Relationships with and beliefs about voices: A 12-month longitudinal study with clinical and non-clinical voice hearers

Nicky Hartigan

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Department of Psychology
School of Human Sciences
University of Surrey

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The course team is attempting to involve service users and carers in many aspects of the Surrey Clinical Psychology Training Programme. With reference to the evolving literature on involvement in both training and research, explore ways of involving users and carers in the Programme. What issues and dilemmas might such involvement create?

Year 1

January 2005
Approaches to Distress Essay

Introduction

I have chosen this essay due to my previous experience of working as a mental health nurse. Throughout my training service user involvement was mentioned although no real explanation of what this involved, why it was important or how we could attempt to achieve it was offered. Whilst working on inpatient wards I found most attempts at user involvement were humiliatingly tokenistic, such as users choosing the colour of paint for the smoke room. I soon became aware that despite a rise in the 'user movement' and Government policies advocating 'partnerships' in care, in practice mental health services appeared to be largely unresponsive to what the people I met wanted. As described by Snow (as cited in Bertram, 2002) at the 1st National Conference of Survivor Workers UK 'no matter what progress is made in making staff aware of our issues, at the end of the day not much changes'.

The aim of involving user perspectives in clinical psychology training is to create clinical psychologists and ultimately services that reflect and respond to the needs of people who use the National Health Service. In exploring how the Surrey Programme can attempt to achieve this it is necessary to understand the ways in which users have traditionally been prohibited from having their views heard. Firstly I will outline the socio-political context of service provision in Britain and examine how user perspectives are valued and utilized within the profession of clinical psychology. I will then go on to discuss how the Surrey Training

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1 Throughout this essay, the term 'user' refers with respect to those who have used, received or survived Mental Health Services, either by direct experience or through their role as carer
2 For the purpose of this essay, the term 'services' refers to mental health care provided within the National Health Service
Programme can effectively involve users in a way which is meaningful and sustained, addressing dilemmas and issues this may create.

The Service User within Mental Health Services

The Socio-political Context of Mental Health Services
User involvement in health services has been advocated by the Government at the macro level since the early 1990s. Recent frameworks (The National Service Framework (NSF), 1999; The NHS Plan, 2000; Involving Patients and the Public, 2001) suggest that users can expect to be involved in individual decisions about their care, policy making and the training of professionals who deliver that care.

These policies have developed within the context of a rise over the last two decades of the user and civil rights movements and an increased social consciousness; it is acknowledged that users want a say in how their care is provided and have a right to be consulted about services (Robert et al, 2002). This was in part fuelled by the consumerist ideology of the previous Conservative Government; however the reality of the users' position within services remains incompatible with consumerist ideology. As one survivor commented - 'Consumerism? I consume psychiatric services in the same way that cockroaches consume Rentokil' (as cited in Barker & Peck, 1996). In addition as the Government, not those who use services, reimburse mental health professionals the impact of expressed user dissatisfaction is diminished.
It has been proposed that Governmental mandates have had limited effect as they lack specificity as to how the processes of involvement should be facilitated locally, leading to dissonance between their philosophy of partnership and evidence of the existence of these at the micro level (Anthony & Crawford, 2000). However, the biggest barrier preventing user involvement filtering to the micro level is the dominance of psychiatry in the popular understanding of mental health, in training of professionals and in services provided by the NHS.

**Psychiatric Dominance**

The psychiatric 'medical' model, prevalent since the Victorian period, remains the dominant way of conceptualising mental distress within services in Britain; the 'problem' lies within the patient and the solution resides with the physician and his medication (Hannigan & Cutcliffe, 2002). This idea that someone either does or does not have a 'mental illness' instantly defines users as fundamentally 'different' from others, creating 'mentalisms' or assumptions that users are amongst other things 'incompetent and irrational' (Szasz, 1987). This perspective dictates overarching political and legal frameworks in which services are provided, evident in proposals for the Mental Health Act 1983 to become increasingly coercive, emphasising risk and the need for people to be controlled.

Of course there are many professionals who use different frames of reference and methods of intervention, recognising the limits a medical model places on our understanding. However, as I have experienced personally, it can be frustrating and disheartening for those professionals when currently both services and the training of many professionals are
dominated by this model, or the left over 'mentalisms' that are generated by it.

Pilgrim & Waldron (1998) report constructive user involvement developments in local services although these have tended to lack financial backing. Therefore, despite a raised consciousness and the rhetoric of partnership in Government policies, users continue to be disempowered, stigmatised and dehumanised by the system, whilst professional power is protected. This critique is not intended to minimize or criticize the efforts and achievements of the user movement, which has achieved a great deal. In 2002 there were at least 318 user groups representing 9000 users (Sainsbury Centre, 2002) and approximately 1000 'survivor workers' employed (Bertram, 2002). I make the point that users and campaigners who advocate for them have limited impact, in relation to the size of the population for whom they speak (Hannigan & Cutcliffe, 2002). The user movement is still reliant on professional backing in order to be legitimized, as Relton (as cited in Bertram, 2002), a user worker describes, success is dependent on 'progressive professionals in power who want to challenge the existing differentials in the mental health system and work with users on a partnership basis'.

**The Service User within Clinical Psychology**

**An Alternative Paradigm**

The psychiatric profession has a vested interest in perpetuating the medical model, which is likely to be congruent with the belief that user involvement has few benefits (Kent & Read, 1998). Summers (2003) reports 'psychiatrists' readiness to think about user involvement from a
scientific, utilitarian viewpoint', commenting that this central paradigm limits the influence of user perspectives and contributes to stigmatisation.

However, it is well recognised in the literature of other professions including clinical psychology that current understanding of psychological distress is partial, limited and cannot be explained by a medical model (Diamond et al. 2003). It is suggested by the user movement and those who support it that the first-hand experience of those who have used services are ideally placed to increase this limited understanding of distress, confusion, social exclusion and what helps recovery (May, 2001). This allows for a new paradigm which goes beyond what is 'fair' and the ideas championed by the civil rights movement, opening up a new way of inquiry and understanding based on a belief that 'the newly included will bring something valuable' (Campbell, 2001).

These ideas, espoused by critical and community psychology, advocate collaboration, address issues of power and seek to challenge stigma and pathologies perpetuated within systems (Diamond et al. 2003). Replacing the psychopathology of mental distress with an alternative 'survivor discourse' will elaborate and enrich our current understanding: users' views about what aids recovery, desirable outcomes and the qualities valued in professionals can be seen as a rich evidence base waiting to be explored. Therefore, it is not only that clinical psychology training should involve users but that we need to for the advancement the profession; it is this paradigm shift which can drive the user agenda forward.
Does Clinical Psychology Accept this Paradigm?

In line with the user involvement philosophy the British Psychological Society accreditation criteria for courses (BPS, 2002) state that one outcome for training is that trainees will have 'the skills, knowledge and values to work effectively with systems relevant to clients including...user led systems'. Goodbody (2003) cites attempts to embrace the idea of user involvement in clinical psychology training from the mid-eighties, although Soffe (2004), states that there has been only limited consideration given to service user involvement issues within clinical psychology practice and training. Currently user involvement is seen as fringe activity or an optional extra.

Power & the Expert Model

 Whilst advocating alternative views to the medical model, clinical psychology proposes its own distinct professional viewpoints and 'expert models'. Clinical psychology has established itself as a science; we are 'scientist-practitioners' who carry out 'evidence based practice' and the discipline has developed a largely conservative, positivist stance. The evidence given privilege is that from empirical studies, psychological experiments, randomised controlled trials (RCTs) and articles published in scientific journals supported by complex statistical analyses which determine what is or is not evident. Rather amusingly, the British Medical Journal published a systematic review of RCTs (Simpson & O House, 2002) which provided 'evidence' that users can be involved as employees, trainers or researchers without detrimental effect. The superiority given to this kind of evidence is explicitly stated in the NSF (1999).
Expert knowledge models within clinical psychology put the measure of power with the professional, not the user. Soffe (2004) quotes one clinical psychologist - 'it's about scientific practice and expertise. It's about professional knowledge; that's why we are who we are, we're paid what we're paid.....by asking people who AREN'T experts would maybe undermine that'. It seems that a desire to protect professional identities exists within psychology, as it does within psychiatry. This possibly stems from clinical psychologists' insecurity about their identities in what is a relatively new profession and their need to assert their expertise within medically dominated mental health services. This presents a significant hurdle for those seeking to achieve true user involvement. Importantly, as Repper and Perkins (as cited in Rush, 2004) state, 'it is not the case that professionals lack expertise, rather they do not have monopoly on wisdom'.

'Us and Them' Thinking
In her study exploring clinical psychologists' views on service user involvement within services, Soffe (2004) found that psychologists might perceive service users as being fundamentally different to themselves, rather than people like themselves, who also use mental health services; these perceptions are likely to affect clinical psychologists' practice. Whilst psychiatrists' 'us and them' thinking stems from the medical model which is rejected by clinical psychology, there remains a sense of difference and separateness, retaining its own assumptions about what users have to offer.
Whilst all of us will experience psychological distress at some point in our lives and can use this to relate to the people we try to help as psychologists, many of us do not have direct experience of using mental health services, of the oppressive and censorial powers of the current mental health system, or of extreme distress which would have us labelled as having a 'mental illness'; or maybe we have managed extreme expressions of our own emotions without services. It is difficult for psychologists to avoid minimising others' extreme experiences, whilst accepting that these do not make users in some fundamental way different from other people, only that they have used mental health services and that others (may) have not. Harper et al. (2003) report that professionals often become socialised into seeing some people as 'Other' and into using language that supports this; this can be viewed as a protective defence mechanism, distancing ourselves from the distress and suffering of those we see in a professional capacity (Wood & Wilson-Barnett, 1999). This categorical thinking is as damaging to the user and as limiting to our understanding as the medical model of distress.

**Service User Involvement at Surrey**

**Where Are We Now?**

Mental health services and negative aspects of professionalism within clinical psychology have led users to be disempowered and quietened to the dominant professional discourse. However, there is increasing recognition from several forward thinking clinical psychology training programmes that it is essential to drive forward user involvement in order to improve the extent to which clinical psychologists and services respond to the needs of people who use them.
Until the beginning of the academic year 2004-2005, user involvement on the Surrey Programme was limited to the odd workshop when users were invited to contribute. This puts Surrey at Level 2 of 5 on the 'The Ladder of Involvement', a framework devised by Goss & Miller (1995) to rate progress towards equal partnership. Whilst user involvement and the ethos of partnership has no doubt been discussed with trainees, as Tew et al (2004) and psychological theory will tell us, 'the medium must be congruent with the message', that is the process of education is more powerful than its content in shaping attitudes and capabilities.

The process of increasing user involvement on the Programme has begun, following the model used on the Exeter programme (Curle & Mitchell, 2003), although a desire move beyond this model has been expressed by Surrey course team members. So far there have been four informal meetings between members of the course team, users and clinicians where a 'vision' for involvement has been discussed. The Surrey Programme is currently in the process of change developing key issues, including user involvement; involving users in this working group from the outset is congruous with an ethos of equality and partnership. On the Manchester Programme where a similar process was undertaken, it was recognised that a great many stakeholders would not be represented by this working group. To address this, a database comprising over 300 stakeholders was developed to serve as a consultation network. This would be useful for the Surrey Programme as the issue of representativeness is often seen as a barrier to user involvement (Robert et al, 2002)
Representativeness

Concerns that particular users may be ‘too well’ or vocal to represent the views of users more generally have been expressed (Robert et al. 2002). This is a dangerous concept which can be viewed as a method of resisting user involvement by dismissing users as unrepresentative if they defy perceptions of the ‘mad’ as irrational and incompetent (Szasz, 1989). Although there are likely to be common themes through experiences of distress, ‘it would be unwise to claim uniformity in the ideas of users’ (Goodbody, 2003) and it is important that multiple voices are heard. Debate and discussion of professional views is encouraged and so should those of users; I recently found it useful to read a series of debating articles between two survivor activists on the issue of medication and user movement pressure to ‘dis drugs’ (Read, 2004; Wells, 2004).

Efforts should be made to develop alliances with minority groups and people with particularly stigmatising diagnoses who can feel excluded from user organisations. This is especially important as some services in which Surrey trainees complete placements have low levels of cultural diversity3. It is also likely that at times users views may differ from those who have used services via the role of carer, therefore opportunities should be made for these views to be heard separately.

At Surrey a job share co-ordinator post has been committed to for the next academic year, which will be filled by service users on a secondment basis. Having the posts seconded is intended to prevent the co-ordinators becoming too distant or divorced from their experiences as users by being

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3 According to Commission for Racial Equality Guidelines classification system, the service I am currently placed in received only 2% of referrals for individuals of non-white ethnic origin last year.
lost behind job titles and department agendas. The coordinator roles are essential in linking and networking with other agencies that can have input into the course, in gaining a wide range of views and filtering these through to the Surrey Programme. A consultation group to support the coordinators and keep them grounded in their task has been proposed. Similarly, the Manchester Programme developed a funded steering committee, made up of user representatives, who act as a source of ideas and can take an ongoing evaluative and developmental role.

