerment and involvement in the approach. This in turn may increase satisfaction with the service (Rose, 2003) and may help to explain the poor result for the CPA standard associated with the user questionnaire, CUES, found in this study. Although all service users should have completed the questionnaire this was evident in only 18% of the files audited. Thus assuming that the team were distributing CUES questionnaires, service users limited involvement may have resulted in their reluctance to provide feedback.

Evaluating practice
This audit has been successful in measuring the implementation of CPA. As discussed earlier, it is questionable whether successful use of the CPA results in the best outcome for service users and, what’s more, some question its relevance and
congruence with the ethos of psychological work (Knowles, 1998). However it is the
method that has been stipulated by the government and it is useful to consider other
ways of evaluating its effectiveness. For example a further study could correlate
outcome measures with the total scores the files obtained. In addition, discussions
with staff would provide valuable insight into their understanding of the approach and
its components such as the keyworker role (Downing and Hatfield, 1999). As
advocated by the government's framework the team could conduct audits from the
service users perspective, perhaps using the results from the CUES questionnaire if
response rates increased, or replicating the work of others (e.g. Lawson et al., 1999).
Perhaps the ultimate empowerment of service users would be evaluations from their
perspective, highlighting elements of care they viewed as vital. This could result in
the development of autonomous evaluation tools stimulated by local need and not
based on government directives.

ACKNOWLEDGEMENTS

Appreciation for their support and advice go to all staff in the CMHT, Jencil Austin,
Mick Finlay and Alex Gachette.
REFERENCES


Department of Health (1999b). Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. London: HMSO.


Appendix 1 – The Audit Questionnaire

Multi-Disciplinary File Audit

ASSESSMENTS:

1. Is there an assessment on file
   □ Yes □ No

2. Is the user view identified
   □ Yes □ No

3. Are Carers’ views identified
   □ Yes □ No

4. Was a letter to GP sent within 10 days of assessment
   □ Yes □ No

FOR ALL PATIENTS:

5. Is there a Care Plan
   □ Yes □ No

5a. Is diagnosis/ICD 10 coding completed
   □ Yes □ No

6. Has a Care Plan been signed by Service User
   □ Yes □ No

6a. Is there a date for next review
   □ Yes □ No

Date of next review: __________

7. Is there a Risk Assessment
   □ Yes □ No

7a. If No- has the reason been identified
   □ Yes □ No

8. Is there a Risk Management Plan
   □ Yes □ No

8a. If No- has the reason been identified
   □ Yes □ No

9. Has a CUES questionnaire been completed
   □ Yes □ No

10. Has the service user been asked if they want to be copied into correspondence
    □ Yes □ No

10a. Is the consent form filed at the front of their file
    □ Yes □ No

FOR ENHANCED PATIENTS:

11. Has a meaningful occupation been identified in the Care Plan
    □ Yes □ No

12. Has the patient's financial situation been identified
    □ Yes □ No
Appendix 1 – The Audit Questionnaire contd.

13. For those on enhanced CPA with identified Carer has an assessment been offered  □ Yes □ No

13a. Has an assessment taken place if requested  □ Yes □ No

14. Has ETHNIC group religion and first language data been collected  □ Yes □ No

15. Do multidisciplinary notes have signature, and discipline after each entry  □ Yes □ No
Appendix 2 – Additional Demographic Variables

1. Diagnosis/ICD10 code _________________________

2. Are there significant risks
   Yes  No
   If yes which categories were identified:
   • Aggression & violence  Yes  No
   • Risk to children and young adults  Yes  No
   • Suicide & self-harm  Yes  No
   • Severe self-neglect  Yes  No
   • Expolitation (self or others)  Yes  No
   • Other (please specify)  Yes  No

3. How long has the client been a service user (month and year) ____________
## Appendix 3 – Rationale for the demographic variables

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Reason for Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>It was thought that the files of service users with a diagnosis the team associated with poor attendance (e.g. schizophrenia) would demonstrate greater CPA implementation.</td>
</tr>
<tr>
<td>Risk history</td>
<td>It was thought that without a risk history, keyworkers would worry less about the service user and the file would adhere less to CPA than those with a risk history would.</td>
</tr>
<tr>
<td>Length of time in the service</td>
<td>It was thought that older files would have less adherence to CPA than newer ones as some of the standards had only been recently introduced.</td>
</tr>
</tbody>
</table>
Appendix 4 – Standards and Criteria for Measurement

Questions indicated with * were included to calculate the total score. Questions related to carers were excluded, as only 35% of service users had an identified carer. This resulted in a maximum score of 16.

1. Is there an assessment on file? *
   - There should be a distinct assessment report in the file.
   - Comprehensive correspondence regarding the assessment is acceptable.
   - If the file is the second volume or greater, there should be a copy of the original report in there too.
   - A summary of the client’s mental health history is acceptable.

2. Is the user view identified? *
   - The service user’s view should be stated in the care plan.
   - If the care plan is absent or is more than 1 year old then this counts as “no”.

3. Are carer’s views identified?
   - If an identified carer is not stated in the care plan then assume that no carer is involved and code as “n/a”.
   - If there is an identified carer their views should be stated in the care plan.
   - If the care plan is absent or is more than 1 year old then this counts as “no”.

4. Was a letter sent to the GP within 10 days of assessment? *
   - If sent but not within 10 days then this counts as “no”.
   - If file is the second volume then this is recorded as “n/a”.

5. Is there a care plan? *
   - If more than 1 year old then this counts as “no”.
   - If there is no date on the care plan record as “yes”.

5a. Is diagnosis/ICD 10 coding completed? *
   - This information should be on the most recent care plan.
   - If the care plan is absent or is more than 1 year old then this counts as “no”.

113
Appendix 4 – Standards and Criteria for Measurement contd.

6. Has the care plan been signed by the service user? *
   - If the care plan is absent or is more than 1 year old then this counts as “no”.
   - If there is no signature and the care plan states that they are agreeable, this also counts as “no”.

6a. Is there a date for next review? *
   - If not recorded in the care plan then “no”.
   - If the care plan is absent or is more than 1 year old then this counts as “no”.

7. Is there a risk assessment? *
   - If risk assessment document is more than 1 year old then this counts as “no”.

7a. If no has the reason been identified?
   - Use “n/a” where necessary.

8. Is there a risk management plan? *
   - If risk management plan is more than 1 year old then this counts as “no”.

8a. If no has the reason been identified?
   - Use “n/a” where necessary.

9. Has a CUES questionnaire been completed? *
   - If not in the file then “no”.

10. Has the service user been asked if they want to be copied into correspondence? *
    - Should be clearly stated if a copy of the consent form is not in the file.
    - If second volume of the file should be a copy of the consent form or clearly stated.

10a. Is the consent form filed at the front? *
    - Can code as yes if filed elsewhere in the file.

11. Has a meaningful occupation been identified in the care plan? *
    - Any daytime activity constitutes “meaningful”.
    - If not recorded in the care plan then “no”.
    - If the care plan is absent or is more than 1 year old then this counts as “no”.
12. Has the patient's financial situation been identified? *
   - This should be described or referred to.
   - If not recorded in the care plan then “no”.
   - If a care plan is not present or is more than 1 year old then this counts as “no”.

13. For those on enhanced CPA with identified carer has an assessment been offered?
   - If no identified carer then record as “n/a”.

13a. Has an assessment taken place if requested?
   - If no identified carer then record as “n/a”.

14. Has ethnic group, religion and first language data been collected? *
   - If copy of Trust form not present then “no”.

15. Do multidisciplinary notes have signature and discipline after each entry? *
   - Only look in the previous six months of entries (up to February 2002).

---

Diagnosis/ICD10 Code

- Identify by diagnosis recorded on care plan.
- If two diagnoses have been given, record the first/primary diagnosis.

Risk history

- Identify by risk assessment form in the file.
- If indicated on the risk assessment form that the service user has a risk history, code as “yes”.

Length of time with service

- Record the date to allow later categorisation.
- If a care plan is not present or is more than 1 year old then this counts as “no”.

---

115
Dear

Many thanks for sending me your report on the audit of our casefiles, which will be of invaluable help to the Team.

I'm also enclosing the follow-up letter on your patient who continues to do very well.

With all best wishes,
Yours sincerely,

Clinical Psychologist
Appendix 6 – Ethics Sheet

University of Surrey

PSYCHD CLINICAL PSYCHOLOGY

Service Related Research Project
Ethical Scrutiny Form

The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust’s ethical committee.

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
More than the Score: The Role of Football in Everyday Emotional Expression

Year 2

June 2004

Qualitative Research Project

Written in collaboration with Chris Gillmore, Vanessa Bryant, Joanne McLoughlin & Kate Telford
## Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>119</td>
<td>Abstract</td>
</tr>
<tr>
<td>120</td>
<td>Introduction</td>
</tr>
<tr>
<td>123</td>
<td>Method</td>
</tr>
<tr>
<td>126</td>
<td>Results</td>
</tr>
<tr>
<td>131</td>
<td>Discussion</td>
</tr>
<tr>
<td>136</td>
<td>References</td>
</tr>
<tr>
<td>138</td>
<td>Appendix 1: <em>Interview schedule</em></td>
</tr>
<tr>
<td>143</td>
<td>Appendix 2: <em>The Timeline</em></td>
</tr>
<tr>
<td>145</td>
<td>Appendix 3: <em>Information sheet and consent form</em></td>
</tr>
<tr>
<td>147</td>
<td>Appendix 4: <em>Example interview transcript</em></td>
</tr>
<tr>
<td>167</td>
<td>Appendix 5: <em>Reflections from each of the researchers</em></td>
</tr>
<tr>
<td>175</td>
<td>Appendix 6: <em>Reflections from the whole team</em></td>
</tr>
</tbody>
</table>
Abstract

Objectives
This study explored the perspectives of committed football supporters in relation to the emotions experienced and expressed during matches.

Method
Five in-depth interviews were conducted with supporters of a number of clubs from the English League. Interviews were transcribed and analysed, using interpretative phenomenological analysis, in order to explore recurrent themes reflecting football supporters' views about the utility of the football context to facilitate the experience of emotions and emotional expression.

Results
Results from the study suggested that participants experienced intense emotions connected to football that served a number of emotional functions. The ability of football to serve such functions appeared to be dependent on the perceived safety that the football context provided and was connected to concepts of social identity and enhanced self-esteem. A number of strategies appeared to be employed to sustain emotional well-being.

Conclusions
The results were discussed in the light of current theories of football and provide an alternative account for continuing football support that may have therapeutic value in the clinical setting.
Introduction

There has been a great deal of interest in what drives football fans to support their team, with a number of theories originating from psychology, sociology and anthropology (Sloan, 1979). An obvious motivator is that football is a source of entertainment and Sloan argues that the attraction comes from the aesthetic qualities and the value of sport in shaping character and providing lessons on life (Pavli, 1998). An alternative theory comes from the work of Elias and Dunning (1986; Dunning, 1999) identifying that football fans may seek emotional excitement that may be missing from everyday life. Another theory linked to emotion is that watching football can be cathartic for the supporter. Sloan (1979) notes that early research has suggested that watching aggressive acts will subsequently reduce feelings of aggression in the observer. However, more recent findings have found the opposite effect, with an increase in aggressive acts (Sloan, 1979).

Other motivators for supporting football relate to themes of identity. Cialdini, Borden, Thorne, Walker, Freeman and Sloan (1976) identify a tendency to 'bask in reflected glory' where fans associate themselves with the positive aspects of their teams as a means to increase self-esteem. Allied to this, Jones (2000) suggests that supporting a particular team provides a strong sense of social identity which influences the person's thoughts, feelings and behaviour. In addition, Sandy Wolfson (personal communication, 8th March 2004) has identified other psychological benefits of being a fan which include social interaction, tension regulation and intellectual challenge.

There are, therefore, a number of explanations for why football fans continue to support their team. Walton, Coyle and Lyons (in press) and Pavli (1998) found an alternative function of football whereby its specific, rule-governed context permitted
male fans to express emotion. Therefore, a further function of football is that it may provide a context for the safe expression of emotion. Following on from this, the aim of this research was to explore the potential utility of football as a vehicle for emotional expression.

As the research question was broad and essentially exploratory, it was decided that a qualitative methodology, specifically interpretative phenomenological analysis (IPA: Smith, 1996), would be most appropriate. This is because IPA aims to reflect the views of the participants and create a dialogue with their thoughts and intentions using a 'realist' epistemology. IPA was felt to be relevant to this research on the premise that fans think and reflect about their experiences of football.
Method

How the idea was conceived

The topic was identified by one of the research team with a personal interest in football. Fellow researchers identified themselves as having an interest in the topic and the ways in which emotion is felt and expressed at football matches. In addition, some researchers self-identified as football fans.

How the schedule was constructed

An interview schedule (see appendix 1) was constructed from a review of the literature and questions that interested or puzzled the researchers during their discussions. The schedule consisted of structured contextual questions and semi-structured questions. A timeline (see appendix 2) was also incorporated into the schedule to help identify when certain events happened during the respondents' time as a football fan, and to facilitate their recall of surrounding circumstances in their lives at that time. The semi-structured questions afforded the respondents the opportunity to expand on their emotional experience of being a football fan in five major areas (Table 1):

Table 1: Areas explored in the interview schedule

<table>
<thead>
<tr>
<th>No.</th>
<th>Areas of exploration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emotions felt</td>
</tr>
<tr>
<td>2</td>
<td>Emotions expressed</td>
</tr>
<tr>
<td>3</td>
<td>Concurrent life events</td>
</tr>
<tr>
<td>4</td>
<td>Exploring the expression of emotions at football and outside football</td>
</tr>
<tr>
<td>5</td>
<td>The psychological effects of being a football fan</td>
</tr>
</tbody>
</table>
Selection of respondents

Respondents were gathered from associates of the researchers. Criteria for inclusion in the study were that participants described themselves as being long-term and committed football fans. Demographic details of the respondents are presented in Table 2 below.

Table 2: Demographic details of the participants

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>22-39 years</td>
</tr>
<tr>
<td>Mean</td>
<td>32.2 years</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>4</td>
</tr>
<tr>
<td>Black British</td>
<td>1</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
</tr>
<tr>
<td>M.A./M.Sc.</td>
<td>2</td>
</tr>
<tr>
<td>B.A.</td>
<td>1</td>
</tr>
<tr>
<td>G.C.S.E.</td>
<td>2</td>
</tr>
<tr>
<td>Years as a football fan</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>15-33 years</td>
</tr>
<tr>
<td>Mean</td>
<td>22.6 years</td>
</tr>
</tbody>
</table>

Conducting the interview

Written consent was gained from each of the participants before the interviews commenced (see appendix 3). All interviews were conducted in a location convenient to the participant and lasted between forty-five minutes to an hour.
How the analysis was conducted

After the data had been collected, copies of the transcripts of each interview were distributed to all members of the research team for an initial reading (see appendix 4 for an example transcript). The researchers met as a group to analyse one of the scripts to ensure that as much as possible they adopted a uniform approach to the analysis of the data. Each researcher then carried out a preliminary analysis of their own interview transcript by noting down in the left-hand margin anything that was of interest or significance. The team then met in order to contribute any additional comments or observations about each other's transcripts. This entailed going through and discussing each transcript in turn thus giving a richer interpretation of the material. The researchers then agreed to analyse their own transcripts further and to identify the major themes emerging from the material. At a subsequent meeting they were able to identify a number of themes and subsidiary themes. The relevant parts of each transcript, according to these themes, were then collated in readiness for reporting the results.

Reflection

Members of the team reflected individually on their experience of the research process (see appendix 5). In addition, towards completion of the project, the researchers met as a group and reflected together on their experience of conducting the research as a team (see appendix 6).
Results

Themes derived from the analysis are shown in Table 3. In view of limited space, the team decided to focus on the first five of the listed themes, as these appeared to afford the most interesting and evocative insights into the emotional world of the football fan.

Table 3: Identified themes and sub categories

<table>
<thead>
<tr>
<th>No.</th>
<th>Theme and sub category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Phenomenology of emotion</td>
</tr>
<tr>
<td></td>
<td>a) Intensity</td>
</tr>
<tr>
<td></td>
<td>b) Duration</td>
</tr>
<tr>
<td></td>
<td>c) Fluctuation</td>
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<tr>
<td>2</td>
<td>Emotional function of football</td>
</tr>
<tr>
<td></td>
<td>a) Escape</td>
</tr>
<tr>
<td></td>
<td>b) Unsafe not to express</td>
</tr>
<tr>
<td></td>
<td>c) Therapeutic</td>
</tr>
<tr>
<td></td>
<td>i) Release</td>
</tr>
<tr>
<td></td>
<td>ii) Catharsis</td>
</tr>
<tr>
<td>3</td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td>a) The football environment</td>
</tr>
<tr>
<td></td>
<td>b) Impact of difference</td>
</tr>
<tr>
<td>4</td>
<td>Sustaining emotional well-being</td>
</tr>
<tr>
<td></td>
<td>a) Expecting the worst</td>
</tr>
<tr>
<td></td>
<td>b) Moving the goalposts</td>
</tr>
<tr>
<td>5</td>
<td>Wider effects on well-being</td>
</tr>
<tr>
<td></td>
<td>a) Belonging</td>
</tr>
<tr>
<td></td>
<td>b) Basking in reflected glory</td>
</tr>
<tr>
<td></td>
<td>c) A learning experience</td>
</tr>
<tr>
<td>6</td>
<td>Pride and shame</td>
</tr>
<tr>
<td>7</td>
<td>Loyalty</td>
</tr>
<tr>
<td>8</td>
<td>Football mirroring life</td>
</tr>
<tr>
<td>9</td>
<td>Team identity and fans’ identity</td>
</tr>
<tr>
<td>10</td>
<td>Quality of the narrative</td>
</tr>
</tbody>
</table>
Phenomenology of Emotions
Participants described that emotions experienced in a football context were more intense than in everyday life, describing how "emotions become elemental... it's absolute highs and lows" (Annette, line 525). Emotions ranged from the "sheer, sheer exhilaration" (Henry, line 112) to a "total demotivation" (Jim, line 220). The intensity was accentuated by dramatic fluctuations in the course of a match or season. This emotional roller-coaster was welcomed by some participants - "it can feel that nothing's going right, and then just suddenly something turns on its head, and life's brilliant and life's fantastic" (Annette, line 641), but was also seen as potentially dangerous - "there's some bad physical [...] consequences to stressing yourself up too much or allowing yourself to go up and down too much" (Andrew, line 321).

Participants were asked how long their mood was affected by an important match. Those who described a positive event (Andrew, Annette and Henry) described a sustained impact "lasting for weeks" (Annette, line 302), "certainly a good month or so"; (Henry, line 190), whereas those recalling a negative event (Jim and Vincent) both reported a lowering of mood lasting around a week. It may well be that those who wished to bask in their team's glory used strategies to keep their mood elevated for as long as possible and enable them to "hold on to these little moments of glory" (Andrew, line 235). Henry described "wanting to relive that goal time and time again [...] in my mind... on news bulletins or video or whatever" (Henry, line 181). Negative events also engendered intense emotions which might be prolonged "by being dragged up in the newspapers" (Vincent, line 89), but they seemed more fleeting, perhaps due to fans' efforts to move on "and think, oh well – they'll do it next season" (Jim, line 268).
Emotional Function of Football

This theme emerged from the participant's descriptions of the role that football served in allowing them to experience and express a range of emotions: "I don't know what it is about football [...] it's quite a good way of expressing your feelings" (Vincent, line 243). Participants described how the pressures that build up in everyday life can undergo cathartic release in the context of a football match, "[football is] useful as a release for their emotions, it may be that they're bringing stresses and strains from [...] their everyday lives [...] and maybe releasing it through that way" (Henry, line 294); "[in everyday life] you end up internalising a lot, but you don't have to do that, you've paid your thirty quid" (Annette, line 514). In addition to releasing everyday stresses, football for some (Henry, Jim, Annette) represented a way of forgetting about day-to-day life: "it's an escape more than anything" (Jim, line 637); "it's engaging and it's escapism" (Annette, line 659).

Participants were attuned to the "physical manifestation of emotion" (Annette, line 335) both as an internal event: "I've had times where I've had to say to myself calm down because I've got headaches and it's felt like I've burst a blood vessel in my head" (Andrew, line 318) and as an observable behaviour: "[I] just jump up and down and shout at [the referee] and probably swear a little bit and it makes me feel a little bit better" (Vincent, line 262). However the consequence of not venting emotions was also commented on: "if you don't you'd just explode" (Annette, line 334).

Safety

Participants described how the safety and containment of the environment supported their emotional expression "there's ten or eleven thousand other people doing it as well" (Vincent, line 246); "if you're in the crowd [...] shouting quite literally like a dickhead [...] or being slumped in your seat with your head in your hands everyone
else is doing it [there's a] uniformity of reaction" (Annette, line 343). Nonetheless participants described an acute awareness of difference and the effect this had on their behaviour whether due to their age or gender: "I was conscious of controlling what I was saying and the content of, and obviously the language I was using, because of the presence of women and younger children" (Henry, line 331) or their identification as being from a minority group: "if there were more black people I would have wanted to say some different stuff" (Andrew, line 387).

Sustaining emotional well-being

Participants described techniques to protect themselves against the extremes of negative emotions by anticipating failure: "if you go in there thinking "oh we've got this sewn up" then you're going to be heavily disappointed – so you always have that anticipation that you're gonna lose" (Jim, line 286); "even if they're playing Cheltenham Girl's School you go into games thinking, well I know they can fuck this up" (Annette, line 234). This was made explicit by Henry: "I tend to...err on the side of...pessimism" (Henry, line 196); "I think I keep expectations low, in order not to be too disappointed" (Henry, line 251).

Participants tended towards negativity rather than positivity. This could reflect the reality of being a football fan - "they've never done anything in that whole time [approximately 20 years] so why would I expect them to ever do anything" (Andrew, line 533). It could also be linked to the fear of enjoying success to the extent that future disappointment or failure would be too much to bear. One positive strategy used by participants involved emphasising different criteria by which their team's value could be measured, in the absence of obvious markers of success such as trophies: "Tottenham are shit...but they've got a history and tradition of playing entertaining football and having entertaining footballers...show me something
beautiful please” (Andrew, line 255). By focusing on different measures of success, fans could sustain their well-being and self-esteem in the face of mediocre team performance.

Wider effects on well-being

As well as providing a safe environment for emotional expression, the crowd provided participants with a strong sense that they were part of a particular community. Henry described, "a sense of belonging or an affiliation with the team" (Henry, line 520) and this was echoed by others: "it’s quite tribal in respect of you’re part of one clan and they’re part of another clan and you’ve got to make sure your drums sound louder than their drums" (Jim, line 438). There was a wider sense of a community of football fans which overarched team rivalries; "we’re all just football fans at the end of the day" (Vincent, line 324).
Discussion

Links between the themes

The results identified five major themes arising from the interview transcripts, and a coherent thread emerged linking these themes. The phenomenology of emotions showed that the participants were able to describe intense emotions connected to football, which served particular emotional functions for them. However, this appeared to be dependent on feelings of safety that the football context provided. Connected to the theme of safety were the notions of social identity and boosting self esteem through positive associations with the team and a number of strategies appeared to be employed for sustaining emotional well-being.

Focusing on the phenomenology of emotions, the participants produced rich and vivid descriptions of how they felt whilst watching football. This was likened to a roller-coaster which was characterised by dramatic fluctuations that were more intense than in everyday life, supporting the previous findings by Elias & Dunning (1986; Dunning, 1999). Therefore, a function of football for some fans could be gaining access to intense emotions otherwise not available to them.

Further to this, other emotional functions were identified, whereby football was an escape or distraction from the stress of everyday life. It was also described as 'cathartic' or a way of venting pent-up stresses and strains, which resonated with the beliefs of the researchers where we had hypothesised that football may serve a 'therapeutic' purpose in helping people express accumulated emotions from their everyday lives. However, this notion of catharsis deviates from that previously identified in the literature by Sloan (1979) who described a process of catharsis occurring through the observation of football (specifically aggressive acts). In the
current study, the participants described a cathartic release through the expression of emotion rather than through observation alone, suggesting that a more active process may be required.

The theme of safety appeared to be a prerequisite to allowing people to express their emotions. Factors connected to safety included being part of the crowd (belonging) and sensing the uniformity of reaction. It was also apparent that the participants were aware that their emotional expression would be affected if they perceived themselves as different from others in the crowd. Being aware of differences within the crowd appeared to strongly influence participants' feelings of safety and their ability to express emotions in the football context. Therefore, being part of the crowd and experiencing a sense of belonging helped the participants to feel safe, as well as providing a source of social identity (Jones, 2000). In addition, Cialdini (1976) and Jones (2000) identified that associating with a football team and its supporters can boost self-esteem through 'basking in reflected glory' and it was evident that the football fans defended themselves against negative emotions by being pessimistic about the team's performance or by finding 'alternative successes' such as flashes of beautiful or inspired play, a concept also noted by Jones. This desire to protect oneself and sustain emotional well-being was commonly reported.

**Emotions outside the football context**

When describing football events, the participants gave vivid narratives. This produced a powerful sense that during the interviews, participants were fully engaged in the process and were reliving the events they described. However, it was apparent that the participants did not produce the same richness of description for emotions in other contexts. This fits with Walton, Coyle and Lyons (in press) who found that football was a place were it was permissible to talk about emotions.
Although it was felt that the participants were fully engaged in the interview process, some people found it easier to recall their emotional experiences than others and in relative terms, all participants found it easier to discuss emotions in the football context than in other areas of their life. There appear to be four potential explanations for this. Firstly, the participants may have felt inhibited from a more general discussion of emotions due to not feeling 'safe' during interviews. This would support the notion that football serves as a vehicle for emotional expression.

A second explanation is that it could be an artefact of memory processes as the football emotions were particularly strong and possessed rarity value (Wagenaar, 1986). In contrast, emotions at this time outside of the football context may not have had the same salience and significance for the participant, making them less memorable. In addition, memories of emotions were not specifically cued outside of football since participants were not asked to recall a specific event. Thirdly it is possible that the questions were less effective at facilitating the discussion of emotions outside of football. Finally, as participants were known to the interviewers, for some this may have inhibited emotional expression. However, there was no evidence to suggest that this had occurred.

**Evaluation of the research**

The validity of this research was evaluated against criteria proposed by Yardley (2000) who suggests that good qualitative research contains the essential elements of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The current study demonstrates sensitivity to context by consideration and discussion of relevant theories and evidence and by placing emphasis on participants' perspectives, their socio-cultural context and the social
context of the research process. Commitment and rigour has been evidenced by the thoroughness with which data was collected, analysed and reported. For example, this was conducted at both an individual and group level, suggesting the researchers were fully engaged with the data and research process (see appendix 5 & 6). Descriptions and interpretations have been accompanied by extracts from the data, resulting in a construction of reality that is both transparent and coherent to the reader. As a result the investigation provides a rich account of the emotional function of football. It has been able to elaborate on the nature of emotions and the conditions that football may provide in order to facilitate emotional expression, providing an alternative account of why so many people support football.

A potential limitation of the research may be that the interview schedule facilitated the exploration of emotions in the football context, but was less effective at exploring emotions in other areas of peoples’ lives. Therefore further research in this area may need to revise this aspect. A possible solution could be to use two timelines, one for a significant football event and one for a significant emotional event from everyday life (non-football). This may help to focus the participant’s mind on equally important and salient emotional events, allowing a better qualitative exploration of the participant’s emotions in each context. Additionally, the number of participants is problematic, as it is a small sample of people and further qualitative investigation will be necessary to be able to generalise the findings.

Implications for Clinical Psychology

In general, there has been very little published research on football in scientific forums, despite the preponderance of opinions disseminated through the media and social circles. The findings of this research tentatively suggest that being a football supporter may serve purposes for the fan which include the expression and
experiencing of intense emotion in a way that feels safe and appropriate. This may be of interest to clinical psychologists as for some people, football may be a topic through which intense emotions can be described and understood. Certainly, a shared interest in football can be an instant way of connecting and joining in conversation with a stranger, a phenomenon described by several participants. Therefore, if nothing else, football may offer a means for clinicians to gain an initial rapport with a person. With creativity, it may also be a way to facilitate exploring or relating to complex emotions.

Ideas for further research

An idea to explore further is why some people may seek to experience intense emotions at football events. If people lack access to these emotional experiences in other areas of their lives, this would appear to be an area of interest to clinical psychologists.

Summary of the research

Overall, this research has met its aims, as a greater understanding has been gained of the role of football in the expression of emotion from five football supporters using interpretative phenomenological analysis (Smith, 1996). Whilst it is difficult to generalise from a small sample, the results have suggested that supporting football may serve purposes for the fan which are not commonly discussed in the existing literature. This relates to the finding that football may have utility in facilitating everyday emotional expression. Also, the highs and lows of football were seen as mirroring life, as Henry (line 509) articulately summarised - "[the team's performance] does act as a barometer sometimes for, for your own life".
References


Appendix 1:

Interview schedule
Qualitative Research Project Questions

Introduction

Thank you for agreeing to take part in this interview. Please take a moment to read through this information sheet; you don’t have to sign it right now [hand over information sheet and pen - pause]. I would like to talk to you about your views and feelings about being a football supporter. I will start by asking you some questions to find out a bit more about the team you support and then we will move on to the main interview. If any of the questions do not seem relevant to you, please tell me and we can expand or move on as you wish. If there is anything you wish to add at any time, please do so. You can stop the interview at any time if you wish to do so. At the end I will ask you to read through and answer some simple background questions. Do you have any questions? Are you ready to sign the information sheet? If you are ready we can begin the interview.

Contextual questions

1. Who do you support?
2. How long have you been a fan?
3. How did you start supporting [your team]?
4. Could you give a brief description of how committed you see yourself as being to [your team]?
5. Could you briefly describe the things you do to follow your team? (Prompt: go to matches; read newspapers; listen to radio; watch on TV)
6. How would you rate [your team’s] performance at the moment on a scale of 1 to 5. 1 = Very Poor, 5 = Excellent

Introduce timeline (see attached)

This is a timeline. It is meant to represent your life, past, present and future. We can use it to help you identify when certain things happened or occurred in your time as a football fan and what else might have been going on at those times. I will ask you a few questions and we can use the time-line when you are answering.

1. I’d like you to describe for me some significant event that has happened over the time that you have been supporting [your team]. It might be a positive event, like an important win, or it might be a negative event, such as relegation. Indicate on the timeline when it happened, and tell me something about it.

Preamble: I’m interested in how you felt about [the event] and would like to ask you something about your feelings at the time.

2. Tell me about your emotions at this time.
   - How long did these feelings last/how long do your feelings last?
   - What were you like the day after? Week after?
   - Was the event you described in line with your expectations? How did that affect how you felt?
   - When do you feel the strongest emotions during a match (or a season)?
Preamble: You’ve described how you felt about [the event] and I’d also like to ask you something about what happened to those feelings.

3 Did you show your feelings?
   ■ How did you show them?
   ■ What did you get from showing your emotions?
   ■ Some people show their emotions more than others when they’re watching a match. What do you think are the benefits/drawbacks of this?
   ■ If you perceive the people around you to be different from yourself, does that affect the emotions you express?

4 Looking at the timeline, I’d like you to think about what things unrelated to football were going on in your life at that time. Can you tell me something about that?
   ■ Did these events have any effect on each other?

   ■ Either: [Other event/circumstances] sounds difficult. Do you think the fact your team were doing well/badly helped/made things more difficult?
   ■ Or: [other event/circumstances] sounds like a good time in your life. Do you think the fact your team were doing well/badly helped/made things more difficult?
   ■ If [your team]'s performance had been the opposite at that time, do you think that would have affected other events in your life?

5. Is it easier to express negative emotions at a football match rather than showing negative emotions in other areas of life? And similarly, is it easier to express positive emotions at a football match than it is to show positive emotions in other areas of your life?

6 Changing focus a little, I’m interested in the differences between fans of teams that are winning and fans of teams that are losing. Do you think a team’s performance can affect how fans see themselves?
   ■ Does the team’s performance affect how they behave in areas of their life outside football?

7 What do you personally get from being a football fan?
Background information sheet

The following information is collected so that people who read the final report can know more about the people who have taken part. However, you will not be identifiable in the research as the study is complete confidential.

1. How old are you? ___________

2. How would you describe your ethnicity?

(Please choose one section from (a) to (e) and tick the appropriate box to indicate your cultural background).

(a) White
   British □
   Irish □
   Any other White background, please write in below

(b) Mixed
   White and Black Caribbean □
   White and Black African □
   White and Asian □
   Any other mixed background, please write in below

(c) Asian or Asian British
   Indian □
   Pakistani □
   Bangladeshi □
   Any other Asian background, please write in below

(d) Black or Black British
   Caribbean □
   African □
Any other Black background, please write in below

(e) Chinese or Other ethnic group

Chinese □

Any other, please write in below

...........................................................................