Curriculum Planning & Teaching
The DoH (1999, 2001) require that ‘users are involved more in curriculum design and assessment’, in order to avoid ‘an over acadademicisation of basic training...which emphasises academic ability over caring skills’. User views should not be seen as additional views that merit some consideration alongside established professional ideas but as meriting equality in determining the core agenda and value base for the whole course (Tew et al. 2004).

Concerns have been expressed at the Surrey meetings about how conflicting views between stakeholders might be resolved within a philosophy of partnership and equality. The curriculum should not aim to conform conflicting views and reach consensus, but make conflict explicit in a climate that promotes debate and mutual respect (Forrest et al. 2000). This requires good working relationships based on frank open discussion about issues of power and ideas from all stakeholders of how these may be managed.
A wide range of approaches to involving users in planning and teaching have been successful across various disciplines, ranging from users consulting and advising on existing curriculum contents to designing and delivering entire modules. It has been suggested that seeing users in the university setting adds veracity to user accounts in that it is seen to value their input in the same context as research and theory (McAndrew & Samociuk, 2003). However trainees should be enabled to meet with users in other settings and via resources such as websites, videos and conferences, avoiding the presentation of user views within a psychology department 'bubble'. Some people may also feel more empowered to express their views outside of academic or professional institutions.

What is established in the literature is that direct involvement in teaching should be clear in its objectives, well planned and feel safe and validating for all parties. Examples of models which appear to have achieved this include collaborative, exploratory ventures such the Psychosis Revisited format (Bassett et al. 2003), Cooperative enquiry (Tee & Coldham, as cited on mhhe website) and a case study approach using action research methodology (McAndrew & Samociuk, 2003). More diverse teaching methods such as creative writing courses for occupational therapists and drama workshops have also been successfully used by survivors to teach professionals about their experiences (Tew et al. 2004). At Sheffield Hallam and Leeds Universities users have devised 'simulated patient roles' and case studies for action learning initiatives; these could be used to provide rich and realistic experiences for the Problem Based Learning module at Surrey.
It is important that users are not left to carry their message alone; this would be contrary to the philosophy of inclusion, only contributing further to an 'us and them' culture. In order to prevent this the Surrey Programme could utilise members of the consultation group and the user coordinators to consult and provide training on the non user led teaching (Tew et al. 2004). This has been successful on the Manchester Programme, where users have been involved in training course staff on how to integrate user perspectives into their modules and lectures. It has been reported that academic staff may find this challenge to organisational structure, procedures and endemic expert knowledge models difficult (Harper et al. 2003), which could create resistance to some initiatives. 'Away days' for course members to explore their aspirations and anxieties about progress towards a new course culture may help breakdown attitudinal barriers towards progress (Tew et al. 2004).

Commitment to training and preparation is crucial in involving users in planning and teaching on an equal, continuous and sustainable basis (Wood & Wilson-Barnett, 1999). To support a philosophy of equality and collaboration people need to develop confidence as 'experts by experience'; a difficult role for many users given previous experiences and the current socio-political climate. Users involved in teaching should be supported by the provision of 'training for trainers', of which there are many successful examples (Tew et al. 2004). Programmes like that devised by Shula Ramon at Anglia Polytechnic (available on mhhe website) designed to enable service users to develop the knowledge and skills to become effective committee members should also be explored. It must also be ensured that users are well supported in their various roles in the programme, which will by their nature be challenging and demanding.
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Tew et al. (2004) suggest it may be useful for users to work in teams or pairs rather than individually; this may reduce anxieties and provide more flexibility for taking time off when necessary for personal well being.

Whilst achieving equality in power and status suggests equality in pay, a complex benefits system may make this problematic for some users, creating a potential barrier for more people to become involved. It has been suggested that users could receive payment in kind for some contributions through receiving training and skills (Robert et al. 2003) and the Mental Health Foundation (2003) have produced payment guidelines for those seeking to involve users.

I feel that the curriculum at Surrey should include modules that deal explicitly with the issues arising in this essay in order to enable trainees to appreciate user perspectives and deconstruct dominant discourses. These should include power and control, socio-political influences, the teaching of rhetoric, philosophy and the theory of knowledge.

Placements
The Exeter working group felt 'empowered by the user group to advocate more strongly about issues of power and inequalities' (Goodbody, 2003). Increased involvement of users on the Programme will equip trainees with the knowledge and experience to critique services and challenge inequalities if they are faced with them on placement.

In line with The Ten Shared Capabilities (NIMHE, 2004) trainees should generate specific placement objectives to enhance their competence in working collaboratively with users. It should be ensured that placement
supervisors are modelling a genuine commitment to working with people, rather than performing interventions on them (Tew et al. 2004) and the possibility for users to be trained as additional placement supervisors could be explored. Explicit community psychology placements or those which focus on working with user groups would help to keep trainees grounded in the reality of peoples' lives outside the therapy room, something which I think I may have found difficult on the course without a background in other mental health services.

The idea of 'client attachment' (Turner et al. as cited in Tew et al. 2004) may help to achieve this. This model, utilised in my nursing training at Manchester University, involves trainees making specific attachments with clients, rather than undertaking a series of separate service based placements. This provided me with the opportunity to work in many statutory and volunteer organisations, make links, network and really understand the 'user journey'. Some trainees on the Surrey Programme have had user mentors on placement, having the opportunity to discuss services and experiences outside a professional relationship; it would be useful for all trainees to have this experience.

It has been proposed that users could be involved in assessing trainees on placement, although the Manchester Programme consultation group received negative feedback on this point, with concerns that users' expectations about and knowledge of the role of the psychologist may conflict with the profession's view. The trainee may be left in a position where they feel they have to appease clients in order to achieve good marks and users may feel they have to give good feedback in order to receive good services; this would not be therapeutic or ethical. Tew et al.
(2004) propose that a first step may be users giving structured feedback to trainees' supervisors who can consider this in their overall assessment.

**Assessment of Trainees**

User perspectives should be considered in assessment of trainees' assignments and case reports. On the master's degree in mental health at the University of Birmingham (Tew et al. 2004) users have provided feedback on students' portfolios, however ultimately it may be possible for users to receive training in independently marking trainees' work. Alternatively users could provide guidance for academic staff on marking criteria. However, the Manchester Programme found that some stakeholders felt there was no need to make any changes to the assessment process and that users do not have the required knowledge to contribute. It was also commented that suggestions to train users in assessment are too idealistic; it appears that academics may place high value on intellectual ability of trainees and their assumed superior ability to assess this.

**Research & Evidence Base**

There are examples of users getting involved in all stages of the research process (Faulkner & Morris, 2002) from an advisory capacity, to carrying out interviews and undertaking user controlled research (Davies & Braithwaite, 2001; The Mental Health Foundation, 1999). This should ultimately play a critical role in influencing the research agenda and in allowing users to determine how services are evaluated and changed. Whilst Surrey trainees should be encouraged to draw on the growing
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evidence base from user led research, at this time these projects are limited.

The Surrey Programme should seek to challenge the 'identity' of the researcher, as has been traditionally conceived in Western scientific discourse. Rather than pursuing the myth of 'value free objectivity' (The Mental Health Foundation, 1999), trainees should be encouraged to utilize research methods that give a voice to disempowered groups, such as qualitative methods; as Goodbody (2003) points out, clinical psychology's expertise in this area is one that concords well with the interests of users and their involvement.

Trainees should where possible undertake collaborative research with consumer groups, not merely by having users as their participants, but by enabling users to define the areas of research and questions relevant to their needs; as it is through user research that a clearer picture of what constitutes good practice will emerge (Faulkner & Thomas, 2002). There should be a requirement that trainees state how the researched group's views will be represented and the Manchester Programme have proposed that jargon free abstracts should be made available for feedback from users via the university website.

In order to create an inclusive course philosophy that does not prize scientific expert knowledge above all else, trainees should be encouraged to use a variety of evidence. It is probable that psychologists do this in practice—drawing on experience, philosophy, literature and poetry; although we can be constrained by the rhetoric of the profession from openly advocating these (Newnes, 2001). Tutors should introduce novels and biography to reading lists and encourage trainees to reflect on the
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lessons and meanings derived from these. Other lecturers have had success in illustrating themes of distress and therapy through film and popular cinema (Spellman, 1998). Discussion groups on film, poetry and literature could be built into the curriculum and the importance of the arts to therapy and our lives should be explored in classes.

The 'reflective-practitioner' model encourages introspection and is respectful of evidence from personal experiences, which Goodbody (2003) states coupled with reflexivity, could reduce some of the limitations of our professional knowing. However, trainees can be warned against consciously using personal experience as this can be seen as counter-transference or as 'less objective' than other evidence; this equates to the personal experience of service users being viewed similarly. Lecturers should actively encourage openness and the exploration of personal experiences and it may be a powerful message for trainees if members of the team were willing to be open about their own distress or help seeking, challenging categorical 'Us and Them' thinking which maintain inequalities in power and status. Attempts to increase the social heterogeneity of cohorts should be made, as this will increase the range of experiences and viewpoints to be drawn upon.

Trainee Cohorts

The Programme may benefit from having users involved in the selection process by contributing to the criteria for short listing or through direct involvement in interviews, although stakeholders in the Manchester Programme raised concerns about users' limited knowledge of clinical psychology issues. Despite this view, and concerns expressed by trainees at Surrey that it may feel more anxiety provoking to have a user on the
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panel, experience suggests that these interviewers may be more able to evoke certain attitudinal responses from candidates and can look at more general factors that users value (Harper et al. 2003). Arguably, attitudes and values should be prioritised at interview as they are likely to be harder to change in training than skills and academic knowledge.

Enabling users to become trainees or those user trainees who exist to be open about their experience would be a significant step in furthering the user agenda. However, admitting to experiencing mental health problems is likely to lead to 'felt stigma' (Williams & Healy, 2001) and whilst 'coming out' holds the potential to be validating, rewarding, cathartic, therapeutic and offer the chance to give something back or to bring about a change, it would require a significant leap of faith on the part of the user to be sure of colleagues' and staff responses. The Programme advertisement material should make it explicit that experience of using services would be seen as an advantage and be specific about the support available, safety to disclose mental health problems and issues of confidentiality.

Conclusion

In this essay I have outlined the socio political context of service provision in Britain and how this has traditionally marginalised and disempowered service users. I have looked at the dominant models and professional discourse within clinical psychology and the ways in which these have also quietened the users' voice. I have argued that in order to overcome these traditional inequalities and provide legitimacy to the growing user movement, clinical psychology must encourage a paradigm which views
user involvement not only as desirable in a just society but as essential in furthering our understanding of the experience of distress and recovery.

I have suggested that meaningful user involvement on the Surrey Clinical Psychology Programme must be developed to span across teaching, placements and research so that the results can go beyond rote learning of correct terminology and tokenism to affect real change in the core curriculum and learning culture; addressing issues of power, challenging stigma and pathologies perpetuated within systems. I have identified a number of dilemmas and issues raised in attempting to do this and have discussed how these may be addressed.

There is no doubt that increasing service user involvement on the Surrey Programme represents a significant challenge, with many practical and symbolic barriers. However, it is by attempting to do this and learning from the experience that the profession of clinical psychology can help create and drive forward the changes required to realise a new future for people who use mental health services.
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Under the proposed reforms to the Mental Health Act, clinical psychologists will be able to assume greater involvement in the process of 'sectioning' and supervising the treatment of people who are subject to compulsion. What are the advantages and disadvantages of our profession getting involved in these processes? What issues and dilemmas might need to be considered by clinical psychologists as they make a decision about whether to accept these responsibilities? How would you decide?
Professional Issues Essay

Introduction

I have chosen to write this essay as I remember early in the course being the only trainee to raise their hand when asked if they would consider accepting the ‘clinical supervisor’ role, proposed in the Draft Mental Health Bill (2004)\(^4\). Over the last year, my opinion on this has shifted somewhat towards a less positive view of what accepting this role might mean for clinical psychologists and those subject to compulsory powers; this essay will draw on the academic, professional and clinical experiences that have influenced this process.

In considering whether or not clinical psychologists should become increasingly involved with ‘sectioning’, it is necessary to examine the concept of mental health legislation in itself. Therefore, I will firstly outline the contexts in which legal powers to ‘care’ for those who are distressed emerged, and the context currently influencing proposed Mental Health Act reforms. In light of this, I will then discuss possible advantages and disadvantages of clinical psychologists taking on the role of clinical supervisor and the issues and dilemmas these raise. Finally, I will answer the question posed ‘How would you decide?’ by outlining how I believe the profession should respond to the proposed reforms and the ways in which psychologists can influence the use of mental health legislation positively.

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\(^4\) Throughout this essay, the terms ‘Draft Bill’ and ‘Bill’, refer to the revised Draft Mental Health Bill (2004), which supersedes the original Draft Mental Health Bill (2002).
Mental Health Law

Madness, Law & Medicine

The system our society has developed to deal with psychological distress locates 'madness' in the domains of Medicine and Law. An acceptance of these concepts can be observed across the mental health professions, mental health policy, services and the public psyche.

The link between Law and psychological distress developed amid concerns of public protection, with the Vagrancy Act 1744, which allowed unregulated confinement of the "mad" in work houses or Houses of Correction (Department of Health [DoH], 2005). Following reports in the early 19th century of widespread abuse in these asylums, mental health law developed a further function, distinct from that of incarcerating the mad; the responsibility to protect patients' interests.

Therefore, in an attempt to regulate and improve conditions, the 1828 Madhouses Act passed responsibility for the 'care' of 'lunatics' from the local civil authorities to the Royal College of Physicians within London’s madhouses. Forging the link between psychological distress and Medicine, the Act instantiated two massive (worldwide) concepts; that 'lunatics' are 'ill' and that doctors should care for them (Kinderman, 2005).

With increasing concerns about wrongful detention, the Government introduced the concept of 'sectioning' through the 1890 Lunacy Act, whereby people could only be detained following 'certification' by both a

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3 For the purpose of this essay, the term 'services' refers to statutory mental health or learning disability services delivered within the National Health Service in England and Wales, in which people are detained under the MHA 1983.
magistrate and a doctor. The role of the judiciary and legal proceedings in 'commitment' was maintained throughout further legislative reforms until the 1959 Mental Health Act (MHA) abolished the requirement of a magistrate. Thus, with this Act, the Government entirely relinquished responsibility for determining madness and 'sectioning' to professionals, namely psychiatrists. In 1983, prompted by the growth of the civil rights movement, the Act was amended, narrowing definitions of mental disorder, restricting treatment without consent and introducing The Mental Health Act Commission; however the main treatment framework in use today remains largely unchanged since 1959.

The 1983 MHA permits compulsory detention, assessment and treatment of a 'mentally disordered' patient in hospital, if the 'disorder' is of a degree which represents a danger to his health or safety or that of others. Neither the definition of 'mental disorder' nor the conditions for the use of compulsion make any distinction between people with capacity and those without and the power to discharge a person resides with the psychiatrist Responsible Medical Officer (RMO).

As has been laid down in history, the MHA continues to have two distinct (possibly contradictory) functions; incarcerating people whilst also protecting their rights. Therefore the detained person has the right of appeal at specified times to both a Review Tribunal and the Hospital Managers.

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6 Within the Act, Mental Disorder refers to 'mental illness', 'arrested or incomplete development of mind' (Learning Disability), 'psychopathic disorder' and 'any other disorder or disability of mind'.

7 A comprehensive outline of the powers of Mental Health Act (1983) are beyond the scope of this essay, therefore those most relevant have been briefly outlined. See Dolan & Powell (2001) for comprehensive explication.
The Current Proposals for Reform

The reform of the MHA began in 1998. Following a series of pre-legislative stages and publications* and an open invitation for consultation from stakeholders, the Government detailed their vision for a new mental health act in the revised Draft Bill (2004).

Under the previous Conservative Government, policy was often driven by lurid newspaper headlines (Bracken & Thomas, 2003) and the false perception that the closing of asylums in the 1980's meant that the 'mentally ill' were uncontained, putting the community at risk (Moncrieff, 2003; Taylor & Gunn, 1999). In contrast, the New Labour Government have formally stated that planned reforms arise from a need to update the current law which has been rendered outdated due to medical and therapeutic advances (DoH, 1999) and a desire to reduce rates of compulsion (DoH, 2000).

However, many groups (including the BPS, 1999:9 & The Royal College of Psychiatrists, 1999) feel that informally, the political impetus to reform continues to be centered around false associations of the 'mentally ill' with risk and dangerousness and a social control agenda. Fuelling these perceptions, the Government has stated that 'concerns of risk will always take precedence' and that non compliance will not be an option (DoH/Home Office, 2000).

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* See DoH website for full details of pre-legislative stages, publications and consultations undertaken (including: Green Paper, DoH, 1999; White Paper, 2000; Draft Bill, 2002).
Several of the changes proposed in the Draft Bill\textsuperscript{9} seem to confirm this informal agenda by significantly extending the scope of legislation; namely the broad definition of 'mental disorder' and introduction of compulsory powers in the community. The Government intend these powers to provide the 'flexibility' to treat people in the 'least restrictive environment' (DoH, 2002). However, the proposals have united almost every pressure group, charity and professional body (Moncrieff, 2003) in the opinion that, on the contrary, the Bill represents the most repressive and coercive mental health legislation of recent times.

At present, the Draft Bill has undergone Pre-legislative Scrutiny, the function of which is to recommend improvements before the Bill is accepted by Parliament and becomes an Act. Having considered evidence from professionals, carers and service users, the Scrutiny Committee concluded that the Bill should proceed, with 107 amendments\textsuperscript{10}; agreeing with all recommendations made by the BPS (Kinderman, 2005). The Government has responded conceding some amendments\textsuperscript{11}; therefore it is likely that the Bill will proceed with some degree of urgency and this new legal framework will be accepted.

\textsuperscript{9} A full discussion of all proposed changes is beyond the scope of this essay. Summaries of the main differences between the draft Bill (2004) and the Mental Health Act (1983) have been provided elsewhere (see DoH website; Moncrieff, 2004).

\textsuperscript{10} See House of Lords/House of Commons Scrutiny Report (2005) for full details of recommended amendments (DoH website).

\textsuperscript{11} See Government Response to House of Commons/House of Lords Scrutiny Report (2005) for full response to recommendations (DoH website).
Clinical Psychology and the Draft Bill

The Clinical Supervisor Role
The whole of the Draft Bill should be a matter of concern for clinical psychologists, as the proposals have wide reaching implications for our clients and the future of mental health services in the UK.

More specifically, psychologists’ roles will be irretrievably changed (Diamond, 2002) by the introduction of the clinical supervisor (CS) role. As specified in the Draft Bill, the CS is ‘an approved clinician appointed to be in charge of the assessment of the patient and any treatment provided’ (replacing the current function of the RMO). The CS will also have the responsibility to impose restrictions in the case of community treatment orders, to grant leave from hospital and to discharge, either from a hospital or community order (except for some ‘high risk’ cases where the new Tribunals will be responsible for these decisions; DoH, 2004).

The DoH have explicitly stated that, whilst in most cases the CS will be a psychiatrist, there may be cases when it will be more appropriate for the role to be undertaken by a clinical psychologist (DoH, 2004). It is not clear from the proposals whether the ‘Approved Mental Health Professional’ replacing the Approved Social Worker in the Mental Health Act Assessment could be a role for clinical psychologists, although presumably this could be the case.\(^\text{12}\)

\(^{12}\) The discussion that follows could be equally applied to consideration of the Approved Mental Health Professional role, however, as this is not specified in the proposals, this essay will focus on the Clinical Supervisor role.
Peter Kinderman (Chair of the Division of Clinical Psychology Working Party on Mental Health Act Reform), the main negotiator between the profession and the Government, has stated that psychologists have successfully influenced the proposed legislation through ongoing constructive dialogue with the DoH (2003). However, the vast majority of clinical psychologists have so far remained silent on the matter (May et al, 2005), and the only survey of the profession's opinion was a brief questionnaire (Cooke et al, 2002a) with a 16 per cent response rate, concluding that opinion on the Bill is 'divided'. Thus, those informing this consultation represent a narrow sample of practitioners.

Some have speculated why the profession appears so ambivalent about the proposals (e.g. Diamond, 2003), however, this may now be a purely academic debate; the proposals for clinical psychologists' involvement in the CS role were upheld by the Scrutiny Committee and hence it seems certain these will be retained when the Bill becomes an Act. In line with this supposition, the BPS have been fully involved with discussions concerning the preparation and training of professionals to resource its implementation (Kinderman, 2005).

Whether this role will then be compulsory or optional, and how many of us accept it, remains to be seen.

**Advantages and Disadvantages**

**Sectioning- are there advantages?**

As outlined, the Government's reform agenda has been heavily criticized as being overly influenced by the turbulence and public disquiet resulting
from the move to community based treatment of the 'mentally ill' (Barham, 1997) and a social control agenda.

However, in my clinical experience, it would be difficult to argue that on rare occasions a minority of people do not pose a risk to themselves or others as a consequence of 'impaired psychological processes' (Kinderman, 2002) or what Barker (2005) has called 'problems of living'. Therefore I believe that compulsory detention in hospital does at times prevent vulnerable people from significant harm; the premise under which I have at times used powers under the Mental Health Act whilst working as a mental health nurse. However, doing so created significant professional dilemmas for me, resulting ultimately in my desire to leave the nursing profession; these dilemmas are important for clinical psychologists when considering the CS role.

Firstly, sectioning someone does not, as one might desire, convey them to a place of safety and sanctuary, where a process of recovery can be encouraged. Rather, it turns them over to a medically dominated system, the potentially damaging effects of which have been well documented in the writings of the survivor movement and by critical psychiatrists and psychologists (i.e. Campbell, 1996; Newnes et al, 1999; May, 2000). The environments people are conveyed to under the Act are usually poorly resourced, experienced as 'bizarre and threatening' (Hartley, 2001) and have provided the setting for widespread psychological and physical abuse towards clients. Therefore, detention in hospital often does not meet the accepted (but not expressly legally stated) Principle of Reciprocity; that is - civil liberties and autonomy should be restricted only
if there are sufficient resources to ensure that they receive good quality care (Bracken & Thomas, 2003).

Secondly, 'sectioning' someone does not only permit detention in hospital but sanctions further uses of the Act, many of which sit uncomfortably with the philosophies and belief systems of those from non-medical backgrounds. These include enforcing psychiatric medication and ECT, physical restraint, seclusion and restricting of freedom upon discharge. The notion that compliance with these regimes (enforced or otherwise) leads to clinical improvement and a reduction of 'risk' has never been proven (Cooke et al, 2002) and as we know, the ability of any profession to accurately assess or predict risk is highly questionable (Johns, cited in Cooke 2001), however these continue to be the mainstay of 'specialist' mental health services.

Thus, I suggest, it is not that the Government and services do not have a duty to protect vulnerable people from harming themselves or others (what may be termed social control), but that they have become overly influenced by inflated associations between risk and mental distress and the notion that 'compliance' with medical regimes will remedy this situation. This has led to the over use and misuse of the Act, with truly disastrous outcomes for those who come into contact with services. Recognition of this has led to some welcoming the fact that the Government have been more explicit about the social control function in the Draft Bill (Kinderman, 2002).
Change - Within or Outwith?

It may seem strange then, that having left a psychiatrically dominated profession for these reasons, I would consider it a good thing for psychologists to accept the CS role. However, I originally perceived that by becoming more involved in ‘sectioning’ and accepting the CS role, psychologists would have the opportunity to positively influence individual care packages and mental health services; to, as Bentall (1990) writes, ‘overturn the hegemony of the medical model’ and offer effective psychological alternatives.

Psychologists writing since the publication of the Bill agree that change within the mental health system is necessary. However, debate over the CS role has split into two camps; those who believe that services can be positively influenced by taking the role (Kinderman, 2005; Taylor et al, 2003) and those who think that this end can best be achieved by refusing it (Diamond, 2003; May et al, 2005).

Kinderman and Taylor et al (2003), in support of accepting the CS role, assert that psychologists have a ‘strikingly different framework of knowledge, understanding and skills’ and therefore can develop care plans which will better meet clients’ needs. As clinical supervisors will have legal responsibility for organizing, coordinating and supporting colleagues in the delivery of these care plans, they believe this reform will promote a radical departure from the medical domination on psychiatric wards, moving specialist psychological expertise into mainstream services and preventing the overuse of medication or ECT.
Whilst I agree that these competencies benefit clients and that psychology should be at the heart of services, Kinderman (2005) has also claimed that psychologists' actions are 'right... just fundamentally correct, effective and moral' and that they would 'relish positions that give them greater leadership, influence and power'; these somewhat grandiose claims about the superior position of psychology in comparison to other disciplines and a craving for power have attracted skepticism. Barker (2005) congratulated Kinderman on this 'pragmatic rhetoric', questioning the assumption that clinical psychology represents 'anywhere near a unanimous profession'.

In my experience so far, it is evident that not all clinical psychologists share a desire to overturn the medical hegemony, a unanimous view on the best way to support someone on their personal journey to recovery, or the belief that 'recovery' from a 'serious mental illness' is even possible. As Newnes (2002) points out, psychologists can act as accomplices, rather than critics of the psychiatric system and in doing so have themselves oppressed and caused distress to service users.

Barker also expresses concern that clinical psychologists crave power for the same (unfortunate) reasons that mental health nurses crave this ersatz (but well accepted) form of psychiatric authority (Barker, 2005). Whilst I would argue that mental health nurses also are not a unanimous profession, the point is made that the motives for psychologists in acquiring the 'golden chalice' (Ross 2003) of powers equivalent to those of the RMO, are in some cases less benign than suggested by Kinderman.
Furthermore, May et al, (2005), have highlighted their concerns about the corrupting influence of power. Whilst clinical psychologists such as Kinderman (and myself) may have philanthropic intentions for the use of the CS powers and the hope that these can be maintained in practice, psychological research such as the Stanford Prison Experiment has powerfully shown that the roles that people take are crucial in determining their (sometimes oppressive) behaviour. Also, in my experience of psychiatric wards, exposure to commonplace coercive practices can desensitize staff to the magnitude of what they are doing and the psychological implications for clients; this can result in complacency and the over-use of such practices even when there is no maleficent intent.

Even if we assume that psychologists will strive to use their CS powers more benignly than our medical colleagues, Newnes (2002) has highlighted that clinical psychology, like psychiatry, cannot provide simple answers to the complex ‘problems of living’ that exist in our society. Therefore it is likely that in ‘difficult’ and complex cases we will practice ‘defensively’, reverting to compliance with psychiatric interventions and increased compulsory powers; particularly in the current ‘blame culture’ which saw a 75% rise sectioning between 1989-1999 (DoH, 1999a).