3. What is your highest qualification? (please tick appropriate box)

None □
GCSE(s)/O level(s)/CSE(s) □
A level(s) □
Diploma □
Degree □
Postgraduate degree □

4. What is your current job (or, if you are not working, what was your last job)?

...........................................................................
Appendix 2:

The timeline
Time Line - representing your life from birth until now and a little into the future

Birth

Your age
Appendix 3:

Information Sheet and Consent Form
INFORMATION SHEET AND CONSENT FORM

An Exploration of the Relationship Between Team Performance and Reported Emotional State of Committed Football Fans

You are invited to take part in a study looking at the types of experiences reported by committed football fans. Your participation will help to develop an understanding of the types of feelings that supporting football can generate in fans and how these may relate to other events in your life.

If you agree to take part you will be asked a number of questions about your team’s performance and how you felt about this. You will be asked some questions about what it is like to be a football supporter. You will also be asked some more general questions about yourself.

The interview will be audiotaped and the conversation will be transcribed to provide a paper copy of the interview. On this paper copy all names and identifiable information will be changed to preserve anonymity. Once the study is completed, the audiotape will be erased. The anonymised paper copy may be kept as a record. All members of our research group will have access to the transcripts. If, at any time, you decide that you wish the tape to be erased immediately, let the interviewer know.

The total duration of the study is about 45 minutes.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason.

The data collected from your participation will be completely confidential.

I agree/do not agree to take part in this study. (Please delete as appropriate)

Signature of Participant: ........................................... Date: ............................

Name in Block Capitals: .........................................................................................

Signature of Interviewer: ........................................... Date: ............................

Name in Block Capitals: .........................................................................................
Appendix 4:

Example Interview Transcript
<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Teddy:</td>
<td>The tape’s on. Okay I’m going to start with some contextual questions. Who do you support?</td>
</tr>
<tr>
<td>02</td>
<td>Henry:</td>
<td>Arsenal.</td>
</tr>
<tr>
<td>03</td>
<td>Teddy:</td>
<td>As if I didn't know that!</td>
</tr>
<tr>
<td>04</td>
<td>Henry:</td>
<td>[Laughs]</td>
</tr>
<tr>
<td>05</td>
<td>Teddy:</td>
<td>Okay. How long have you been a fan?</td>
</tr>
<tr>
<td>06</td>
<td>Henry:</td>
<td>About... thirty... three years. Yep</td>
</tr>
<tr>
<td>07</td>
<td>Teddy:</td>
<td>Quite a long time then.</td>
</tr>
<tr>
<td>08</td>
<td>Henry:</td>
<td>Suffering... [Laughs]. Long suffering</td>
</tr>
<tr>
<td>09</td>
<td>Teddy:</td>
<td>Long suffering okay. How did you start supporting Arsenal?</td>
</tr>
<tr>
<td>10</td>
<td>Henry:</td>
<td>I think I first became aware of the significance of football and teams and supporting teams around about 1970-71 cup final, day, on cup final day 71 and from that decided that it's good, a good thing to support the team that wins the FA cup, so sort of following that really.</td>
</tr>
<tr>
<td>11</td>
<td>Teddy:</td>
<td>Could you briefly describe the things you do to follow your team?</td>
</tr>
<tr>
<td>12</td>
<td>Henry:</td>
<td>I check the website, probably the official club website probably daily, umm, look out for the results err when I'm not actually watching or listening to matches. Try and watch the games when they're on TV, if I can't get to a TV I'll listen to them on the radio and occasionally I'll even make a visit and trip to watch a game.</td>
</tr>
<tr>
<td>13</td>
<td>Teddy:</td>
<td>Ok. And how would you rate your, how would you rate Arsenal's performance at the moment on a scale of one to five, where one is very poor and five is excellent?</td>
</tr>
</tbody>
</table>
Henry: At the moment I'd probably put them on a three.

Teddy: Ok. Ok the next bit... I'll need this piece of paper and this is a timeline. It's meant to represent your life past, present and future. We can use it to help you identify when certain things happened or occurred in your time as a football fan and what else might have been going on at those times. I will ask you a few questions and we can use the time-line when you are answering. I'd like you to describe for me some significant event that has happened over the time that you have been supporting Arsenal. It might be a positive event, like an important win, or it might be a negative event, such as relegation. Indicate on the timeline when it happened, and tell me something about it.

Henry: I suppose my first recollection, significant recollection would be the cup final in 1972. So we're looking...this kind of stage here [writing on timeline]... they played in the cup final and lost that game to Leeds United 1-0. That was quite a downer, a very negative event. I would say the next recollection of the team was... in their performance in the late 70s, 78 to 80, and they appeared in three cup finals in succession winning one of them, I especially remember 1979 cup final win against Manchester United. After that [laughs] the team went through I can only describe as a bit of a wilderness, barrens patch and, I think, the next significant event and I suppose this is one which is particularly poignant event for me cause I went, was the Littlewoods Cup Final at Wembley in 1987 and I actually was fortunate enough to be at the game to watch them win that 2-1. Particularly good, I'd, I'd being at a Wembley, Wembley Cup Final to watch the team win, excellent. The next year the 88-89
season was particularly significant because that was the year they won the championship, for in, for first time in about 20 years, and of course there was the err dramatic late winner at Anfield against Liverpool in that match. And I do particularly remember that, watching at home on TV, having given up hope of them winning it and then them scoring in the last minute, I think I can definitely recall screaming and rolling around [laughs]

Teddy: [laughs]

Henry: on my sitting room floor when that, when that went in. That was another particularly uh memorable one and [unintelligible] a couple of good seasons following that, another championship win a couple of years later. Umm... 1994 I remember... them winning the European Cup Winners Cup, the first time I remember ever seeing them win a European Final. Err, again the following year they appeared in the final again but happened to lose that one... and I would say it wasn't until 1998 when I first saw them win the double... that, I really, again, really remember that cup final watching that with a friend round at his house and watching them beat Newcasical, err Newcastle United in the final 2-0, err win the double that was good. And then err again in 2002 winning the double again, umm... I suppose err devaluing it a little bit, that that the the trophies coming a bit too too thick and fast for me as an Arsenal supporter but err, no particularly enjoyable 2002 that that season there. And I think particularly from the year sort of 98 onwards not only the winning of the trophies but I think it was significant that the style of play and the way that they played football was a significant improvement in
what the team and certainly the club had served up before and
the, they were playing with a style and panache I think which as
an Arsenal supporter I certainly wasn’t used to so. Yea. That
was good.

Teddy: Does that bring it up to the present?
Henry: Yep, to the current season, of course which, they’re currently
umm trying to win the league title having more recently gone out
of two competitions and I have to say that was a little sad, but
umm, nonetheless playing good football again.

Ok, you you’ve identified a number across this time is there one
of these which you feel is the most significant out of all those?

I think the one which, the event which... I think just due to the
excitement and the climax of the season and the events was the
1989 league championship win at err Liverpool which I saw on
the television, yeah I’d say that was the most significant in my
lifetime. First time I’d actually seen the team win the league
umm, but... so that was good, yeah very good.

Ok. I’m interested in how you felt about that event, the league
championship win, and would like to ask you something about
your feelings at this time. Can you tell me anything about your
feelings at the time?

At the actual time I think it was just one of sheer, sheer
exhilaration. I think, the way the season had gone and the build
up to the match a kind of... the demands on Arsenal of having to
win 2-0 and although they were leading 1-0 at half time, as the
game grew on and got closer to the final whistle, it just, it just
didn’t look as though a goal was going to come and I think
remembering back to the evening, getting into injury time, just
expecting to hear the final whistle and the, the subsequent
disappointment coming from even though they’d won the game
1-0 was really yeah quite poignant. So, the players, the Liverpool
players I think by that time quite rightly so in many respects were
almost kind of congratulating each other, sort of, saying that
they’d won it and err I think for that goal to come when it did it, it
just was, the sheer exhilaration of of winning a game that close
to the edge, and and for it to be such a a major trophy as well, I
think the combination, I actually felt exhilarated, I I I was on a
high and I remember, I think going out to see my girlfriend
afterwards, and it almost being impossible really to hold any kind
of sensible conversation [laughs] so yeah it was umm it was
amazing, and er but I felt alone it many respects because I
wasn’t sharing it with other Arsenal supporters, err my girlfriend’s
family at the time all being quite avid Spurs supporters and they
weren’t quite sympathetic to my excitement and I actually
remember going into a pub that was full of Tottenham supporters
after that, that game, and again being almost met with a stony
wall of silence really [laughs] I don’t think [laughs] it was the right
place for me to have been at the time so I had to contain my
excitement somewhat, umm so it’s quite, although it’s quite
exhilarating it’s quite a a kind of lonely experience [laughs] but I, I
also valued my safety [laughs]
144
145 Teddy: [laughs]... You said that you felt that exhilaration
146 Henry: Hmmm hmmm
147 Teddy: Umm, that excitement, was that throughout the match?
148 Henry: I think ummm
149 Teddy: Or were there other emotions that you felt during the match?
150
151 Henry: Oh certainly other emotions, I, as I said, as I said, prior to the
152 umm the goal, the final goal going in there was a sinking feeling
153 of of been here before, you know we've seen it, been so close,
154 they've got so close this time. And there was the feeling of the
155 inevitable, you know I felt resigned, I think it was that, that
156 combination of of having resigned myself to the fate of them not
157 winning sufficiently to win the league. Err, and and sort of
158 thinking I can't bear to watch this I I want to go out now, but of
159 thinking, for some reason, strange reason wanting to hang on
160 there until the end in the kind of vain hope that something good
161 would come. So I think it was the sheer unexpectedness of it
162 and the kind of air of resignation, disappointment, feelings of
163 despondency really, that had preceded the goal going in. I think
164 that roller coaster if you like of emotions certainly was you know
165 to the fore there, where you, you're kind of sunk and sort of
166 thought, oh well that's it for another year, got so close and to this
167 point, come to that. But then I think, you know to be lifted, in the
168 way, there was no time for Liverpool to come back, and you
169 knew, basically the last kick of the game, I think it was just, yeah,
170 just from, complete low to high in the space of of, of a, you know,
171 half a minute, it was, sheer exhilaration.
And that exhilaration, that high, how long did that last for?

I think the, the intensity of the moment as I said the rest of the evening, I mean it was just impossible really to think about anything else or to hold a a sensible conversation about any other subject really and err, I would say that probably stayed with me for a few days and I think reading about it, wanted to read every paper, see every report on the TV, you know, relive that that goal time and time again whether it was just in my mind or just, on news bulletins or video or whatever, I can't remember whether I taped it or not. But I, I say, its, you know, for the next week or so just thinking about nothing else really, umm, apart from getting on with day to day life but it mean it was, it was that significant and I would say that the enjoyment of that has lasted, ever since although obviously that initial feeling of exhilaration obviously dissipates after a while, it was certainly, a good month or so I think umm before things really really moved on and err it was just a case of wanting to relive that moment by whatever means, whether papers, or reports or TV, whatever means possible really.

Was, was the, was the result of that match in line with your expectations?

I tend to underplay or err on the side of caution or pessimism with these games and I, if I'm honest, although obviously willing and wanting them to win my head would have said, due to the form of Liverpool at that time, and Arsenal not having won a trophy, err for some, for a significant, the league championship for about 20 years, my expectations I think were, that the, the team wouldn't
202 win, certainly by the significant margin of two goals, to actually
203 win the league, no my expectations were not, positive.
204
205 Teddy: So knowing that, that it didn't fit... your expectations weren't
206 positive, how did you think that affected how you felt?
207
208 Henry: I'm sure that, as I've said, umm relating to the kind of sensations
209 leading up to the goal going in and the kind of, the air or
210 resignation about everything, sinking into a kind of, oh well we
211 gave it a good go you know, it was you know, a good try a good
212 effort but in the end we just weren't quite good enough. I think it
213 was significant, that the expectations were, not there to win that
214 actually produced the exhilaration of when they actually did win.
215 So I think it was that combination, both over the build up to the
216 game and actually during the course of the game, that led to the
217 incredible high that followed the goal going in, yes.
218
219
220 Teddy: When do you think you feel the strongest emotions during the
221 match?
222 Henry: I think, [cough] strongest emotions are at the time of goals...
223 either goals being scored by your team, or against, and the
224 inevitable highs and lows, and... that exhilaration when a goal
225 goes in especially when it's a significant goal or err a winning
226 goal, although of course during the course of a game you don't
227 know when a winning goal is going in but I think if they start to
228 extend the lead by two or three goals, you become confident the
229 team should win that match. But again, the lows occur umm,
230 when, I think, particularly the opposing team scores, either really
Teddy: early on in the game, and you think oh no it's going to be an avalanche and they are going to wop us sort of five or six nil, or I think towards the end of the game that the opposing team scores because, if it's, particularly if it's a tight game, there's not many goals in it, you think, I think the tendency is to think well that's it they, they've blown it. So I think at those times, err particularly strong and, I'd say they're the particular low points of a game, when the opposing team scores.

On balance, do you think you experience more lows or more highs during a game?

Henry: Again I think it's umm, a, a kind of, almost like a defense mechanism, to kind of keep expectations low, and almost accentuate the negative in the belief that, if something positive comes, or a goal comes, it's more like, more of a bonus. So I think it's like a deliberate, even though the evidence and the performance of the team, especially this season suggests that I should be confident and going into it expect expecting them to win, because actually in the league they've been unbeaten, but, umm, I think I keep expectations low, in order not to be too disappointed if they don't fulfill them. [laughs].

Teddy: You've described how you've felt about the, this event, the winning the league, and I'd also like to ask you something about what happened to those feelings. Did you show your feelings and how did you show them?

Henry: When I was at home and the goal, I was watching it on Television and the goal went in, yes, I I think there was a high degree of,
certainly the most intense shouting or screaming that I have ever experienced watching a football match, I think it was partly because I was in the safety of my own home, and umm... it was the sheer disbelief that that, of, of that going in that, that led to that. So I was extremely vociferous [laughs]

Teddy: [laughs]

Henry: When that goal went in, and I think almost uncontrolled in terms of rolling around the floor or, just jumping around for joy really yeah, certainly the most intense emotions I have ever experienced watching football, yeah, and I think partly that was due to, yeah, being at home and not being in a pub, but I I think if I was in a pub watching with friends or around watching, I would have done the same, I think there would have been a collective, even more of a collective

Teddy: So what did you get from showing those emotions and doing that?

Henry: A release [laughs] an amazing release, I mean it was, yeah, I don't think it would have been safe to try and contain that in any other way [laughs], yeah [laughs].

Teddy: Some people show their emotions more than others when they are watching a match. What do you think are the benefits or drawbacks of that?

Henry: I think, I would say for a lot of people when I have actually been to games and watched or listened to them, as I've been there, taken notes on people it's clear that people find it therapeutic in terms of a release for emotions, and, to some degree I think it's quite healthy, people as a safety valve and having to have that outlet, it's almost like in a safe contained environment where, I
think due to the behaviour of those, those other supporters around them it appears to be quite the norm, to, certainly shout, sing or, you know, be emotionally... verbose or, or... trying to think of the right words, articulate, emotionally articulate the one, the when, when one normally is but, and I think a lot of people find that useful as a release for their emotions, it may be that they're bringing stresses and strains from their lives, their everyday lives to sort of, that game, and maybe releasing it through that way, so I think that's useful. But of course the downside to that is when that becomes over the top and it starts impinging either on those sitting around them and clearly people can get upset certainly by the use of, of foul language, and also of course when it overspills into abuse either of players or of opposing supporters, and its clearly, you know, the there are people who who, umm I think, abuse those situations umm to the effect of, detriment of other people.

Teddy: What about abusing the referee? Is that cathartic, is that a release or what is that?

Henry: In the same way that, I think its all again, its almost a, I think he's amongst football supporters a legitimate target, I mean he's, he's the official so he, he doesn't carry any favour in terms of any supporters but, again I suppose within reason I would say ok to have a go, have a question his decisions but, but again umm he's a human being like anyone else and doesn't deserve to be, verbally abused.

Teddy: If you, one of the... you mentioned about the people around you.

If you perceive the people around you to be different from
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Henry: Interesting point. I, I, I, I compared umm a game, a match or matches that I’d watched err in the early 70s when standing on the North Bank terracing at Highbury to a situation where I was then sitting in the same stand but it all being all seated and I did compare the crowd that was around me in the early 70s, there was an all male crowd, err one of lots of singing and shouting and and foul language I have to say... umm to one where I found myself in later years, I think the early 90s, sitting in a stand with women and children, almost a like a more family err environment, and I must say that, it did, I was more aware of what I myself was shouting and saying, in that, in the latter environment than I was earlier on because I think I was conscious of controlling what I was saying and the content of, and obviously the language I was using, because of the presence of women and younger children. I would say that it was more restrained, in that environment, certainly.

Teddy: Ok, so the emotions you expressed might have been slightly more restrained, depending on the people that were around.

Henry: Yes, certainly would have affected that, I was actually quite conscious of that yeah, at the time, I was there yeah.

Teddy: If you perceive the people around you to be supporting a different team to yourself would that affect the emotions you express?

Henry: Absolutely umm [laughs]...

Teddy: And how so?

Henry: Good case in point, I actually went to a game at Arsenal, but I went with a friend of mine who was err a Spurs supporter, and
347 because err, of the way things worked out I decided to go in to
348 stand with him in the Tottenham supporters end... and it was
349 amazing because, although Arsenal had the good fortune to win
350 the game, when they scored, when Arsenal scored, of course,
351 because I was surrounded and I mean compacted, surrounded in
352 a standing terrace full of Tottenham supporters, I actually
353 changed my responses to the goals, the Arsenal goals going in,
354 so when umm the Arsenal goals went in, in terms of not jumping
355 up for joy in terms of the release of that emotion, I'm sure I
356 shouted words to the effect of oh damn {laughs} and it was clear
357 by my, probably clear by my overreaction {laughs} to these
358 events that, that it was probably quite, quite marked and false
359 compared to the rest of the Tottenham, who just sat stony faced
360 and silent {laughs} so, that that was how I dealt with that in that
361 situation of course yeah. Although the release was there when
362 the goals went in, the content or the, or the guise of it was
363 certainly changed, because I, I, I feared that I would be abused
364 either verbally or probably physically if I had of shouted, started
365 shouting when that goal went in {laughs}.
366
367 Teddy: Do you think that the umm, those emotions that you felt, that
368 release
369 Henry: Hmmmm
370 Teddy: The intensity of it
371 Henry: Hmmmm
372 Teddy: Do you think that it was diminished because you had those
373 different fans around you?
374 Henry: Yes, oh certainly
Would you have got a more intense burst of emotion if...

Absolutely I would have been jumping and shouting for joy if I had of been with the right, set of supporters certainly. So I had to contain, you know even even voicing disappointment, I had to temper that or tailor that down, err simply because you, its clear, the normal reaction for an opposing supporter is really just not to do anything emotionally, just stand there stony faced and probably shout the odd word of verbal abuse at the player who had scored but certainly yeah it was more constrained, yes.

Ok, so looking at the timeline, I'd like you to think about what things unrelated to football were going on in your life at that time. So when they won the league. Can you tell me something about that?

I think at the time umm, I was, working as... as an estate agent... that's right it was a career change and... I think, in a way the football provided an escape or a release... umm probably for the confusion or dissatisfaction, I was having err at the time in that, in that, in that job. Yeah I'd say it was a a positive distraction from an otherwise umm... transitional, career kind of move at the time, yeah. It was quite good. Although I had a a stable relationship with a girlfriend... ummm, most things were pretty ok, umm, but I think football always acts especially when the team's doing well as a welcome, escape from sort of day to day life, yeah.

So was it the estate agent part that was

I think yeah, it was the uncertainty of having made a career change umm and and the dissatisfaction job dissatisfaction of the
actual work yeah, it wasn't fulfilling actually.

So that that part of it sounds quite difficult do you think the fact
that your team were doing well... helped make things better?

Absolutely oh yeah. I, I think umm, in the way that it acts and
serves in most people's lives it's a welcome release, I think from
the day to day life umm... that you have and I think if if things are
p-possibly quite difficult or troublesome, in any err at any level
then it serves as a good distraction umm a welcome release I
think away from those day to day pressures yeah.

Cause you mentioned how you were kind of on a high for about a
month

hmmmm

weren't you, you were feeling

absolutely

how do you think that affected?

I'm, I'm sure it had had a positive impact across the rest of my life
and you know in terms of, who I was with and, who I was working
with or you know in a small office or whatever I'm, I'm sure my
mood would have been elevated and and was probably elevated
at the time because of that umm result yeah that outcome yeah.

If Arsenal's performance had been the opposite at that time

hmm

do you think that would have affected other events in your life?

... it's hard to say umm, I don't think to any significant degree, but

I'm sure, that my mood, would have been, would have been sorry
somewhat, lower or, I would have been less enthusiastic,
enthusiastic, enthusiastic about my work or, relationships at the time, so I'm I'm, yeah, I'm sure it does, although I think it's difficult to put any kind of umm, tangible kind of measure on it.
I'm sure it does have some, some err impact on your mood,
yeah.

Teddy: Do you think, is it easier to express negative emotions at a football match rather than showing negative emotions in other areas of life?

Henry: I think it, it, as I said the football environment certainly the crowd environment does, permit, the release of a lot of negative... emotions or thoughts... and I think consciously or subconsciously they can be channeled out... as a a you know through legiti legitimate targets like either the opposition, or the referee I think, yes, I, I think it's almost like a, a kind of safe environment, to release that kind of negative emotion, even though I think it has umm potential negative outcomes in terms of the, players or referees and and the opposing supporters being overtly, abused,
yeah.

Teddy: What makes it safer... to express negative emotions at a football match?

Henry: I think if you are sitting, sorry

Teddy: Rather than generally?

Henry: If you are sitting with supporters of, your team, err the safety in numbers element I think you feel, you're amongst like minded people, like thinking people, and and actually this is, you're just following the consensus of what's around you and if that's the prevailing mood or, thoughts that are, you're experiencing which obviously you can hear and pick up on, then you feel that security
Teddy: And similarly, is it easier to express positive emotions at a football match than it is to show positive emotions in other areas of your life?

Henry: Yes... umm for the same reasons I think you're, you're amongst... you're... tribe if you like, your, your you know your family or whatever they're, they're people of like minds who, who, who you feel it's safe to release, it's safe to release that that kind of emotion with and of course ironically they're people you might only meet sort of once a week or may, once a month or once a year and actually probably don't know them any more closely than you would someone in the street, but... err I think the... the bond that's held between the football supporters is sufficiently strong... to allow... the safety err valve of of emotional release that probably, wouldn't occur unless you were sort of either within the safety of your your own home or own family.

Teddy: Changing focus a little, I'm interested in the differences between fans of teams that are winning and fans of teams that are losing. Do you think a team's performance can affect how fans see themselves?

Henry: ...I think that's quite umm...difficult question to gauge it but I mean in terms of behaviour, what you would normally find of course is the, the team, supporters of the team that is winning, more exuberant, more vociferous... umm probably singing and chanting a lot more err and I would have thought that they would,
they would obviously feel more positively about themselves and be looking to assert that through, the chanting and singing that would be going on. So I, I would think from the behaviour of team’s supporters who were losing, it is a question of, they do want to encourage their team and some will react very positively, and keep chanting and singing for them, but undeniably, they’re aware, only too aware from the noise going on around them... umm... that they are on the, the wrong end of the, the result so I would have thought their self-perception would, would definitely decrease or fall, absolutely, yeah.

What about outside the match, would the the performance of the team, whether they’re winning or losing affect how the fans see themselves when you’re away from the match and during the week say?

Yeah absolutely, I, I, I think the team’s performance, does act as a barometer sometimes for, for your own life and I think if, the team does suffer a particularly negative or bad result, there is a tendency either you want to, immerse yourself in a distraction to, to kind of, alleviate the mood and getting away from thinking about that, or, or I think, alternatively it can highlight other negative aspects or areas going on in your life at the time. But I think it can act as a trigger sometimes, to to channel your, other negative thoughts or emotions err with, yeah, yeah.

... Umm, what do you get personally from being a football fan?

... I think there’s a sense of... I think there is a sense of
belonging or an affiliation with the team... and following their progress, is... a welcome distraction... and and almost umm, it’s like acting out successes or failures vicariously, err through someone else’s endeavours you feel... umm... a sense of not being in control of events and not, not being able to influence them but nonetheless emotionally bonded or attracted, to, that that end, I mean to their end sorry. So I argh, I, I think it’s... it is a question of feeling, of belonging really and, and being... part of something... hopefully... err something good... umm, that, you know can give you, the exhilaration and the pluses... but of course with that I think you have to buy into the fact that, there’s going to be some lows, and some disappointments on the way, but umm, I, I think the, the emotional appeal of of that err rollercoaster ride is, is too strong to kind of, for a lot of people anyway to kind of, distract so, yeah or detract from that so no it’s good... a positive thing.

Teddy: That’s it
Henry: That’s it
Teddy: Yep we’re finished, thank you.
Appendix 5:

Reflections from each of the researchers
Personal reflection - One

Reflections throughout the research process included consideration of the interview process as well as the conceptions and preconceptions that I brought to the project. The interview was conducted using a schedule of questions. I chose to stick fairly closely to this schedule, using only a small number of additional questions and probes. This was to ensure that, while the participant's perspective was explored I did not influence the process by asking any ad hoc questions that could have been considered leading. The disadvantage of this, of course, is that there may have been some interesting avenues that were not explored in great detail, thereby limiting the data.

Being a female researcher who had not been committed to football in recent years may have had a positive effect on the responses given. The balance between what knowledge and interest I had about football against what I didn't know about the topic made me genuinely curious during the interview. Evidence that this was picked up by the participant came from the elaborate explanation provided during the interview about the system by which teams play each other in a bid to secure league promotion.

The fact that I haven't followed football for a number of years placed me in a relatively neutral position throughout the research. Although I came to the study having had the experience of being swept along by the emotions of watching football from the terraces (in most cases literally, due to experiences prior to the introduction of all-seater stadiums) I had always been left with a nagging feeling that I was somehow missing out because I didn't quite get it.
Personal reflection - Two

It was a slightly apprehensive time, choosing the research topic from the choices given and waiting to see who else would be interested. The topic seemed to provide an opportunity to add a light-hearted aspect to my clinical training, however this was somewhat dependent on my fellow researchers: would we get on, did they have similar ideas to mine about how the project might “go”, would we be able to negotiate whatever differences arose? Nevertheless I recall being pleased with the final group, one of whom I knew fairly well and the remainder I perceived to be friendly and sociable people.

Once discussions began it became clear that others appeared to have the same approach as I did. Banter and friendly rivalry emerged between those of us that were football fans; the remainder joined in with the laughter and sought to gain more understanding about the game. I can say with contentment that the subsequent steps in the research process passed unremarkably. We seemed to be able to listen to one another’s ideas, commenting on the positives and negatives where necessary; thinking back I hope that everyone felt as free as I did to both challenge and praise suggestions. I think the interview schedule is testament to our cooperative working style and when it arrived typed and formatted in my email box I was proud of and impressed with the finished product.

The interview itself was a somewhat nerve-wracking experience. I was conscious not only of how the participant perceived me but also what my fellow researchers would learn about me as a clinical interviewer. However I recall enjoying the interview – I had thought myself a football fan until I conversed with my participant! He was able to engage me and take me into the very strong positive emotions he was still feeling despite the chosen event occurring some years previously. However my “high” soon became a “low” when the realisation of the arduousness of the transcribing process hit me. Remaining true to the recording was hard particularly where I perceived my questioning to be slightly flawed, yet I persisted in order to be faithful to the process. Throughout I wondered how my colleagues’ interviews had gone and how my transcript would “stand up” to theirs; had I gathered sufficient information to be able to generate themes, had I wandered too far away from the interview schedule? Handing over the completed transcript to the others was another anxious moment.

Reading the other transcripts was fun! Like my participant the other fans were engaging and even when describing a negative event were able to evoke feelings in me; the life of a true fan really amazed me! For example I recall keeping an eye out for the results of all the participants’ teams so that I could have some idea of how they might be feeling on that particular weekend. A similar amount of fun came through re-reading the transcripts with my
colleagues; the banter remained and it felt like we were "quite good at this qualitative stuff" having generated a number of themes common to most or all participants.

The final stage – the write-up seems to have gone almost too smoothly. Schedules have been kept to, joint writing has been enjoyable and a high standard of work has been produced. Despite the extra workload I shall really miss this project and am glad to have been left with new football friendships!
"It became apparent during the course of the research process that my interest in the subject of football and football fandom - which had originally been driven by a scientific curiosity rather than emotional involvement - had undergone subtle changes whereby I began to notice (and worry about!) the fortunes of the football clubs followed by the research interviewees, especially the club supported by my interviewee, poor old downtrodden, stigmatised Millwall. I started to listen to the five minute sport slots after the news on television and even stopped to read the Sun at the newstands in the supermarket! All this was possibly exacerbated by Millwall's gutsy performance leading up to the cup final where sadly they were absolutely crushed by Manchester United, but nevertheless gave me real insight into what it must be like for the committed lifelong football fan and the emotional highs and lows of the football season. My reactions were a complete surprise to me and it will be interesting to see if they are sustained for any length of time. I might even go to a match next season!"
Personal reflection - Four

When the topic was first proposed I expressed immediate interest, and was pleased when several others did too. I was a little surprised to see who joined the group – as a football fan myself, I have a good idea which members of the course have an interest in football, and had expected more of these people to join us. On reflection, I was pleased with the group – had there been less football fans, I would have worried that the project would be too distant from the topic, and could not express what I felt was important about football and emotions. However, I was also aware that in a group containing more (male) football fans, I may have felt the authenticity of my “fandom” challenged. As a female fan, I sometimes feel more pressure to prove my commitment, or display my soccer knowledge. Moreover, living far from my club and no longer going to matches, I am very aware that I do not feel as “true” a fan as in the past, and I was grateful that my research group would not be comprised of those whose season-ticket-holding dedication would expose me as the fraud I sometimes feel.

Throughout the project, I inhabited two roles, that of the fan as well as the researcher. An ongoing interest in the complexities of football fandom certainly helped in applying myself to onerous research tasks such as transcribing. Looking back at the transcription, I was also aware that my status as a fan helped the interview progress smoothly, as my participant (also female) knew of my interest in football and therefore a common language and understanding was quickly established, and a richer vein of information was tapped than might otherwise have been possible. However, in the course of the interview it was a struggle to maintain any semblence of an “outsider” perspective, to the extent that on occasion I finished my interviewee’s sentences for her, over-confident that nothing she could say about the emotional highs and lows of football could be a surprise to me.

Naturally, my participant and the others who took part described widely varying experiences and opinions about fandom and their feelings, and it was this privileged insight into the differences and commonalities of fans which was the highlight of the research for me. I was pleased that the write-up seemed to capture the passion, dedication and even some of the humour of our participants. Through this project, I have gained an insight and empathy into the experience of all fans, beyond the blinkers of traditional club rivalries. I also feel that working as a group has been a worthwhile experience, and a valuable introduction into qualitative research.
As an enthusiastic football fan, researching this area has been fascinating, engaging, stimulating and fun. I think this is largely attributable to my fellow researchers, who have delighted me with their similar interest and passion for the topic. We have been a great team and I feel proud to identify myself with them.

At the outset of this research we had a belief that football may serve emotional purposes for the fan which we had not heard discussed before. Consequently it was very satisfying to find that our participants described experiences that supported these beliefs and fulfilled the research question. However, the parallels between the research topic and our experience of it seem uncanny. For example, I recently found myself thinking that even if we don't achieve a good mark, then we'll still know that we had the most fun, or we were the best team. Clearly I was finding an alternative success to protect myself. There has also been a sense of unity, with people wanting to be involved in all aspects of the work and supporting each other.

The requirements of the course have affected the research, as the nature of the project has been influenced by the marking criteria. At one point this was particularly notable due to the request that we grade each others' contributions. I felt very strongly against this as it seemed to jeopardize the integrity of our team-spirit, placing us in competition. Since this has been revoked, the project has rolled along very smoothly and entirely without hitches or conflict.

The use of IPA has been very effective, however, this methodology was restrictive and consequently frustrating in one instance. During a group meeting where we were analysing each interview transcript, it was observed that one of the transcripts contained very little emotion. We were finding it hard to identify themes in the transcript and everyone seemed a little 'flat'. In particular I found myself feeling subdued and having nothing to say about it. I remember thinking about this and wondering why I had nothing to say, at which point I was struck by the similarity between my feelings and the content of the interview. I felt nothing, and this seemed to reflect the content of the transcript which had very little emotion.