Therefore, it seems likely that clinical psychologists will succumb to these influences and prove to be as corruptible as any other professional grouping; thus creating a tension between what we may seek to challenge and change by working within the system [through taking the CS role] and what we might unintentionally support or collude with (Diamond, 2002).
Influences on Decision Making

There exists considerable local variation in requests for MHA assessments (Huxley & Kerfoot, 1993) and in rates of detention (Bindman, 2000) across the UK. This is not surprising, considering that the MHA (and draft Bill) endorse the use of 'clinical discretion' in decisions about compulsion, resulting in what is a 'fundamentally interpretive exercise' (Eastman & Peay, 1999).

Psychiatrists (and the proposed clinical supervisors) are tasked with the contradictory demands of acting in the client's best interests, whilst maximising their autonomy, protecting their rights and freedoms and ensuring that risk of harm to the individual or others is minimised (Bingley & Heginbotham, 1999). Sarkar (2005) highlights the complexity of determining 'best interests', noting that this can mean different things to different clients, and is not always the same as (but is often conflated with) 'best medical' or 'best social' interests\(^{13}\). Professionals making commitment decisions also work under the (sometimes conflicting) frameworks of common law; mental health law; human rights law; a 'duty of care' and professional Codes of Practice. It is not clear how psychologists are better placed to balance these demands using a psychological, rather than a medical perspective.

Also, research suggests that several non-clinical and extra legal influences are important in determining how clinicians use these discretionary powers. Influential factors in lowering the threshold for compulsion include work pressures and a lack of alternatives to inpatient care; this is likely to have a 'profound' influence in poorer areas where clinicians

\(^{13}\) See *F v West Berkshire Health Authority*(1990).
cannot rely on comprehensive community resources when considering discharge (Quirk et al, 2003).

Another decisive factor influencing compulsion rates is perceived support from the team (Quirk et al, 2003). Given that the argument for psychologists taking the CS role is based upon the premise that we think about things and work differently from our colleagues, it may be that we do not often have this support. Further, discussion with colleagues, peer support and peer evaluation is one way that informal operational norms are invoked and sustained (Greer, 1988). Whilst these norms could influence CS to use compulsion as a 'last resort', it is clear that in some cases they will support a risk focused, 'section happy' culture.

Therefore, it seems plausible to assume that the 'clinical' decisions of psychologists who assume the CS role will not be based purely on their psychological knowledge, formulation and skills, but on wider considerations faced by all professional groups. Indeed, as Holdsworth & Dodgson (2003) note, in clinical practice, research evidence recedes to become background knowledge and decisions and judgements about 'risk' are based on individual opinion about difficult-to-quantify information.

Whilst there are safeguards embodied in the Act and Draft Bill, these are patchy and institutionally highly limited (Eastman & Peay, 1999); it has been said that clinicians' opinion is rarely challenged in Tribunal hearings and that the draft Bill has fewer, rather than stricter, procedural safeguards than the current Act (Sarkar, 2005).
Keeping Our Hands Clean

It has long been accepted in the psychotherapeutic domain that the relationship between client and clinician is the foundation for, if not the central component of, the effectiveness of psychological interventions. Thus another argument against clinical psychologists accepting the CS role is the notion that the profession should remain distinctly separate from the legal aspects of the mental health system in order to preserve the opportunity to form this therapeutic alliance.

As Smail (1993) has argued "what makes [psychologists] different from other professions in the field is that... [we]...can’t lock them up; we can’t drug them up or stun them with electricity. The only power we have is the power of persuasion and this...more or less forces us into an attitude of respect towards our clients". However, the clinico-legal nature of 'sectioning' means that psychologists acting as clinical supervisors' would struggle to base these relationships on many of the principles inherent in our training and professional codes, such as consent, respect for autonomy and trust.

By definition, people legally detained do not consent to be in hospital and therefore do not experience respect for their autonomy. Also, from the service users' perspective there can be a deep suspicion, often founded on past experience, that those with 'mental disorders' are not treated with equal respect and dignity' (Caldicott et al, 1999), hence trust is unlikely. The undesired effect being that people will avoid mental health services, or contact with psychologists, because of the ever present threat of compulsion (Perkins, 1999).
However, as Taylor et al. (2003) point out, there is no evidence to support the assumption that psychologists will ever be charged with the joint role of CS and primary therapist. Indeed, many European countries have recognised the problems that arise when psychiatrists are given dual roles and have begun to keep their 'doctor' and 'imprisoner' roles apart (Bracken & Thomas, 2003).

Therefore, whilst the CS may be perceived as an authoritarian 'agent of the state', psychological therapy interventions could be undertaken through a therapeutic relationship with another therapist, without legislative powers. There is the risk that all psychologists will become negatively associated with the threat of compulsion; minimising the effect of this would rely upon clear and honest discussion with our clients about the extent of our involvement in this process, whether a CS or therapist. Arguably, in this scenario, the likelihood that psychological intervention would be 'prescribed' will increase, given that a psychologist would be devising the care plan.

Taking this into account, Smail's view of the 'unsullied role' of the clinical psychologist within services has been criticized as, rose-tinted, misplaced preciousness (Taylor, 2003; Barker, 2005), which rather than benefiting our clients, protects our profession from aspects of mental health work which we find distasteful and ethically difficult. It seems to me that for psychologists working with clients detained under the MHA, who in their clinical judgement should remain in hospital, this is a difficult position to justify. As Taylor et al. (2003) note, why should we expect our equally principled colleagues in other disciplines to soil their hands with the more
'unsavoury aspects' of the work, whilst we remain on the sidelines, criticizing their efforts?

I would also contest Smail's view that psychologists have no power to 'lock people up' - every time we write a report, complete a risk assessment or converse with our colleagues about a client who we think should be in hospital, we use our 'professional power' to influence these decisions. Does it not then represent dishonesty in our relationships with our clients to maintain that we have nothing to do with their detention; honesty being a principle on which the therapeutic relationship is based and which is essential for trust.

My intention here is not to undermine the extremely negative psychological effects of the process of sectioning, both for professionals and more significantly the person who is being detained. Being sectioned can lead to feelings of unworthiness, vulnerability, humiliation, fear, anger, hatred, fatalism, negativism, a lack of control and symptoms of post-traumatic stress (Morrison et al., 1999; Hesford, cited in Ross, 2003) and increased burnout effects on professionals have been documented (Evans et al., 2005). Therefore a desire to distance ourselves from this process is perfectly understandable.

However, if we accept that in a minority of cases and as a last resort, sectioning is required to protect peoples' safety (a view that appears to be predominantly supported by both voluntary and detained patients; Ross, 2003) it seems to me that 'keeping our hands clean' does not represent a valid argument against accepting the CS role.
The Scope of Influence

The Government have specified that in most cases, the CS will continue to be a psychiatrist; the size of our profession relative to that of psychiatry and the number of people detained under the Act also predefines this. The basis on which it will be decided that a case can more appropriately be managed by a clinical psychologist is not clear, however, it has been suggested that this is likely to be limited to two specific circumstances; the rare scenario when 'psychosis' is managed with predominantly psychological interventions and the much more likely management of personality disorder (which is deemed by psychiatry not to be a 'mental illness', and thus cannot be 'treated' with medication) (Pilgrim & Hewitt, 2001).

As the vast majority of people we come into contact with in services are taking (and in many cases addicted to) psychiatric medication, in these cases a psychiatrist would continue to be largely involved in treatment (as psychologists do not have the expertise to prescribe or discontinue medication). It is difficult then to imagine how a psychologist CS could prevent the over-use of medication anymore than they could by working as a therapist advocating for a reduction in their client's medication. However, this may present an opportunity to prevent over medication in first contact cases.

Also, whilst the RMO is seen to be in charge (as will be the CS), factors such as the ward culture, informal philosophies and attitudes of individual staff members can equally influence a client's experience of hospital; what goes on when the RMO leaves the ward is largely out of his control. It is not clear from the proposals how 'present' the CS will be on
the ward in order to ensure their 'psychological care plan' is enacted; however, attempting to change a medically or risk oriented ward culture will be a difficult task (e.g. Johnstone, 2001), especially when acting as CS in a minority of cases.

Conclusion

How Would I Decide?
I have discussed the reasons why I believe that 'sectioning' should exist as a last resort option in a minority of cases, but also how significant problems within the system, make it ethically problematic for professionals to take the decision to detain someone.

I have considered an argument that psychologists, by accepting the CS role, could seek to remedy, or at least limit the impact of, these problems by using mental health legislation more benignly than is currently the case. However, I have concluded that non-clinical and extra-legal influences, the corrupting influence of power and the minimal role for psychologists in the Draft Bill, would make this unlikely to happen; although there remains a part of me that idealistically awaits this to be proven wrong.

I have also considered the argument that psychologists should 'keep their hands clean' and reject the CS role on the grounds of maintaining the ability to form therapeutic and trusting relationships with their clients. However, I have rejected this argument on the basis that, if we agree with the notion of 'sectioning' per se (whether or not we wish to radically change mental health services), it is unjust and dishonest to expect the
responsibility to fall to our colleagues from other disciplines, claiming to have no part of it whilst criticizing their efforts.

Thus, I have rejected an argument for accepting the clinical supervisor role and equally one for refusing it; perhaps representing the contradictions inherent in the act of sectioning - 'both abusive and protective, both liberal and authoritarian, both benevolent and detrimental' (Ross, 2003).

Therefore, my decision whether or not to take the role is largely based on consideration of the Bill as a whole, which I believe to be significantly flawed. To accept the clinical supervisor role would mean to work within and enforce an Act which is likely to increase the numbers of people subject to compulsion; that would extend compulsion into the community; which may not comply with the Human Rights Act 1988; that continues to endorse enforced medication and ECT; that does not make advance directives legally binding; that does not include an 'incapacity' clause and which weakens safeguards of clients' rights to autonomy and liberty.

Considering these issues, I believe that clinical psychologists should not accept increased responsibility for 'sectioning' through the Clinical Supervisor or Approved Mental Health Professional role, as laid out in the draft Bill. In my opinion, services do not currently provide an environment that would enable psychologists (or other professionals) to use these powers more benignly than they are currently used, and the Bill does not support a move towards this position.
Alternatives

I agree with May et al (2005) that there should be a democratic ballot of clinical psychologists, in order to gain a clearer picture of views on the CS role. Although it may be too late to change the Bill, if this vote was against accepting increased powers, psychologists could at least communicate a consensus opinion to the DoH.

Maybe in this instance, the profession would mount a 'conscientious objection' towards the role; however, it might be that acceptance of MHA duties will become embedded in what is expected of our profession and necessary for career advancement. And of course, there are clinical psychologists who welcome the powers.

At this point, I believe that those psychologists who perceive a need for change and seek to overturn the medical hegemony, should continue to embrace the expertise of those with personal experience of services and develop their own practice and thus services in line with this. We might also campaign for a more collaborative and compassionate approach to 'sectioning' for example, by advocating for advance directives and nominated representatives' decisions to be made legally enforceable.

'Winning hearts and minds' by demonstrating the effectiveness of this approach may be a more long-sighted route to change than taking up the golden (or poison) chalice of the CS role. However, we should take encouragement from the successes of those professionals who, by embracing service user involvement, have already developed more humane and responsive services that can assist people on their personal journey of recovery.
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Problem Based Learning Reflective Account

The Relationship to Change

Year 1

March 2005
On reflection our PBL group approached the 'the relationship to change' in a primarily task oriented way. This was helpful in keeping us focussed, on schedule, grounded in an evidence base and working in the same direction. We used pragmatic criteria to assign roles of minute taker and chair and quickly made a start on discussing 'change'. This generated a lot of information through similar and diverse experiences of change and elicited a strongly shared sense that 'change is difficult'. As we all connected on this point it became the basis on which we moved forward, setting homework tasks to each research a model which could explain why change is difficult. Following this we each presented our chosen model back to the group and in a similar way all converged on a strong connection with the 'Stages of Change Model' (SoCM), (Prochaska & DiClemente, 1992). This then, quite naturally, became our presentation.

This approach of independent information gathering, feeding back to the group and discussing individual experiences with different models was extremely useful; it allowed members of our group to experience models they had not used through others recalling what they had done. It also enabled those describing their experiences to re-experience them with the benefit of reflections and contributions from other group members. This is similar to my experiences of facilitating a cognitive behavioural group on placement, in which I have found the model quickly and more easily became alive as compared to using the model with individual clients. By sharing and connecting with each others' experiences and re evaluating events to draw different conclusions, group members were able to believe in the model and see how it applied to their own and others' situations.
I also feel that in some respects, the structured approach we used, focussing quickly on models of change constrained us somewhat. Some ideas were dismissed as too 'out there' to be included from the first session, such as the subject I raised of a male to female transsexual who had received extensive recent media coverage - therefore overlooking some of the wider, societal and cultural issues a conversation about this could have raised; subsequent placement experience and systemic supervision has highlighted to me the importance of these wider contextual issues.

With hindsight, it was easy to be influenced by others in not pursuing this, due to my feelings of uncertainty and inadequacy at the beginning of training and concerns about how other members of the group would view me, not wanting to appear un-psychological or unscientific by not pursuing a 'model of change'. As pointed out by Knights (1995) 'groups, like any other form of collectivity, are cultural forms, and as cultural forms exercise influence over the being of their members'.

This mirrors the way the clients we see in therapy may feel towards us and how suggestible they may be to our influence and understandings, having often waited for long periods with much hope about what we can offer them. I have learned on placement to try to minimise this by continuously checking out my understanding and seeking clarification with clients. Therefore, whilst it felt comfortable for both the group and facilitator to take a structured, presentation and model focussed route from the first session, the experience could have been richer if we had paid more attention to exploring and clarifying individual understandings of the 'problem'. Similarly, a more detailed explication of the title may have led
to further consideration of the 'relationship' which to a large extent we overlooked at that time, focussing mostly on the word 'change'.

Although we were relatively task focussed in our approach, throughout the process of PBL we sought to be encouraging and respectful of each other, using humanistic principles which Sreinert (2004) found to be most valued by students for effective small group teaching. Despite us all having doubts and insecurities about our abilities, by session 3, once we had developed a rapport and supportive relationships with each other, we were able to discuss these openly. This created a non threatening group atmosphere which enabled me to feel more at ease with sharing my ideas collaboratively from a position of equality.

Creating this type of collaboration and equality with clients on placement has often been more difficult. I have found inherent power differentials have positioned me in the expert role and also many of the people I have worked with have a low sense of self efficacy, self belief and autonomy. I have found that when faced with a client who feels uncertain of what to do, who is looking to you for the answers, the urge to take the lead and 'do something' can be strong. This reminded me of our initial approach to the fairly open ended PBL task. With hindsight, allowing time to encourage discussion and uncover individual aspirations and ideas rather than having an over prescriptive agenda is essential for therapy and effective PBL. This can ensure that others want to tackle the problems you do, and that alternative ways to attempt this have been explored.

Throughout the PBL sessions we sought to allocate tasks appropriately according to our individual strengths, experiences and resources and
attempted to be fair in terms of sharing the workload and final presentation. This contributed to a strong feeling of group cohesion and coordination, which was reflected through formal and informal feedback from others of our final presentation. Whilst establishing these relationships based on support and encouragement has been important and helpful to the PBL group, as it is to clients in practice, I have become increasingly aware of the importance and usefulness of challenging and questioning. Through clinical supervision and reflection on my practice, I have found that although it can feel difficult to contravene socially appropriate norms, to ask uncomfortable questions or to pose an alternative viewpoint, this distinguishes a therapeutic relationship from a social relationship. This also applies to work with colleagues and other members of the multi disciplinary team and whilst our relationships with other trainees do take a social form, within our PBL groups it is primarily a working relationship.

Whilst I think there is a genuine similarity in some views and experiences within our PBL group, possibly in part due to high level of social homogeneity, we have also found it difficult to challenge each other’s views and therefore the convergence in our ideas of ‘change’ and what we chose to present may also reflect this. Therefore I feel it is important for group members to use our developing skills in respectfully but robustly challenging and questioning each other in order to respect diversity and to allow multiple viewpoints to be heard. As Knights (1995) comments in his paper on group work in education, small group learning allows us to become ‘experientially aware of the processes by which knowledge comes into being... and nurtures dialogue and difference’. It is also important for us as a group to think more about developing creative ways of
enabling feedback about our impact on each other. As a group we found this difficult after the presentation, however increasingly I have become aware that this is an essential element of reflective practice when working with others (Lavender, 2003).

Using the Stages of Change Model, we were able to conceptualise the processes involved in helping clients to move from one stage to the next in order to make changes in their lives and also to understand the changes we were going through from undergraduate learning styles to those on the doctorate programme. At the time, knowing I would soon be going out on placement, starting to see my first clients and trying to help them, I was desperate to know how to help people change, what to 'do' to improve their chances of success and to alleviate some of my anxieties about being exposed as not knowing what to do! It was therefore reassuring to conceptualise change in a stage wise way, with matched interventions depending on which stage the client was in. Luckily my supervisor had selected my first client on the basis that her problem was a fairly discrete entity which I could apply a cognitive behavioural treatment approach to with relative ease. My knowledge of the SoCM fitted well with this and therefore I was able to use this to further contribute to my conceptualisation and formulation of her situation.

However, as we acknowledged in our presentation, there are limitations to this model and evidence against change occurring in discrete stages or in a sequential process (Jensen et al, 2000; Littell et al, 2002). With the benefit of hindsight and the experience of working with a range of clients with complex and diverse problems, these limitations are all the more evident. To me, it has seemed like change both in myself and my clients
increasingly appears as a less organised process, where the changes that occur are not always the ones that were foreseen or expected and new problems, resistance and strengths are unearthed along the way. Something I read which rings true with my experience is 'change does not look like a marching band; it looks more like a teeming mob'.

The process of learning with my clients in therapy through discontinuities, breakthroughs, regression and leaps, rather than a proceeding through a sequential process mirrors the learning potential of our PBL group. Knights (1995) points out that learning groups such as our PBL group can 'strengthen our hand in attending to those elements which do not seem to fit' by 'challenging the progressistic view of learning as a simple one-way road from ignorance to knowledge'.

In gathering information about models of change, selecting one which made most sense to us and presenting this I feel we overlooked to an extent the process level of PBL, which with the benefit of hindsight reflects the way I initially approached my work with clients. I spent most of my time planning what to say to my clients, listing essential topics to cover and reading up about their various problems in order to reduce my anxieties about getting it wrong or having nothing to say. Now I feel more at ease with being a trainee 'doing therapy' and through supervision with a psychodynamic focus I have been able to make time to reflect on process issues. In further PBL exercises I hope consideration of process issues will be more evident since our fears and anxieties about giving a presentation have been somewhat reduced through exposure.

Looking back on the PBL title with the benefit of subsequent clinical experience and encouragement to reflect upon process issues, 'the
relationship to change' looks glaringly different. What then prompted us to think about our clients’ and our own relationship with change, now invites me to think about our relationships with our clients. As my relationships with my clients on placement have developed I have begun to see that these relationships are not additional to the content of 'therapy' and models which can be learned and delivered, but that the relationship is the essential ingredient for change to occur. Some would even go so far to say the relationship is the therapy (Khan, 1991).

The limitations of applying purely research based theory to complex clinical situations described by Schon (1983) as 'swampy lowland, where messy, confusing problems defy technical solution', soon became evident to me on placement. Exploring concepts of transference, counter transference, defenses and resistance through supervision has enabled me to reflect on the relationship itself and what is often considered to be the 'artistry' of therapy; the intuitive processes involved in working with people's problems. Therefore, during further PBL exercises, the importance of the relationship, the process of working with others and the art involved in our work will remain in the foreground.
References


Problem Based Learning Reflective Account

Child Protection, Domestic Violence, Parenting, and Learning Disabilities

Year 2

March 2006
Introduction
In this account I will aim to critically reflect upon the second Problem Based Learning exercise which was concerned with issues of Child Protection, Domestic Violence, Parenting and Learning Disabilities. My account will particularly look at how our group constructed the 'problem' as that of 'society', our focus on the importance of discourse and narrative and how this has impacted on and been influenced by my clinical experience.

The Scenario
We were presented with some background information, a geneogram and some information about the network of professionals involved with a family, the Strides. The background information told us about a man and a woman, both identified as having learning disabilities, whose 3 year old twins were on the child protection register for emotional abuse and neglect and who were in foster care. The information told us that the family live in poverty and that Mr Stride has assaulted Mrs Stride, who has also experienced domestic violence from a previous partner. Mrs Stride has two children from this relationship who were adopted and who she is not allowed to have contact with.

Everyone in the group initially felt overwhelmed and saddened after reading the information, aware that this was a deeply upsetting and complex situation which we could not attempt to 'fix' with a prescribed therapy or intervention.
Constructing the Problem

Having been quite task focussed in our previous PBL task, we felt that we wanted to explore the issues more widely and pay attention to the process issues in future exercises. This instinctively felt important when we received the background information and realised the complexity of the situation.

We brainstormed our thoughts which drew out many different themes, issues and concerns. This really highlighted to me the diversity in our previous experiences, both personal and professional and how these led each of us to pay attention to certain aspects of the scenario, focussing our interests and priorities in different directions. For example, at the time of the exercise I was partway through a book about social inequality and also had experience in my previous job supporting a gentleman living in poverty and with a label of 'schizophrenia' through child protection procedures. These focussed my attention towards the massive impact that poverty had on the Stride family, on the assumptions made about people as a consequence of labels placed on them and on the complex and confusing child protection process which the family would have been subject to.

Other group members' personal and professional experiences which led them to feel passionate about different aspects of the 'problem'. Discussing our own positions in the group was a valuable opportunity, enabling us to notice our prejudices and how our views had developed. For example, one group member felt strongly about the social construction of 'learning disability'. I had previously not considered this in relation to
learning disability and realised I had been too accepting of the meaning, validity and consequences attached to this label.

Despite us each having a differing focus on the 'problem', we all believed that a desirable outcome for Mr & Mrs Stride would be to have their children returned to their care as they appeared to have a strong desire to be 'good' parents. We each hoped that they would be enabled to look after and provide for their children but felt that many factors sought to disable, rather than enable them in their attempts to do this.

It therefore struck us that the 'problem' could be viewed as these disabling circumstances, and therefore was both created and maintained by 'society'. We talked about how this disabling societal influence worked at many levels, ranging from global and institutional effects (Capitalism, Government, Media) to more local and individual influences (attitudes, actions and values) which we reflected, are inextricably linked. This led us to the idea of creating a 'Jo Bloggs' character to represent the public and society, through whom we could stimulate thinking about these three issues in our presentation.

From our discussions and subsequent reading, we highlighted three significant disabling societal factors: i) attitudes towards people with learning disabilities; ii) poverty and iii) the Services set up to deal with these problems.

What role do we have in societal problems?
Having identified some of the societal issues that disabled the Stride's we felt unsure about how we could improve this situation. However, it felt
extremely important not to turn these issues inwards on the family, locating the problem as inherent an existing within them.

Pelton (1978; in Rodger, 1996) has spoken of this dilemma, highlighting how professionals can collude with locating problems within families, viewing child abuse and neglect as mainly psychodynamic problems, rather than as predominantly sociological and poverty-related problems. This has been called the 'molestation of normality' distracting us from societal problems for which there are no readily available solutions, focussing our attention on those which appear more easily addressed such as psychopathology and family dysfunction (Krauthammer, 1993; in Rodger, 1996).

However, recognising that society is full of problems and that everyone has a responsibility to pursue justice and equality, we reflected was idealistic and not something we could necessarily influence as psychologists. Therefore we also wondered if we had chosen to take a societal view on the 'problem' in order to relinquish our professional responsibility, because it somehow seemed too big for us as clinicians in the system to tackle or change.

Our group facilitator, whilst encouraging of our stance, appeared frustrated by our unwillingness to adopt any specific clinical approach and our wide societal focus. She attempted to orientate us to the 'real world' of psychology where we would be pressured to 'do something' and to the issue of what we were going to present. Indeed, this has been highlighted to me in my current placement in a learning disabilities service; when an individual, home or day centre has made a referral for
help, they want help that will make things better for them and with knowing what they can 'do' - not a sociological analysis.

Also whilst we had identified that the Strides were not a pathological family whose problems were inherent within them, this did not mean that the children were not being neglected or caused harm. Whilst we felt that enabling a return of the children to their parents would be the desired outcome, the potentially damaging consequences if abuse and neglect were present and continued, drew us back to the issue of professional decision making and responsibility.

However, having previously been in a professional role where I had responsibility for making risk assessments on the basis of difficult to quantify and confusing clinical information, I realise that this responsibility and a lack of support can obscure thinking about wider issues and result in restrictive actions by professionals. This could be equally as damaging if the Strides' children were adopted when they may have otherwise successfully been supported in remaining together.

With no clear resolution to this issue, we concluded that this difficult issue of risk assessment and decision making did not mean we had to collude with only looking inwards at the family and assessing their risk, but that our societal perspective could translate to a clinical setting, working with the Stride family whilst attempting not to locate the problem within them.

Narrative
Our societal perspective focussed our discussions specifically on the narrative, discourse and the construction of 'reality'. We talked a lot about
how the Strides were being talked about, written about and constructed by society and professionals. Lister (2004) highlights the significance of the narrative specifically in relation to child protection issues, stating that ‘the modern concept of child abuse and neglect is one which is being constructed out of competing public discourses anchored in the conflict between opposing professional interests, and in the midst of wide public anxiety about dangerousness and deviance at the core of society’.

Reflecting on the variation of focus on the initial ‘problem’ within our group drew our attention to the huge number of people involved in the Strides’ case, and consequently the vast array of specific (perhaps competing) interests and positions being occupied. We felt in our clinical experience it is rare for professionals to be able to be explicit about their position and the motives and experiences which drive their actions and decisions, often presenting their opinion or perception of reality as clinical fact.