At the time I found this fascinating, as it had a transference type quality to it, where I felt that I was picking up this 'nothingness' from the transcript and was feeling it myself. However, what could be done with this? It was an interesting observation to us as a group, but what use was it to the analysis? Nothing, really. This was frustrating as there was no way to discuss this, to articulate it, or to represent these feelings that the transcript generated, although at the time I found them striking. In retrospect, the best that I can make of these feelings is that they demonstrate how strongly we were engaged with the data from our participants.
I think the process of completing this research has changed my perception of football. Above everything, football is entertainment and drama, but having intimately encountered the beliefs of our participants, I can see that football is much more than that. There is a diversity and plurality of functions that football serves, and the next time that someone says to me “I don’t see why people get so excited watching adults chase a ball for 90 minutes”, I will have a number of opinions to share with them.
Appendix 6:

Reflections from the whole team
Towards the end of the project, we met as a group to share our reflections on our group processes. As discussion progressed, it quickly became apparent the extent to which our experience of being football researchers mirrored the experiences of the football fans we sought to describe.

We had entered into this research topic because football fandom was of interest to us, but also because we had a strong sense that the topic had the potential to be more light-hearted than the other proposed subjects. We welcomed the opportunity to incorporate a frivolous element into our coursework, as an escape from the day-to-day realities of clinical training. Looking back, we are pleased that this sense of fun was sustained throughout the project's life. Opportunities for the use of football analogies in group discussion were rarely missed, and when difficult decisions regarding allocation of work or negotiating contrasting ideas arose, these humorous asides served to deflect potential tensions and make us a more bonded group. For example, when one of the group expressed a reluctance to work late, her commitment and loyalty to the project was questioned with accusations of being a “fairweather fan”!

The fact that the project was a “friendly” (rather than a “competitive fixture”) eased performance pressure and allowed us to develop as a team. Had the project counted towards our portfolio, perhaps there would have been more of a clash of individual preferences and styles. As it was, we seemed to forge a safe arena in which opinions could be expressed and ideas challenged, without damage to the group’s cohesion. As the project progressed, we became strongly bonded as a group, choosing to sit together in teaching sessions. On an occasion when one group member was unable to sit close to the others, he experienced strong feelings of isolation, likened to being seated amongst the opposing team’s fans! Comments made by members of other research groups, concerning our apparent organisation and the laughter so often heard during our discussions, increased our sense of belonging to a “football family”.

It was entirely coincidental that the research took place during the most important and exciting period of the football season, namely the climax of the league and FA cup competitions. This added impetus permeated discussions and heightened our awareness of the ‘emotional rollercoaster’ that was so
evident in the fans' interviews. The fact that our research topic was being so vividly expressed in real
live terms in the outside world very likely contributed to our sense of its value as a phenomenon worthy
of formal investigation. This value seemed doubtful at the outset, when the topic seemed rather flippant
and we were unsure what data would be generated. However, the richness of the data and the drama of
the climax of the football season affirmed and justified our position relative to the other research
groups. Accordingly, towards the end of the project the group felt vindicated in our choice of research
topic, to the extent that the phenomenon of 'basking in reflected glory' noted in football fans became
part of our experience, as we revelled in what we hoped were our project's mounting successes.

We have also noted that group members whose interest in football was fleeting prior to this project now
profess some allegiance to the team supported by their interviewee. This seems a measure of the value
of the qualitative methodology in capturing the experience of participants in such a way that outsiders
are drawn into their world.
Relationships with Voices: Does This Make Any Sense to the Hearers?
An Interpretative Phenomenological Analysis

Year 3

July 2005

Major Research Project
(MRP)

Please note that some of the participants' details have been changed to preserve confidentiality
ACKNOWLEDGEMENTS

My faith has helped me to get through this challenging piece of work and so firstly my thanks to God for making all things possible.

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# CONTENTS

<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>181</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>182</td>
</tr>
<tr>
<td>METHODOLOGY &amp; METHOD</td>
<td>201</td>
</tr>
<tr>
<td>RESULTS/ANALYSIS</td>
<td>212</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>229</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>248</td>
</tr>
<tr>
<td>Appendix 1: <em>The Interview Schedule</em></td>
<td>254</td>
</tr>
<tr>
<td>Appendix 2: <em>University Ethical Approval</em></td>
<td>262</td>
</tr>
<tr>
<td>Appendix 3: <em>LREC Approval</em></td>
<td>265</td>
</tr>
<tr>
<td>Appendix 4: <em>Participant Information Sheet</em></td>
<td>269</td>
</tr>
<tr>
<td>Appendix 5: <em>Consent Form</em></td>
<td>274</td>
</tr>
<tr>
<td>Appendix 6: <em>Transcript Interpretation</em></td>
<td>277</td>
</tr>
<tr>
<td>Appendix 7: <em>Sample Transcript</em></td>
<td>281</td>
</tr>
<tr>
<td>Appendix 8: <em>Table of Themes</em></td>
<td>305</td>
</tr>
<tr>
<td>Appendix 9: <em>Linked Themes</em></td>
<td>309</td>
</tr>
<tr>
<td>Appendix 10: <em>Transcript Notations</em></td>
<td>312</td>
</tr>
<tr>
<td>Appendix 11: <em>Feedback Letters</em></td>
<td>314</td>
</tr>
</tbody>
</table>
ABSTRACT

Objectives  Conceptualising interactions between voice hearers and their voices as a 'relationship', has recently become an area of psychological enquiry. The present study aimed to establish the perspectives of voice hearers regarding their relationship with their voices across a number of dimensions.

Method  In-depth interviews were conducted with 10 service users who have heard voices for at least 12 months. The interviews were transcribed and analysed using interpretative phenomenological analysis.

Results  Analysis resulted in five major themes: 'Defining the 'other'' detailed the personification process; 'Me vs. the Voice' explored oppositional positioning between participants and their voice and strategies employed to retain power; 'the Voice & Me' considered the union that was apparent as well as participants' rejection of this concept; 'Impact on Self' encapsulated the emotions, processes and attributes which were evident, and 'A social experience' described associations between the voice experience and social context. The concept of a 'relationship' was both accepted and rejected by participants. Acceptance was considered in terms of coping with the experience. Rejections were considered in terms of preservation of self-hood and conflict with personal explanatory models.

Conclusions  This study throws light on the complexity of the voice experience for hearers. The ambivalence of 'relationships' with voices has implications for intervention beyond a medical framework. Working with this group of service users within a 'relationship' frame may ameliorate distress, however this concept needs to be posed as a possible rather than an established conceptualisation.
INTRODUCTION

Overview
Hearing voices is not a new phenomenon; the originators of three world religions (Jesus, Mohammed, Moses) were all reported to have heard voices that guided them (Davies, Griffin & Vice, 2001). However, within British society a glance at the media coverage of fatal incidents reveals the negative stereotypes prevalent today about people with schizophrenia and mental health problems in general (Hannigan, 1999; Sieff, 2003), and more specifically voice hearers (Leudar & Thomas, 2000). Perceptions of voice hearers as dangerous and requiring cure, arguably underlies the medical approach in treating such individuals. However there has been a shift in how this experience is being understood and the focus has turned to the meaning the individual attributes to their experiences. Within psychological research specifically, interactions between the individual and their voice have taken prominence. This study hopes to contribute to this body of research by considering individuals' awareness of and views on having developed a 'relationship' with their voice.

Prior to exploring this in more detail some of the literature relevant to this area of work will be reviewed. It will consider variations in the voice hearing experience between and within individuals, reviewing the meaning individuals ascribe to their experiences. It will then consider the experience interpersonally exploring relevant psychological mechanisms used to understand voice hearing. Finally, the body of work concerned with positions individuals take in relation to their voice will be considered. Throughout, the experiences of clinical voice hearers will be privileged over hearers who do not access services, due to practical restraints.

Psychiatric as well as psychological narratives on voice hearing have great importance as they largely determine what happens to people in services (Leudar & Thomas, 2000). As voice hearing is commonly explained as an auditory verbal hallucination and a symptom of schizophrenia, this introduction will begin with a brief review of the development of schizophrenia as a diagnostic concept to place this research in its historical context.

Voice hearing and schizophrenia
In the early 1900s Bleuler introduced 'schizophrenia' into the medical field to describe a dissociation of mental functions (Barham, 1995). Its use fitted the psychiatry-
dominated institutions prevalent during its inception, where ideas of incurability were commonplace (Barham, 1995), and even today it implies an underlying biological disease with severe chronicity and poor prognosis (Jackson, 1995), encouraging some to use "psychosis" as a less dehumanising description of unusual experiences (British Psychological Society, 2000). Auditory hallucinations are thought to occur in 63% of those diagnosed with schizophrenia (Slade & Bentall, 1988, in Morrison, 2002) making it one of the most common experiences reported, with prevalence rates varying between 10 – 39% (Wykes, 2004). Within the diagnostic systems used in mental health services three types of auditory hallucinations are suggestive of a diagnosis of schizophrenia: voices speaking thoughts aloud, voices running a commentary about thoughts or actions, or voices discussing the individual in the third person.

Recent guidelines for the management and treatment of schizophrenia in the community (NICE, 2002) devote almost half of the document to pharmacological interventions (Barker & Buchanan-Barker, 2003). This is reflected in services and some professional training: historically the advice has been to promote reality and discourage talking about voices or their content (Coffey, Higgon & Kinnear, 2004). My\(^1\) own clinical experience suggests that this traditional medical approach to voice hearers is still prevalent. This approach is founded on the belief or fear that listening reinforces the credibility and power of an apparently non-existent world (Romme & Escher, 2000), which would have detrimental consequences, particularly where command hallucinations were prevalent (Leudar & Thomas, 2000). Such fear appears to underpin the medical approach that aims to dampen down or eradicate the experience. Yet reports suggest that 20-50% continue to hear voices despite taking neuroleptic medication (Newton et al., 2005). The work of Chadwick and Birchwood (1994) has been pioneering in enabling professionals to talk to their clients about their voices. Their work shall be considered shortly, following a discussion of the existence of voices outside of a psychiatric framework.

**Voice hearing beyond psychiatry**

Romme and Escher (1989) have been instrumental in reframing voice hearing beyond the diagnosis of schizophrenia and describe individuals appearing to have

\(^1\) This study will be written in the first person to acknowledge how my own values/beliefs contributed to the research process.
the characteristics of auditory hallucinations that do not fulfil the criteria for schizophrenia (Romme & Escher, 2000). Johns, Nazaroo, Bebbington & Kuipers (2002) confirmed this in their study of hallucinatory experiences in a community sample. The authors acknowledged their failure to control for illicit substance use which, given the increasing use of mind-altering drugs in society, has implications for the validity of their results. Their findings nonetheless suggested that only 25% met the criteria for a diagnosis of psychosis. 56% met the criteria for an affective disorder suggesting that these experiences are not limited to the psychiatric classification of schizophrenia. Furthermore 19% failed to meet criteria for any psychiatric disorder. Indeed voice hearing occurs as a consequence of physical complaints such as tinnitus (Johns, Hemsley & Kuipers, 2002) and within religious populations (Davies et al., 2001), but estimates indicate that in only 30-40% of cases has the impact been significant enough to warrant professional help (Romme & Escher, 1989; Tien, 1991).

The above findings suggest that in contrast to the psychiatric categorical approach a continuum model of voice hearing is more appropriate (Johns, Helmsley et al., 2002) whereby such experiences range from healthy functioning through to eccentricity, towards a more florid presentation (Peters, Day, McKenna & Orbach, 1999). Consideration of voice hearing within a continuum model allows for further exploration of this heterogeneous group and the variations that have been identified shall now be briefly explored.

**Variation amongst hearers**

The incidence of voice hearing can vary according to a range of demographic variables. Young men aged 25 – 30 were more likely to report auditory hallucinations than women or other age groups in Tien's (1991) survey. Ethnicity variations also exist and when compared to their White or South Asian counterparts, individuals of Caribbean descent are respectively two or four times more likely to report hallucinations (Goater et al., 1999). This finding suggests a role for social factors similar to those which account for increased rates of psychosis amongst minority groups born in the UK (Mahey, Mallet, Leff & Bhughra, 1999). Social context at a more micro level is also thought to be influential and up to 80% of hearers have reported loneliness to worsen their experience (Nayani & David, 1996).
Voice hearing varies according to intra-personal factors and a range of emotional changes both precipitate and follow the experience (Johns, Hemsley et al., 2002). Although a negative emotional response is not a given amongst service users (Nayani & David, 1996), it is more likely (Johns, Hemsley et al., 2002) and service using voice hearers are more likely to feel frightened and perceive the experience negatively (Jones, Guy & Ormrod, 2003). Understanding why and how individuals report differing responses to their voices has become a significant development in the voice-hearing field and the meaning attributed to the experience has been considered.

The impact of meaning on the voice hearing experience

The cognitive model

Using the cognitive model as traditionally applied to affective states, Chadwick and Birchwood (1994) were pioneering in their novel approach to voice hearers. They proposed that the response of voice hearers derived from the beliefs individuals constructed about their voices, rather than being influenced by other features such as form or content. Their study identified that in approximately one-third of participants, incongruity was evident with content and the person’s affective state and behavioural response. They give an example of a voice that told one participant to ‘be careful’ that was construed as a malevolent witch, initiating fear in the respondent. Instead, specific beliefs regarding the power, purpose and identity of the voices were found to produce a more consistent perception of the voice as either malevolent or benevolent and, in line with the cognitive model influenced the behavioural response of engagement or disengagement with the voice. Where beliefs of malevolent intent dominated anxiety, anger and depression were triggered and the hearer was likely to cope by disengaging or resisting the voice. In contrast beliefs of benevolence evoked amusement and promoted engagement.

Studies have provided empirical support for the role of beliefs in mediating interactions with the voice. Birchwood and Chadwick (1997) interviewed 62 (mostly male) voice hearers with a number of measures, including the Cognitive Assessment Schedule (CAS; Chadwick & Birchwood, 1995) and the Beliefs about Voices Questionnaire (Chadwick & Birchwood, 1995) to assess the characteristics of the voice and associated beliefs. All participants were more likely to engage with the voice if they believed it to be benevolent. Where beliefs of malevolence were present
resistance was reported, with only 7% of participants in this category reporting engagement. In cases of benign appraisal, a variety of strategies were employed. Beliefs also correlated significantly with affect. For example, malevolent voices were associated with negative affect. In only 24% of cases did beliefs derive directly from voice content.

Van der Gagg, Hagemann and Birchwood (2003) recently provided confirmation that emotional and behavioural responses have more direct associations to appraisals of voice purpose and power. However this does not detract from a number of limitations that have been identified regarding the diversity of Birchwood and Chadwick's sample and their focuses on power and dominance, and malevolence and benevolence. Each of these shall now be briefly considered.

Limitations of Birchwood and Chadwick
Firstly, the authors failed to provide specific details of the ethnic variation in their sample, which considering the findings of Goater and colleagues (1999) discussed earlier is limiting. Secondly, participants were asked to hold in mind the most 'powerful' or 'dominant' voice whilst completing the measures. Undoubtedly this was to help eradicate confounding variants, which is a necessary requirement for quantitative methodologies. It is nonetheless unsurprising that such large percentages of participants identified their voice as 'very powerful' (89.3% where malevolent beliefs were held, 82.4% and 64.7% for benevolent and benign beliefs, respectively). In addition, terms such as 'powerful' and 'dominant' have been assumed to be synonymous and the authors have ignored the possibility that each concept might have a different meaning for individuals. Moreover, restriction to the most powerful/dominant voice presents a somewhat limited view of voice hearing, leaving experiences beyond power and/or domination unexplored. Finally, a fundamental criticism that has been levied at cognitive approaches is also applicable here and that is its assumption of linear causality without any clear evidence to support this. Thus whilst the significant correlatory findings implicate an association between beliefs, affect and response, the direction of this correlation cannot be accurately defined.
Replicating the findings

Initial replications of Chadwick and Birchwood's (1994) findings by Close and Garety (1998) have added further insight to the field. Their sample of 30 voice hearers ranged in age from 19 to 69 and the authors report that 83% were of white European origin (1998). Using identical measures, their results supported Chadwick and Birchwood (1994) regarding behavioural response whereby malevolent voices were resisted and benevolent voices were engaged. However they identified a more central role for the content of the voice, with correlations between positive content and benevolent beliefs, and negative content and malevolent beliefs evident for all participants. Moreover, negative affect was not dependent on beliefs and they suggest that the voice experience in itself was sufficient to evoke negative affect, even where voice appraisals were of benevolence. Ambivalence was also identified with regard to the voice's intent and 46% of their sample remained uncertain, whilst 30% believed the voice to have mixed intentions. The authors concluded that the measures used were unable to capture the range and complexity of beliefs that participants may hold with regard to their voices.

Close and Garety (1998) attempted to account for the different results found by themselves and Chadwick and Birchwood (1994), by considering the number of years participants had heard voices. For Close and Garety the range was 6 months to 40 years. In contrast Chadwick and Birchwood (1994) reported that participants had been hearing voices for at least 2 years. Close and Garety hypothesise that beliefs about the voice experience fluctuate over time quoting one participant who initially viewed his voice as powerful but at the time of the study described resignation and sadness with their incessant presence.

Birchwood and Chadwick's (1997; Chadwick & Birchwood, 1994; 1995; Chadwick, Birchwood & Trower, 1996) contribution to the field cannot be underestimated in identifying the range of beliefs that individuals can have about their voice, such as beliefs in the voice's identity, omnipotence, malevolence and benevolence. However as Close & Garety have stated: "the specific categories identified by Chadwick & Birchwood do not appear to encapsulate the whole range of beliefs about voices identified by those who hear voices" (1998, pp.185). Furthermore, Close and Garety's findings that voice content is also integral to beliefs and behaviour cannot be ignored. But what of the content of voices? What is it that hearers hear? Whilst a
wide range of material has been reported, links are frequently made between voice content and aspects of the hearer's past and present life. It seems then that the voice has interpersonal significance for the hearer. This hypothesis will now be explored.

An interpersonal event

Clinical material suggests that voice content can be related to earlier interpersonal experiences. Within Romme and Escher's (2000) sample, over half of hearers were able to link voice onset with an earlier traumatic event. Read, Agar, Argyle, and Aderhold (2003) provided strong evidence that auditory hallucinations are often associated with a history of sexual and physical abuse in child and adulthood, with 52% of survivors of child sexual abuse reporting hallucinations compared to 18% where abuse was not evident.

The experience is not only associated with interpersonal events but also with specific qualities identified in social others. Hearers report the recurring presence of particular 'individuals' (voices) to which they have ascribed stable identities (Leudar, Thomas, McNally & Glinski, 1997). Properties of the voice are used to distinguish one voice from another including the tone of the voice and the assumed gender (Leudar et al., 1997). Whilst the identity of particular voices can be described as someone 'out of this world' (e.g. the devil; Johns, Hemsley et al., 2002) many hearers report the voice to have characteristics of people known to them and recognise the voice as someone in their social world (Leudar & Thomas, 2000). Accordingly variation exists amongst hearers: young people are more likely to report a young voice with some suggestion that the voice ages with the individual (Nayani & David, 1996). Work by Garrett and Silva (2003) has supported these interpersonal attributions, with the suggestion that cognitive judgement errors might partly account for the conclusion that the voice presents as similar to a real person.

Hearers have described their experience as voices talking to them as if in conversation (Nayani & David, 1996). Furthermore hearers respond back (Leudar et al., 1997) causing some to suggest that the construal of the voice as possessing human-like qualities facilitates the development of emotional, interpersonal relationships with the voice (Garrett & Silva, 2003). Where such relationships have been considered possible, some theorists have attempted to understand notions of
the hearer's self-hood before understanding how this 'self' then begins to relate to another.

The development of the self

Lysaker and Lysaker (2002) have framed voice hearing (and more generally psychosis) as a skewed aspect of self-experience. In exploring this they drew on the work of theorists such as Nietzsche (1886) who conceptualised the self as inherently dialogical and the product of ongoing conversations both within the individual and between the individual and others. Thomas (1997), also concerned with developing an interpersonal understanding of voice hearing, considered the work of Mead (1934, in Thomas, 1997). Mead argued that inner speech was used to talk to oneself as if talking to another person. He highlighted the similarities between processes of self-awareness and relationships with other people, proposing that reflexivity was essentially equivalent to the self relating to itself as both a subject and object. For Mead this was only feasible through indirect experience of ourselves from the feedback obtained from others. Thus a dialogue is established between the self ('I') and 'others' view of ourselves ('generalised other').

Both Thomas and Lysaker and Lysaker also draw on the work of Bakhtin (1986 in Thomas, 1997) who highlighted the centrality of social context in spoken language. Thomas utilises these theories to suggest how a voice may be identified as an 'other' within the self with whom a dialogue can be maintained. Within this dialogue facets of the individual's social relationships from the past and present can be identified, as the literature presented earlier supports.

An unwanted self experience?

Interpersonal theorists from analytic backgrounds also suggest that the self is made up of symbolic representations of significant others who have been internalised (Lemma, 2003). Respondents in Nayani and David's (1996) study elucidate this: the critical voices described could be the internalisation of an authoritative other. In addition the voice may represent facets of the self that could not be tolerated, with the hearer finding it easier to attribute unwanted features of the self in others (Benjamin, 1997). The Kleinian process of 'projective identification' encapsulates this process. Projective identification refers to a primitive defence mechanism, whereby unwanted feelings and aspects of the self are 'split off' and identified as belonging to another
(Klein, 1957, in Lemma, 2003). Confusion is then experienced regarding differentiations between self and other, and between internal and external (Lemma, 2003). Theorists from this school would suggest that projective identification is widely employed amongst us all to cope with difficult feelings. The voice hearer however, would be using it to excess to protect against and manage intense anxieties (Jackson, 1995).

Having considered the development of the ‘self’, and how this might contribute to both the development of the voice and the content of what is heard, it is necessary to explore in more detail how the hearer’s ‘self’ relates to this voice as an ‘other’.

**Voice hearing and interpersonal relating**

Specific exploration of the existence of a relationship between the hearer and their voice began with Benjamin (1989) who reported the existence of interpersonally coherent relationships between the hearer and their voice. Benjamin was concerned with the aetiological role of social factors in schizophrenia, proposing that psychosis was an adaptive response to an impoverished social environment.

Using measures based on a validated model of social interactions, Benjamin surveyed 30 in-patients who reported auditory hallucinations, although did not report their gender, age or ethnicity. Whilst Benjamin did not specify whether the hallucinations were verbal and did not provide any descriptions of the content of their experiences, participants were reported to easily complete questionnaires where self – other relationships were explored suggesting that it was voices that were heard. Thus participants were asked to rate views of themselves in relation to perceptions of both social others and their voice as an ‘other’.

Participants were free to rate their interpersonal experience of their voice as non-existent, which none did, implying that for all participants, an interpersonal framework was a meaningful one. Furthermore the structure of the relationship developed with the voice bore similarities to those developed in social relationships where complex dynamics are evident. Benjamin utilised qualitative data to explore her findings, although she failed to provide details of the analytic process employed. Nonetheless she concluded that the relationship with the voice functioned to define the self in
more acceptable terms than social relationships and suggested that interventions would need to focus on "more satisfactory social alternatives" (p.308, 1989).

Complex emotions held in relation to the voice were also apparent in Romme and Esher's (2000) sample where hearers described companionship obtained by the voice despite the distress it also generated. Such relationships may be adaptive allowing the individual to reduce any distress associated with the experience. Both findings complement the work of Chadwick and Birchwood (1994) where incongruity between content and response were evident. In support of Close and Garety's (1998) work Benjamin also asserted a significant role to the content of the voice, reporting it to be integral to reported distress and relationship perceptions. Thus where voice content was negative hearers were likely to perceive the voice as controlling and hostile and attempt to retreat away from the voice.

The significance of control and power, as implicated in Chadwick and Birchwood's work has been developed further by Birchwood, Meaden, Trower, Gilbert and Plaistow (2000), who considered the genesis of power appraisals to further understand the relationship between the voice and the hearer.

Exploring the dynamic of the relationship: the role of power
Birchwood et al. (2000) utilised theories of social rank (Gilbert and Allen, 1998) to examine the voice relationship, exploring how conditions of entrapment and dominance as processes might explain the behaviour of voice hearers with negative voice perceptions.

Gilbert and Allen's (1998) social rank theory describes the evolution of psychological mechanisms to elucidate societal hierarchies and inequalities. They suggested that those with enhanced strengths and skills were located in higher social positions enabling them to exert power over those less able. For the subordinate individual, where perceptions of safety were prevalent, care was elicited from the other. However perceptions of threat activated defence responses where feelings of entrapment and humiliation, as well as submissive behaviour were instigated. They also argued that the individual was likely to comply to others' demands where perceptions of domination existed.
Birchwood et al. (2000) hypothesised that similar mechanisms occur where hearers report distress from voices they perceive to be hostile. In this regard the voice in its attacking and critical form is viewed as being in the superior position, lowering the voice hearers self esteem and instigating negative affect. The individual responds to this internal state by submitting as they would in an external social situation. In addition they proposed that these processes would be mirrored in social relationships.

Investigating this empirically, they specifically aimed to determine correlations between perceptions of differences in social rank and power between the individual and their voice and between the individual and social others. A specific measure of power differentials was developed which incorporated constructs relevant to social rank theory such as superiority and respect, requiring participants to rate themselves in relation to their voice and a significant social other on a 5 point Likert scale. Measures of social rank, voice topography and beliefs about their most powerful voice were also obtained, and in support of Birchwood et al.’s (2000) hypotheses, the results obtained indicated that voice hearers perceived themselves to be of lower rank and hold less power than the voice. Similarly voice hearers' perceptions of social rank and social power were also low compared to their ranking of significant others in their social world.

Birchwood et al. (2000) argue that subordinate positioning to the voice is the likely result of a core self-perception of lower social rank thus integrating cognitive models with the social constructions of self models described earlier. Such a model might derive from early care-giver relationships (Drayton, Birchwood & Trower, 1998) or from the onset of psychosis itself and subsequent social outcomes such as involuntary admission, loss of roles, increased stigma and social oppression (Birchwood, Meaden, Trower & Gilbert, 2002). As such beliefs about voices may change over time as the relationship develops further (Birchwood & Chadwick, 1997; Close & Garety, 1998) or perhaps as social positioning is altered. Birchwood et al. (2000) utilise literature examining the higher incidence of psychosis in Black Britons relative to white British or indigenous Caribbean populations (Harrison et al., 1997) thought to be associated with low social status and oppressive practices in the UK (Bhughra et al., 1997; both in Birchwood et al., 2000). The inclusion of ethnicity figures or data indicative of social class would have helped to confirm their theory as
they could have examined associations between these two variables and perceptions of rank and power.

This model is supported by hearers' descriptions of voice identity. Where hearers have reported that the voice accent differed from their own, there was a tendency for it to be perceived as coming from a higher social class (Nayani & David, 1996). Together with the preponderance of male voices reported (Nayani & David, 1996) there is some suggestion of those who constitute the powerful groups in society being more frequently represented as voices. Empirical findings also support the model and for voice hearers with a diagnosis of schizophrenia disengagement with their voice, the 'flight' response, derives from perceptions of the voice as powerful, dominant and hostile (Gilbert et al., 2001).

As before the findings refer only to hearers' most 'powerful' voice arguably introducing bias into their findings. The authors counter this critique by suggesting that it is this dominant voice that results in distress and is therefore of most clinical significance. Nonetheless it does not allow for exploration of relationships with all of client's voices as suggested by Vaughan and Fowler (2004).

The argument for conceptualising the dynamic between a voice hearer and the voice as a relationship has been well considered with regards to power and submission. However psychological perspectives on relationships encompass dimensions beyond this (Dallos & Dallos, 1997). In particular ideas of intimacy and attachment are often utilised by interpersonal theorists (e.g. Bowlby, 1969). As was highlighted previously, the development of a sense of personal intimacy has been implicated in the voice hearing literature and so warrants further exploration alongside the established knowledge regarding power. Birtchnell's (1996, 2002) theory of relating encapsulates both of these facets and shall now be explored, followed by applications of this model to voice hearers.

**Birtchnell's Interpersonal Theory**

Birtchnell's (1996, 2002) theory of relating is useful in that it integrates theories of power like social rank theory with a model of the closeness or attachment which voice hearers describe. In addition it describes the reciprocity of the process – that is it speaks of relating and being related to.
Birtchnell argues that relating is an inevitable process because of the constant development of feelings and attitudes in response to the presence of others. He suggests that relating occurs on two orthogonal axes: the horizontal proximity axis characterised by closeness and distance, and the vertical power axis of upperness and lowerness.

Summary of the states
With closeness the individual is predisposed to be with others, seeking close proximity and involvement with the other and often receiving confirmation of ones existence. Attachment theory (Bowlby, 1969) is an established example of this state and empirical literature supports this assertion. Where distance is chosen, individuals are seeking solitude and separation from others, possibly to reinforce their sense of selfhood. The attachment literature also supports this position. For example once a secure base has been established an infant will seek individuation from its caregiver (Ainsworth, 1985). Positions of upperness are relative requiring others to be lower for this position to be attained. Upperness predominantly involves having the power to influence another and tends to generate feelings of superiority. In contrast, lowerness is not necessarily a sign of inferiority as help seeking is inevitable and deference and compliance are essential for society to function (Birtchnell, 1996). This position evolved out of a condition of being parented and so feelings of security and satisfaction can also be gained.

Each state has its own advantages: one might choose distance over closeness in the 'fight/flight' dilemma where 'flight' is chosen (Birtchnell, 1996). Furthermore, whilst the states have been differentiated, Birtchnell suggests that they are not oppositional: for example one can feel simultaneously close and distant to another, such as an individual in a loving couple relationship who enjoys spending time alone. He also describes intermediary positions between the 4 states resulting in an interpersonal octagon.

Birtchnell argues that although relating can be objectively identified, one can also perceive being related to by another, as did the hearers in both Benjamin (1989) and Birchwood et al.'s (2000) studies. In addition, the states of relating are hypothesised
to develop over time. Indeed where onset of voices was recent in Nayani and David's (1996) sample, a dialogical relationship was less likely to be reported.

As with Drayton et al. (1998) Birchwood looks to early socialisation experiences to account for the positive or negative relating styles of individuals. Thus the relating of a well-adjusted individual is described as positive: the person is comfortable with and competent in maintaining particular relating positions. Where early experiences are impoverished, negative relating dominates. Here the individual tends to relate inflexibly and is not always responsive to others' relating needs. Birtchnell's interpersonal octagon has been presented below with examples of both positive and negative relating (Figure 1).

Figure 1: The Interpersonal Octagon (adapted from Birtchnell, 2001, pp.67)

P = examples of positive relating characteristics; N = examples of negative characteristics

![Interpersonal Octagon Diagram]

- **UPPERNESS**
  - P = advising
  - N = bullying, domineering

- **DISTANCE**
  - P = respectful of own & others' space
  - N = suspicious, uncommunicative

- **CLOSENESS**
  - P = openness & sharing
  - N = fear of separation, imposing

- **LOWERNESS**
  - P = seeking help/guidance
  - N = insecurity/self-accusation

- **Upper distant**
  - P = maintaining order
  - N = suppressive, exploitative

- **Upper close**
  - P = nurturing, protective
  - N = restrictive, intrusive

- **Lower distant**
  - P = obedient/respectful
  - N = withdrawn, subservient

- **Lower close**
  - P = seeking protection & care
  - N = fear of abandonment/rejection

195
Empirical evidence for Birtchnell’s relating in hearers

Having adapted measures designed by Birtchnell to assess maladaptive styles of relating in couples, Vaughan and Fowler (2004) surveyed 29 hearers to investigate perceptions of interrelating and how these related to distress. Characteristics of negative relating were examined exploring concepts such as those presented in Figure 1, with each rated on Likert scales. Higher scores were indicative of a greater tendency to relate from that position. Assessments of beliefs about voices, mood and subjective measures of distress were also analysed.

Their results supported Chadwick and Birchwood’s (1994) findings regarding power, as perceptions of the voice relating from an ‘upper’ position were significantly associated with distress, accounting for greater proportions of distress than perceptions of malevolence. Voice upperness also correlated significantly with perceptions of voice malevolence and benevolence leading Vaughan and Fowler to suggest that “it is not the perceived powerfulness of the voice per se that is problematic, but perhaps the way in which the voice is perceived to use its power” (p.150, 2003; italics in original). Hearer lowerness and distress were also correlated but an inverse relationship was identified: the more distressing the individual rated the experience the less likely they were to relate from a lower position. As can occur in social relationships this ‘couple’ had therefore reached the systemic principle of homeostasis (Vetere & Dallos, 2003) and Vaughan and Fowler suggest that what might be perceived by others as dysfunctional (e.g. submissiveness) was functional in their relationship, possibly decreasing the distress associated with the voice hearing experience and maintaining the hearer’s self esteem.