We all felt a negative impact from reading the Strides’ ‘background information’. The clinical nature of the information, focussed on the deficits rather than strengths of the family, led us down a path of being overwhelmed which made it difficult to see a way forward. We also thought about the ‘power of the pen’ and the strength and permanence of the written word, compared with the spoken word (Payne, 2002). This had specific significance for the Strides as they were unable to read and therefore unable to know about or refute any of the things that were written about them.
Therefore, we all felt a strong need to re-narrate the Strides' background information, focusing on the strengths and resilience of the family. It felt important to reframe the Strides situation in writing, to give the same power and permanence to the positives within the family. Doing this was a therapeutic process for the group as it enabled us to be hopeful about the Stride family and therefore reduced our anxieties about working alongside them.

Conclusions
Reflecting on the experience of the group, I realise that these hopeful conversations and a narrative approach changed my perspective on the scenario, helping to relieve some of the feelings of being overwhelmed and professionally impotent when faced with problems inherent in our society. Eventually we were able to see how we might marry our societal perspective on the problem with specific clinical actions; working with individuals, families or services whilst attempting not to collude with constructing them as the problem.

Talking differently about the problem had enabled us to think clearer, not to feel overwhelmed and to remain hopeful about the situation, which then allowed us to think about what we could do to help the Strides. Therefore it seemed that part of our role when working with the family would be in using this narrative, social constructionist approach to enable other people to do the same. We thought about how we would try to achieve this by specifically relocating the problem outside of the family; in drawing on their strengths, resilience and ways of coping; in highlighting these to other professionals through our use of language and ways of talking about 'the problem'.
The presentation which evolved from this firstly highlighted the 3 issues of poverty, Services and attitudes towards people with learning disabilities through the Jo Bloggs character who represented our societal perspective. We then went on to talk about process issues, particularly focussing on the importance of discourse and narrative. Whilst we initially had reservations about presenting from a wider sociological perspective, rather than focussing on what a clinical psychologist would do in this situation, doing so felt like an achievement. We were pleased that we had been able to use the process of giving a presentation as an opportunity to try to decentre the problem from the family, rather than feel pressured into deciding what ‘to do’ with them.

The most important thing I have taken away from this exercise is the benefit of remaining hopeful about complex situations. At times I feel very overwhelmed as a trainee clinical psychologist to be charged with helping to remedy ‘problems’ arising from societal issues, for which there are no readily available answers. Through this exercise our group moved from feeling stuck to feeling hopeful about a complex clinical situation, enabling us to think more creatively and imaginatively about ways forward. This has demonstrated to me that supporting other professionals (including others within our profession), to do the same can be one important role for clinical psychologists in striving to overcome some of the problems inherent in our society.
References


Problem Based Learning Reflective Account

Working with Older People

Year 3

April 2007
Introduction
In this account I will reflect upon the final Problem Based Learning (PBL) exercise, entitled 'Working with older people'. Throughout this account I will focus on issues of diversity, culture and family in relation to the scenario, my own life experience and my clinical practice. I also hope to convey the process by which our group departed from what, over the three years of training, has become 'the PBL norm', the impact this had on us and our audience and the implications this has for 'trying something different' in the future.

The Scenario
We were given information about Mr Khan, a 72 year old man who migrated to the UK from Pakistan in his mid 30's. Before his retirement, Mr Khan worked as a bus driver and his wife was a home maker, working occasionally as a dressmaker. Mr Khan learnt to speak English after he arrived in the UK, although Mrs Khan spoke only Urdu.

Mr Khan has two daughters, who were both born in the UK and have an English Education. His eldest daughter Shazia had an arranged marriage in Pakistan where she lives with her husband and 3 children. Mr Khan's youngest daughter Maya, married a European man and was disowned by the family, having no contact with her father until her mother died of cancer nine months ago. She and her husband were university educated and are both journalists who travel regularly.

Recently Mr Khan has been suffering from memory loss, neglecting himself and deteriorating physically. He has also fallen out with the Mosque about the way that they responded to his wife's death and has
stopped attending, losing contact with much of the Muslim community. Maya is urging Social Services to do something and also asking Shazia to return from Pakistan to help sort out a solution for their father's care.

First thoughts
When reading the information about the Khan family it seemed clear that the scenario was designed to stimulate thinking around issues of race and diversity. Despite the potential of these issues to provoke thought and debate, when we met as a group we struggled to explore the scenario further and our ensuing conversation was uncharacteristically unenthusiastic. We considered for a while why we were facing this difficulty...was it because we did not know enough about these issues? Or that our brains were full to capacity with thoughts of major research projects? Or were we just tired of the PBL exercises?

With hindsight, I feel that what initially inhibited our discussion were the stereotyped images of Pakistani migrants in Britain which the scenario evoked. These included themes of parents who came to Britain wanting a better life for their children, but not wanting them to become too 'Westernised'; Children lured away from the family by the opportunities and experiences that their parent's migration afforded them; Recourse to strict and punitive measures when traditional and religious ideals are not met; Men who drive buses or run shops; and women who stay at home and 'don't speak the language'.

The stereotyped nature of this information narrowly focussed our attention on difference, particularly visible difference, which for a while stopped us approaching the work with the Khan family as we would if we
met them in the consulting room. Instead, following what has become the 'PBL norm', with the aid of the prompt questions we identified the 'issues' (difference, diversity, the Muslim culture, migration) and tried to think of how to best explore these further. Due to the narrative approach favoured by our group, we thought about how we could do so from an individual perspective, focussing on personalised representations rather than collecting facts or information.

We considered what we had learned from films ('East is East', 'My Beautiful Laundrette', 'Bend it Like Beckham') and literature ('Life Isn't All Ha Ha He He', 'Anita and Me', 'Brick Lane') about the Muslim faith and Pakistani culture, about the impact of migration, about being part of an ethnic minority group in Britain and the tensions this may have created across generations. We also talked about visiting local Muslim community groups and discussing the issues with people there. However, something didn't feel quite right and our usual energy and enthusiasm still had not returned.

Universality in Diversity
Whilst continuing to mull over the information, waiting for inspiration, I thought about a workshop where I had constructed a geneogram of my own. I was surprised whilst doing so, to realise how many ways I had broken the mould in my family and deviated from the family script. I started to think about what this had been like at the time, the tensions these deviations sometimes caused and the loyalties that had been stretched and questioned along the way. I thought about the similarities between some of these experiences and what Maya may be experiencing, despite our apparent 'differences'. Sharing this thought with the group,
more and more reflections on tensions and loyalties within our own families and those of people we know emerged, as did our enthusiasm.

We then realised what we had done - focussed on visible difference, whilst neglecting similarity and universality. This reminded us of filling in documentation about the diversity of the clients we see for clinical placements, with a small space to mark down the number of people seen who are a different sex, age, religion etc to yourself. This 'tick box' approach also focuses on visible difference and does not seem to reflect the complexity and relational nature of diversity and universality as it applies to our work. This prompted us to think about how we have tried to address these issues in a meaningful way when on placement and how we might do the same with the Khan family.

We imagined that if we met with the Khan family in a clinical setting we would talk with them and listen to their detailed and individual stories, finding out which aspects of the situation were personally significant and where their difficulties and strengths lay. We would no doubt hear these accounts through a filter, made up of our own experiences, feelings and beliefs about family tensions and loyalties. We would be curious about issues of migration, culture, religion, and ethnicity, whilst being careful not to impose our own preconceptions about their impact and meaning for the family. It became clear then why our initial approach to the scenario and the 'PBL norm' felt constraining and superficial.

Doing Something Different
Following these discussions we thought about the points we wanted to convey through our presentation:– the importance of seeing people as
individuals and understanding the richness of their personal stories; the
importance of not making assumptions about what peoples’ difficulties
are based on their membership of a particular group; the importance of
seeing common experiences and connecting with people, rather than only
focussing on difference and feeling disconnected. We also wanted our
presentation to provoke thought about doing something different and not
feeling constrained or pigeon holed by ‘the way things are usually done’,
as we initially had.

We therefore wanted to use a creative approach to the presentation to
highlight this point and decided to make a video featuring people we
know being interviewed about their experiences of ‘tensions and loyalties’
within their families. By featuring people from various cultural and
religious backgrounds, speaking about various sources of conflict and
tension, we attempted to demonstrate the importance of thinking about
‘universality within diversity’ and allowing people to author their own
story of ethnicity and culture.

Arriving at a creative way to explore the PBL exercise that we felt
comfortable with, and enthused by, was liberating and exciting. As a
group we felt proud of our hard work and creativity, and that of our
friends and relatives when we saw the final footage put together. The
addition of a personally significant song chosen by each interviewee really
emphasised personal meaning and spirituality and we all felt moved when
we previewed the final video to be shown to the rest of our year group.

We discussed with our facilitator whether to provide an introduction to
the video and explain how our line of thinking had developed or some
concluding ‘reflections’ on this process. However, as a group we felt that our approach to the task and our video were our reflections which hopefully spoke for themselves and had the capacity to provoke thought amongst our audience. We thought that adding a more didactic element to the presentation may detract from this and may feel like justifying, or even apologising for breaking with the norm. Therefore we decided to just show the video, entitled ‘Universality in Diversity’ and let people take away from it what they chose to.

Despite all thinking this would be the easiest PBL presentation we had ever done (given that we were not required to speak) on the day all of us felt very nervous. Discussing this later I think it was partly due to our investment in the video and the people we interviewed, wanting their effort and willingness to give something personal to be respected and honoured by our audience. I also think we were aware on some level that doing something different may be perceived as a criticism of ‘the norm’.

Each of us has spoken at length in our case discussion groups about the difficulties of trying to be creative on placement and find alternative ways to approach things when the system you work within can feel stuck or rigid. We have all felt that suggesting something new runs the risk of a ‘who do you think you are’ or ‘there’s nothing wrong with the way we do things thanks very much’ response at work. Whilst the university environment often feels like a safer place to take these kinds of risks than on placement, we were still concerned about how our message would be received by our peers.
Conclusions
The presentation was received with a somewhat mixed response. We were praised for our creativity, although we had clearly confused someone who thought we had a different scenario to the rest of the year! The group following us reported that their presentation was 'more traditional' than ours, prompting one member of the audience to retort 'that's more like it!'. I think this person may have felt criticized and I sensed a slight unease in the room. However, I do think the presentation provoked thought, which is ultimately what we had hoped for.

Many of the other groups described in their reflections how they had felt constrained by time and other pressures and had therefore stuck to the norm and a 'traditional' presentation. This made me think about how change comes about within teams, and how sometimes people can see the need to try something different but do not feel they are in a position to do so. The other more 'traditional' presentations also highlighted to me how different approaches to problems can be complementary, rather than competing. These other presentations provided me with information and ideas about various aspects of the scenario which we had not explored, and it felt important to give feedback about the importance and usefulness of these contributions.

Undertaking this PBL exercise enabled me to think about what had been the prerequisites for our group to try something new and how I can use these within my clinical practice if feeling stuck within a team or with a piece of work. A key factor was having the support of each other and knowing that we would be encouraged by our group facilitator (i.e. someone in a position of seniority and perceived as more knowledgeable
and influential). Also, being surrounded by committed and passionate colleagues with a belief in doing something meaningful enabled me to devote time and energy to this project. This highlighted to me the importance of seeking out good supervision, support, and allies, of being creative in my approach to work and of remaining focussed on how beneficial trying something different might be.
Case Discussion Group
Reflective Account Summaries

Year 1:
September 2005

Year 2:
July 2006
Case discussion groups (CDGs) were introduced as a way of creating safer and more intimate spaces within the clinical training programme where clinical practice could be reflected upon. Five trainees plus a facilitator (qualified clinical psychologist) were allocated to each case discussion group at the beginning of year one. Trainees remained in the groups throughout the three years whilst the facilitator alternated each year. The group met fortnightly (approximately 15 sessions per year) for 1.5 hours. Following the Year 1 and Year 2 CDGs, trainees were required to write a 3000 word reflective account of their experiences within the group. This allowed trainees the opportunity to reflect upon their contributions to the group, the ways in which they utilised and learnt from the group's discussions and their experience of the group process.
Summary of Year 1 CDG Reflective Account

This account focused upon my own and the group's utilisation of and contribution to this 'safe space', how this unfolded throughout the first year and what we might do differently in Year 2.

Roles within the group
I reflected upon the informal, emerging roles, which are not assigned and rarely openly acknowledged (Adler & Rodman, 1994). I reflected upon my emerging role as the person to offer a critical perspective, and how this was initially difficult given that others did not seem to share my antipathy for psychiatric diagnoses and treatment. I also reflected upon my informal role as the 'tension reliever' which involved the use of humour to reduce the formality of the situation and relax group members (Adler & Rodman, 1994). I also considered how these roles relate to my clinical work and my role within professional teams.

Utilisation of the Group
I reflected upon the fact that we had utilised the group in a very structured way, taking turns to present a case which we would then discuss. Whilst this was helpful, we could have used the group in a more flexible and broader way. I reflected upon the reasons why we had taken this approach, including the power imbalance between trainees and the facilitator; methods of decision making within the group; different theoretical orientations; and 'in group' and 'out group' processes. I considered how these processes operate within clinical practice, with regard to both work with clients and dynamics within teams.
Thoughts for the Future

I reflected upon the opportunity within the following year's CDG meetings to take more risks; to tolerate uncertainty; to be less rigid in our approach to the sessions; and to use the time to focus on process issues, ethical dilemmas and the more emotional aspects of our work.
Summaries of CDG Reflective Accounts

References

Summary of Year 2 CDG Reflective Account

This account focussed upon why the year 2 CDG had a significant impact upon my ideas, my clinical practice, my professional identity and my enthusiasm for my future career.