The proximity axis was also implicated and perceptions of the hearer relating from a position of distance had equally large and significant positive correlations. Internal reliability was not obtained on the voice distance subscale and so this was not analysed. Indeed the authors acknowledge that their findings need to be considered in the context of the reliability and validity of the new relating scales they devised. Moreover, as with Birchwood et al. (2000) only current relationships with the predominant voice were investigated limiting the validity of their findings in its ability to capture the extent of the voice-hearer relationship.
Relating to voices and social relating

Associations between voice and social relationships beyond Birchwood et al.'s power and rank dimensions have recently been identified, also within Birtchnell's interpersonal frame. Hayward (2003) sought to explore the unidirectional relating of the voice hearer to the voice and social others, using identical measures to Vaughan and Fowler. Within the power axis positive correlations were obtained between relating from an 'upper' position to the voice and to social others, although the internal consistency of the upperness scale limit the reliability of the findings. Trends towards significance for relating from 'lower' positions were also identified.

With regard to the proximity axis associations between relating from positions of 'closeness' to the voice and others was significant. However correlations between voice and social relating from a position of 'distance' were not significant and Hayward suggests that this relating style may be a unique feature of relating to the voice. As with Close and Garety's findings voice content was implicated: where voice content was negative, hearers were more likely to relate from a distant position. In addition voices for which the identity was unknown were also more likely to initiate hearer withdrawal and Hayward suggests that both variables in combination are likely to be relevant.

A limitation of Hayward's work is that perceptions of the voice relating to the hearer were not explored. Furthermore as with all correlatory studies ambiguity exists about the direction of the associations: do social relating patterns influence relating to the voice or is the reverse true? Interpersonal theorists suggest that influential early experiences contribute to the development of relating templates or schema (Birtchnell, 1996; Lemma, 2003) suggesting that relating styles used with the voice reflect general relating schema used in the social network.

Clinical relevance

Exploring the meaning attributed to voice hearing is particularly relevant given the limitations of behavioural approaches in eradicating voices (Leudar & Thomas, 2000) or ameliorating distress (Tarrier, 1994). Eliciting meaning from the voice hearing experience, particularly during the initial stages, can help the individual to decrease their anxiety (Romme & Escher, 1989). Indeed amongst religious, service-using and non service-using voice hearers, psychological narratives featured prominently in the
explanatory frameworks used to describe the experience, as identified in a qualitative analysis by Jones et al. (2003).

More specifically employing an interpersonal framework is likely to offer new therapeutic tools to clinicians working with voice hearers. The cognitive models have demonstrated the efficacy of addressing the power dynamic in the hearer–voice relationship with individuals (Trower et al., 2004) and with groups (Wykes, Parr & Landau, 1999). Newton et al. (2005) investigated the efficacy of group cognitive-behavioural therapy (CBT) for early onset voice hearers and reported trends for increased perceived control over the voices, with significant correlations with decreases in reported distress. They also observed trends towards decreases in perceptions of voice power, although this was not associated with lowered distress. Birchwood et al. (2002) provide case examples where instead of targeting the relationship with the voice, social empowerment was the focus of therapy where low perceptions of rank and power with regard to their voice and others were evident. The authors suggested that modifying social relating might enhance the individual's self-esteem and consequently alter perceptions of the voice and reduce distress.

Whilst the above appear promising, Turkington, Kingdon and Chadwick (2003) have commented that the published CBT studies for voices have utilised poor comparative therapies as controls and present ambiguity regarding the 'active components' of therapy. Longitudinal studies are also required to assess the approach's advantage over other therapies, particularly in the long-term (Wykes, 2004).

Leudar and Thomas (2000) have levied more fundamental criticisms at the cognitive approach. They argue that the psychologist's account of voice hearing is privileged at the expense of the individual's explanatory framework when beliefs about voices are challenged in this way. They suggest that personal explanations about voices are akin to personal narratives and that ignoring and undermining these denies the complexity of the experience, particularly when one considers that the voice is used by some to achieve resolution over deep-seated personal issues (Knudson & Coyle, 2002). The view of one voice hearer obtained in a qualitative analysis of the experience of CBT supports this, presenting a discourse of CBT as 'compliance with the powerful medical establishment' rather than as a healing process (Messari & Hallam, 2003).
When considering the clinical implications of their findings, Vaughan and Fowler (2004) emphasise that opportunities exist for modifying the relationship with the voice. Leudar and Thomas (2000) report on the use of such an approach beyond the 'predominant voice' that has been the focus of previous studies. In their work with a voice hearer 'Peg' they describe facilitating the formation of dialogically different relationships with her voices resulting in reductions of reported distress. They provided her with the option of considering and making judgements on the content of the voice and encouraged her to rehearse responses to the voices "like learning the lines of a play" (p. 136). Arguably Leudar and Thomas' approach is a form of increasing the upper relating state of the individual by empowering them and providing a form of social skills training which has been suggested by others (Hayward, 2003).

What do voice hearers make of it?
The studies described thus far suggest that an interpersonal framework might be useful for voice hearers. At this point however the framework could be viewed as another narrative that has been ascribed to the voice hearing experience by mental health professionals. That hearers were able to rate their 'relationships' with ease (such as Benjamin's study) and that significant statistical findings have been obtained suggests that it is a meaningful explanatory model. However at present it is unknown whether the approach is meaningful for the hearer and whether hearers ascribe to this model to understand what exists between them and their voice. As such the word 'relationship' will be placed in quotation marks when referring to the dynamic between the voice hearer and the voice to acknowledge that this may not have truth status for them.

Rationale for the present study
The relevance for this study has been developed in that: i) a number of researchers have highlighted the need for continued research into the experiences of voice hearers; ii) specific reference to the existence of a meaningful relationship is a concept that at present belongs to the academic field; contributions of the hearers themselves to this field have been primarily restricted to quantifiable data or clinical material. iii) existing investigations have focused on current, negative relating with a dominant voice. Exploring other aspects of relating is likely to widen this debate...
further; iv) suggestions for the use of a relating therapy are restricted by an absence of the type/form of questions that could be asked.

Research aims
This study aims to provide a greater understanding of the experiences of voice hearers and their perceptions of any 'relationship' with the voice(s) they hear, thus enhancing existing knowledge. Specifically it aims to explore whether (and the extent to which) participants are able to describe interpersonally relating to their voice as they would relate to a person in their social world. In addition it aims to pilot questions used as to their suitability for exploring this area with participants.

Research questions
1. What sense does it make for an individual to consider their experiences of hearing voices within a relational framework?
   a. What might be the form of a relationship with a voice/voices?
   b. To what extent are aspects of power relevant to the hearer?
   c. To what extent are aspects of intimacy relevant to the hearer?

2. If a relational framework is meaningful for them, how do voice hearers understand how this relationship developed?
   a. What do hearers understand to be their role in this relationship?
   b. What impact does this have on them as a person?
   c. To what extent has this relationship changed over time?

3. To what extent do any relationships with voices compare to social relationships in the hearer's past or present?
METHODOLOGY & METHOD

Methodological Rationale
Existing empirical investigations have produced statistically reliable and valid results, however these have limited exploration of how such experiences might be understood from the individual's perspective. Qualitative methodologies value the meaning participants ascribe to particular events or experiences (Henwood, 1996) and are interested in how they make sense of the world (Willig, 2001). The resulting data is acknowledged to be the product of a dynamic interaction between meanings ascribed by participants and the researcher's interpretations. This gives participants some influence in challenging assumptions about the meaning and relevance of concepts (Willig, 2001), providing an opportunity for those who are traditionally excluded from academic discussions to make some contribution.

Underlying epistemological assumptions
Qualitative methodologies are underpinned by a range of epistemological assumptions (Henwood & Pidgeon, 1994). Epistemology refers to the theories made about knowledge, in particular what (and how) knowledge can be established about the world (Willig, 2001). Willig acknowledges three epistemological positions. The realist approach aims to discover valid representations of social phenomena within the individual and in the "objective" world. At the other end of the epistemological continuum is the social constructionist position where an individual's experience is seen to be constructed through language rather than representing an objective reality.

The position taken for this study was critical realist (constructionist), which shares some features with the two previous positions. This position argues for the existence of representations of social and psychological phenomena accessible through conversation. Thus what a respondent says is related in some way to beliefs or narratives they hold about themselves and has some significance for them in their life. Such representations are not objective but are mediated through culture, language and political interests, rooted in aspects of diversity such as gender and ethnicity (Smith, 1995). However the main mediating factor is the interpretative framework of the researcher and as stated previously it is vital that the researcher asserts the perspective which underlies any resulting analysis. According to
Charmaz (1990) this includes personal values, interests and experiences which guide the questions asked and the conclusions drawn. In this regard it is important to state my own assumptions and values in so far as this is possible (King, 1996).

**My position as researcher**

I am a 27-year old, female, Black trainee clinical psychologist. My interest in severe and enduring mental health problems has been influenced by the experiences of a family member who was also a service user. I became sensitised to the discrimination and stigma this client group faces and the similarities this had with experiences I and others close to me had as Black Britons. This in turn fuelled my interest towards a reframe of experiences away from medical models, which seem to contribute to unhelpful labelling processes.

My specific interest in voice hearers was sparked during my first training placement and I can recall my fascination when a client described this seemingly abstract phenomenon. One particular session with a hearer resonates, where we were able to moderate the volume of the voices running commentary during our session. Hopefully I have developed my fascination into a genuine curiosity for this experience. I have been particularly inspired by the existence of the Hearing Voices Network where voice hearing has been construed as an experience that can be understood within a range of explanatory frameworks.

**Rationale for Interpretative Phenomenological Analysis (IPA)**

IPA provides a systematic approach to the analysis of qualitative data (Smith & Osborn, 2003). Its aims match those of this study; that is to explore and interpret the meanings participants ascribe to particular experiences in their social and psychological world (Smith & Osborn, 2003).

Other constructionist approaches were not considered appropriate for this study. For example Grounded Theory is used primarily to establish new theories (Willig, 2001), which was not the aim here. Other established qualitative methods such as Discourse Analysis (DA), derive from other epistemological positions (e.g. DA sees meaning as socially constructed) and so were disregarded.
Rationale for semi-structured interviewing

In order to encourage participants' meaning-making to be explored a flexible approach to data collection was required. Semi-structured interviewing fulfilled this aim by guiding the questioning for the researcher (Willig, 2001). Arguably, it is the most appropriate method for a study using IPA (Smith & Osborn, 2003), as it allows the "respondent (to share) more closely in the direction the interview takes (allowing them to) introduce an issue the investigator had not thought of" (Smith, 1995, pp.12).

Construction of the interview

The construction of the schedule followed guidelines for semi-structured interviews developed by Smith (1995) and Willig (2001). The main function of the tool was to guide rather than dictate the interview (Smith, 1995), obtaining participants' attitudes about the area of enquiry, as well as helping to predict difficulties with wording questions (Smith, 1995).

The development of the schedule occurred as follows:

i. A brainstorming of the research proposal and relevant literature occurred resulting in areas that the interview would cover. For example following a review of Hayward's (2003) work it was considered important to explore participants' attitudes towards the relationship with the voice in comparison to relationships with social others.

ii. These different areas of enquiry were sequenced with regard to sensitivity and complexity. Thus those topics that I assumed to be least sensitive were placed earlier in the schedule. Similarly, those aspects that I assumed to be more complex and/or abstract were placed towards the end of the schedule.

iii. Questions were developed on the basis of these areas of enquiry and sequenced accordingly. Questions were designed within a framework of genuine curiosity to encourage participants to share their views; those that may have appeared too probing were avoided. To facilitate this the questions followed Smith's (1995) suggestion that they should be open-ended.

iv. To increase the validity of the tool, feedback was obtained on the proposed topics and questions from two clinical psychologists with expertise in the field. Amendments were made to the schedule on the basis of their suggestions.

The main topics included in the schedule were as follows:
Construction of the schedule was an evolving process which underwent constant review as my thoughts about the research developed. A copy of the final schedule used can be found in Appendix 1. It was anticipated that the interviews might be shorter than in other studies utilising IPA, as people with psychosis can find an interview situation overly demanding (Fowler, Garety & Kuipers, 1995).

Procedure

Ethical approval
Ethical approval was obtained from the university (Appendix 2) and from the Research & Development (R&D) committee and the NHS local research ethics committee (LREC) in the area from which the participants were recruited (Appendix 3). Consultation with the local Service Users Consultation Forum also occurred, achieving approval for the research design.

Inclusion and exclusion criteria
3 community mental health teams (CMHTs) in an outer London borough were approached. Participants were considered eligible for the study if: they reported
hearing voices for a minimum of 12 months; they were in receipt of clinical care for this experience; their experiences had been confirmed by a consultant psychiatrist; they did not have a psychosis due to dementia or the misuse of substances; they were fluent in English; and they were able to consent to participate in the study.

Participants & data collection
In total thirteen participants were approached and given written information regarding the study (Appendix 4) and a copy of the consent form (Appendix 5) by their key worker. Ten participants agreed to take part and meetings were arranged at a location convenient and safe to all involved. Written consent was gained from each of the participants before the study commenced. Participants ranged in age from 24 – 67 years with an average (mean) age of 44.56 years (median age = 41 years). Participants’ main characteristics are detailed in Tables 1 and 2.

Participants were interviewed based on procedures identified by Smith (1995) who stated that “the interview does not have to follow the sequence on the schedule, nor does every question have to be asked, or asked in exactly the same way of each respondent” (pp.17). Deviations from the schedule generated by the participant were encouraged and explored as valuable in their own right. Thus whilst the questions developed were used as a guide, each interview was a unique event: not all participants were asked exactly the same questions. Nonetheless all topic areas planned for in the development of the schedule were covered with each participant. The similarity of qualitative methodologies to clinical work suggests a distinct advantage to utilising clinical skills whilst conducting the research. Thus principles identified within the client-centred tradition (Rogers, 2003) were employed during the interview such as reflective listening.

Each interview lasted between 25 and 60 minutes and was tape-recorded so as to facilitate accurate transcribing. Each interview was allocated a code to retain participants’ anonymity. Any identifying details were also changed during the transcribing process to ensure confidentiality.

Although all ten participants were interviewed, the tape recorder malfunctioned for one of these (participant 5) and so one participant was excluded.
Table 1: Description of participants' characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Nationality</th>
<th>Voice Descriptions</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 - Michael</td>
<td>41</td>
<td>White British</td>
<td>4 - 5 voices of unknown identity for 23 years</td>
<td>Residual schizophrenia</td>
</tr>
<tr>
<td>P2 - Russell</td>
<td>61</td>
<td>White British, paraplegia</td>
<td>3 voices of unknown identity, first heard 25 years ago</td>
<td>Paranoid schizophrenia</td>
</tr>
<tr>
<td>P3 - Sean</td>
<td>24</td>
<td>White British</td>
<td>5 voices (&quot;my parents and 3 old friends&quot;), currently employed</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>P4 - Nathan</td>
<td>37</td>
<td>White British</td>
<td>Voice of one woman (&quot;a woman I used to know&quot;), previously worked in building trade</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>P6 - Norman</td>
<td>48</td>
<td>White British</td>
<td>First voice at age 5, &quot;my Nan&quot;, currently heard 10 voices (&quot;my parents, sister, grandparents, uncles and aunts as each one has died&quot;), obtained 11+</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>P7 - Gail</td>
<td>67</td>
<td>White British</td>
<td>Only ever heard one voice (male - &quot;my old GP&quot;), currently worked voluntarily for charity shop and lived alone</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>P8 - Ulrika</td>
<td>31</td>
<td>White Scandinavian</td>
<td>Heard voices for 5 years (male - unknown identity), worked as market researcher</td>
<td>Schizophrenia (in her homeland)</td>
</tr>
<tr>
<td>P9 - Donna</td>
<td>47</td>
<td>White British</td>
<td>First heard 2 voices 5 years ago, obtained A’ level at school</td>
<td>Personality disorder (unspecified)</td>
</tr>
<tr>
<td>P10 - George</td>
<td>36</td>
<td>White British</td>
<td>First heard voices approximately 12 years ago, heard voices as crowd, previously heard individual voices (&quot;my Dad&quot;), in-patient in secure unit</td>
<td>Paranoid schizophrenia</td>
</tr>
</tbody>
</table>

2 Voice descriptions in brackets are specific details provided by participants.
Table 2: Summary of participants' details correct at time of interviews

<table>
<thead>
<tr>
<th>Participant number &amp; name</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Length of time they would identify as a voice hearer</th>
<th>Service provision</th>
<th>Previous experience of psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1. Michael</td>
<td>41</td>
<td>Male</td>
<td>White British</td>
<td>23 years</td>
<td>First contact with services in 1989; currently well-engaged; receiving anti-psychotic medication.</td>
<td>Unknown amount of psychology sessions in 1999 #</td>
</tr>
<tr>
<td>P2. Russell</td>
<td>61</td>
<td>Male</td>
<td>White British</td>
<td>25 years</td>
<td>First contact with services in 1974; well-engaged in multi-disciplinary and multi-agency services; receiving anti-psychotic and anti-depressant medication;</td>
<td>6 sessions psychological therapy in 2001#</td>
</tr>
<tr>
<td>P3. Sean</td>
<td>24</td>
<td>Male</td>
<td>White British</td>
<td>3 years</td>
<td>First contact with services in 1999; currently well-engaged; receiving anti-psychotic medication</td>
<td>20 sessions individual psychotherapy in 2004#. At time of interview was in a mixed service user “recovery” therapy group.</td>
</tr>
<tr>
<td>P4. Nathan</td>
<td>37</td>
<td>Male</td>
<td>White British</td>
<td>8 years</td>
<td>First contact with services in 1997; currently well-engaged with multi-disciplinary services; receiving anti-psychotic medication</td>
<td>Assessed for psychological therapy in 1997*; no other psychological input.</td>
</tr>
<tr>
<td>P6. Norman</td>
<td>48</td>
<td>Male</td>
<td>White British</td>
<td>43 years</td>
<td>First contact with services in 1986; currently well-engaged; receiving anti-psychotic medication,</td>
<td>20 sessions psychotherapy with a psychologist, ongoing at time of interview to manage voices</td>
</tr>
</tbody>
</table>

* denotes that details were unavailable on the number of sessions attended
# denotes that details of the content of the work was not available
**Table 2 continued.**

<table>
<thead>
<tr>
<th>Participant number &amp; name</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Length of time they would identify as a voice hearer</th>
<th>Service provision</th>
<th>Previous experience of psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>P7. Gail</td>
<td>67</td>
<td>Female</td>
<td>White British</td>
<td>18 years</td>
<td>First contact with services in 1969; currently engaged in multi-disciplinary services and a healthy living group; receives anti-psychotic and anti-depressant medication</td>
<td>Bereavement counselling* in 2000; 6 sessions of CBT in 2004 to manage voices.</td>
</tr>
<tr>
<td>P8. Ulrika</td>
<td>31</td>
<td>Female</td>
<td>White Scandinavian</td>
<td>5 years</td>
<td>First contact with UK mental health services in 2002; contact with Scandinavian services since 1994; currently well-engaged; receiving anti-psychotic medication.</td>
<td>CBT intervention with a CPN ongoing at time of interview*#</td>
</tr>
<tr>
<td>P9. Donna</td>
<td>47</td>
<td>Female</td>
<td>White British</td>
<td>5 years</td>
<td>First contact with services in 1985; currently well-engaged in multi-disciplinary services; receiving anti-psychotic, mood stabilisers and anti-depressant medication.</td>
<td>Psychological therapy* ongoing at the time of the interview for depression and voices.</td>
</tr>
<tr>
<td>P.10 George</td>
<td>36</td>
<td>Male</td>
<td>White British</td>
<td>12 years</td>
<td>First contact with services in 1985; within the unit participates in a therapeutic programme e.g. art/music; also receives anti-psychotic medication.</td>
<td>10 sessions of CBT ongoing at the time of the interview focused on developing coping strategies for voices.</td>
</tr>
</tbody>
</table>

**Analysis**

The analysis for the transcripts followed Smith & Osborn's (2003) guidelines. They suggest that “this is not a prescriptive methodology... (but) is there to be adapted by researchers, who will have their own personal way of working” (pp.66). Smith &
Osborn (2003) also acknowledge that "qualitative analysis is inevitably a personal process, and the analysis itself is the interpretative work which the investigator does at each of the stages" (pp.66). The general process used in the study was as follows:

i. One transcript was chosen and read a number of times, noting in the left column anything which the participant had said that I deemed to be of interest or importance. Smith & Osborn (2003) have noted that "there are no rules about what is commented upon" (pp.67), however my initial comments were "attempts at summarizing or paraphrasing,...associations or connections that (came) to mind, ... (and) preliminary interpretations". During the analytic process, passages of speech that I perceived to have derived from less open-ended (‘leading’) questions were not interpreted or analysed as I was concerned that this might not be a valid representation of the respondent’s world view.

ii. The transcript was read again, but this time attempts were made to describe higher level theme titles in the right-hand margin. These attempted to “capture the essential quality of what was found in the text” (Smith & Osborn, 2003, pp.68) from my own perspective, and also allow connections to be made within the transcript. Examples of the interpretative process can be found in the transcript excerpts in Appendix 6. This resulted in recurring theme names throughout the transcript.

iii. A summary of major themes for this first transcript was collated, initially in chronological order and with line references to the original transcript in order to check the interpretation against what was originally said.

iv. Tentative connections between the themes were then made where, on the basis of my clinical experience and my reading of the literature, some of the topics clustered together. Clusters were allocated a superordinate theme name and placed in a table of themes for that respondent.

v. Steps i – iv were continued with the remaining transcripts, with a slight variation: themes that had already been identified were kept in mind whilst

3 Space constrains a detailed description of the development of themes for each transcript. It is hoped that a sufficient overview is described here. Readers are referred to Smith & Osborn’s (2003) work for further clarification.

4 Smith & Osborn go on to suggest "...you may find yourself commenting on the use of language by the participants and/or the sense of the person themselves which is coming across. As you move through the transcript, you are likely to comment on similarities and differences, echoes, amplifications and contradictions of what a person is saying" (2003, pp.67).
also remaining sensitive to the uniqueness and differences of the particular transcript. Thus theoretical connections within and across transcripts were made.

vi. Once this process had been completed for all transcripts, the themes were amalgamated and a process of theme reduction and redefinition then occurred resulting in the super-ordinate and sub themes presented in the Results. Rather than purely selecting themes on the basis of prevalence within and across transcripts, factors such as the richness of the transcript that generated the theme were also acknowledged (Smith & Osbom, 2003). Nonetheless, for most themes, evidence could be found in all of the transcripts. Reflection and re-definition of themes continued throughout writing the Results/Analysis. This process can be followed for one transcript in Appendices 7 to 9

Evaluation
Although criteria traditionally applied to quantitative research such as 'reliability' are unsuitable for qualitative methodologies (Yardley, 2000), Elliott, Fischer and Rennie (1999) and Yardley (2000) have developed standards by which qualitative research can be evaluated. The extent to which this study adheres to these guidelines will be explored here and in the Discussion.

Guidelines produced by Elliott et al. are as follows: i) owning one's perspective, (see Method, pp. 202); ii) situating the sample, (see Method, pp. 206); iii) grounding in examples and providing credibility checks, (see Results, pp. 214 and below); iv) coherence (see text and Figure 2 in Results); and v) resonating with readers.

With regard to 'resonating with readers', it is hoped that having read this study, the reader will conclude that the material sufficiently represents the phenomenon under investigation and will have developed a new insight and appreciation of the experiences of voice hearers. 'Credibility checks' were also undertaken to check the credibility of my themes. This involved the analysis of one transcript by individual members of a qualitative research group, and the analysis of two other transcripts by a clinical psychologist with expertise in the voice-hearing field. In both instances, where differences or elaborations arose, these were discussed and agreement was reached about which should be integrated into the analysis for that transcript. These
new insights were then incorporated into re-readings of the remaining transcripts. An example of this has been provided in the Results/Analysis.

Yardley suggests that the following characteristics would be evident in a good qualitative research project: i) sensitivity to context; (see Introduction and Method, pp. 206); ii) commitment and rigour; including criteria such as methodological competence and thorough data collection (see all of Method and Discussion pp. 241) iii) transparency and coherence involving criteria such as the fit between theory and method (see Method pp. 201) and reflexivity (Discussion pp. 241) and iv) impact and importance (see Discussion, pp. 244 onwards).
RESULTS/ANALYSIS

This study aimed to obtain a greater understanding of the extent to which voice hearers were able to describe their voice hearing experience within an interpersonal framework. The interviews provided a wealth of rich data, and these were developed into super-ordinate and sub-themes, which due to practical limitations, correspond to the research questions (Table 3).

Overview of the themes
The first theme explores the descriptions and characteristics of the voice provided by the hearers. The second theme then considers how participants viewed themselves as oppositional to their voice and details the strategies both hearer and voice used to obtain control and power over the other. The third theme details the union between the voice and the hearer, and variations within this process. An exploration of the hearer occurs in the fourth theme, focusing specifically on the multitudinous ways that the experience impacts on their personhood. The final theme that will be explored in this section draws on participants' use of their social context in describing their experience. Descriptions will be supported by excerpts from the participant's accounts1.

The remainder of the themes (VI – IX) illustrate the process of the interviews. Whilst they will be alluded to here, they will be fully explored in the 'Discussion' section.

1 Quotes will give the name of the participant followed by its line number(s) in the transcript. More detailed transcript notations can be found in Appendix 10
Table 3: Themes derived from the participants’ accounts

<table>
<thead>
<tr>
<th>Super-ordinate theme</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| I. Defining the other | i. Personification & Individuation  
ii. Intimate knowing |
| II. Me vs. the Voice(s) | i. Control  
ii. Power  
iii. Strategies employed by the voice(s)  
iv. Strategies employed by the hearer |
| III. The Voice(s) & Me | i. Creating & sustaining ‘we-ness’  
ii. Evolution over time  
iii. Rejecting we-ness  
iv. A conditional process |
| IV. Impact on self | i. Emotions  
ii. Processes  
iii. Attributes |
| V. A social experience | i. Transitional relating  
ii. Drawing on social experience  
iii. Sharing the experience with others  
   a) Social network  
   b) Professionals  
iv. Culture & society |
| VI. Narrative | i. It all started when…  
ii. Making sense of the experience |
| VII. Defining the experience | i. Complexity of the experience  
ii. Richness of the narrative  
iii. Incomprehensible  
iv. A struggle to describe |
| VIII. The interview process | i. An evolving process  
ii. The participant  
   a) Motivation to participate  
   b) Incomprehension  
   c) Frustration  
iii. The interviewer  
   a) Personal characteristics  
   b) Personal style |
Spread of themes
IPA as theme analysis is not a content analysis per se, however it is sometimes useful to look at the spread of super-ordinate themes across the participants. This has been detailed in Table 4 below. This spread of themes can give an indication of where some consensus might lie in respect to the themes and the relationship between them, and where a theme might be unique or particular to a participant. This is not a content analysis, but details the themes generated by an interpretative process as described in the Method.

Table 4: Spread of themes

<table>
<thead>
<tr>
<th></th>
<th>I. Defining the voice</th>
<th>II. Me vs. the Voice</th>
<th>III. The Voice &amp; Me</th>
<th>IV. Impact on self</th>
<th>V. A social experience</th>
<th>VI. Narrative</th>
<th>VII. Defining the experience</th>
<th>VIII. The interview process</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 Michael</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P2 Russell</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P3 Sean</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P4 Nathan</td>
<td>✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P6 Norman</td>
<td>✓✓✓</td>
<td>✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P7 Gail</td>
<td>✓✓</td>
<td>✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P8 Ulrika</td>
<td>✓✓✓</td>
<td>✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P9 Donna</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>P10 George</td>
<td>✓✓</td>
<td>✓✓✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓ = Theme appeared now and again in their talk, not so important
✓✓ = Theme quite important to them, appears in connection with other issues
✓✓✓ = Theme very important to the participant, appears throughout, or emphasised a lot in one transcript.

Although the individual themes will be discussed in greater detail shortly, it is clear from the above table that the first theme was particularly meaningful to the participants. In contrast Theme VI – Narrative, which encapsulated participants' tendency to tell their story from the beginning, was unique to only a few participants.

As has been described earlier, (see Method) auditors provided credibility checks on the validity of the themes. For example, the qualitative group queried my interpretation of Donna's frequent chuckling as a paradoxical contrast to her difficulties, instead describing it as 'humour', indicative of a reflective stance. Following discussion we agreed that both 'humour' and 'reflectivity' was more
meaningful to the transcript and were allocated to the right-hand margin for that transcript.

**Theme I – Defining the other**

This first theme emerged from the creative ways participants sought to define the voices that they heard, and sets the context for the remaining themes.

**i. Personification & individuation**

Most participants described their voice as sounding like “a real voice” (George, 201), although for Ulrika rather than possessing a human quality it “sounds more like a computer to me because [of] the tone” (56-7). The “different voices and different tones” (Michael, 7), appeared to help to differentiate them, as did gender assignment. However this was not possible for all of the current voices heard and for George it “sounds like 20 people talking at once” (39).

Names were associated with different voices for five participants; a process which seemed to be taken for granted and deemed ordinary. Where naming had not occurred (or the voice was not referred to by its name) participants appeared to take responsibility, describing it as a nonchalant process: “I haven’t actually put a name or face to the voices” (Michael, 6); “I just call it anything that comes into my mind at the time” (Nathan, 19), as well as an active decision in order to maintain control: “I refuse to give them names” (Donna, 59), with the implication that naming would sanction their existence: “because I don’t want to have a relationship with Fred and Joe [...]” (Donna 61-2). Despite her refusal to name, Donna provided particularly visual images of how her voices looked as if the temptation to personify was too compelling. During the interview this appeared to facilitate talking about the voices for both of us, as can be seen by my comment “the blonde one, he’s...” (315).

The individuation process also served to distinguish different voices from each other: “[...] one is very loud and [...] aggressive [...] and then there’s his friend [...] who’s quiet” (Donna, 51-3), with implications for how distinct voices should be managed:

“I don’t think it’s the same with each voice, it’s got to be something different [...]” (Nathan, 596-7).
ii. **Intimate knowing**

Participants described their voices as having personality traits, often associated with their unpleasant experiences with the voice:

"I don't think they know how to be nice dear, to tell you the truth, I don't think they know how to be nice whatsoever" (George, 329-30).

However these traits were not fixed; voices were experienced as both altruistic and unhelpful, often leaving the individual confused: "I don't know if [...] they're trying to warn me, or whether [...] they're just playing into my fears" (Donna, 507-9).

Not only were voices described as possessing human sensory capacities like hearing ability "I told them [...]" (Norman 59), participants were also sensitive to a complex cognitive, affective and behavioural state that the voice was described as displaying. For example the voice was described as having intentions: "[...] I think they want to harm me or they want to upset me" (Russell, 82-3); experiencing emotions: "[...] they certainly seem to get some kind of a kick out of the fact that ..." (Donna, 144-5); "they probably felt [...]" (Sean, 217) and demonstrating faulty reasoning capabilities as Norman explained of his voices' (in)comprehension of his boundary setting: "my mum [...] she still don't understand but my dad does" (49).

**Theme II – Me vs. the voice(s)**

The next theme describes how participants viewed themselves and their voice in conflict, positioned against one other, with each battling for control and power. When specifically asked about this, participants tended to respond without hesitation, suggesting that being subjected to their voice in this way was particularly meaningful for them. Even without prompting, similar descriptions emerged from the hearers.

i. **Control**

Participants spoke of their overwhelming experience of the voice as an 'other' wielding its control over the minutiae and the wider aspects of their life:

"[...] I have this idea in my head that er they try to control on every possible way my life [...]. They sort of try to affect who is my friend and er who I'm gonna get close and what type of person they have about me" (Ulrika, 409-14).
However this was not a complete process as the above excerpts suggests (they try to...) and so perhaps describing the voice as attempting (rather than attaining) control allowed the participant to retain a sense of their own mastery. Participants were in fact able to establish mastery over the experience; this tended not to be through direct interaction but rather by employing diversionary tactics:

“\textsc{I’ve got lots of other hobbies and that erm so I always, I can always do something to take my mind off of them}” (Michael, 49-50)

Participants were acutely aware of the necessity of maintaining some command over the voice fearing the consequences if this did not occur:

“\textsc{[...] I’ve hopefully got it under control as best I can, which is a good thing. Cos if I hadn’t, I could be to and fro to hospital so I’ve got to keep it under control}” (Nathan, 461-3).

As Nathan demonstrates with his use of ‘hopefully’, participants were uncertain about the extent of control they possessed. However, it seemed that any control, no matter how tenuous, allowed them, rather than their voice, to be in command.

\textbf{ii. Power}

The experience of feeling “\textsc{constantly trampled by them}” (Ulrika, 592) was a recurrent theme for all participants who described feelings of subjugation in contrast to the voice: “\textsc{I feel very small}” (Sean, 318).

Voices were directly attributed with authority: “\textsc{they seem to always have this kind of erm, er...air of, authority}” (Donna, 520), or power was implied by either attributing ‘powerful’ abilities to the voice: “\textsc{well he, sort of experiments on me, you know, I get body pains}” (Gail, 29), or by associating the experience with authoritarians in the dominant culture: “\textsc{I believe it’s God putting the voice there as a warning to what’s coming}” (Nathan, 175-6).

However, in a similar manner to the previous sub-theme, power appeared to shift between the hearer and their voice, and with regard to self-attribution of power, George stood out amongst the participants as one who had positioned himself above the voices as this short excerpt illustrates:
George:  I see me like that and them like that (hand gestured first up then down)
Jasmine:  why are they like that and you like that, what does that mean?
George:  it just means that er I'm more powerful than them
Jasmine:  right yeah, so even though there's 20 of them, you've been able to
minimise them down to this
George:  yeah even though, even though they're from God, I've minimised them
Jasmine:  mmm
George:  because I'm Satan and I have my own rights to live as a normal being on
this planet (281-88)

It seems that only by employing what might be described as a delusional explanation,
is George able to identify himself as powerful, relying again on socially informed
power icons. Indeed George creatively utilises a prevailing cultural representation of
a struggle for supremacy between God and Satan to illustrate the dynamic between
him and his voice.

Norman and Donna were two other participants who seemed cognizant of this pattern
whereby their attempts to influence the voice and its consequential response led to a
tussle. Donna spontaneously used this power struggle to define the unchanging
interaction between her and her voice:

"Erm we still have this 'go away I'm not listening', 'yes you are, you're going to listen
to me' kind of relationship" (Donna, 32-3).

Others like Sean used the battle to enhance their self-worth by engaging in a
competition with the voices, again employing delusional techniques:

“But then I seem to go into a state of mind where I'm then thinking that I'm god and
so I'm arguing with them saying 'well actually I'm more God-like than you are'” (Sean,
67-8).

The sense of a battle was further enhanced by the rich narrative and imagery evident
in the participants' accounts with use of phrases such as "[...] they only want to strike
me down [...]" (Donna, 188-9) and “fight it out” (Nathan, 88).
iii. **Strategies employed by the voice**

All participants experienced the voice as utilising numerous strategies to maintain its established position. Issuing general commands: "*giving me orders erm you know telling me to do things*" (Michael, 20) and specific instructions about how participants' time should be spent domestically: "*well he tells me to do housework every now and again*" (Gail, 58), and more generally: "*they want me to get a job, I can't get a job, not yet anyway*" (Norman, 241) was described. The invasive quality of the experience further served to highlight the inescapable nature of the voice's power:

"*Every thought I'm thinking, they're hearing and they're saying 'well that thought was wrong and you should change it like this'"* (Sean, 45-6).

The voice's apparent awareness of the hearer's weaknesses appeared to be disturbing for all participants, particularly Donna. This strategy was doubly efficient in that it seemed to serve the function of maintaining their one-down position by escalating the participants' vulnerability further:

"*They'll magnify whatever it is I'm concerned about, or they'll comment on something I'm concerned about, which isn't very helpful and quite often makes me more stressed than I was*" (Donna, 99-101).

iv. **Strategies employed by the hearer**

Discerning such patterns as described above appeared to facilitate predicting the voice to some extent, which appeared to re-instigate some power in the hearer. Clearly the existence of the power struggles described above illustrates the hearers' determination not to be dominated. For Norman, Donna and Nathan additional strategies entailed establishing boundaries about when the voice would be spoken to:

"*[...]. Now I've put down guide rules guidelines, I speak to them they don't speak to me*" (Norman, 27-8) although this required considerable effort: "*it's actually directing me to do [things] and I'm forcing myself not to*" (Nathan, 85)

Indeed an apparent absence of voice omniscience was at times evident in participants' speech, suggesting they were able to retain some privacy and avoid complete subjugation. As well as distracting techniques such as decorating (Nathan),
participants also utilised paradoxical mechanisms of self-assertion\(^2\) and surrender in order to retain control. With regard to surrender participants appeared resigned to the futility of fighting as Michael describes "but when they get really bad the best thing is to actually accept them erm instead of fighting them" (52-3), explaining how engaging in battle was counter-productive for both parties, "I find that better for them, and (I don't) wear myself out" (57). However this was not so easily described for others and admitting use of this strategy appeared to cause some embarrassment as is evident in Sean's faltering – "I'm very erm.... ... compliant" (47).

Theme III – the Voice(s) & Me

In contrast to the oppositional positioning of the previous theme some participants described their experience of their voice in more intimate terms, to the extent that as a listener, I at times felt excluded, particularly when talking to Norman who frequently differentiated "my world" from "your world" (330). All participants referred to an engagement process that served to sustain a constant link with the voice, although this ranged from the discordant verbal exchanges described previously to a more relaxed stance where interacting with the voice "[...j just goes smoothly throughout the day [...j]" (Gail, 313) and to a "quite intense" (Donna, 417) encounter.

i. Creating & sustaining 'we-ness'

This sub-theme illustrates the seemingly explicit awareness that participants had with regard to a union with the voice. For Norman and Sean it was an active choice to spend time engaging the voice: "I haven't got many friends...so the only thing I can stay very close to are the voices and I do stay very close to them" (Norman, 404-5). Even where proactive choosing was not evident, as was the case for Russell, there was acknowledgement of a concealed attachment having been formed:

"I haven't told anyone this for years, I made a little joke with the consultant in the hospital and said if they stopped I'd quite miss them (laughs) [...] they're almost like part of me and err...sometimes when I don't hear them I think 'where are the voices?'" (289-99).

\(^2\) 'self-assertion' will be elaborated on within the 'Impact on Self' theme

220
For Russell and others the formation of a bond with the voice is further illustrated by the show of concern for the other, to the extent that for Sean an interaction with the voice was only considered to be positive “if we've both like felt alright about it” (221).

Norman was distinct in being provided with “a loving warm feeling” (316) from his sister’s voice which told him that “she still loves (him)” (325), however others as Russell earlier described, and Sean were also attentive to the gains they made in sustaining ‘we-ness’: “[...] well if they went away I’d feel alone” (328).

For these hearers, the existence of an alliance was frequently normalised: “it always seems pretty normal, in having good and bad points to it” (Sean, 210). “Expecting normalcy or normality” (Sean, 255) appeared to facilitate managing the experience providing innocuous conversational topics: “when I talk to [the voice of] my mum she asks me how my day’s going and I tell her what I’ve done and what I’m doing” (Norman, 147-9). Indeed the formation of the union appeared to derive from sharing pastimes: “[...] we talk about things we’re interested in” (Sean, 197). However expectations of normality also had negative consequences resulting in frustration “when I say ‘why don’t you leave me’, he’ll never say anything you know” (Gail, 458-9), and anxiety in the hearer. Alliances occurred at multiple levels and individual voices were also described as interacting in specific ways with one another as Donna elaborated with regards to her voices “and then there’s his friend [...]” (52) who “[...] agrees with things the loud one says” (57) suggesting that the pattern of dominance in her interaction with the voice was mirrored in the voices’ interactions with each other.

Circular and reciprocal processes were evident in participants’ exchanges with their voices as Norman describes in his interaction with his deceased mother’s voice: “she asks me how my day’s going and I tell her what I’ve done [...] then I ask how she’s been today, what she’d done [...]” (148-52). Sustaining the connection also relied on physical reciprocal acts: “well if I shut both my eyes and put my hands over my ears they say f-ing idiot [...] that seems to happen almost every time I, I do that” (Russell, 128-30). For Nathan the voice was persuasive in inciting interaction with it in order to resolve social isolation: “it tells me she wants to get to know me and that and and then a friendship may develop and I make more friends cos I’ve got very little friends at the moment, because of the voices” (65-8).
ii. **Evolution over time**

For all participants the voice experience was described as dynamic. Whilst for most “it started off really bad, yes it started off really bad” (Nathan, 511) for others the reverse was true: “yeah it’s got worse as the time’s gone on [...]” (Norman, 116). This experience of change was constant “from day to day it’s different, you know” (Gail, 538) but largely predictable “[...] sometimes they get worse than other times [...] my worst time is in the morning” (Michael, 32-4).

Unlike Russell for whom “the voices [...] have much diminished with the Risperidone” (35-6), participants did not tend to attribute change to medical intervention. Either the voice was responsible: “we used to talk more about different things [...] whereas now [...] I don’t hear him and all of a sudden he talks again, you know” (Gail, 404-6); or the participant’s role was emphasised as illustrated with Norman’s use of the active verb: “I told them I am getting sick and tired of them talking to me all the time” (59-60). George used the change to accentuate his own increasing supremacy, and followed the excerpt described earlier (p.211) with a contrasting anecdote: “at first I actually got a bit scared of them [...]” (298). For him it seems that the transformation in his ability to manage the situation differently, from fear to (satanic) control, was almost unbelievable.

Where longitudinal change was not manifest, this was taken as further evidence of a naturally occurring process “[...] as soon as I started hearing them it, it just seemed to naturally be there as a relationship so it wasn’t that there was any ground set or anything” (Sean, 354-5).

iii. **Rejecting we-ness**

Rejecting the union was most apparent in hearers’ implementation of boundaries as described previously. In addition participants vocalised their rejection to the voice directly: “[...] I’ve said to them many times that er ‘there’s you or me but no we’” (Ulrika, 272-3), with six participants responding negatively to the suggestion of a relationship. This definite stance and longing for ultimate freedom from the voice was echoed by others who “just want(ed) to get rid of it” (Gail, 278) and participants were clear about how easily responsiveness could be misinterpreted by the voice: “I don’t want to make friends with them because I don’t want to invite them into my life” (Donna, 29).
Frequently the voice was attributed responsibility for attempting to instigate unions: "they keep talking about [...] that we're all in this together and er we're gonna be married with each other for the rest of our lives" (Ulrika, 275-7), and whilst for Nathan and Norman the voices' pursuance was acknowledged to be benign, it was still not embraced:

"[...] since my Mum died [...] she wants me to be with her all the time [...] and I told her I'm not gonna be with her all the time" (Norman, 259-63).

"that's what it talks to me about [...] that she would like to get to know me and whatever, but I'm not interested in that" (Nathan, 52-4).

The dysfunctional impact of the voice-union on forming relationships with social others was cited as relevant for Ulrika: "and I sometimes feel that er you know I don't have, you know any kind of strength or interest basically to make a new relationship" (593-4).

iv. A conditional process
Participants appeared to reach compromises in their interactions with the voice: "[...] I don't mind talking to him as long as he's not trying to cause me pain" (Gail 293-4), perhaps in an attempt to maintain a homeostatic balance: "to keep it as it is, I've got to talk to it right away...but I don't want to" (Nathan, 447-8). In addition, participants set conditions on the process suggesting that interacting with the voice would be considered "if they were a little less negative and a bit more positive" (Michael, 456). However even without conditions having been met, a "reluctant relationship" (Donna, 265) was evident for seven participants.

Theme IV – Impact on self
Although previous themes have alluded to this, this theme provides a more detailed account of the impact of 'Me vs. Voice(s)' and 'Voice(s) & Me' positioning on the participants.

i. Emotions
The multitude and intensity of emotions described across accounts was striking. Some individuals described fear as a consequence of the voice's perceived power (e.g. fortune-telling) but also feared consequences for their own future — Nathan for
example feared further admissions when the voices spoke to him. Participants also described how they “hated them” (Michael, 423) reporting that it “makes me very angry” (George, 188) as well as “vulnerable and uptight” (Russell, 58) when the voice speak to them. However for some like Sean affective change was not necessarily contingent on what the voice had said, but rather the process of the interaction: “[...] I get stressed about the conversation ending I suppose” (Sean, 253). Certainly, participants were able to think about their experience at a more abstract level reporting that they “[...] get all nervous [...]” (Sean, 88) and experience “sometimes fear, sometimes embarrassment” (Russell, 252) when considering their interactions with the voice. There was a similar heterogeneity within individual accounts for others like Norman as illustrated in his description of “[...] a calm feeling, a loving feeling and an angry feeling” (301-2) that he experienced when considering his voices, which was, at times incongruent with his experience of the voice: “[...] I don't hate my Mum, I might say my Mum's volatile now, but I still love her to bits” (574-5).

ii. Processes

A range of processes were evident in participants’ accounts that seemed functional in preserving self-esteem. A recurring mechanism was ‘self-assertion’ which was achieved in various ways. During the interview all participants at times, spoke with authority and confidence about themselves and their conduct: “I don’t deserve that and I’m a good person and [...] I can and have made good decisions in the past” (Sean, 529-30). Participants also described actions seemingly taken to combat submission and disparagement by the voice. Michael, for example described how developing social relationships or embarking on further education would be “[...] the sort of thing which gives them negative feedback” (403-4).

However self-assertion was not easily sustained and frequently participants appeared to project attributes into the voice such as intelligence, leaving themselves depleted. Russell explained how the voice as a research participant would “be more articulate [...]”, as did two other participants, suggesting that the process of being interviewed further accentuated participants’ perceived inadequacies. Voices were credited with superior and mystical talents such as predicting the future (Donna, Nathan). Participants were also more explicit in conveying their shortcomings and a process of self-denigration was apparent throughout some of their accounts, with a likely correlation to the widespread feeling of being bullied by a tyrant.
iii. **Attributes**

Particular characteristics of participants became evident throughout the interviews. A nonchalant attitude facilitated Norman in pursuing his boundary setting strategy despite the wrath encountered from his voices: "[...] my Mum was a bit angry [...] but I thought 'sod it'" (68-9). Resilience was evident in the multiple strategies that participants employed in an attempt to establish mastery. For George, Ulrika and Donna resilience in the form of humour was also apparent by their own admission: "sometimes I be a little bit giggling because they just go over the top" (Ulrika, 157), and throughout the interview process, as with Donna, whose frequent ‘chuckling’ additionally implied a degree of reflexivity.

**Theme V – A Social Experience**

i. **Transitional relating**

Norman, Sean, Gail and Nathan identified their voices as someone they knew, with the suggestion for these participants that the voice was a continuation of a social relationship they had been or were still part of. In addition George and Ulrika had previously heard the voices of parents, Donna drew links between her “loud” voice and abusive ex-partners and Nathan had “even heard Tony Blair’s voice, believe it or not” (28-9). There was the suggestion that an ascribed voice identity would be facilitative in making sense of the experience:

"It’s weird, I mean it’s bad enough hearing voices but when you don’t know who they are either you think to yourself ‘is this somebody I met once’, you know and [...] it doesn’t seem right that you’ve got this person’s voice and I can’t relate it to anybody I know" (Donna, 68-71).

Rather than a random assignment, the specific voices heard appeared to have further meaning for the individual; Sean for example heard the voices of significant others from different sequential life stages (parents and a friend each from primary school, secondary school and university). During the interviews I found it somewhat confusing and with Gail in particular, frequently had to ascertain whether we were speaking of the real person or the voice. This was magnified by her and Nathan’s assertion that meeting the voice would be beneficial: "maybe I’ve got to go and see this girl, and tell her to leave me alone and maybe break the connection [...]” (Nathan, 135-6). It may be that my confusion was a microscopic reflection of similar process occurring for the hearer.
There was not always a complete mapping of social experience onto the experience with the voice. Thus for Norman there was asymmetry in his parents' personalities: "[...] somehow they're different after they died cos my Mum was loving now she's vile, she's vindictive to me, my Dad was very quiet towards me, never said he loved me but now he's more talkative" (378-80), requiring him to “start all over again” (376) in forming bonds with them. Nonetheless, the effect on the individual was frequently mirrored and often experienced as subjugating.

ii. Drawing on social experience
Interactions with the voice appeared to be influenced by social experience. Descriptions of the voices' appearance were knowingly based on cultural "[...] misperceptions about, you know dark haired people being the baddies" (Donna, 125). Mildly aggressive statements made by the voice were given more sinister interpretations based on real events:

"[...] I've witnessed a member of staff murder a patient [...] so when the voices say things like ‘it'd be a pleasure to do you’ I sometimes think about these fairly, very terrible things that have happened [...]” (Russell, 451-5).

The voice was also expected to behave in accordance with social norms: “why don't they say something nice to me like happy birthday” (George, 326-7), with the suggestion that they would be easier to manage if they did: “It's not like you can phone them up and say I'll meet you later they're just there” (Donna, 414-5).

Participants' engagement in this comparative process between social and voice interactions highlighted further similarities and differences in their own behaviour as illustrated by Michael:

"[...] it used to be the same, I used to interact with my voices the same as I interacted with people, very very negatively” (417-9).

iii. Sharing the experience with others
Participants made spontaneous and frequent reference to how people in their social network facilitated or hindered their interactions with their voices, possibly in an attempt to reduce feelings of isolation that the voice experience engendered.
Russell, Michael and Donna all made reference to having shared stories and strategies with other voice hearers whilst simultaneously engaging in a process of social comparison: “when [CPN] used to take the Hearing Voices Group I felt almost a bit of a phoney because [...] one woman heard a voice like a radio in her head […] and I just had these voices of derision” (Russell, 112-8). Although a medical discourse was embraced by four of the participants: “I do look on this as an illness” (Michael, 101), the supportive role of professionals in facilitating management of the experience was also drawn upon: “he [CPN] said most people (with voices) try to have a normal life and that gave me courage” (Nathan, 687-8).

iv. Culture & society

Wider cultural influences were also frequently drawn upon by participants. Spirituality featured significantly as has been previously illustrated with Sean, George and Nathan’s references to God and Satan. It may well be that the unexplainable and “people don’t believe me” (Gail, 421) quality of the interaction with the voice, precipitated comparison with a higher-order or supernatural experience.

The experience of stigma was also relevant, as both an inhibitory factor: “[…] I don’t want to get into the habit of talking out loud to (the voices), people might lock me up” (Donna, 134-5), and as a source of frustration: “[…] they don’t understand but they should ask me why am I talking out loud…instead of getting up and walking off” (Norman, 514-5). However empathy for this position was also reported: “[…] I know I wouldn’t believe anyone like me either” (Gail, 421-2).

Summary

The themes were divided in order to facilitate their exploration, however many of the themes are considered interdependent and elaborate each other. The relationship between some of the themes has been represented in Figure 2 below³. The terms contextual and implicative have been borrowed from Pearce and Cronen’s theory of communication, the ‘Coordinated Management of Meaning’ (CMM; 1980, in Tomm, 1997) to account for the construction of meaning and associations between the voice experience and social experience.

³ Corresponding theme numbers are in brackets.
Figure 2: Theme interdependence
DISCUSSION

Overview of this section
On the basis of the themes identified, I will now consider the extent to which the original research aims were achieved, utilising established literature to further elucidate the findings. I will then go on to evaluate the research process before considering the implications the findings have clinically and at service levels. Specific research questions were developed in order to facilitate an exploration of the research aims, and each of these will now be considered in turn.

1. What sense does it make for an individual to consider their experiences of hearing voices within a relational framework?

Analysis of participants' speech suggests that hearers do indeed interact with their voice in a way reminiscent of a relationship. The construction of the voice as a personified other appeared to facilitate this process and will be considered prior to examining the form of this relationship in more detail. This implicit existence of a relational framework is, however in sharp contrast to participants' explicit views about the existence of such a dynamic. This aspect of the analysis will be considered at a later point.

The individuation process
The rich and complex descriptions provided exemplify participants' experience of the voice, not as a symptom but as an 'other'. The descriptions provided by the participants bore similarities to those of Nayani and David (1996) and Leudar et al. (1997) where personification was evident. Many aspects of the voice were taken for granted and assumed to 'just be' - why shouldn't the voice that sounds like a person, act like a person? This individuation process appeared to be a way of making sense of the experience as a whole and, possibly allowed individuals to gain understanding of the interactions that occurred between the voice and themselves. The attribution of a complex psyche may have facilitated the hearer in coping with this strange experience, perhaps by making it more believable. It may also have provided the hearer with knowledge of the other's 'personality', helping them to predict how the voice might 'behave' in any given circumstance.

4 The singular 'voice' will be used to facilitate readability. Distinctions applying to more than one voice will be clarified as necessary
It makes sense to consider that voice hearers seek out ways to understand this ‘other’ that is constantly present. In the formation of personal social relationships, similar processes of learning about the other in order to develop a greater understanding of their motivations has been observed (Dallos & Dallos, 1997). In this regard, in order to make sense of or conceptualise relating, it might be that hearers needed to construct a complex other with whom they could relate to.

Those participants who to a lesser degree had provided an embodied description of their voice further support this hypothesis: both Michael and Russell’s narratives were generally impoverished relative to other participants. Moreover, both subscribed to a psychiatric model more than other participants did, as is evident by Russell’s endorsement of medication and Michael’s analogy of his voices being similar to a broken leg. Thus it might be that for those participants, who are more attached to traditional psychiatric perspectives of voice hearing, alternative explanatory models are less relevant and consequently the need to personify the voice in order to make sense of it becomes redundant. An alternative explanation for the contrasting perspectives of these participants may be constructed around the interview process itself: Michael and Russell were respectively the first and second participants to be interviewed and so it may be that my interview style was at an earlier developmental stage in eliciting the multifaceted perspectives of these participants than it was for subsequent hearers.

Aspects of power

Dynamics of power were overtly evident within the hearer-voice interaction as has been identified previously in the literature (e.g. Birchwood et al., 2000). This was not only demonstrated by the hearers’ instinctive descriptions of how they experienced their voice but also in the content and form of their speech when talking about the voice. Deconstructing how this power manifested reveals similar mechanisms to those postulated by Vaughan and Fowler (2004) in their application of Birtchnell’s (1996, 2002) theory of relating. Hearers perceived the voice to use a range of processes to sustain its power, as might a social ‘other’ relating negatively from Birtchnell’s upper positions. For example the voice was perceived to be tyrannical as judged by its issues of commands. Its intrusive, incessant nature was further evidence of its power and is suggestive of the voice operating from Birtchnell’s Upper Close position (see Figure 1, p.195). In addition the voice’s exploitation of hearers’
weaknesses implies the voice was perceived to be relating from a negative *upper distant* position.

Participants' use of socially existing events to increase the odds of their fears occurring, as with Russell’s association with the adversities he had witnessed in hospitals, was an additional technique that supported their perceptions of power. However participants’ employment of delusional explanations to give credence to their perceptions, like Gail’s belief that her body pains were the work of the voice, suggests that the experience of the voice’s power superseded social experiences of disempowerment, limiting the application of Birtchnell’s relating theory. Participants in Birchwood and Chadwick’s (1997) study similarly utilised mystical events as evidence of the voice’s power, and so perhaps only out-of-this-world explanatory models serve to provide a credible explanation for such extraordinary experiences.

In contrast to Vaughan and Fowler’s findings, power was bi-directional as evident by the participants’ sensitivity to and evidence of their own empowerment in relation to the voice. Their resilience to the voice’s power was evident not only in the multiple strategies employed, but also in their ability to be simultaneously attentive to my questions whilst hearing their disparaging voices, who frequently commented on their anxiety within the interview situation. This skill of participants did not cease to amaze me during the ten interviews. Boschi *et al.* (2000) suggests that more emphasis should be placed on voice hearers’ existing coping skills to instil a sense of self-efficacy.

The tentativeness with which positions of power were held might have been a product of the voice’s unpredictable presence; perhaps for hearers, definitive control of the voice would be marked by either complete influence over the voice or total eradication of the ‘other’ altogether. Nonetheless, self-empowerment in relation to the voice appeared to serve two functions. Firstly, as might be expected, it enhanced participants’ own control and power, allowing them to manipulate to some (albeit limited) extent varying aspects of their experience. Movement into this position appeared to be motivated by a fear of the consequence of voice dominance, particularly inpatient admission. It should be noted that this aspect emerged from an analysis of mostly outpatient hearers, so it is possible that a sample of voice hearers who were currently inpatients might not be attuned to this empowerment role. However, the one inpatient in this sample, George, was arguably the most au fait
with the concept of empowerment. Further exploration of this concept with voice hearers who have not accessed services might also shed light on this.

The second function of self-empowerment appeared to be as a buffer against damage to participants' self-esteem as for example with the mechanism of 'self-assertion', again serving as a mechanism to maintain well-being. It seems then that the participants in this sample were not completely powerless to the voice's dominance. It is therefore notable that writings about hearer-voice interactions have focused almost exclusively on hearer powerlessness and voice dominance.

Parallels can be drawn here with the positioning of women in violent relationships as viewed by Hyden (2005). She argued that dominant cultural discourses of battered women as helpless, was the likely result of the omnipresence of women's resistance, and had a double consequence in that the subtle ways in which women opposed violence remained unexplored and hidden. The subtle ways which voice hearers resist their voice was also evident in this study, with regard to the mechanism of surrender. Existing literature has focused on 'surrender' as an act of helplessness whereas it may in fact be an active act of resistance and thus empowerment (Dallos & Dallos, 1997). There is scope for exploring this further, and future research might wish to consider hearers' resilience and strengths with regard to how they respond to their voices. One approach to doing this might follow Hyden, exploring the discursive strategies and positions adopted by hearers in their narratives about resisting the voice, identifying movement between different positions such as 'subjugated' or 'empowered'. Use of narrative approaches in this way might help the hearer to re-tell their story of their voice in a way that reinforced their own strengths, as has occurred with survivors of traumatic abuse (Herman, 1992)

Aspects of intimacy
Aspects of intimacy appeared to be relevant to seven of the participants and there was, in contrast to previous literature, confirmation of the hearer seeking involvement with, and showing interest in the other. This aspect of relating to the voice provides further evidence of the complexity of the personification process, with assumptions that the other had thoughts and feelings that needed to be considered and protected. The intimate relationship with the voice appeared to be facilitated by the personal knowledge each had of the other. Undeniably, it would take a great leap of faith to develop intimacy with someone who was unknown and again the individuation process appears functional at this stage too.
The development of intimacy with the voice appeared to be purposive, providing closeness for some participants where this would otherwise have been absent. It is common that in the absence of an ideal other to relate to, individuals will settle for replacements, be it another person or even an object as occurs with infants who relate to transitional objects (Lemma, 2003) to provide them with comfort. Birtchnell (1996) suggests that relating is an inevitable process that individuals seek to attain. The inevitability of relating seems apparent here and it seems that over time, participants had developed affection for the voice.

Participants' tendency to normalise the interaction is worthy of further consideration and one way of understanding this process is to view it as a response to stigma. Seven participants made reference to their own negative perceptions of voice hearers as well as the negative responses they had encountered from family and strangers, with the overwhelming view that voice hearers are different or in some way 'not normal'. In their analysis of stigma Knight, Wykes and Hayward (2003) found that service users were acutely attuned to the prejudice and discrimination of others with negative ramifications for their self-concept. Thus by normalising the interactions with the voice, the hearers may have been attempting to normalise themselves in response to the prevalent stigmatising perceptions. This mechanism of self-preservation has been proposed by Kelleher (1988), who suggested that the process of normalising difficult experiences facilitated the retention of a social identity that is acceptable within one's social context.

It is interesting to consider what was particular about Norman that made his experience distinctly different from the other participants, in his report of love between him and his voices. It may have been that the association of the voices with his deceased relatives made it difficult for him to openly reject them and consequently he developed feelings at the opposite end of the continuum from the hate that Ulrika felt for her voices. Hayward (2003) suggested that not knowing the identity of the voice precipitated withdrawal from the hearer, and so it may be that an opposite process was in operation for Norman, whereby intimate knowledge of the voices' identity instigated feelings of closeness. Birtchnell's (1996, 2002) interpersonal frame can again explain the relating of the participants with regard to the development of an intimate connection with the voice. On the whole it would seem that participants experienced their voice as being able to relate positively from a position of closeness, whilst Norman was distinct in that this was reciprocated.
Denouncing a relating framework

Equally apparent to an awareness of a relationship with the voice, was, for most participants, a clear reluctance to acknowledge the experience in this way. This was evident by the implementation of boundaries in an attempt to create space between them and the voice. Similarly, the maintenance of neutral or aggressive stances (rather than a friendly, welcoming disposition) served to further reinforce the distance that had been established.

The clearest rejection of this framework however came from participants’ response to the interview question “would you say that you have a relationship with your voice?” Three participants responded positively, with the remainder either giving an unequivocal “No” or being reticent in their admittance. This refusal was further evident for some in their concealment and possibly even embarrassment of a fondness for the voice. So, what of this reticence or dismissal of this concept – what does it mean to participants to acknowledge their interaction with their voice as a ‘relationship’? One explanation has been proposed previously and that is preservation of self-hood. Thus in a similar way to the normalising process described previously, it may also have been a way of rejecting the stigma attached to talking to an invisible other.

A related explanation for the rejection of a relational framework is that this model did not fit with participants’ own explanatory models. This position was most striking for the four participants who instead adopted illness/symptom narratives about their experience. Garrett and Silva have suggested, “the more complex its (the voice’s) interactive capacity, the more autonomous, alive and real (it) appears” (2003, pp.447). It may therefore be that a relational framework reinforces the notion of the voice as real and so in order to remain consistent with their beliefs (that the voice is a mere symptom), the framework has to be refuted.

An alternative explanation draws on participants’ conceptualisation of the term ‘relationship’. Most participants conveyed narratives that described features like support and mutual interest as relevant, correlating with Birtchnell’s intimacy axis. Indeed, findings in social-cognition research are applicable here, and closeness has been found to be central to an individual’s conception of an ‘ideal’ social relationship (Fletcher, Simpson, Thomas & Giles, 1999). In contrast, in this study (and in Fletcher et al.’s work), aspects of Birtchnell’s power axis such as authority, dominance or
leadership were only referred to implicitly. Thus it may have been that a relational framework was less likely to be spontaneously meaningful to participants, because the essential feature of their notion of a relationship (closeness) was largely absent from their experience with the voice (power). A further exploration of Fletcher et al.'s work clarifies the potential position hearers were in. They described relationship ideals as a set of hopes or expectations that were used as evaluative standards against which other relationships/partners were judged. Exploring the impact of this, Fletcher et al., postulated that the higher the consistency between ideals and current perceptions of the other/the relationship, the more positive their view of it. For the present study the existing 'relationship' with the voice may have been so disparate from the hearers' ideal that it practically did not qualify as a relationship. Replicating Fletcher et al.'s work with voice hearers, establishing discrepancies between evaluations of voice and ideal relationships, could easily provide verification of this hypothesis.

Despite the explicit rejections of the framework, participants could not easily be categorised, as those that were versus those that were not able to describe a relationship with their voice. Ulrika for example gave explicit disagreement but throughout spoke of her voices in ways suggestive of interpersonal others that she interacted with. There are three (not necessarily distinct) potential explanations for this inconsistency. Firstly, participants may have wished to retain a constant link with the voice perhaps to make the experience more predictable. Secondly it may be that relating is not a conscious process. Psychoanalytic theorists frequently make reference to relating which occurs out of conscious awareness such as when transferential processes are occurring (Lemma, 2003). A final consideration is that relating is not a dichotomous process, with implications that it instead occurs on a continuum. I would like to propose that this occurs on two orthogonal axes (after Birtchnell, 1996) as represented in Figure 3: a horizontal engagement axis and a vertical preference axis.
It might have been useful to use a dimensional approach such as this to allow participants to further specify their positions. My analysis of the data suggests that most participants would be located somewhere in the lower right quadrant exemplifying their preference not to be relating to the voice but recognising that they frequently did. However these would not be static fixed points; Norman for example would probably move up and down along the right hand side of the preference axis. Nonetheless, what the above demonstrates is the complexity of the relating concept for individuals.

2. If a relational framework is meaningful for them, how do voice hearers understand how this relationship developed?

Where development of a relationship was either explicitly or implicitly meaningful, this process appeared to provide a replacement for social relating, providing companionship (Gail), relieving loneliness (Sean) and maintaining links with desired others (Nathan, Norman). As noted previously, Birtchnell's (1996, 2002) assertion that relating is inevitable is also apparent here. Although for Sean there was no apparent developmental process for his relationship with his voice, for others the onset of this interaction appeared to be a coping mechanism for managing both the voice and social isolation. However, for Ulrika, Norman, and Gail this relationship further entrenched feelings of isolation, perhaps because of their awareness of prejudice and stigma (Knight et al., 2003).
Roles
The acknowledgement of reciprocity in the exchanges between the hearer and the voice suggests that hearers were cognizant of their own contribution to the maintenance of interactions with the voice. This was seen as a necessary task as the processes of self-assertion and empowerment testify. As such, participants' active role could be understood as a way of managing the experience. O'Sullivan (1994) in his exploration of hearers' coping strategies identified four categories, proposing that each existed along three dimensions: active/passive, accepting/rejecting and hopeful/despairing. O'Sullivan's third factor "active, ambivalent acceptance" correlates with the findings here, indicating the sense of resignation that participants' may have felt. In fulfilling this role participants drew on their social experience to inform their behaviour. Donna's report of attempting to engage her voices in friendly small talk suggests that she was utilising a strategy that any one of us might employ if confronted with a persistently offensive other.