Organising the group differently
I reflected upon our ability to assert our wishes as a group this year, in contrast to the previous year. This appeared to be due to our growing confidence; our group identity; and our increased knowledge of theoretical frameworks to which we felt drawn. I considered the benefits of using a more open and flexible format, whereby we would prioritise issues arising each week, which paid attention to the individual contexts of group members.

Post-Structuralist Ideas
I reflected upon how throughout year 2, our group had grown to share a commitment to post-structuralist ideas with a drive to explore the political aspects of psychology, social and personal explanations of psychological difficulties and narrative ideas. I reflected how this was at times challenging for our facilitator, eager to redirect us to “the reality of working in the NHS”, which mainly consisted of doing rather than philosophizing. I considered how this might be understood within a narrative framework as the dominant ‘NHS story’ which has us thinking that the status quo is too difficult to challenge and that there is little place for questioning.
Thoughts for the Future

I reflected upon how my experiences throughout clinical psychology training and CDG had equipped me with a knowledge of social constructionism, structuralist versus post-structuralist (non-structuralist) ideas and narrative practices. These provided me with an organizing framework for my frustrations with structuralist ideas and the 'NHS story'. I considered how the CDGs had helped all group members, at times of difficulty, to resist the dominant 'NHS story'. I also reflected upon how this impacted upon my clinical approach, my professional identity and self perception.

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14 The term non-structuralism as opposed to post structuralism is used by Michael White to acknowledge the distinction that before modernity, structural understandings of the world were not general in Europe or elsewhere in the world and that there continues to be cultures where structuralist thought is non-dominant.
Summary of Experience Gained on Clinical Placements
# Summaries of Clinical Placements

## Adult Mental Health, Year 1

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<tr>
<th>Dates</th>
<th>3rd November 2004 – 23rd September 2005</th>
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<tr>
<td>Title of Placement</td>
<td>Adult Mental Health (core)</td>
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<tr>
<td>Settings</td>
<td>Community Mental Health Team; Day Treatment Centre; Primary Care (GP surgery)</td>
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<tr>
<td>Theoretical Models</td>
<td>CBT; psychodynamic; narrative; integrative</td>
</tr>
<tr>
<td>Presenting Difficulties</td>
<td>Depression; anxiety (panic, generalised, OCD, phobia); low self-esteem; binge eating; sexual abuse; anger; postnatal psychosis; relationship difficulties</td>
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<tr>
<td>Range of Experience</td>
<td>Direct 1:1 work with 14 working age clients; co-facilitated CBT group; extended psychometric assessment; service related audit; presentations to the CMHT &amp; consultants; developed referral protocol; visits to other services &amp; training courses</td>
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## Child, Adolescent and Family, Year 2

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<tr>
<td>Title of Placement</td>
<td>Year-long split Child &amp; Learning Disabilities (core)</td>
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<tr>
<td>Settings</td>
<td>Child psychology outpatients; Child and adolescent mental health outpatients clinic; tier 3 adolescent service</td>
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<tr>
<td>Theoretical Models</td>
<td>CBT; narrative; psychodynamic; behavioural</td>
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<tr>
<td>Presenting Difficulties</td>
<td>Anxiety (panic, phobia, OCD); eating difficulties; behavioural difficulties; social communication disorder; sleeping difficulties; learning disabilities; school exclusion; substance misuse; psychosis</td>
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<tr>
<td>Range of Experience</td>
<td>Direct 1:1 work with 12 clients aged 18 months – 17 years; involvement in family therapy (reflecting team); psychometric assessments; structured observation; liaison with education &amp; YOT; joint / indirect work with teachers; visits to other services</td>
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### People with Learning Disabilities, Year 2

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<td>Year-long split child &amp; learning disabilities (core)</td>
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<tr>
<td>Settings</td>
<td>Community team for people with learning disabilities (outpatients; residential; clients’ homes; inpatient ward; day centre)</td>
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<tr>
<td>Theoretical Models</td>
<td>CBT; narrative; psychodynamic; behavioural</td>
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<tr>
<td>Presenting Difficulties</td>
<td>Bereavement; sexuality &amp; relationships; self harm; challenging behaviour; psychosis; placement breakdown; anxiety; agoraphobia; dementia; sexual offending</td>
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<tr>
<td>Range of Experience</td>
<td>Direct 1-1 work with 10 clients of working age; co facilitated assertiveness group; psychometric assessments; functional assessment; capacity to consent assessments; indirect work with carers &amp; staff; joint work with OT &amp; SALT; training courses</td>
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### Older People, Year 3

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<th>Dates</th>
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<tr>
<td>Title of Placement</td>
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<tr>
<td>Settings</td>
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<td>Theoretical Models</td>
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<td>Presenting Difficulties</td>
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<tr>
<td>Range of Experience</td>
<td>Direct 1-1 work with 13 clients aged 59-92; direct work with 2 carers; indirect work with ward staff; service user consultation project; co facilitated stroke support group &amp; Parkinson’s group; presentation to psychologists meeting; published article about support group; psychometric assessment; training courses</td>
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**Advanced competencies, Year 3**

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<td>Title of Placement</td>
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<td>Settings</td>
<td>Residential/community hospital hostels</td>
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<tr>
<td>Theoretical Models</td>
<td>Recovery; systemic; narrative; psychodynamic; person-centred</td>
</tr>
<tr>
<td>Presenting Difficulties</td>
<td>Psychosis; complex mental health needs; severe emotional distress</td>
</tr>
<tr>
<td>Range of Experience</td>
<td>This placement focussed mainly on service development work, consultation to teams and specifically developing a women-only service. I also completed 1:1 work with individuals and developed and co-facilitated a women's group. Other experiences included: attending training events; presenting to the team briefing; visiting women's services; facilitating a staff support group; running a psychology drop-in on an inpatient unit; involvement in service's Recovery &amp; Social Inclusion Working Party.</td>
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</table>
Summary of Clinical Case Report

**Adult Mental Health 1:**
Cognitive behavioural intervention with a 23 year old woman presenting with binge eating

*All identifying details of services, service users and their families have been removed. Some details have been changed to preserve anonymity*

**Year 1**

**May 2005**
Adult Case Report 1 Summary

Referral of the Problem
Laura is a 23 year old single woman of white British origin. She was referred to the psychology service by her GP due to concerns about binge eating.

Presenting Problem
Laura ate irregularly, over-ate and binged every evening. Most of Laura’s day is taken up by planning binges and shopping for food. Laura did not use any compensatory behaviour and consequently was extremely overweight. Laura reported that it provided emotional comfort to binge eat, however afterwards she felt sick, ashamed and disgusted with herself. Laura also reported low self esteem (SE) and feeling ‘low’ at times.

Initial Assessment of the Problem
Laura was assessed via a one hour face-to-face interview. Laura was asked to self monitor using an eating diary for two weeks prior to the assessment interview, as this is likely to be more accurate and reliable than standardised eating questionnaires (Crowther et al 1984). These diary entries were discussed during the assessment in order to gain specific information, and also provided a baseline measure for evaluation of treatment outcome. Background information was gathered from Laura, including treatment history, weight and food history, personal and family history and details of any past and current risk issues.

Initial Formulation
Several factors were hypothesised to have precipitated Laura’s bingeing including: repeated exposure to negative comments from others about shape, weight and eating (Fairburn et al, 1998); insufficient nurturing and
Adult Case Report 1 Summary

empathy from family (Humphrey 1987); socialisation to eating alone in childhood (e.g. Johnson et al, 1987); and familial eating disorders (Strober et al, 1987). Several authors (Stickney & Miltenberger, 1999) have proposed that as an operant behaviour, binge eating serves some function for the individual. In Laura’s case the initial reinforcing function of her bingeing and secret eating appeared to be self nurture and coping in childhood.

Fairburn et al,’s (1993) cognitive behavioural model was used to conceptualise the maintenance of this binge eating behaviour.

Figure 1. The cognitive view of binge eating, Fairburn et al (1993)

Action Plan
Cognitive behaviour therapy (CBT) is as or more effective than other therapies for eating disorders, with demonstrated long-term efficacy (Waller & Kennerly, 2003). The primary goal of CBT for BED is decreasing bingeing and normalising eating patterns; the goal of bodyweight loss is
Adult Case Report 1 Summary

Laura’s goals were in line with these, therefore, a CBT approach was indicated. Expected Outcomes were:
1. Regular eating pattern
2. Reduction in binge episodes
3. Reduction in feelings of being out of control of eating
4. Decrease in negative self evaluation/improved self esteem

Intervention
Initially 20 sessions were offered based upon the Fairburn et al (1993) manualised approach for BN, utilizing suggested modifications for use with BED. This treatment is semi-structured, problem-oriented and concerned with factors that are maintaining bingeing, rather than on those that operated earlier in its evolution. Specific attention is drawn toward behaviour and thoughts; emphasising education, monitoring of food intake and identifying and modifying cognitive distortions. Treatment is broadly divided into 3 stages.

Stage one (sessions 1-8)
These focussed on psycho-education and structuring Laura’s day around three planned meals plus two planned snacks. Specific behavioural strategies, including stimulus control measures and distraction techniques were identified and tried.

Each session included:
- A detailed review of food diary from the previous week
- Review of achievement of two or three tasks negotiated during previous session

15 Sixteen sessions had been conducted at the time of writing the case report.
Stage two (sessions 9-16)
Once overeating was intermittent, attention was directed to identifying cognitive biases and using cognitive strategies to identify more adaptive ways of thinking and behaving. Therapeutic strategies included thought diaries; behavioural experiments to test out 'alternative beliefs'; and guided exposure tasks where she would behave in previously avoided ways. Themes occurring during this stage were assertiveness; concerns about weight and low self esteem.

Outcome and Follow up
Laura’s diary demonstrated she had begun to eat three meals a day with rare exception and that there had been a significant reduction in binges. Laura’s subjective experience of being controlled by food had diminished and binges began to take up much less of her time. Laura said her ‘food thoughts’ were less prominent; she no longer hoarded food and had not shopped specifically to binge for 2 months. Diary entries and observation during sessions demonstrated Laura’s increased ability to identify negative thoughts and use cognitive restructuring to challenge these. Laura also reported feeling empowered by becoming more assertive, especially with her mother; feeling more self-efficacious; and becoming less secretive, thus combating feelings of shame and embarrassment. Laura reported being more able to initiate social contact with friends, although she still avoided many situations due to her low SE and negative self appraisals.
Adult Case Report 1 Summary

It was planned for Laura to move into stage 3 of treatment, which focuses on maintaining progress and consists of three interviews at two-week intervals.

Reformulation of the problem
It appeared in stage two of therapy that the initial formulation did not fully account for the maintenance of Laura’s problems. It emerged that loneliness and isolation were significant factors maintaining low SE and bingeing. The cognitive view of low SE (Jenkins & Fennell, 2004) was used to conceptualize this.

Critical evaluation of the work
Utilizing the Fairburn CBT treatment approach with suggested modifications for bingeing was sufficiently flexible to be tailored to Laura’s situation (Waller & Kennerley, 2003). The intervention was successful in helping Laura achieve her aim of being less controlled by food. However, it was only partially successful in enabling her to feel better about herself and enjoy life as she would like.

It may be that a focus on superficial level cognitions (negative automatic thoughts and underlying assumptions) was not sufficient to alter the ideas Laura held about herself at a deeper ‘schema’ level (Waller & Kennerley, 2003). One approach which could be more beneficial to Laura is schema focused cognitive-behaviour therapy (SFCBT) an extension of ‘classic’ CBT which can be helpful in more complex eating cases (Waller & Kennerley, 2003).
References


Summary of Clinical Case Report

Adult Mental Health 2:

Extended neuropsychological assessment of a 41 year old lady with a frontal lobe impairment

All identifying details of services, service users and their families have been removed. Some details have been changed to preserve anonymity

Year 1

September 2005
Referral of the problem
Jean is a 41 year old woman of white British origin; on assessment she was an inpatient on a psychiatric ward. Jean was referred due to her belief that her brain had ‘died’, that she had no thoughts and feelings and that she could not retain information. Jean presented as highly distressed and tearful about her situation and as depressed, with low motivation. The MDT were struggling to understand her presentation and had proposed several diagnoses, including depression with psychotic features. Psychometric assessment was requested in order to determine if there was neurological basis for her difficulties.

Presenting Problem
Jean described an 18 month history of ‘total blankness’, stating that she has no emotions or thoughts to tell her what to do. Jean said that no one believed her or could find out what was wrong with her; leaving her feeling hopeless and uncertain. Jean was reported to function well on the ward, although remained highly distressed and tearful about ‘having no brain’. Jean had several admissions to psychiatric wards over the 18 month period, but had rapidly deteriorated after discharge, resulting in readmission.

Extended Assessment
A history of the presenting difficulties was taken from Jean. This included information on previous psychiatric history and treatments, medical history, and personal/family history (including educational achievement and developmental milestones). Case notes and ward staff were also consulted in order to gain more detailed medical and psychiatric information. Following this initial assessment, it was hypothesised that
there may be a neurological basis to Jean's subjective experience of blankness and expressed difficulties with thought and behaviour.