Participants' appeared to view their roles as both instigative (as Russell did when he covered his ears with his hands) and reactive (e.g. telling the voice to "go away" was frequently cited). These actions then precipitated a response in the other: Ulrika for example experienced her voices as "upping the ante" when she retorted, which in turn left her more compliant to their commands. The systemic principle of circular causality encapsulates this process. Circular causality emphasises the recursive connections between events (Vetere & Dallos, 2003). In this sense participants were continually involved in patterns of interactional processes (Vetere & Dallos, 2003).

Consequences
The fourth theme that emerged from the analysis (Impact on Self) detailed the many ways in which the hearer was affected as a person. The range of emotions encountered, particularly those that could be categorised as 'negative' has previously been documented (e.g. Johns, Hemsley et al., 2002). These findings have however been extended by the present study with evidence of negative emotional reactions as a result of the interaction itself, not just in response to the total experience. This is clear in Sean's report of anxiety in anticipation of the voice feeling dissatisfied with their exchange. Moreover, the heterogeneity of emotions within individual accounts demonstrates the complex positions that hearers held in relation to the voice, which the previous literature has arguably underestimated and simplified with its positive/negative categorical approach. In this study the impact on the hearer was also described in terms of attributes and processes, both of which appeared to derive
from the relationship itself. The existence of humour for example appeared to be a mechanism by which participants retained some distance, allowing them to reflect on the experience. In contrast the projective mechanisms evident possibly demonstrates the difficulty participants had in sustaining a reflexive, meta-position with regards to the voice.

Change over time
As was speculated by Close and Garety (1998), developments in the ‘relationship’ over time were evident for all participants and engaging the voice appeared to facilitate this process. Only by utilising multiple strategies did the interactions with the voice vary, allowing the hearer to move from being paralysed with fear, to developing a more resilient and reflexive approach. Indeed, Norman had heard his voices for the longest period and so perhaps this is an additional explanation for why he was comfortable in openly acknowledging his positive feelings towards his voices. Longitudinal studies would serve to tease this process out further. Ratings of relating preferences and engagement on the axes described earlier would be a concrete way of establishing hearers self-evaluations of this at different stages of their experience.

3. To what extent do any relationships with voices compare to social relationships in the hearer’s past or present?

As has been reported by other authors (e.g. Johns, Hemsley et al., 2002; Leudar et al., 1997) six of the hearers identified current and previous voices as associated with someone known to them both intimately (e.g. parents) and more distantly (Tony Blair). There was some acknowledgement by the hearers that as a consequence of this, their approach was similar to how they might interact with a domineering social other, supporting Hayward’s (2003) findings regarding the correlation of relating styles. The multiplicity of voices that were heard, each with individual personalities also encouraged some participants to relate to each with a different approach. This finding highlights the limitations of previous investigations that have encouraged participants to consider only one voice (e.g. Vaughan & Fowler, 2004) and suggests that clinical interventions adopting a similarly singular approach may also be inadequate.

There were mixed views regarding similarities between the voice’s perceived relating style and social others. For participants like Donna there was a clear link between experiences of being in a submissive position to two men and feelings of subjugation.
with regard to her two (male) voices. Therefore it perhaps requires a social experience that has salient similarities before associations between social and voice relating can be made. It would have been helpful to ascertain information regarding participants’ current social relationships to further compare their experience of each. Sean for example spoke of his own shortcomings in social relationships, which it would have been interesting to examine further. It is perhaps a limitation of the interview schedule that additional findings were not revealed regarding this facet of the study. Alternatively it may be that for participants this was not a meaningful aspect of their experience, particularly in light of their reluctance to define their voice experience in relational terms.

Participants took their experience beyond relating with another and appeared to consider their wider social environment. As was demonstrated in Figure 2, Pearce and Cronen’s CMM theory (1980, in Tomm 1987) might explain this link as it describes interactions between different experiences. CMM theory proposes a hierarchy of levels of meaning ascribed to communicative acts, from the content of speech through to cultural pattern. Tomm suggests that it is useful in explaining the interdependence between interpersonal exchanges and social context to provide meaning because it suggests that the relationship between the different levels is circular. Thus whilst social environment provided a context of meaning for the voice experience (exerting a contextual force), a circular relationship was also evident and the voice experience influenced social experience (implicative force).

The findings obtained thus far have implications for clinical practice. Before exploring these, the next section will reflect on and critically evaluate the process of conducting the research.

**Critical Evaluation**

Guidelines for evaluating qualitative research by Elliott et al. (1999) and Yardley (2000) were introduced in the Method, and will now be re-considered here.

*Situating the sample.* Participants’ characteristics were provided in the ‘Method’ to allow readers to evaluate the “representativeness” of the findings (Willig, 2001), based on recorded demographic information and self-report. A more valid representation may have been obtained if I had corroborated my descriptions with the participants themselves.
Some individuals who were approached did not consent to participate, so this sample of hearers may have had a particular motivation or willingness to speak about their experiences. Furthermore some clinicians were less willing than others in assisting with recruitment, citing fears of relapse as a likely consequence of talking about voices (a similar finding was reported by Close & Garety, 1998). It may be that the participants interviewed were to some extent socialised by their care teams into viewing their voice experience in a novel way. That all participants had been offered psychological therapy at some point during their experience might be seen to support this statement.

**Grounding interpretations in examples.** This particular guideline suggests that examples of data are provided in order to allow the reader to evaluate the findings (Elliott et al., 1999). Excerpts from the transcripts supported the analysis. There was also an attempt to ensure that references were made to each participant in discussion of the themes and where necessary exceptions were highlighted.

**Providing credibility checks.** The researchers used to audit the analysis and give credibility to the themes derived from a range of theoretical orientations. The group was comprised solely of psychologists and other professional groups may have provided a different interpretation. Nonetheless, this process of triangulation (Madhii et al., 2000) assisted with my own reflexivity and allowed me to see the transcripts from multiple perspectives whilst assessing the consistency of my findings. For example the degree of personification was novel to those who had not previously encountered this phenomenon before, thus encouraging the development of Theme I. Elliott et al. (1999) further suggest that testimonial validity checks be conducted – that is presenting the themes to the original participants or similar others, which would have been a useful addition in ascertaining the themes' validity.

**Coherence.** Elliott et al. (1999) suggest that interpretations of data should be presented in a way that achieves coherence and integration without oversimplification. It is hoped that the diagrammatic representation of themes (Figure 2) supports this notion.

**Sensitivity to context.** Links have been made in the current study to existing theoretical knowledge however unique findings in the data have also been analysed...
in their own right. The contexts within which participants were located with regards to service provision and other socio-cultural demographics have also been described.

**Commitment and rigour.** Although a thorough approach was taken to collecting and analysing data, additional insights might have been gained by employing a range of approaches to data collection, to achieve what Yardley describes as a "rounded, multilayered understanding of the research topic" (2000, pp. 222). This could have included obtaining data from observations, interviewing participants' significant others, or asking participants to keep diaries about their experiences.

**Reflexive Evaluation**

Within qualitative research, reflexivity encompasses "an awareness of the researcher's contribution to the construction of meaning" during the research process (Willig, 2001, p.10). Two different types have been identified and each of these shall be considered here alongside a review of the interview process as summarised by Themes VI – VIII in the analysis.

*Epistemological reflexivity* considers how the design and method constructed and constrained the data and findings (Willig, 2001). Participants were all recruited from CMHTs, which placed constraints on the age range of the interviewees (all of the teams had a lower limit of 18 years). Thus, as with other studies exploring this concept where voice hearers of similar ages were recruited (e.g. average of 39.52 years in Hayward, 2003; 38.93 years in Vaughan and Fowler, 2004; 43.56 years in this study), the views of very young hearers were not explored. One might consider that a sample of voice hearers in their late thirties and early forties might describe 'relating' to their voice differently than a much younger or much older sample, and further research with differently aged voice hearers would be needed to verify this. However Nayani and David (1996) identified that the length of time the individual had been a voice hearer (rather than the age of the voice hearer per se, or indeed the number of hospital admissions), was more significant in both determining the complexity of the voice heard and the likelihood of the voice encouraging a dialogue with the hearer.

Within this study, the interview schedule was the main tool used to collate information. Its design and use had a significant impact on the subsequent data obtained and so is worthy of further consideration. The schedule utilised Chadwick et al.'s (1996) Cognitive Assessment of Voices schedule to provide a semi-structured
opening to the interview. However on reflection some of the questions were not relevant to this study (e.g. “does the voice come from outside the ears?”). In addition it seemed to set the interview up for both participants and myself, as an information-gathering session, rather than as an exploratory conversation.

One critique that might be levied at this study was that the interview style used with some participants was more akin to a client-centred clinical interview rather than a research interview, as illustrated by my prompts and summaries of the interviewees’ speech (Theme VIII). Whilst therapeutic skills such as empathy are important, Smith (1995) suggests that use of these should not be at the expense of the client’s perspective being privileged. However defining the experience was at times a struggle for some participants (Theme VII), perhaps due to its complexity and so summarising and paraphrasing their speech was deemed necessary. Other researchers have commented on the potential difficulty in interviewing participants with psychosis (Knight et al., 2003). Piloting the schedule with other service users or even voice hearers who have not utilised services, may have helped to eliminate excessive use of prompts, and encouraged the creation of more open-ended questions that tapped easily into participants’ views and opinions. In addition, asking service users to become co-researchers in the development of the schedule may also have ameliorated these shortcomings and would have further emphasised their role in the research (Reason & Heron, 1995).

Some participants appeared to use the interview to share their narrative (Theme VI), with spontaneous descriptions of how and why their experience began. Indeed qualitative methodologies have increasingly been viewed as a tool allowing people to ‘tell their stories’ (Barker, Pistrang & Elliott, 2002) and may have been a motivating factor for participating in the research. The absence of this in the interview schedule might have been a cause for the frustration that some appeared to experience during the interview (Theme VIII). It is therefore unfortunate that space did not allow for a specific exploration of this aspect of participants’ experience considering the centrality of this for them. Future qualitative research with this group should nonetheless be informed by this result.

As can be seen in Table 2 (pp. 207) and in line with the NICE guidelines for schizophrenia (NICE, 2002) all participants had received some form of talking therapy, which as noted above may have contributed to their willingness to participate in the study. It would have been useful to explore this experience with
participants in more detail, as it is likely to have also contributed to their perceptions of 'relating' to their voice. Indeed ascertaining details of a range of interpersonal experiences participants had had with regards to their voice (for example talking to others outside of formal psychotherapeutic contexts) would also have been highly relevant in helping to track the development of participants ideas and beliefs.

On reflection, throughout this process I have experienced considerable frustration with the amount of fascinating data that has had to be set aside in order to remain focused with regard to the research aims. Furthermore whilst attempts have been made to address the research questions, it might have been more useful to address one of these thoroughly, rather than the brief overviews that have been provided here. For example an in-depth exploration of power might have considered self-empowerment to the voice in the context of participants’ gender and occupation status.

Personal reflexivity  Whilst my "history, values and assumptions" (King, 1996, p.176) were acknowledged in the 'Method' I think further elaboration is needed. My preferred theoretical orientation is systemic with subsidiary affiliation for psychoanalytic and cognitive-behavioural models. These models stand out, from the literature review through to the analysis and interpretation. It has also been possible for me to track my clinical experience alongside the development of the research: whilst writing my introduction I was on a specialist psychosis placement which both enhanced my knowledge base and developed my skills in interviewing voice hearers. However as I write I am on a specialist systemic placement, which has helped me to develop a greater understanding of general interpersonal theories as applied to clinical populations.

My personal demographics were influential on the interviews (Theme VIII) and subsequent analysis. For example two participants referred to racism, perhaps as an unwitting acknowledgement of our differing ethnic backgrounds. Another client referred to difficulties she has in speaking to men and I wondered how the interview might have transpired had I been of a different gender. My focus on hearer (dis)empowerment arguably derives from my own membership to two socially disempowered groups by way of my gender and ethnicity, and my commitment in my personal life to challenging this. Other aspects of my identity (e.g. social class) might

5 As stated on p. 202 of the Method
also have influenced the research but I (or the participants?) were not sensitised to these in the same way.

Personal reflexivity is considered a reciprocal process: not only does the researcher influence the research but the research also has a personal impact on the researcher (Willig, 2001). One aspect of personal change that stands out was my increasing awareness of my interview style and my difficulty in hearing people struggle to answer questions I had posed. At times this resulted in me suggesting answers which participants then agreed or disagreed with, rather than describing aspects of their experience in their own words. In my clinical work it has since encouraged me to give clients more time and space to think and I have since striven to sit for longer with my own discomfort when I see clients in difficulty.

Summary & Conclusions
The current paradigm shift where voices are seen to be a meaningful occurrence is further endorsed in the present study and use of a qualitative methodology has provided new insights into the experience. Participants' reluctance to understand their interactions specifically as a relationship has been understood in three ways: as a preservation of self-hood, as a way of protecting personal explanatory models and as a discrepancy from 'ideal relationship' conceptualisations. However the themes of Me vs. the Voice(s) and the Voice(s) & Me also derived from the analysis suggesting that at some level the experience could be encapsulated as a 'relationship', thus emphasising the complexity of the concept. To some extent this 'relationship' displayed features of familiar social relationships, however it is likely that refutation of the relating framework underlined the limited associations that could be made here.

Unique features of the hearer have been identified, namely the ability to self-empower and the development of intimate feelings for the voice; both of these facets demonstrate the complexity of the experience. Although not identified as an initial area of enquiry the social aspect of the voice experience is pertinent for these individuals with regards to sharing, support and stigma.

Clinical implications
Suggestions have previously been made about how an identified 'relationship' with a voice might benefit hearers. Hayward (2003) advocates Birtchnell's (2002) 'relating therapy' as an approach that might allow hearers to alter the relationship they have with the voice, thus ameliorating distress. This will be considered at a later point,
however it is first important to consider the implications of the ambivalence demonstrated by participants towards this concept.

Participants' open and implicit rejection of the concept suggests that proposals of a 'relationship' with the voice should be used tentatively with voice hearers, posed as a possibility rather than an identified truth. Leudar and Thomas (2000) highlighted the danger of imposing clinician's explanatory models with regard to the cognitive model, suggesting that the clinician's worldview and power would be endorsed at the expense of the hearer. A similar caution could be levied here. Furthermore incongruity in explanatory models between clients and services are less likely to result in treatment satisfaction or positive relationships with clinicians (McCabe & Priebe, 2004). Ultimately, most participants wanted the voice to go away and so the rationale for maintaining its presence would have to be described thoroughly and sensitively; it is difficult to see how any therapeutic intervention within this framework could be pursued if this was not the case.

It might be that where illness models are unequivocally endorsed (as with Michael and Russell) this approach would not be of benefit. Initially this led me to consider Early Intervention Services as the appropriate time for this framework to be introduced. However my experience here suggests that for some service users 'symptom' eradication is the primary goal, and so perhaps clients who have heard voices for longer might benefit most. The use of the dual-axis continuum proposed earlier might facilitate identification of those who would be suitable and where might such individuals be located on the continuums.

Bearing in mind the above cautions, it seems that continuing to explore the power dynamics between the hearer and the voice in an attempt to diminish distress is advantageous. Within this, it would be important to help participants consider the multitudinous ways in which power manifests in the voice. Ignoring the individual's self-empowerment would be to disregard their resilience, and so the various strategies used would also be worthy of exploration. This study also supports the notion that other aspects of relating to the voice such as attachment or intimacy might also be relevant to the hearer's experience and therefore any intervention exploring power must also explore these other facets. This attachment might otherwise present an impediment to therapeutic change where amelioration of the voice is the aim.
The elaborate personifications of the voice in the current study presents an opportunity for clinical work to use this medium as a mechanism for change, by engaging the ‘couple’ in a therapeutic approach designed to modify relating styles. Bearing in mind the applicability of Birtchnell’s (1996) model here and the use of modified versions of his measures in previous studies (Hayward, 2003; Vaughan & Fowler, 2004), Hayward’s suggestion of Birtchnell’s Interpersonal Therapy (2002) seems feasible. This approach aims to highlight and reduce negative relating patterns and enable individuals to tolerate the negative relating of others (Birtchnell, 2001). Systemic approaches are also well established in altering relating patterns (Vetere & Dallos, 2003) and alerting voice hearers to the circular processes that can occur between them and their voice, and helping them to generate alternative approaches might be beneficial. Therapy assessments using either approach might also wish to explore notions of ideal relationships – where large discrepancies between this and perceptions of the voice ‘relationship’ are implicated it might be useful to help hearers re-evaluate both of these.

Should such an approach be employed, clinicians would have to be cognizant of the reliance some hearers had on the voice for companionship and ensure that alternative or supplementary relating experiences were provided. This could comprise opportunities for social relating, or might follow Davis, Thomas and Leudar’s (1999) approach involving the formation of a dialogically different relationship with a new voice to aid management of tyrannical voices. In this sample Donna, for example might be encouraged to instigate her docile voice as an ally against the dominant voice.

Service implications
At a service level, this study contributes to the paradigmatic shift in mental health services away from purely medical constructions of mental health towards broader understandings. Contrary to the fears expressed by some teams regarding the detrimental consequences of talking about voices, this study provides further evidence that talking to hearers about what they hear is not dangerous but rather is advantageous in understanding the client’s difficulties. In addition it is viewed as a helpful process even without expectations of therapeutic change, as the feedback from participants in this study confirms. It is clear then that further training of staff working with voice hearers is required. I hope to begin this process by forwarding the results of this study to the participants and their care co-ordinators, inviting the latter
to share the findings with their colleagues. In addition, clinicians will be invited to a locally organised conference on voice hearing (see Appendix 11).

Societal Implications
This study also has implications for challenging prevalent societal views on this distinct group of mental health service users, particularly as participants raised issues of stigma and misunderstanding as an important aspect of their experience. Vakili (2003) suggests that at a personal level, researchers in mental health should challenge friends and acquaintances in their views of mental distress. This is vital specifically because societal narratives on unusual experiences have an important effect on how these are subsequently understood and managed (Leudar & Thomas, 2000). I will therefore endeavour to do this.

Final word
The benefits of researching voices with a qualitative methodology have hopefully been highlighted throughout this research and it will make a valuable contribution to the field. As a result, I have become further convinced that research into hypothesised phenomenon should have at its inception and foundation the perspective of the person under enquiry; if proposed phenomena are not meaningful to them then there is little point in exploring its suitability as a mechanism for therapeutic change.
REFERENCES


Hyden, M. (2005). 'I must have been an idiot to let it go on': agency and positioning in battered women's narratives of leaving. *Feminism and Psychology, 15*(2), 169-188.


Appendix 1 – The Interview Schedule
Interview Script

☐ Thank you for agreeing to take part in the study
☐ Please take a moment to read the information sheet. Take as long as you need.
☐ Have you got any questions?
☐ Can you please read and sign the consent form
☐ I'd just like to remind you that we could stop the interview at any point. Similarly you can choose not to answer any specific question.
☐ I'll just check that the mike can pick up your voice. Could you say your name for me please? Thank you.
☐ At some point I may need to turn the tape recorder over. Try not to let it distract you too much.

INSERT TAPE, PRESS RECORD, THENREWIND AND CHECK TAPE.

☐ If you are ready then we'll begin.

TURN TAPE RECORDER ON AND PROCEED WITH INTERVIEW

☐ That's the end of the interview.
☐ The tape recorder has now been switched off
☐ It would be helpful for me if you could give me some feedback on the interview, the study and being a participant.
☐ Were there any questions you liked/disliked? Found difficult/uncomfortable?
☐ How has the interview left you — is there anything I should know before you go?
Research Dossier – MRP Appendices

Interview schedule – voice hearers’ experiences study

The interview will start by gathering some general information about your voices. I will then ask you about your personal explanation of voice hearing. Finally I’ll ask you about relationships and specifically how you relate to your voice.

So, I’ll begin by asking you some questions about the voice or voices you hear:

☐ When did you first start hearing voices? What was that like?

☐ How many voices do you hear?

☐ Do you have an idea whose voice you hear? Does it/do they have names?

☐ Does the voice talk to you or about you?
(Prompt: – what types of things does it say? Command/advice/commentary/critical/hostile?)

☐ How often do you hear it?
(Prompt: – e.g. hourly, daily, weekly, when you do particular things etc).

☐ Has it been a constant presence or has it come and gone over the months/years? When did you first hear your voice?

☐ How do you feel when the voice speaks?
(Prompt: – is the voice trying to harm you in any way or is it trying to help you or something else? Punishment for bad deed vs. protection, is it powerful etc).

☐ Does the voice come through the ears or from inside the head?

☐ Is the voice a man or woman or are you unsure?

☐ How do you manage this experience – what helps & what doesn’t?

☐ Which voice/is there a particular voice that you would like us to explore in detail?
(Prompt: – if not already apparent how would you like me to refer to you voice; shall I call it by name?)
Relationship questions

I would now like to ask you some questions about relationships in general and what they mean to you. Human beings, like others in the animal kingdom have a range of different various relationships. However I'm interested to know:

- What does the word “relationship” mean to you?
  (OR how do you understand the term “relationship”? OR what do you understand by the term “relationship”?)

**HOW DO YOU KNOW WHEN YOU ARE IN A RELATIONSHIP WITH SOMEONE?**

(Prompt: ask them to describe a relationship they have with another person and the role it plays in their life?)

(Prompt: the dictionary describes “a relationship” as the way in which people or things are related or interrelated / how we behave towards one another

(Prompt: listen out for reciprocity in their description i.e. relating vs. being related to)

WHAT ARE YOU DOING? WHAT IS THE OTHER PERSON DOING? WHAT ABOUT BAD REALTIONSHPES?

- Considering your understanding/description of what a relationship is, would you say that you have a relationship with your voice?

If YES: (NB relationship NOT relating to. Start with v-p, then p-v

- How would you describe your relationship currently? (Prompt – e.g. good/bad, one-way two-way, who feels like they are “on top”? How many people are in this relationship; does it feel like you have any influence?)

IS THE RELATIONSHIP THE SAME WITH EACH OF THE VOICES? Are there things your voice knows about you that others don’t?
When thinking about your relationship what feeling does it evoke/stir up in you?
(Prompt – be aware that they may talk about feelings the voice evokes)
POSITIVE EMOTIONS/NEGATIVE EMOTIONS e.g. distress?

Have you always had this type of relationship with your voice?
(Prompt – How is it that you have come to form this type of relationship with your voice? When did you first start to see your voice in this way? WHEN DID IT CHANGE FROM JUST BEING SOMETHING YOU HEARD TO SOMEONE YOU DEPENDED ON FOR E.G. WHAT HAVE YOU DONE TO FACILITATE THIS CHANGE? What changes it or keeps it the same? Has it changed over time?)

How would your life be the same or different if you did not have this relationship?
(Prompt – How important a relationship is it to you?)

Would you like your relationship with your voice to change?
(Prompt – if you could how would you change it)

How similar or different is this relationship to other relationships you might have?
DO YOU ACT THE SAME AS YOU DO IN OTHER RELATIONSHIPS?
DOES THE VOICE ACT LIKE PEOPLE YOU KNOW OR IS IT V DIFFERENT
(Prompt – in rest of life, family, friends, work colleagues, past & present).

If I were to ask your voice some of these questions how similar or different might their answers be? CAN WE DO THAT?

GO TO DEMOGRAPHICS QUESTIONNAIRE
If NO:
☐ How is it that you feel you do not have a relationship?

☐ What stops you from having a relationship/ what would make it easier to have a relationship with your voice?

☐ How would your life be the same or different if you did have a relationship with your voice? / If you had a relationship with your voice is there anyway that would be useful to you?

☐ If you were to have a relationship with your voice what kind of relationship would it be?

☐ Is there any way that a relationship with your voice might be useful?

☐ If I were to ask your voice these same types of questions how similar or different might their answers be?

GO TO DEMOGRAPHICS QUESTIONNAIRE
Background Information Sheet

The following information is collected so that people who read the final report can know more about the people who have taken part. However, you will not be identifiable in the research as the study is completely confidential.

1. How old are you? ______

2. How would you describe your ethnicity?

(Please choose one section from (a) to (e) and tick the appropriate box to indicate your cultural background).

(a) White
   British □
   Irish □
   Any other White background, please write in below

(b) Mixed
   White and Black Caribbean □
   White and Black African □
   White and Asian □
   Any other mixed background, please write in below

(c) Asian or Asian British
   Indian □
   Pakistani □
   Bangladeshi □
   Any other Asian background, please write in below

(d) Black or Black British
   Caribbean □
   African □
   Any other Black background, please write in below
(e) Chinese or Other ethnic group
Chinese □
Any other, please write in below

3. What is your highest qualification? (please tick appropriate box)

None □
GCSE(s) / O level(s) / CSE(s) □
A level(s) □
Diploma □
Degree □
Postgraduate degree □

4. What is your current job (or, if you are not working, what was your last job)?

..........................................................................................................................

RETURN TO FIRST PAGE
03 December 2004

Ms Jasmine Chin
Trainee Clinical Psychologist
Department of Psychology
School of Human Sciences.

Dear Ms Chin

Are voice hearers able to relate to their voices: an interpretative phenomenological analysis (EC/2004/116/Psych) - FAST TRACK

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 03 December 2004

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

Document Type: Application
Version: 1
Received: 26/11/04

Document Type: Summary of Risk Assessment Issues
Version: 1
Received: 26/11/04

Document Type: Insurance Proforma
Version: 1
Received: 26/11/04

Document Type: Approval Letter from the Bromley LREC
Version: 1
Dated: 05/11/04
Received: 26/11/04
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
   Dr M Hayward, Supervisor, Psychology
   Dr A Drinnan, Co-Investigator, Stepping Stones CMHT
Appendix 3 – NHS Local Research Ethics Committee (LREC) Approval
05 November 2004

Ms Jasmine Chin
Trainee Clinical Psychologist
Psychology Department
University of Surrey
Guildford
GU2 7HX

Dear Ms Chin,

*Full title of study:* *Are voice hearers able to 'relate' to their voices: an interpretative phenomenological analysis*
*REC reference number:* 04/Q0705/26
*Protocol number:* N/A

Thank you for your letter of 10 October 2004, responding to the Committee’s request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chairman.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation.

The favourable opinion applies to the following research site:

- **Site:** Stepping Stones CMHT (Oxleas NHS Trust)
- **Principal Investigator:** Ms Jasmine Chin

**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:

- **Document Type:** Application
  - **Version:** 3
  - **Dated:** 16/08/2004
  - **Date Received:** 19/08/2004

- **Document Type:** Investigator CV
  - **Version:**
Management approval

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.
Notification of other bodies

We shall notify the research sponsor, Stepping Stones CMHT (Oxleas NHS Trust) that the study has a favourable ethical opinion.

Statement of compliance (from 1 May 2004)

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.

REC reference number: 04/Q0705/26 Please quote this number on all correspondence

Yours sincerely,

Carol Jones
Chairman

cc. Anthony Davis, R&D Co-ordinator, Oxleas NHS Trust
Dr Ange Drinnan, Stepping Stones CMHT

Enclosures: Standard approval conditions [SL-AC1 or SL-AC2]
Appendix 4 – Participant Information Sheet
Exploring the relationship developed with a voice

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

Thank you for reading this.

What is it about?
Although much research has been conducted into the experience of hearing voices it has tended to be based on questionnaires and have not considered how the voice hearers themselves would explain their experience. This study is looking at the personal reports of voice hearers regarding the voice(s) they hear and any relations they may have formed with them. It is concerned with any relationship they might have developed with their voice(s) and where the pattern of this relationship may have come from. It is hoped that greater understanding of how voice hearers relate to their voice may provide useful strategies that can be shared with others.

Why have I been chosen?
You were invited to take part because you have reported hearing voices for at least one year. In total it is hoped that eleven other individuals will also be interviewed.
**Do I have to take part?**
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision to participate or not participate, will not affect the standard of care you receive.

**What will it involve?**
If you agree to take part you will meet with a researcher at a time and place convenient to you. You will be asked to participate in an interview about the voice(s) you hear. You will also be asked some questions about what it is like to hear voices and asked about your views on your experience. Finally you will be asked some more general questions about yourself. The interview will be tape recorded to assist the researcher in later transcribing your experiences. The total duration of the study is approximately 1 hour.

We are also interested in the views of the Doctors who work with you and how they have understood your experiences. This would involve looking at your medical records which are held on file at the mental health team.

You will be reimbursed for any expenses that you incur as a result of participating in the research (e.g. travel costs), at the time of the interview.

With your consent, your GP will also be informed of your involvement in the study.

**If I am unhappy about the interview, will there be additional support?**
If following the interview you feel that you would like further support from the community team has agreed to offer you an appointment. If your concerns are unable to be resolved by the research team or your keyworker, and you wish to take your complaint further, arrangements have been made to provide compensation.

**What will happen to the information I provide?**
The interview will be audio taped and the conversation will be transcribed to provide a paper copy of the interview. On this paper copy, all names and identifiable information will be changed to preserve anonymity. Once the study is completed, the audiotape will be erased.
The anonymous paper copy will be kept as a record. Only the researcher and her supervisors will have access to the transcripts. If at any time you decide that you wish the tape to be erased immediately, let the interviewer know.

All information which is collected about you during the course of the research will be kept strictly confidential. However during the interview, should anything be described which suggests you or someone else may come to some harm, this information will be passed on to your Care Coordinator or Consultant Psychiatrist. You will be informed of this at the time. This guideline will apply whether or not you complete the research process.

Any information about you that leaves the mental health team will have your name and address removed so that you cannot be recognised from it.

You will be able to obtain a copy of the results of the study by Summer 2005. You can indicate on the consent form below if you would like a copy and the mental health team will pass these on to you. It is also hoped that the results will be published in a psychology journal.

Who has reviewed this study?
This study has been reviewed by Bromley Local Research Ethics Committee.

I still have questions – who can I ask?
Further information for this study can be obtained from:
You will be given a copy of this information sheet and a signed consent form to keep for your records.

Thank you for taking the time to read this information.
Appendix 5 – Consent Form
CONSENT FORM

Exploring the relationship developed with a voice

Name of Researcher: Jasmine Chin

Please tick box

☐ I confirm that I have read and understand the information sheet dated ......................... for the above study and have had the opportunity to ask questions.

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

☐ I agree to my GP being informed of my involvement of the study

☐ I understand that participation in this study will require the researcher to gain access of my medical records in order to obtain the views of the Doctors who work with me.

☐ I understand that participation in this study will also involve having the interview tape-recorded.

☐ I agree to take part in the above study.

Please delete

I would / would not like to receive a copy of the results of the study.
<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person taking consent (if different from researcher)</td>
<td>Signature</td>
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Appendix 6 – Transcript Interpretation
34 Michael: my worst time is in the morning
35 Jasmine: oh right that's interesting
36 Michael: yeah in the morning
37 Jasmine: just when you've woken up
38 Michael: yeah and sometimes stress makes them very bad as well
39 if I've got a bit of a stressful day or if something's happened it really
40 brings them on
41 Jasmine: yeah yeah and how do you manage it how do you cope
42 with it?
43 Michael: well (sighs) somebody said to me once erm and erm in a
44 way we've all got we've all got different sorts of coping strategies
45 haven't we
46 Jasmine: mmm mmm
47 Michael: and mine is if they're not too bad I can actually I keep
48 myself occupied I've got quite a lot of interest and my computer and
49 I've got lots of other hobbies and that erm so I always I can always
50 do something to take me mind off of them
51 Jasmine: right yeah
52 Michael: but when they get really really bad erm the best thing is to
53 actually accept them erm instead of fighting them
54 Jasmine: yeah
55 Michael: actually accept them as though I've xxxx a good day
56 today, I've had a good rest I'm not gonna do nothing erm sometimes
57 I find that better for them xxxx and wear meself out
58 Jasmine: yeah yeah
59 Michael: (laughs)
60 Jasmine: and how when those times coz I mean that sounds like a
61 very sensible approach to try and just live with it but those times
62 when you feel like fighting against them as you said what what are
63 the types of things you do how is it that you can fight against them?
64 Michael: well one thing is to not take any notice of them so what I
65 try and do I try and focus my mind on on other things like like I've got
Transcript – Participant B6

From interview on 04.02.05

Norman: yeah especially when my sister talks to me
Jasmine: right tell me a bit about that
Norman: oh god cos cos the last time I saw her she was in ..., hospital ...
that was in 1966 when she she died in St ..., hospital and I never saw her
since I never saw her after she left died er left Penley hospital ...went up to St
my parents never took me up there
Jasmine: right you must have been quite young
Norman: I was 9 and she was 8
Jasmine: right she died at a young age
Norman: yep.
Jasmine: so when you hear her voice it ...
Norman: it's a loving warm feeling cos that what she left me with
Jasmine: really
Norman: yeah
Jasmine: yeah. Her voice that you hear is it her voice as she was when she
was 8
Norman: yeah yes
Jasmine: so still a [child's voice]
Norman: still a child's voice yeah] a lovely warm little voice
Jasmine: what sorts of things does she say to you Norman
Norman: well she she says that she still loves me
Jasmine: that must be nice
Norman: yeah and we do play together somehow she as I told (psychologist)
everyone who dies in my world they're still alive
Jasmine: mhmm
Norman: in your world they're dead but in my world they're still alive because I
can see 'em hear them and touch they're solid
Jasmine: right so its not just the voices you hear
Norman: no I can see them as well
Jasmine: you see them. Can you see them now
Norman: no when I get in I don't know what it is when its in these rooms I shut
'tem outside
Jasmine: right
Norman: I don't let 'em in here
Jasmine: it must be hard
Donna: (chuckles)
Jasmine: it sounds really difficult
Donna: (chuckling) it is difficult yes
Jasmine: are you able to share your experience with anyone, do you
Donna: erm not really, some people say they hear voices, one woman
at the Mind place I went to
Donna: (I've heard voices) she said just talk to them, be nice to them and they'll be nice to you
Jasmine: mmmm
Donna: erm she said 'oh I hear voices all the time, I have done since I was a child and I had the flu and ever since then I've heard voices' she said just talk to them, be nice to them and they'll be nice to you
Jasmine: mmmm
Donna: but I've never found that with mine.
Jasmine: so have you, did you try, did you give it a go
Donna: I've tried being nice, I've tried saying 'hi, how are you' and you know, isn't it a lovely day' and you know, generally sort of, pleasantries
Jasmine: yes
Donna: and they just ignore me so...
Jasmine: right. So it seems like they, they're not interested in my conversation, they only want to strike me down with the horrible things they say
Donna: and it sounds like the conversation starts with them, so when you try to initiate conversation they're not that interested, it needs to start from them
Donna: yes
Jasmine: do they erm, you talked about them belittling you and saying unkind things to you
Donna: (chuckles)
Jasmine: do they ever command you to do things, well you said they told you to find a brick wall
Donna: yeah find a brick wall, and they told me to cut myself, they told me to go in the kitchen to find a knife and cut myself, which I've done before but I must have very blunt skin, erm but I've tried before to cut
Appendix 7 – Sample Transcript (Nathan)\textsuperscript{6}

\textsuperscript{6} Transcript notations can be found in Appendix 10. Please note that all identifying details have been altered
Jasmine: ...and at some point I may have to turn the tape recorder over so try not to let that distract you too much. INTERVIEW INTRODUCTION.

Ok so how many voice do you hear?

Nathan: I've got just the one voice

Jasmine: and do you have an idea whose voice it is?

Nathan: yes.

Jasmine: who's is that?

Nathan: it's a young female girl xxxxx

Jasmine: right so its someone you know?

Nathan: no I don't actually know her

Jasmine: oh right

Nathan: but there was a time I did, xxxxxxx

Jasmine: right so someone from your past

Nathan: well not actually my past but recently in the last five years

Jasmine: right ok. And has it always been this, has she got a name?

Nathan: Emma.

Jasmine: Emma. Do, do you call her by name or do you just call it the voice?

Nathan: I just call it anything that comes into my mind at the time

Jasmine: right

Nathan: and most of the time I just say leave me alone and go away

Jasmine: right ok. And erm has it, has the voice that you heard always been this, this particular person.

Nathan: recently yes

Jasmine: and so previously did you hear the voice of someone else?

Nathan: I heard loads of voices

Jasmine: right

Nathan: most of them were people I knew, I've even heard Tony Blair's voice, believe it or not.

Jasmine: but now the last

Nathan: [but now the last five years it's just been this one girl

Jasmine: right ok. And does the voice talk to you or about you or

Nathan: yes, no it doesn't talk about me, well not actually about me but it says things about me that I believe other people know as well

Jasmine: right ok, and it will say, it will say 'you do this or that'

Nathan: yeah it says you

Jasmine: rather than Nathan
Nathan: yes. Doesn't say my name, other than when it's actually talking to me.

Jasmine: like in conversation?

Nathan: [in conversation.

Jasmine: what kinds of things does it say?

Nathan: well most, most of the time it tells me to masturbate, so now and again I do, but I've stopped that this year, I'm going through the second week now of not doing it, which is hard from where I was doing it for so long.

Jasmine: so this is like your new years resolution is it?

Nathan: yes, well I'm trying to give up one thing at, that I want to do, at a time, once a week. So come Friday I'll give something else up. So last Friday I gave up masturbating, so other than that its mostly sexual things, that sort of thing.

Jasmine: and that's what it talks to you

Nathan: [that's what it talks to me about, tells me about that she would like to get to know me and maybe go out with me and whatever but, I'm not interested in that.

Jasmine: right

Nathan: all I'm interested in is getting my hearing voices sorted. That's more important to me than anything else. So this is gonna help.

Jasmine: right so your, your main concern is just getting on with life.

Nathan: getting on with life and getting myself better.

Jasmine: and how would you describe the voice?

Nathan: erm ......

Jasmine: would you describe it as friendly or critical or how would you

Nathan: both xxxx

Jasmine: oh right, and in what way it is friendly.

Nathan: well most of the time it says, it just explains, it it tells me she wants to get to know me and that and and then a friendship may develop and I make more friends cos I've got very little friends at the moment, because of the voices.

Jasmine: right

Nathan: cos I don't want them around if I flip, so I've had to get rid of them, not just that I've had to get rid of them because of other things they've done to me, which has hurt me, which may cause the voices later on in life, so I've got rid of that, the beginning of it.

Jasmine: yeah yeah, and so the voices.
Nathan: [most of it is just friendly, its just friendly stuff, but now and again it is horrible
Jasmine: right and what are the kind of horrible things?
Nathan: erm it may, it may say, now and again turn the telly on or do this or do something else if I've got my music on, cos I like my music and I, I, if I was allowed, I'd have it on 24hours a day, and I'd have it up quite loud, cos I like my music loud you see, national radio, so I have to have it loud cos I can't hear without xxxx xxxx, so I have it loud. Er it might say get undressed or something like that
Jasmine: so its directing you
Nathan: its actually directing me to do it and I'm forcing myself not to, because in the past I have done it
Jasmine: so you're strategy now is to
Nathan: [my strategy is to, to fight it out, because I'm out there in this world on my own, I've got very few friends you see. Family have just started to support me a bit more now, so that's a start in the right direction
Jasmine: right, yeah yeah, and
Nathan: [but I'm out there on me own.
Jasmine: yeah ... I understand.
Nathan: and its hard cos people know my business and that's it.
Jasmine: right, yeah, yeah so it's difficult
Nathan: [I'm I'm afr, I'm actually afraid to go out because of it
Jasmine: because people know you
Nathan: because people know your business
Jasmine: right, that must be really hard for you
Nathan: this is the first time since ... Tuesday I've been out
Jasmine: really? Well I really appreciate you coming
Nathan: well I had to, I had to get out because I don't like being stuck indoors
Jasmine: so it sounds like your, does your strategy of trying to ignore them work, when they
Nathan: [well I, I started this, I actually started this January last year, fighting it and March, just before Easter, every voice I heard just disappeared, and all of a sudden something inside me started talking to me, and since that started the voices come back so I was readmitted to NAME OF HOSPITAL in September
Jasmine: September just gone
Nathan: yes. So I, I want to know what the voice is doing inside me. I've
asked Simon, Simon Johnson (CPN), and he doesn't know, doctors won't
tell me, but there is something inside me talking to me, and I want to know
what it is, because it's the start of the voices again, soon as that started the
voices come back
Jasmine: right ok so you're noticing a pattern
Nathan: I'm noticing a pattern yes.
Jasmine: well, I mean this, although we'll be having a conversation about
your voices it won't particularly be trying to look at, what this thing is inside
you
Nathan: mmm yeah thing is it its connected to the voices though
Jasmine: right ok
Nathan: as soon as it, it started Easter of last year, and the voices
disappeared and then this started and then the voices came back again
Jasmine: its difficult
Nathan: it is difficult to when you thought it was so long, you go from
January to March without hearing them, and then they start again
Jasmine: yeah, so your strategy of ignoring them did work
Nathan: did work yes.
Jasmine: what about now? Does it work now?
Nathan: its harder now, because it's the one girl.
Jasmine: right
Nathan: that's the thing it's harder because it's the one, if it was other
voices then yeah, maybe I could do it again but it's just the one voice.
Maybe I've got to go and see this girl and tell her to leave me alone and
maybe break the connection, I don't know, because it's bugging me.
Maybe if I could do that maybe the voices would go and I could get back to
a normal life.
Jasmine: yeah, yeah ok. And how do you feel when the voice speaks?
Nathan: (whispered) I feel scared. I do feel scared.
Jasmine: what's your fear about, what do you fear the voice
Nathan: [what, what it's gonna lead to. I don't know what it's gonna lead to
cos last year it was Simon was saying go down the HOSPITAL NAME, and
doctors forced me back in, I didn't want to go but they forced me back in. I
do get scared of them, when I'm in hospital I get scared as well, because of
them.
Jasmine: so the fear is about being readmitted to hospital
Nathan: yeah, yeah
Jasmine: [and that’s what it’ll lead to
Nathan: yes, mm. I’m I’m actually scared of hospitals as it is... so I can
remember when I was at HOSPITAL NAME, a xxxx way away, then I was
transferred to HOSPITAL NAME2, NAME OF unit, I kept walking out there,
I stayed there for the weekend but I couldn’t take it so I kept walking out
and going home, they weren’t telling me nothing...they just left me to get on
with things
Jasmine: so it sounds like you had quite negative experiences being in
hospital
Nathan: yep, yep
Jasmine: and when you hear the voice, it evokes all those kinds of
memories,
Nathan: [all those memories
Jasmine: they come flooding back?
Nathan: [yes
Jasmine: ok. Is there any other feelings you get from the voice other than
feeling scared?
Nathan: no, no normally I can get on with things
Jasmine: but that’s just the main one
Nathan: it’s just the main one yes
Jasmine: in your view what’s the voice trying to do?
Nathan: I don’t know, I don’t know
Jasmine: you haven’t worked that out yet
Nathan: no I haven’t, because what it is I believe in God xxxxx xxxxx xxxxx
even though the things I told you today, were personal
Jasmine: and they’ll stay personal
Nathan: and erm I believe it’s God putting the voice there as a warning to
what’s coming because I hear things in advance to what’s coming because
I hear God’s voice as well, alright I hear God’s voice, I’ve heard it a few
times and its times that things in the past that come to the future, that
scares me
Jasmine: right, right so the voice tells
Nathan: [the voice tells me what’s coming
Jasmine: that must be frightening
Nathan: yes it is, cos I sit back and I say to myself ‘yeah alright we’ll see
what happens’ and then all of a sudden they start happening...
Jasmine: gosh that's really scary
Nathan: [it is scary
Jasmine: so in a sense, you, you don't know whether the voice is telling you
these things because it wants to protect you or hurt you or
Nathan: I, I, I'm not sure but I think its there for protection
Jasmine: right
Nathan: because of what's happened through my life, because I turned to
God at the hour of need it come to me when I really need it, that's what He
does, when you really need Him he'll come, until then don't bother, that's
my look at it
Jasmine: so it sounds like you heard the voice of God before
Nathan: yes
Jasmine: but that's not the voice you're hearing
Nathan: no, no it's the girl Emma's voice I hear at the moment
Jasmine: right, so this was in the past
Nathan: yes, this was in the past
Jasmine: has it, has it been a constant presence this current voice over the
last 5 years?
Nathan: yes
Jasmine: so is it there daily or every other day, how does it go?
Nathan: most of the time it's there when I'm on my own indoors and I've got
no music on no telly on or nothing I'm there quietly, I'm just sitting there
relaxing. I puff and I'll have a joint now and again and it just comes, but
from what I've been told, it's the Cannabis that causes it, but I can't see that
myself because of things in the past that have happened that I'm trying to
find out about and not getting the information, otherwise I can't get rid of
them and its something I want to find a cure for, even if I have to do it on
my own I will.
Jasmine: so ... you, you're saying you use Cannabis to relax you?
Nathan: yes
Jasmine: but you're getting a different message from the doctors who are
telling you that it's causing the voices that you're hearing
Nathan: yes exactly yes, because I've been pushed round from pillar to
post, from a young age maybe that is the cause of it as well, I've gone right
back to when I first went in care, to find out about it. And I get I get these
feelings in the heart as well, and that started, even before these voices
started, way before. I could, I could say 'yeah that was a part of me' but I
can't see it myself because of the situation I was in at the time so I could
say no, it's not a part of it, so I couldn't get rid of things that maybe other
people can't, because I was there, they wasn't, and most people won't
listen to me
Jasmine: right, that must be so frustrating
Nathan: yeah it is. I've had nobody to turn to for years, until Simon came
along, and I've got someone, and I've got to keep that going
Jasmine: good for you, that's good. Erm and it, so the voices turn, the voice
tends to come on when your
Nathan: when I'm, alone
Jasmine: alone and relaxing
Nathan: relaxing yes
Jasmine: and so its, are there things you can do to distract yourself away
from, to stop yourself from hearing
Nathan: [well no, but yes there is, I can do some decorating cos I just got a
new flat
Jasmine: oh great
Nathan: and I'm in the process of decorating
Jasmine: so that kind of distracts you away
Nathan: [that distracts me and I can put the music on and turn it up and I
can't hear them
Jasmine: so that's how you mostly manage it
Nathan: [manage it with the music yes
Jasmine: [yes, yes. Is there any, anything else that works do you find?
Nathan: no not really cos I, I, I turn the telly and I can hear people on the
telly talking about me, so it's hard ...because there's certain programmes
on during the week that I won't watch and I don't because of the voices
Jasmine: the voices from the telly?
Nathan: yes from the telly
Jasmine: not the ones
Nathan: it's like on Eastenders, have you seen recently with the solicitor
and Sam
Jasmine: oh yes
Nathan: his name's Nathan
Jasmine: Oh that's right
Nathan: and I didn't know that until last year, and I thought they were
talking about me and then I saw Phil with him and he talked with Nathan
... and so I got rid of that as one of the voices. So I can watch Eastenders now, but I don't like them sort of programmes because they're (made a disparaging noise & shuddered)

Jasmine: they're a bit depressing aren't they?

Nathan: they are depressing cos they're doing things other people do in real life, like sleeping round with all different sort of people, that's not right, and they're showing it on telly, prime-time time... for kids, it's not on

Jasmine: yeah I understand what you're saying, yeah

Nathan: it's that sort of thing (disparaging noise) makes me feel disgusted

Jasmine: yeah, yeah

Nathan: no I don't like that sort of stuff, so I don't watch the telly that much

Jasmine: but with your music

Nathan: [with my music, I'll have it on 24hours a day

Jasmine: that's, that's the one that really works for you

Nathan:[that really works

Jasmine: oh well its good that you found something

Nathan: yeah, oh yeah

Jasmine: that, that's helpful. Ok and what doesn't help what, what

Nathan: going out and hearing people talking about me, that doesn't work.

If they was to leave me alone, then maybe I can approach them if they want me to approach them and build a friendship or whatever, but until they leave me alone I'm not gonna do anything, I'm concentrating on my voices

....

Jasmine: that's your main concern

Nathan: that's my main object

Jasmine: and so that's why you're saying you, you're staying in the house a bit more often now

Nathan: yes, because I don't want go, I want to go out I should say but I don't because of it.

Jasmine: ok and ...does the voice that you hear, does it come from outside your head or is it inside

Nathan: outside

Jasmine: so it's like its coming from your ears. Ok. Now I'm going to ask you some questions about relationships in general and what they mean to you. Now human beings, like any other animal can have a range of different relationships, but what I'm interested to know is what does the word relationship mean to you?
Nathan: friends, xxxxx families that are special
Jasmine: yeah, yeah xxxx special relationships that you can have. Ok,
maybe, perhaps you could describe a relationship you have with someone
at the moment... you were talking about Simon earlier
Nathan: Simon, Simon is a very good friend, actually, he has, he's done
more for me than anybody I can ever think of, in my life. He's done more
for me in three years than anybody done for me in 37
Jasmine: right so he's someone that you hold in
Nathan: yep I like him a lot, a lot. I think maybe I can start trusting him a bit
more... cos over the last couple of years I've been gradually talking to him
more and telling him more about my past, what I've done, what I haven't
done, what I would like to do, and he's been guiding me through it, so I
know I can turn to Simon now in my hour of need
Jasmine: right so are you saying
Nathan: so that's the relationship I wanna keep going
Jasmine: and what it sound's like you're saying in this relationship you, at at
first you were holding back a bit but now your feeling more able to trust
Nathan: now I'm feeling more able to trust
Jasmine: and be honest with him
Nathan: yes
Jasmine: yeah, and it, it's something that's quite important to you when
you're in need xxxx that you've got this relationship
Nathan: yes as I was saying just now as well about my family, they've only
just started as well, so that's a good sign, I've, I've got them to turn to, and
in the past I didn't, cos I was on my own all the time, but now its slowly
started to come together that I've got people round me I could turn to,
which is good.
Jasmine: yeah, yeah, developing a network
Nathan: yes
Jasmine: of people around you, ok
Nathan: but there are certain other relationships I'd like to sort out but not
until I sort my voices out
Jasmine: yeah
Nathan: it's just xxxxx xxxxx
Jasmine: yeah. Erm and you've spoken a lot about how these other people
who behave towards you have been there for you and supported you, how
would you describe how you behave towards them
Nathan: oh a lot better,
Jasmine: ok
Nathan: yeah a lot better, I talk to them more, I can get a relative
conversation with them and all that even the friends that I made last year, I
made a few friends last year, some have gone, some have stayed, and I
get on very well with them, so they are there, but it's a slow process
Jasmine: of course it is, of course it is. Ok, well considering your
understanding and description of what a relationship is from what you were
saying xxxx supporting you or not, would you say that you have a
relationship with your voice?
Nathan: ...that's hard, to say but yes I know, I'd rather get rid of them so I
should say on the occasion yeah I have had conversation with them, but I
don't speak out loud I say it to myself quietly, so other people can't hear
Jasmine: yeah, yeah. So you're saying that the fact that you conversate
and respond back to the voice
Nathan: yes
Jasmine: means that you're getting to have a relationship
Nathan: [have a relationship
Jasmine: but you'd rather
Nathan: [I'd rather I didn't yes
Jasmine: you'd rather the voice wasn't there
Nathan: yes exactly
Jasmine: well is it alright, I mean seeing as you, you do see yourself as
having a bit of a relationship with the voice, is it alright if we continue talking
about it as if you do
Nathan: yeah, yeah, yeah, of course.
Jasmine: that's alright?
Nathan: yeah cos I may get a bit more understanding of i
Jasmine: right ok. Well how would you describe your relationship currently
with the voice
Nathan: ...friendly, I would say it was friendly yes
Jasmine: right tell me, some more if you can
Nathan: because its something that's about this girl Emma, its just
concentrating on her, because back in ...2000, Christmas ...January 2001 I
walked in the shop to get my newspaper like a I normally do, and I looked
up on the counter and I see her, and I got this feeling here (pointed to
body), so I let it go and then two years later, I thought to myself, I got the
feeling again, so I went to move on he. And I sent her a Christmas card saying to her if you wanna get to know me, but not in that way I, I, I put it a different way.

Jasmine: yeah in a

Nathan: [but if you want to get to know me, have a try and the thing that happened is the same thing that happens to all, the people I get to know other people get involved

Jasmine: right

Nathan: and I walked away

Jasmine: right

Nathan: and then the voices started, erm again, last March and then this year it’s started again, and its based on her most of the time, its her voice I hear

Jasmine: and because it, because, is it because it was someone you wanted to get to know is that why it’s a friendly relationship

Nathan: most, I think so yes, because, I don’t think it would put me wrong at the moment but it could do, and it could make me depressed and I could end up back in hospital and that is what I’m trying to avoid

Jasmine: but at the moment

Nathan: at the moment it’s friendly, yes and if I can keep it that way, then I’m going to

Jasmine: how do you think you’ll be able to keep it a friendly relationship?

Nathan: (whispered) talk to it now and again, it’s the only thing I can do, or give this girl Emma another hint if she wants to be friends, and maybe get her to talk to me as well, and maybe by doing that it might break it, and it’d disappear and then maybe yeah, something, another voice would come

Jasmine: yeah

Nathan: and then I’ve got to do it to that one

Jasmine: [that one again

Nathan: and then its just continuous and I don’t want that, I want them to leave me alone and then that way the voices won’t be there because I think if it was me, I should approach them…not the other way, if they approach me, the voices would come back

Jasmine: right, right

Nathan: and then if I approach them, like I have in the past, the voices haven’t been there.

Jasmine: so it’s you, you need to be
Nathan: [so it's got to be, I've got to withdraw a bit more from myself and
open up,
Jasmine: right, I see that's what I think it is, I've got to withdraw and open
up because it's been inside me for so long, it all builds up trying to sort them
out and get rid of them
Jasmine: right, so the more you engage
Nathan: [the more I open up, the more I engage yes, the less I hear
Jasmine: right ok, and but you're saying if the person, if it's the person
that comes to you, then your more likely
Nathan: the voices, I'm more likely to hear the voices yes. That's what
I've worked out, whether it's true or not I don't know because I've only just
done it this year
Jasmine: right
Nathan: so I've got to, that's why the other night I went up to her house, I
didn't knock on the door or anything, I was in a mate's car and I got him to
beep cos that's what people do, they do, and I hope she understood what it
meant, but I don't think she did, but if she does then fair enough. If she
wants to be friends then fine, because I could do with friends
Jasmine: yeah
Nathan: in the female variety, I've only got one female friend
Jasmine: right, right
Nathan: it's all I've got. The rest are male, so maybe they can help me as
well
Jasmine: yeah, yeah, yeah. And you said something earlier about erm in
order to maintain the relationship, a friendly relationship with the voice you
needed to keep answering back now and again
Nathan: yeah, not everything, not on everything, on personal things I'll
ignore
Jasmine: when it's being personal about
Nathan: [when it's personal
Jasmine: [about about you?
Nathan: I ignore it now
Jasmine: ok
Nathan: but they're still there
Jasmine: right ok
Nathan: but I don't like it
Jasmine: so you wouldn't be able to maintain a friendly relationship if you ignored it all the time
Nathan: no, I don't think so, it might get worse
Jasmine: so to kind of keep it
Nathan: to keep it as it is I've got to talk to it right away ... but I don't want to ...
Jasmine: so yeah, there's things that you've got to do to just kind of keep it happy, keep the voice happy and then the relationship stays at this friendly level
Nathan: [level yes and I can get on.
Jasmine: yep, yep ok. Do, I don't know if this will make sense to you but, sometimes people in relationships say 'she's the one that's on top' or 'he's the one in that relationship'
Nathan: no
Jasmine: is it, can you are you able to, who's 'on top' in your relationship with your voice, are you able to,
Nathan: I am most of the time
Jasmine: in control?
Nathan: yes yes. I've hopefully got in under control as best as I can, which is a good thing. Cos if I hadn't, I could be to and fro to hospital so I've got to keep it under control
Jasmine: and is one way of you maintaining that control, talking to it now and again
Nathan: yes.
Jasmine: are there other ways that you maintain control?
Nathan: not really no, the voice takes control most of the time, and I try and not let it
Jasmine: erm, sorry so it sounds like you have some influence over it,
Nathan: yeah, yeah yeah
Jasmine: who, who would you say has the most influence
Nathan: the voice, the voice yes, cos if I ignore it, it starts raising its voice and then the music goes up
Jasmine: you turn the music up
Nathan: I turn the music up to, blare it out, so I can't hear it. And then I get problems with housing, people saying I listen to music too loud, most of the time its quiet cos I don't hear it that often
Jasmine: how, how often do you hear it again?
Nathan: two, twice a day

Jasmine: oh right. Ok how long?

Nathan: five ten minutes at the most, so I've got it that far. But if I ignore it, it gets worse. So I say it's got the upper hand

Jasmine: overall?

Nathan: overall yes. Because it could be there 24 hours a day

Jasmine: that's true

Nathan: and that's what I ... put my mind too, and said 'no you're not gonna be like that, you're gonna be like this, and eventually I'm gonna get rid of you', if not then I've got something to xxx as well and I don't wanna do that

Jasmine: so you said earlier that the voice makes you feel scared

Nathan: yes it does, very scared

Jasmine: erm, I don't know if your answer to this question will be different or the same but when thinking about your relationship with the voice xxx friendly, what feeling does that evoke or stir

Nathan: it doesn't, no it doesn't at all

Jasmine: no, no feelings of

Nathan: no feelings, no

Jasmine: erm, and no positive feelings either

Nathan: no no positive ones either, that that's what I can't understand myself

Jasmine: yeah strange isn't it

Nathan: because one's negative one's positive and they don't turn negative

Jasmine: what the voices?

Nathan: yeah the voices turn negative

Jasmine: right. Erm when you described your relationship with you voice as friendly, would you say you've always had this type of relationship

Nathan: no, no

Jasmine: how has it been before?

Nathan: it started off really bad, yes it started off really bad

Jasmine: right in what way?

Nathan: masturbate it tells me to masturbate, erm, yeah most of the time it just told me to masturbate so I can't really go into much detail other than that, cos that's just the gist of it,

Jasmine: right I understand.
Nathan: so, but it does get worse
Jasmine: the voice?
Nathan: yeah it did get worse
Jasmine: So how is it then, do you think that it, it your relationship with
your voice started off so negatively and has become a bit more friendly
now, how's that happened, how's that come about
Nathan: I don't know, I can't answer that ... maybe, maybe he's up there
looking down on me saying 'look he's had a hard life, let's make it a bit
easier for him'
Jasmine: who's he God?
Nathan: [God, yeah. Yeah maybe he's up there looking down on me and
he's saying well let's make it a bit easier for him, we'll sort this out ourself
as well maybe we can get rid of it for him, maybe we should leave it there I
don't know. There's so many questions and answers that need to be asked
Jasmine: but one explanation you have then is that God has decided to
change it for you
Nathan: [decided to change it, yeah, yeah.
Jasmine: yeah ok. And when did you first start to see your voice, when
did the change happen when did you first start to see your voice as more
friendly?
Nathan: ... August. August, round August the 19th, 20th.
Jasmine: right, so it was last year
Nathan: last year yes. Why I don't know. It started getting a bit more
friendlier round that time
Jasmine: and you relationship
Nathan: [relationship just built up
Jasmine: right ok. So when it was negative, did you have a relationship
with it then
Nathan: no, no no, I was ignoring it, I, I was ignoring it
Jasmine: so its only since its become more friendly
Nathan: [more friendly that I started interacting with it
Jasmine: and that was because, what, what prompted you to change how
you dealt with it
Nathan: its just in the past when I first started hearing, because when I
first started hearing, it was telling me about my previous life, what I've been
through and what people know and what was coming. But now it's just this
one voice.
Jasmine: and it's this woman who's saying nice things to you
Nathan: yeah yeah
Jasmine: and so
Nathan: [so I've gradually come to terms with it, and its got less and less
and less, so maybe if I try again to ignore it, maybe it might go away again,
but then all of a sudden it'd come back so, I've got the understanding to it
I'm never gonna get rid of it
Jasmine: so I might as well
Nathan: so I just might as well talk to it and be xxxxx
Jasmine: ok. ... and erm so you first started to see your relationship a
friendly relationship around the 19th, 20th and its maintained, this friendly
relationship is maintained by you talking back to it. How, how would your
life be the same or different maybe if you didn't have this relationship?
Jasmine: I might be able to get out and about more, cos maybe then I xxx cos I hear
them when I'm out as well ...
Jasmine: so it's restricted
Nathan: [it's restricted me yes
Jasmine: in a sense, yeah
Jasmine: would you describe it, I don't know if you would as an important
relationship or
Nathan: the voice, no, maybe the girl, yes ...
Jasmine: so, the relationship you might have with the girl
Nathan: could trigger the voice to be broken
Jasmine: aha
Nathan: that is one explanation I've come up with and it could be broken
Jasmine: mmmm, mmmm. And, but also that the relationship with the girl
might be important, but the relationship with the voice isn't
Nathan: [isn't, no, no
Jasmine: is there any way it could be important?
Nathan: only if it happened to the girl Emma, then it's told me the truth
hasn't it, and then if it comes true the voice can be broken with that as well,
there may be untold ways to break it but I've got to find them
Jasmine: yeah, you haven't quite worked it out
Nathan: I just haven't quite worked out which is which because it, tell
you the truth it happened once before.
Jasmine: right
Nathan: with another girl, and her name was Michelle Bond. I met her in April '87, fell for her at the end of May '87, and xxxx, and then I started getting these feelings in here (pointing to body) like a bolt in the heart, and I had it twice, and I heard the voices at the same time, and I heard the voices from doing it. I got rid of her and the voice went, so I know I've done it once but I don't think it's the same thing with each voice, it's got to be something different, that's how my understanding of it is.

Jasmine: so each voice has a particular way
Nathan: [each voice has a particular way of being got rid of, but it just keeps coming back though, but it's just this one voice sine August of last year
Jasmine: right yeah, so before august, was it this same voice that was being negative or was it a different voice
Nathan: no it was a different voice, but it's just come up recently it's Emma's voice xxxx xxxxxxxxxx xxxxxxxxxxxxx
Jasmine: how ... this friendly relationship you have with your voice at the moment, how similar or different is that to erm other relationships you've had?
Nathan: I don't hear their voices it's just my voice I hear, but the relationship's different, because they're there to help me, they're voice won't be there even though I've heard it in the past
Jasmine: so people like Simon
Nathan: yeah, I've heard Simon's voice, don't get me wrong I've heard
Simon's voice
Jasmine: right you have, ok
Nathan: yeah, only the once, and do you wanna know what he said
Jasmine: mmm
Nathan: he said "we work as a team"...what it meant, I don't know.
Jasmine: mmmm mmm. What was that like hearing him SIMON saying that?
Nathan: (chuckles) from what I experienced at the time, it was a negative thing ... ...
Jasmine: what do you think makes it negative?
Nathan: erm, it's a feeling I got here (puts hand on his chest), its negative and it was like he was trying to lead me into trouble and not to try and help me... Simon doesn't know this
Jasmine: ok well this will remain confidential, so
Nathan: no it's not a voice hearer so if SIMON wants to hear it he's more than likely to cos it was the voice that was saying it not xxxxxxxxxx him so if he wants to hear it he can

Jasmine: right ok I'll well I'll let him know that

Nathan: I don't mind him hearing it cos I can trust him

Jasmine: right

Nathan: since the voice that it is, since the voice I can trust him because nothing bad has happened to me

Jasmine: since August? Since the voice

Nathan: no since I heard Simon voice and Simon's voice was a couple of years ago, so it was ever, since they actually after he took over my care from OLD CMHT NAME

Jasmine: right ok, oh that's right cos you were there

Nathan: [yeah cos I was there and I wasn't getting anywhere with them either...they made appointments and didn't keep them. They wouldn't tell me anything about me illness, nobody did until Simon took over. I was running into people I was going berserk (spoken softly), everything...because when I'm ill, I like to overcome it and get better, so this is an illness, this was to be overcome one way or another....

Jasmine: and you were trying to find

Nathan: [I was trying to find was an answer that nobody said

Jasmine: yeah, well thank goodness

Nathan: [thank goodness for, thank goodness for Simon. He's really helped, he has tremendously and I don't want to lose him

Jasmine: and in terms of having a friendly relationship with your voice, who else, who else can you think of that you've had friendly relationships with

Nathan: with my voices?

Jasmine: no with people

Nathan: people, oh people. Oh I've got a girl called Rachel, the only female friend I've got and she comes to see me two twice a week, sometimes more. She come down Sunday, she come down Monday, she come down Tuesday and she come down Wednesday, so she comes to see me. I should go and see her as well cos we're only ten minutes apart xxx xxx xxx xxx. Err I've got me family, the best one in the family is my niece because we can talk, we do talk, but I don't talk about my illness unless she brings it up and she normally does
Jasmine: oh right ok
Nathan: she does listen to me but she can't give me a lot of advice though because she doesn't know about it
Jasmine: no, yeah
Nathan: erm me brother...erm goodness me erm...recently just started to talk. Because when I first fell ill, me mum was ill and I beat her and she ended up dying and he didn't forgive me for five years so I had to wait for five years for him to forgive me and it's only just last 12 18 months, he's been on my side, helping me through it
Jasmine: right
Nathan: me other brother, he was there. as well now, me sister, me younger sister, nowhere around, nowhere to be seen, haven't seen her in over a year. Me stepsister, haven't seen her in 20 years, so if she was around, she would be fighting left right and centre xxx me
Jasmine: fighting for you?
Nathan: [for you yes on my behalf, believe it or not, like she did years ago. She was there for me then and I want to get hold of her even though I don't know where she is, so we can forget that. Now Simon. June Smith, June she's just come onto the same team, my social worker, she seems to be a nice person, so the relationships are now staring to build up
Jasmine: yeah yeah. So you're getting to have ...positive relationships
Nathan: yeah they're getting better and better. Cos when Simon took over I I smoked xxxxx the voices and he said most people try to have a normal life and that gave me courage, That is what's encouraged me to get to the bottom of it, because he said most people had a normal life in the end. I hear voices, we're gonna overcome it and I've been determined ever since.
Jasmine: that's brilliant
Nathan: and next year I get stronger and stronger through it and closer to getting rid of 'em.
Jasmine: before all this xxxxx when it was this negative voice
Nathan: yeah
Jasmine: and you said you weren't able to have relationships with
Nathan: [with the voices
Jasmine: with the negative voices
Nathan: no I couldn't, no
Research Dossier – MRP Appendices

701 Jasmine: was is that, was that similar or different to people in your world, the relationships you have with them where they are negative
702 Nathan: yes yes
703 Jasmine: could you you give me an example
704 Nathan: ....
705 Jasmine: anyone that you feel able to talk about
706 Nathan: erm Matthew Whetherspoon, from status employment. I thought I was in trouble when I first went to him to help me to get back into employment. I thought I was in trouble, because Simon said about it then told me I don't need to go, then I received letter from them telling me that I had to go and see them for an appointment for a job. And I didn't know what it was about, but I thought I was in trouble then and that was a negative, voice.... I can I understand them xxxxxxxx to the positive, but the positive are hard to understand because I don't know if they're true or not.
716 Jasmine: so it sounds like you don't trust them?
717 Nathan: no I don't trust them, I can't see it myself
718 Jasmine: it sounds a bit more confusing
719 Nathan: they are a bit more confusing but they're friendly, which is the main thing
721 Jasmine: but the negative ones it sounds like you're a bit clearer about
722 Nathan: [are things that might lead me into trouble and I've always maintained, I've, keeping away from, keeping out of trouble but I've been in trouble, don't get me wrong I have and there's things they know about that I haven't been done for, Simon knows everything, I've told him everything, I come clean with him, and he says no don't worry about it so I didn't, so I know anything that happens now, I'm not gonna get into trouble, which is good because this is what caused the voices believe it or not its, what people knew about me before they knew me... that's how it all started I know where it started
731 Jasmine: you've got quite a clear idea
732 Nathan: [I've got a clear idea of where it started.... ....
733 Jasmine: ok. Would you like your relationship with your voices to change.
734 Nathan: I'd like it to go away, that's how I'd like it to change.
735 Jasmine: mmm. You'd like it just not to be there anymore.
736 Nathan: yeah
Jasmine: yeah. Is there anyway it could is there anyway that you would want it to change and still be there?
Nathan: ...No. No. it's got to go. It has, 100% got to go.
Jasmine: so even though it's a friendly relationship
Nathan: [even though it's a friendly relationship its still got to got, because it shouldn't be there at all anyway. Its there but it shouldn't be.
Jasmine: ok. Now if I were to ask your voice some of these questions I've been asking you, how do you think it might respond, like for example
Nathan: right stop there. It won't answer straight away. It'll answer when I've gone home and I'm on me own
Jasmine: right
Nathan: so you won't be able to ...
Jasmine: I won't know
Nathan: no, you won't know until you ask me back again
Jasmine: could you predict what it would say, have you got, have you got any idea of how it would
Nathan: [it'd be, it would be along the same lines as I told you but done differently. It would mostly give you more information in a lesser sentence than you need.
Jasmine: right so it would be very concise.
Nathan: yes it would be very concise.
Jasmine: right and not, because what I've liked about talking to you, is that you've been very descriptive and you've kind o f elaborated on things, but you're saying the voice would be just
Nathan: [it would just use short sentences. Its, its, its like what they say in the bible, a parable it's a shorter sentence but it's got more in it. It's like when you say something and you stop halfway through a sentence and go onto something else, you've said all you needed to say...that's how you understand a parable, because it's a shorter sentence and then you go onto something different
Jasmine: and is that how the
Nathan: [that's how the voices would be.
Jasmine: ok so that's how, that's how it would talk to me, what about the content of what it would say, would it be similar to what you've said
Nathan: yes, it would be along similar lines.
Jasmine: so might it say that yes I have got a relationship with Nathan
Nathan: yes
Jasmine: and it's a friendly one
Nathan: mm
Jasmine: so all those sorts of things
Nathan: yes, yeah.
Jasmine: erm, I think I've asked you all the kind of interview questions I've got I had. Is there anything you feel you'd like to add that I haven't covered or anything
Nathan: no, well I sup, the questions gone.
Jasmine: ohh I'm sorry
Nathan: [yeah, is, is there, is there ever anybody ever gotten over schizophrenia?
Jasmine: I'm not sure
Nathan: I don't think anybody ever has
Jasmine: mmm
Nathan: that's the only negative thing I can think of
Jasmine: yeah. Not knowing
Nathan: not knowing. There's somebody out there, maybe I could go to them and say "look, how did you do it, I've got this far, what did you do to completely get rid of them
Jasmine: yeah yeah. Yeah. Yeah. I don't know
Nathan: I don't know either, but it's something I would like to know.
Jasmine: yeah, to be sure
Nathan: because that would give me a bit more, energy to fight it a bit more
Jasmine: mmm, a bit more hope
Nathan: a bit more hope, yeah. The more hope I get the, I think, the quicker it might go
Jasmine: yeah, that makes sense
Nathan: yeah
Jasmine: ok. Well those are all the questions I had for you. I've just got a couple more questions which are kind of just background information
Nathan: yeah
Jasmine: how old, how old did you say you were
Nathan: I'm 37 this year
Jasmine: and are your family British?
Nathan: yes
Jasmine: and did you manage to get any qualifications when you were younger, a younger man
Nathan: no
Jasmine: and you're not currently working
Nathan: no I'm on sick
Jasmine: and what was your last job you had?
Nathan: the last job I had TAPE ENDED.
Appendix 8 – Table of Themes (Nathan)
<table>
<thead>
<tr>
<th>Themes – chronological order</th>
<th>Line numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice pursuing me</td>
<td>65-6</td>
</tr>
<tr>
<td>Varied voice content</td>
<td>75-6</td>
</tr>
<tr>
<td>Commanding voice</td>
<td>78-9</td>
</tr>
<tr>
<td>Resilience</td>
<td>85-6</td>
</tr>
<tr>
<td>Multiple strategies</td>
<td>85-6, 106, 135-8, 234—6, 241-2,</td>
</tr>
<tr>
<td>Battle imagery</td>
<td>88</td>
</tr>
<tr>
<td>Seeking explanation (from professionals)</td>
<td>111-3, 154, 210</td>
</tr>
<tr>
<td>Detecting patterns associated with onset</td>
<td>117</td>
</tr>
<tr>
<td>One voice – harder</td>
<td>133</td>
</tr>
<tr>
<td>Transition between worlds</td>
<td>135-8</td>
</tr>
<tr>
<td>Fear/ Fear of consequences</td>
<td>140, 142-6, 385-7</td>
</tr>
<tr>
<td>Feeling trapped/ bullied</td>
<td>144-</td>
</tr>
<tr>
<td>Spirituality</td>
<td>175, 192-3</td>
</tr>
<tr>
<td>Personal explanation</td>
<td>175, 208-9, 218</td>
</tr>
<tr>
<td>Predicting future events → fear</td>
<td>178</td>
</tr>
<tr>
<td>Protective role of voice</td>
<td>175, 189</td>
</tr>
<tr>
<td>Predictability</td>
<td>205-7</td>
</tr>
<tr>
<td>Determination</td>
<td>211-2</td>
</tr>
<tr>
<td>Disagreement with professionals</td>
<td>208-9</td>
</tr>
<tr>
<td>Feeling ignored by others</td>
<td>224</td>
</tr>
<tr>
<td>Valuing professional relationships</td>
<td>227-8, 304</td>
</tr>
<tr>
<td>Complexity of the experience</td>
<td>246-8, 277-81,</td>
</tr>
<tr>
<td>Impact of others</td>
<td>277-81,</td>
</tr>
<tr>
<td>Social boundaries</td>
<td>344-5</td>
</tr>
<tr>
<td>Reluctant relating</td>
<td>352-4, 447-8</td>
</tr>
<tr>
<td>Interview process – motivation</td>
<td>360</td>
</tr>
<tr>
<td>Positive relationship</td>
<td>363</td>
</tr>
<tr>
<td>Projection to voice of earlier desires?</td>
<td>366-72</td>
</tr>
<tr>
<td>Partial control</td>
<td>389-90</td>
</tr>
<tr>
<td>Appeasement</td>
<td>392, 443-5</td>
</tr>
<tr>
<td>Engagement</td>
<td>392</td>
</tr>
<tr>
<td>Searching for an explanation/solution (&amp; finding it)</td>
<td>392, 416, 529-31, 586, 539, 783-4, 790-2</td>
</tr>
<tr>
<td>Transition between worlds</td>
<td>393-5, 401-2, 613</td>
</tr>
<tr>
<td>Function of social relating SEAN</td>
<td>413-7</td>
</tr>
<tr>
<td>Conditional relating</td>
<td>430-4, 543-7</td>
</tr>
<tr>
<td>Absence of omniscience</td>
<td>433</td>
</tr>
<tr>
<td>Implementing boundaries</td>
<td>433</td>
</tr>
<tr>
<td>Necessity of control</td>
<td>461-3</td>
</tr>
<tr>
<td>Effort (robustness?)</td>
<td>468, 487</td>
</tr>
<tr>
<td>Voice persistence DONNA</td>
<td>473-4</td>
</tr>
<tr>
<td>Control</td>
<td>483</td>
</tr>
<tr>
<td>Incoherency</td>
<td>500-6, 609-</td>
</tr>
<tr>
<td>Change over time</td>
<td>511, 545-7</td>
</tr>
<tr>
<td>External locus of control</td>
<td>523-5</td>
</tr>
<tr>
<td>Coming to terms</td>
<td>557</td>
</tr>
<tr>
<td>Gaining understanding</td>
<td>559-60</td>
</tr>
<tr>
<td>A freer life DONNA RUSSELL</td>
<td>567</td>
</tr>
<tr>
<td>Uncertainty/uncertainty re meaning</td>
<td>618</td>
</tr>
</tbody>
</table>
Uniqueness of each voice | 596-7
---|---
Determination/resilience | 646, 690
Illness model | 646
Courage | 688
Professional roles-influence of others | 686-91
Telling my story | 729, 732
Certainty | 739, 742
Projection of own attributes (clarity, succinctness) | 761-2 DONNA, RUSSELL,
Spirituality | 762

**Themes for Participant O4 – Nathan**

<table>
<thead>
<tr>
<th>Themes – connections between themes</th>
<th>Line numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1 – power and control (me vs. them; them vs. me)</strong></td>
<td></td>
</tr>
<tr>
<td>Implementing boundaries/distancing</td>
<td>44-5</td>
</tr>
<tr>
<td>Commanding voice</td>
<td>78-9</td>
</tr>
<tr>
<td>Battle imagery</td>
<td>88</td>
</tr>
<tr>
<td>Courage</td>
<td>688</td>
</tr>
<tr>
<td>Fear/ Fear of consequences</td>
<td>140, 142-6, 385-7</td>
</tr>
<tr>
<td>Feeling trapped/ bullied</td>
<td>144-</td>
</tr>
<tr>
<td>Personal explanation</td>
<td>175, 208-9, 218</td>
</tr>
<tr>
<td>Determination</td>
<td>211-2</td>
</tr>
<tr>
<td>Appeasement</td>
<td>392, 443-5</td>
</tr>
<tr>
<td>Necessity of control</td>
<td>461-3</td>
</tr>
<tr>
<td>Control</td>
<td>483</td>
</tr>
<tr>
<td>Partial control</td>
<td>389-90</td>
</tr>
<tr>
<td><strong>Theme 2 – impact on self</strong></td>
<td></td>
</tr>
<tr>
<td>Making an effort</td>
<td>45</td>
</tr>
<tr>
<td>Resilience</td>
<td>85-6</td>
</tr>
<tr>
<td>Multiple strategies</td>
<td>85-6, 106, 135-8, 234—6, 241-2,</td>
</tr>
<tr>
<td>Determination/resilience</td>
<td>646, 690</td>
</tr>
<tr>
<td>Illness model</td>
<td>646</td>
</tr>
<tr>
<td>External locus of control</td>
<td>523-5</td>
</tr>
<tr>
<td>Coming to terms</td>
<td>557</td>
</tr>
<tr>
<td>Gaining understanding</td>
<td>559-60</td>
</tr>
<tr>
<td>A freer life DONNA RUSSELL</td>
<td>567</td>
</tr>
<tr>
<td>Uncertainty/uncertainty re meaning</td>
<td>618</td>
</tr>
<tr>
<td>Searching for an explanation/solution (&amp; finding it)</td>
<td>392, 416, 529-31, 586, 539, 783-4, 790-2</td>
</tr>
<tr>
<td>Effort (robustness?)</td>
<td>468, 487</td>
</tr>
<tr>
<td>Making decisions</td>
<td>27?, 59-61</td>
</tr>
<tr>
<td>Incoherency</td>
<td>500-6, 609-</td>
</tr>
<tr>
<td>Certainty</td>
<td>739, 742</td>
</tr>
</tbody>
</table>
### Theme 3 – the role of social others (profs, friend, family, strangers, society, spirituality)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
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<td>Professional roles— influence of others</td>
<td>686-91</td>
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<td>Seeking explanation (from professionals)</td>
<td>111-3, 154, 210</td>
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<td>Transition between worlds</td>
<td>135-8</td>
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<td>Engagement</td>
<td>392</td>
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<td>Disagreement with professionals</td>
<td>208-9</td>
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<td>Feeling ignored by others</td>
<td>224</td>
</tr>
<tr>
<td>Valuing professional relationships</td>
<td>227-8, 304</td>
</tr>
<tr>
<td>Impact of others</td>
<td>277-81</td>
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<tr>
<td>Social boundaries</td>
<td>344-5</td>
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<tr>
<td>Transition between worlds</td>
<td>393-5, 401-2, 613</td>
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<tr>
<td>Function of social relating SEAN</td>
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<td>Spirituality</td>
<td>175, 192-3, 762</td>
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</table>

### Theme 4 – relational aspects (me & the voice)/me & others

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pages</th>
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<tr>
<td>Interacting</td>
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<td>Voice pursuing me</td>
<td>52-4, 65-6</td>
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<tr>
<td>Change over time</td>
<td>511, 545-7</td>
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<tr>
<td>Reluctant relating</td>
<td>352-4, 447-8</td>
</tr>
<tr>
<td>Positive relationship</td>
<td>363</td>
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<tr>
<td>Conditional relating</td>
<td>430-4, 543-7</td>
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<td>Implementing boundaries</td>
<td>433</td>
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### Theme 5 – defining/ knowing the other

<table>
<thead>
<tr>
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<th>Pages</th>
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<tr>
<td>Personification</td>
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<tr>
<td>Linking the voice with social beings</td>
<td>12, 28</td>
</tr>
<tr>
<td>Depersonalised</td>
<td>19</td>
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<tr>
<td>Commanding</td>
<td>43-4</td>
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<tr>
<td>Uniqueness of each voice</td>
<td>596-7</td>
</tr>
<tr>
<td>One voice – harder</td>
<td>133</td>
</tr>
<tr>
<td>Predicting future events → fear DONNA</td>
<td>178</td>
</tr>
<tr>
<td>Voice persistence DONNA</td>
<td>473-4</td>
</tr>
<tr>
<td>Projection to voice of earlier desires/attributes (clarity succinctness DONNA RUSSELL)</td>
<td>366-72, 761-2</td>
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<tr>
<td>Absence of omniscience</td>
<td>433</td>
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<tr>
<td>Protective role of voice</td>
<td>175, 189</td>
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### Theme 5 – the interview process

<table>
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<tr>
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<tr>
<td>Open-ended questions</td>
<td>60</td>
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<td>Interview process – motivation</td>
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### Theme 6 – telling my story (from the beginning)

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<tr>
<td>Detecting patterns associated with onset</td>
<td>117</td>
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<td>Telling my story</td>
<td>729, 732</td>
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### Theme 7 – defining the experience

<table>
<thead>
<tr>
<th>Topic</th>
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<tr>
<td>Predictability</td>
<td>205-7</td>
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### Theme 8 – extraneous
Appendix 9 – Linking the Themes Across Participants
(an example)
<table>
<thead>
<tr>
<th>Themes</th>
<th>Normal</th>
<th>Sean</th>
<th>Michael</th>
<th>Gail</th>
<th>Nathan</th>
<th>George</th>
<th>Russell</th>
<th>Ulrika</th>
<th>Donna</th>
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<tr>
<td><strong>Theme 2 – relational aspects (me &amp; the voice)/me &amp; others</strong></td>
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<td><strong>EVOLUTION OVER TIME</strong></td>
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<tr>
<td>Changes/development over time (macro vs. micro) [vs. consistency over time]</td>
<td>59, 116, 176, 255, 293, 757-8</td>
<td>[354-5]</td>
<td>18-19, 31-2, 379-80</td>
<td>34-5, 243-4, 404-6, 538</td>
<td>511, 545-7</td>
<td>298-302</td>
<td>199→</td>
<td>37, 231?</td>
<td>251,</td>
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<tr>
<td><strong>CREATING &amp; SUSTAINING WE-NESS</strong></td>
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<td>Belonging</td>
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<td>Closeness/attachment [choosing intimacy]</td>
<td>316-368, 259-60, [403-5, 544]</td>
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<td>290-2, 298-9</td>
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<td>Finding allies (+ve voices)</td>
<td>282-3</td>
<td>115</td>
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<td>We-ness</td>
<td>71, 197</td>
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<td>Engagement in relating</td>
<td>68</td>
<td></td>
<td>313</td>
<td></td>
<td>392, 21</td>
<td>68-72</td>
<td>233, 239</td>
<td>431-2</td>
<td>113</td>
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<td>Relational boundaries (bound by social norms/stigma)</td>
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<td>147-9</td>
<td>210, 253-4</td>
<td>299, 458</td>
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<td>519-20, 542</td>
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<td>We-ness instigated by voice</td>
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<td></td>
<td>339-40</td>
<td>52-4, 65-6</td>
<td>275-6</td>
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<td>5-6, 108-9</td>
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<td>27, 51, 335-6, 344-5</td>
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<td>44-5, 27?, 59-61, 433</td>
<td>29, 59-61, 554-5</td>
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<td>352-4, 447-8</td>
<td>271-3</td>
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<td>152-4, 427-8</td>
<td>29-30, 141, 265, 277-8, 299,</td>
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<td>Ultimate freedom</td>
<td></td>
<td>278, 361, 393</td>
<td>739, 742</td>
<td>354-5</td>
<td>233, 591</td>
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<td>Functional role</td>
<td></td>
<td>402-8</td>
<td>142-8, 328</td>
<td>345</td>
<td>413-7, 175, 189</td>
<td>471</td>
<td>102</td>
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<td>Dysfunctional (afunctional) role</td>
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<td>Balanced view of relationships</td>
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<td>248-53</td>
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<td></td>
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<td>An investment</td>
<td></td>
<td>364, 473, 686-7, 690-1</td>
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<td>Evoking hierarchical respect (reflecting cultural norms?)</td>
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<td>69, 95-6, 277-8, 296-7, 719</td>
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<td>Empathy/concern/consideration for the voice</td>
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<td>221, 540</td>
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<td>Sequential relationships</td>
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REJECTING WE-NESS
Implementing boundaries/distancing (see above)
Reluctant relating
Ultimate freedom
Rejecting we-ness
Omniscience
A CONDITIONAL PROCESS
Conditional relating
FUNCTIONALITY & DYSFUNCTIONALITY
Functional role
Dysfunctional (afunctional) role
Balanced view of relationships
An investment
Evoking hierarchical respect (reflecting cultural norms?)
Empathy/concern/consideration for the voice
Sequential relationships
Appendix 10 – Transcript Notations
Transcript Notations

Notations for the transcripts in general

Any sentences that have been spoken over each other will be contained in the square [ ] brackets

Xxxxxxxx = inaudible

Words in *italics* denotes a change of tone or emphasis in speech

.... = one pause

Non-verbal information will be contained within round ( ) brackets e.g. (laughs)

Notations specific to the results section

- Original quotes will be italicised e.g. "the voice"
- After each quote the participants’ name and the line number in which the quote originated will be reported in round brackets e.g. (John, 123)
- Information omitted from the quote will be denoted by square [ ] brackets.
- Information which I have added to facilitate readability will be contained in round ( ) brackets.
Appendix 11 – Feedback Letters
25th July 2005

Dear

Re: Hearing Voices Study (November 2004 – May 2005), University of Surrey.

Earlier in the year, you helped me to find suitable participants for my doctoral research looking at the experiences of people who hear voices. I would like to take this opportunity to thank you for your help; it was much appreciated.

At the time of the interviews, participants were asked if they would like to receive a copy of the results and your client(s) stated that they would. I have therefore enclosed a summary of the research and I would be grateful if you could pass this on to ______________________________________________________________

I thought that it would be more appropriate if this was sent via you, as you would have the most recent knowledge of your client’s ability to receive this information. A copy is enclosed for your records.

You are also invited to read the enclosed summary, sharing information with your colleagues where appropriate. It is hoped that aspects of the research will be submitted for publication so that the results will be disseminated more widely. However I am happy to receive queries about the research using the contact details above.

As you will see I have suggested the Hearing Voices Network as an organisation that individuals might wish to approach. Some related literature has also been suggested below, should you be interested in this area of enquiry and recent developments in the voice hearing field.
May I also take this opportunity to inform you and your colleagues about a half-day conference on voice hearing, which is being held at the University of Surrey in September (full details are on the enclosed flyer).

Once again, thank you for your assistance in recruiting to my study. If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Jasmine Chin
Trainee Clinical Psychologist

Further Reading

- Hayward, M. (2004). Exploring the experiences of hearing voices within an interpersonal framework. *Clinical Psychology*, 39, 30-33. *This article summarise the most recent developments in considering the voice experience as a ‘relationship’.*


- Romme, M. A. & Escher, A. (2000). *Making Sense of Voices.* London: Mind Publications. *These Dutch authors were amongst the first to re-consider the voice experience, beyond a purely medical model.*
Feedback from study on hearing voices

25th July 2005

Dear

Earlier in the year you took part in a research study exploring the experiences of people who hear voices. Firstly I would like to thank you very much for your contribution, as without the help of you and others like you, developments in understanding this experience would not occur.

At the time of the interview you requested that you would be interested in hearing about the results of the study. From our conversation and the conversations I had with nine other people who hear voices, I was able to identify a number of common themes which I will shortly describe. However, as it was some time ago that we met I thought that I would briefly summarise the aims of the research.

What was the study about?
Researchers have been interested in the interactions that can occur between people who hear voices and the voices they hear. It is thought that understanding these interactions might clarify how and why people become distressed.

Recently these interactions have been understood as similar to relationships with people. Much of this research has used questionnaires to understand the issues, rather than asking individuals to explain their experiences themselves. In particular, it was not known whether the idea of a ‘relationship’ made sense to individuals. This study aimed to explore this.

What was found?
Five major themes were explored:
‘Defining the other’
Participants had different ways of describing the voice(s) that were heard. For some the voice appeared to have a clear identity and was recognisable as someone known socially. For other people this was not possible. However for most people the voice seemed to have it’s own personality that was mostly predictable.

‘Me vs. the Voice’
At some point during all of the conversations, the experience of the voice was as if participants were in conflict with someone who was trying to control them. However what also became clear were the many ways that participants’ stood up for themselves, ensuring that the voice did not completely take over. It seemed that all participants were skilled in looking after themselves.

‘The Voice & Me’
Most participants were hesitant about seeing themselves in a ‘relationship’ with their voice and gave many descriptions of how they tried to resist this. However being in a ‘relationship’ was also acknowledged by others. It seemed that some participants were therefore in a ‘catch-22’ situation – wanting their voice to go away but realising that they might feel lonely without it.

‘Impact on Self’
Hearing voices affected participants in many different ways and emotions included worry, fear and feeling calm. Participants also described different attitudes that they took on to cope with the voices such as being off-hand with the voice, or highlighting their own strength and resilience.

‘A social experience’
There were many associations between the voice experience and social experiences. For example many participants described the attitudes of stigma encountered by others because of the voices. Social experiences were also used to help understand the voices – some participants described using skills they had gained in talking to people in their social world (e.g. being friendly; showing concern), with the voice.

What does this mean?
The concept of a ‘relationship’ was both accepted and rejected by participants. It seemed that in one way, accepting that there was a ‘relationship’ with the voice
helped participants to understand and manage their experiences. In contrast rejecting the idea of a ‘relationship’ seemed to help participants stay separate from the voice and remain as much their ‘own person’ as possible. For some the idea of a relationship also did not fit with their personal understanding of voice hearing.

How will this help people who hear voices?
The results of this study will:

- Help other researchers to be aware of how complicated hearing voices can be
- Let other researchers know that whilst looking at the interactions with the voice as a ‘relationship’ might help some people, not everyone will agree with seeing it in this way
- Show others how important it is that individuals are asked to describe their difficulties in their own words. Although the tape recorder made some people feel uncomfortable, most participants said they either enjoyed or found it helpful to talk about their voices.

Where can I find out more?
The team who currently help you to manage your voice(s) will be able to answer any immediate questions that you have.

You might also have heard of a national organisation called the Hearing Voices Network. They aim to raise awareness of voice hearing, and support anyone with these experiences who wants to find out more about them. Their contact details are Hearing Voices Network, 91 Oldham Street, Manchester, M4 1LW; Tel: 0161 834 5768; Email: info@hearing-voices.org; Website: http://www.hearing-voices.org/
Although they are based in Manchester, they usually have local support groups.

Once again, thank you for your valuable contribution.

Yours sincerely

Jasmine Chin
Trainee Clinical Psychologist
cc. Care Co-ordinator, CMHT
HALF-DAY CONFERENCE

HEARING VOICES: AN ORDINARY EXPERIENCE?

Wednesday 7th September 2005
1 - 6pm

The experience of hearing voices (‘auditory hallucinations’) is usually associated with distress and ‘madness’. Want to consider other possibilities?

Contributors will include:
Marius Romme & Sandra Escher
authors of ‘Accepting Voices’ and ‘Making Sense of Voices’

Phil Thomas
author of ‘Voices of Reason: Voices of Insanity’

Louise Pembroke
Dancer and Voice Hearer

Open Mike

HAVE YOUR SAY

Ask the Panel

All curious people welcome – mental health professionals, service users, carers, voice hearers, students, members of the general public

Lunch provided + Free allocated parking
Tickets priced £50 for waged mental health professionals – all others free

Tickets are required by all those wishing to attend available from:
Box office Tel:- 01483 686876
Email:- information@surrey.ac.uk
<table>
<thead>
<tr>
<th>Research Skill/Experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill/experience acquired</th>
</tr>
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<tbody>
<tr>
<td>Conduct a literature search</td>
<td>Use of online databases to conduct literature searches on all of the assignments submitted. For example in preparation for an essay on parenting in learning disabilities I entered the terms 'parent?', 'learning disab''', 'mental retard'' into PsychInfo resulting in a large amount of results. Search terms were gradually refined.</td>
<td>November 2003 – January 2005</td>
</tr>
<tr>
<td>Critically review the literature</td>
<td>Critical literature reviews occurred for all of the assignments completed. For example, having written a descriptive account of the relevant literature for my major research project (MRP) I then set about critiquing the main studies, considering aspects of their design, the sample used and the conclusions they were able to make.</td>
<td>November 2003 – January 2005</td>
</tr>
<tr>
<td>Formulate a specific research question</td>
<td>Working with colleagues on a qualitative project and having decided upon a general topic (emotions and football) we formulated a specific area of enquiry and from this developed a research question. The value of having a specific question to focus on was apparent when analysing and writing up the project.</td>
<td>February 2004</td>
</tr>
<tr>
<td>Write a brief research proposal</td>
<td>I wrote a brief proposal for my service related research project providing details of how I would conduct the research and analyse the results.</td>
<td>December 2002</td>
</tr>
<tr>
<td>Write a detailed proposal/protocol</td>
<td>I prepared a detailed proposal for my MRP. The initial proposal detailed the rationale, proposed design and methodology (based on a published paper), details of recruitment and ethical considerations. The initial proposal was rejected due to the methodological design and so revisions were necessary.</td>
<td>November 2003 – January 2004</td>
</tr>
<tr>
<td>Obtain appropriate</td>
<td>Following (email) introductions by my university supervisor, I contacted my field.</td>
<td>April 2004 – July</td>
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<td>Task</td>
<td>Description</td>
<td>Date</td>
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<tr>
<td>supervision/collaboration for research</td>
<td>supervisor and discussed my research design and recruitment plans. Agreement was later reached for the field supervisor to provide guidance on writing up sections of the project.</td>
<td>2005</td>
</tr>
<tr>
<td>Write a participant information sheet and consent form</td>
<td>Information sheet and consent form written for MRP in accordance with guidelines published by the Central Office for Research Ethics Committees (COREC).</td>
<td>March 2004</td>
</tr>
<tr>
<td>Judge ethical issues in research and amend plans accordingly</td>
<td>Originally it was planned for MRP interviews to occur within the settings of the mental health teams. However one participant who consented to being interviewed was not comfortable leaving the home and it was deemed inappropriate to ask her to do so. In conjunction with her care co-ordinator a risk assessment was carried out and the interview was conducted in her home.</td>
<td>March 2005</td>
</tr>
<tr>
<td>Obtain approval from a research ethics committee</td>
<td>Approval from a Local Research Ethics Committee (LREC) and the university ethics committee, regarding the MRP was applied for and obtained.</td>
<td>August – September 2004</td>
</tr>
<tr>
<td>Collect data from research participants</td>
<td>Data was collected from 1 participant using a semi-structured interview for the Qualitative Group Project.</td>
<td>April 2004</td>
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<td>Data was collected from 10 participants using semi-structured interviews for the MRP.</td>
<td>December 2004 – March 2005</td>
</tr>
<tr>
<td>Set up a data file</td>
<td>A data file was set up for the SRRP using SPSS.</td>
<td>May 2003</td>
</tr>
<tr>
<td>Analyse quantitative data</td>
<td>The data obtained for the SRRP was analysed.</td>
<td>May 2003</td>
</tr>
<tr>
<td>Analyse qualitative data</td>
<td>The data obtained for the Qualitative Research Project was analysed individually and collaboratively, following transcription of the interviews, using Interpretative</td>
<td>May 2004</td>
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<td>Timeframe</td>
<td>Details</td>
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<tr>
<td>Phenomenological Analysis (IPA)</td>
<td>The data obtained for the MRP was analysed, following transcription of the interviews, using IPA</td>
<td>May 2005</td>
</tr>
<tr>
<td>Summarise results in figures/graphs</td>
<td>The results of the SRRP were summarised in a graph</td>
<td>June 2003</td>
</tr>
<tr>
<td>Interpret results from data analysis</td>
<td>The results of the SRRP were analysed and discussed in terms of the original research question.</td>
<td>June 2003</td>
</tr>
<tr>
<td></td>
<td>The results of the Qualitative Research Project were analysed collaboratively, and discussed in terms of the original research question.</td>
<td>May 2004</td>
</tr>
<tr>
<td></td>
<td>The results of the MRP were analysed and discussed in terms of the original research question.</td>
<td>May – June 2005</td>
</tr>
<tr>
<td>Present research findings/plans to an audience</td>
<td>The details of my SRRP were presented to first year trainee clinical psychologists. The presentation was prepared using Microsoft Power Point. Positive feedback was obtained from those rating my performance.</td>
<td>October 2003</td>
</tr>
<tr>
<td></td>
<td>The details of my MRP were presented to second year trainee clinical psychologists. The presentation was prepared using Microsoft Power Point. Positive feedback was obtained from those rating my performance.</td>
<td>September 2004</td>
</tr>
<tr>
<td>Produce a written report on a research project</td>
<td>A written report was completed for the SRRP</td>
<td>June 2003</td>
</tr>
<tr>
<td></td>
<td>A written report was compiled collaboratively for the Qualitative Research Project. This process involved small groups of two or three researchers meeting to write individual sections, with one member of the group taking an editing role once it was completed, to ensure it was linguistically and stylistically cohesive throughout.</td>
<td>June 2004</td>
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<td>July 2005</td>
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<tr>
<td>Task</td>
<td>Details</td>
<td>Date</td>
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<tr>
<td>----------------------------------------------------------------------</td>
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<tr>
<td>A written report was completed for the MRP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defend research project at an oral examination</td>
<td>Due to take place on 13th September 2005</td>
<td></td>
</tr>
<tr>
<td>Submit research report for publication in a journal/book</td>
<td>This will hopefully occur following examination of my MRP in September 2005</td>
<td></td>
</tr>
</tbody>
</table>