Therefore it was decided to administer tests of general intellectual functioning: The Wechsler Adult Intelligence Scale-Third Edition (WAIS-III; Wechsler, 1997); the Wechsler Memory Scale- Third Edition (WMS-III; Wechsler, 1997); and the Wechsler Test of Adult Reading (WTAR; Wechsler, 2001). Following administration of these tests and informal tests of frontal lobe functioning it appeared that Jean may have had a frontal lobe impairment (FLI).

Further standardised tests sensitive to FLI were administered: The Hayling Sentence Completion Test (Burgess & Shallice, 1997); The Brixton Spatial Anticipation Test (Burgess & Shallice, 1997); The Zoo Map & Key Search Tests from the Behavioural Assessment of the Dysexecutive Syndrome (BADS; Wilson et al, 1996).

Findings
Tests of general intelligence showed that Jean was functioning in the below-average to borderline range in the verbal domain. This level of functioning was consistent with Jean's occupational and educational history. Scores indicated that Jean functioned significantly better using non-verbal rather than verbal intellectual abilities.

Jean's performance on the WMS-III tests did not suggest any immediate or delayed visual memory impairment. It was possible to tentatively suggest that this was also the case for verbal memory, although Jean did not complete all subtests required to state this conclusively.
Jean's performance on the Hayling test was significantly impaired. On the Brixton Test, Jean scored in the 'poor' range. Jean's overall Zoo Map performance was impaired. On the Key Search test, Jean was able to provide a good solution to planning a search for a key in a box representing a field, achieving an average score.

**Discussion**

Jean's scores on the tests of general intelligence indicated that she was functioning in the low average range; there was no evidence of general impairment or decline in functioning. Jean's score on the WMS-III tests showed no evidence of a memory deficit. The most significant finding was that on three of the four standardised tests of frontal lobe functioning, and on two of the informal tests, Jean experienced difficulties of a degree and nature that indicated the presence of FLI.

Testing suggested that Jean's symptomatology may be linked to her FLI and that what Jean was interpreting as 'having no brain', was her correct assessment that her brain was not functioning as it used to. If this was the case, this extreme interpretation (that her brain had died), in addition to the specific difficulties Jean faced due to a true organic deficit, appeared to be what was causing her such extreme distress. FLI would account for her problems with maintaining attention, difficulties with devising and following plans, loss of divergent thinking and thus potentially her sense that she had no mind.
FLI may have also accounted for her depressed presentation; clinically observed in ‘most if not all’ frontal lobe patients (Kolb et al, 1996; pp324). Further, the specific constellation of difficulties Jean experienced may have been masked in the highly structured inpatient psychiatric ward (Lezac, 2004; pp36), accounting for her apparent high functioning on the ward and rapid decline following discharge. Positively, despite this impairment, in many ways Jean’s cognitive functioning and memory ability was still very satisfactory. It was reported that Jean functioned well in her daily activities, socialising and remaining active.

**Recommendations**

A recommendation was made for full neurological assessment to further elucidate the nature and cause of impairment. It was also suggested that her condition be monitored and assessed for any deterioration. Some, provisional rehabilitation principles emerging from frontal lobe theories have been proposed (see Burgess & Robertson, 2002; pp 569) and were recommended for Jean’s care. However, it was highlighted that following further neurological testing, a more detailed and comprehensive rehabilitation plan should be developed. Due to Jean’s distress levels, some therapeutic psychological work around understanding and reframing her difficulties in light of these findings was indicated.

**Critique**

The work carried out successfully addressed the referral question, as it uncovered that Jean had a brain impairment, which may account for her difficulties. Throughout testing there was pressure from the medical team to produce the psychometric report, which was required to secure funding for Jean to go to a neuropsychiatric unit. However, my supervisor and I
Adult Case Report 2 Summary

discussed the importance of thorough assessment and the responsibility of clinicians to use tests in a responsible and appropriate way. Therefore I took time to complete thorough testing, which uncovered vital new information about Jean’s difficulties. This has been an important lesson for my future practice.
References


Summary of Clinical Case Report

Child, Adolescent & Family:

Working in an integrative way with a 9 year old boy and his family to address his eating and behavioural difficulties

All identifying details of services, service users and their families have been removed. Some details have been changed to preserve anonymity

Year 2

April 2006
Referral of the Problem
Tahir is a 9 year old British-Asian boy. He lives with his mother, father, and 3 siblings; a sister Jamila (12), a brother Shar (7) and a baby brother Nasir (8-months). Tahir was referred by his GP to the CAMH Service for 'faddy eating' and a fear of certain foods.

Presenting Difficulties
Tahir's parents were concerned about his limited diet and faddy eating. He would become very upset when he saw certain foods and would report feeling sick. Sometimes Tahir would not eat all day at school and was being taunted by peers about his difficulties. Tahir's parents reported that he did not want to go to school and that he could not sleep at night. There were also concerns about his mood fluctuations, as he was often tearful and had angry outbursts at home.

Initial Assessment of the Problem
My supervisor and I completed a 1 ½ hour assessment interview with Tahir and his parents. They were asked to keep a food diary in order to gain detailed information and to provide a baseline measure for evaluation. Background Information was gained including a full developmental history, history of the presenting difficulties, family history and details of any risk issues associated with the current situation.

Initial Formulation
It was hypothesised that a sensitive reaction to milk from age 2, and consequent vomiting, may have led to a classically conditioned negative association with certain food types or textures (Harris et al 2000). This may
then have led to emotional distress and avoidance of eating certain foods (Blissett et al, 2002).

Due to his food avoidant behaviour his parents were discouraged from offering new foods or discussing 'the problem'. This may have inadvertently maintained the problem through operant conditioning (Douglas, 2002). It was further hypothesised that Tahir's mood fluctuations, temper outbursts and poor sleep may have been linked to his poor diet (Douglas, 2002). With regard to his dislike of school, the effects of Tahir's eating difficulties seemed to be two-fold; in terms of a lack of energy to participate in the day and precipitating the taunting from peers.

**Action Plan**

Current evidence supports the use of behavioural interventions, including contingency management and positive reinforcement of eating non-preferred foods (Kerwin, 1999; Timimi et al, 1997) and shaping and desensitization procedures (Singer et al, 1992; Tapper et al, 2003). Therefore, I planned to use these approaches with the aim of increasing the range and quantity of foods that Tahir would eat.

**Intervention**

The intervention took place over 5 hour-long sessions with Tahir and his mother. Initially we developed a hierarchy of feared foods in order to identify small achievable goals (Blisset et al, 2000). This was done in a creative way, developed for use with children (Young & Brown, 1996), in order to increase Tahir's sense of control. Through this goals were negotiated that Tahir was happy to attempt.
Specific strategies to help motivate Tahir were discussed including the ‘taste test Challenge’ game, modeling by his parents and siblings, a reward ‘star chart’ and praise for small achievements. This can help break the cycle of pressure, stress and upset at meal times (Douglas, 2002). Tahir’s school teacher was also enlisted to create a star chart for his packed lunch.

Reformulation
A systemic approach was used to think about the role that family beliefs and narratives had played in the ‘problem’ of tantrums and anger outbursts (Vetere & Dallos, 2003). These had come to be seen by the family as ‘just part of Tahir’s nature’. However, in light of new information from our sessions it was hypothesised that Tahir’s behaviour and may have reflected relational difficulties and his worries about his place within the family. Specifically it was hypothesised that the outbursts served to regain much valued attention from his mother (which had reduced following the birth of Nasir).

Further Intervention
Tahir and I completed the ‘Happy, sad, angry’ activity (Hobday & Ollier, 1998) in order to explore his feelings in relation to his family system. Tahir was encouraged to discuss this with his mum during the session, which facilitated an open dialogue about these issues. Following this, several strategies were negotiated in order to alleviate Tahir’s worries. These included, allocated fun time for Tahir and his mum; reintroducing extra curricular activities which had stopped since Nasir’s birth; and positive involvement of Tahir in the care of Nasir.
Outcome and Follow up

Eating
At 4 week follow up, Tahir’s mother reported a continued story of success and competence about his relationship with food. Tahir was continuing to eat more and was ‘relaxed and happy’ about eating. Tahir’s mother had continued to reintroduce foods to his diet and Tahir was making a special effort to eat them.

Mood/behaviour
It was reported that Tahir had not had any angry or upset outbursts since our previous appointment. Tahir was reportedly able to relate differently to his brothers, for example through attending karate lessons with Shar and helping his mother to care for Nasir.

Other Outcomes
Tahir’s mother reported that he was now a ‘generally happy little boy’ who was ‘trying very hard to be well behaved’. Tahir was reportedly able to tell her if he was upset about something, rather than ‘dwelling on things’ and becoming distressed. Tahir’s mother also reported being ‘back in control’ of her family and said she had learned to set boundaries with the children, rather than feel overwhelmed by them.

Critical evaluation of the work
The intervention which integrated behavioural and systemic models was successful in bringing about first order change, addressing the ‘referral problem’ and also brought about second order change in the family. Supporting the effectiveness of this approach, Carr (2000a) report that family based interventions which draw on behavioural and systemic
models are effective in working with 'child-focused' referrals. However, integrative and systemic therapies are by their nature more difficult to evaluate than more prescriptive therapies such as CBT (Vetere & Dallos, 2003) and it is therefore more difficult to determine exactly what brought about these changes.
References


Summary of Clinical Case Report

People with Learning Disabilities:

Working in an integrative way with a 32 year old woman described as having a learning disability, in relation to sexuality and relationships

*All identifying details of services, service users and their families have been removed. Some details have been changed to preserve anonymity*

Year 2

October 2006
Referral of the Problem
Sam is a 32 year old white-British female, with a mild learning disability, living in a group home. She has one sister Jan (37); their father died 3 years ago. Sam was referred by her care manager for sexuality and relationship issues.

Presenting Problem
Sam was reported to have poor relationships with her mother and sister, returning from home visits highly distressed. Sam was said to lack understanding of relationships and boundaries, for example continually hugging carers. Concern was expressed that Sam was struggling to explore her sexuality appropriately, and for her personal safety as she had been meeting women through personal ads.

Initial Assessment of the Problem
I met with Sam for two one-hour assessment sessions, during which I explored her perception of the situation and shared with her the referrers concerns. A thorough history was gained from Sam’s case notes.

Sam reported difficult relationships with her mother and father, who showed her inconsistent love and attention as a child, and who were very protective of her. Sam described the carers in her home as her ‘dream family’ who treated her like an adult, and with whom she had lots of fun. Sam had recently come out to Jan and her mother as lesbian, which they disapproved of. Sam reported regularly arguing with them and ambivalent feelings towards these relationships. Her main concern was her difficulty meeting a partner. Her case notes suggested there were
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previous concerns about inappropriate sexual behaviour, although she had had some sex education at school and through social services, aged 23.

Initial Formulation
Bowlby’s Attachment Theory (1969) provided an explanatory framework for Sam’s pattern of interactions with carers and family. This theory proposes that early caring experiences become internally represented as a system of enduring beliefs and expectations about relationships – the child’s ‘attachment model’ or ‘attachment narratives’ (Dallos 2004). Sam’s inconsistent caring experiences may have led her to form an ‘insecure attachment’, consequently developing an ‘ambivalent attachment pattern’, in order to cope with the anxiety generated by unmet caring needs (Bowlby, 1969). This pattern of coping is characterised by hyper-vigilance to any possibility of attention, affection and reassurance, and attempts to maximise these as soon as they appear to be available.

Action Plan
A therapeutic approach which explored attachment narratives was indicated (Dallos, 2004), utilising the therapeutic setting as a secure base through which to consider alternative attachment styles. An assessment of Sam’s sexual knowledge and capacity to consent to sexual relationships was also indicated, in order to inform the decisions being made about Sam’s sexual opportunities.

Intervention
Initially we explored Sam’s attachment narratives and patterns of relating with her family by constructing a geneogram (Dallos, 2004). Reflective and circular questioning was used to broaden out fixed narratives,
exploring the missing detail and alternatives being obscured. Sam also utilised reflective writing between our sessions to further broaden these narratives. We then worked to identify alternative options for relating to Jan and her mother, using role play in order to help Sam gain confidence.

Sam and I also constructed a genogram of relationships in the group home, in order to explore the concerns of carers. Sam was able to make links between her early unmet care needs and consequent 'attachment pattern', with her desire to experience warmth and love through the carers. This enabled us to explore reasons why staff might feel uncomfortable with certain behaviours and to think about alternative ways in which caring can be demonstrated.

The Trust’s Sexuality Assessment Protocol was utilised to assess Sam’s sexual and relationship knowledge. On assessment it was clear that Sam did have capacity to make choices about and consent to sexual relationships. A report was written for Sam’s care manager, outlining the work undertaken, sexual assessment and risk issues/management strategies. Recommendations were made about the support that Sam might need in order to develop a positive sexual identity. A report was provided for the care home manager, with recommendations for supporting Sam and for making the boundaries for relationships within the home clear. I also provided Sam with a summary of the work we had done.

Reformulation
A systemic reformulation was considered in order to think about why Sam’s desire to assert her sexuality was deemed problematic. Systems
Learning Disabilities Case Report Summary

theorists have proposed that systems are continually subject to inner pressures from the developmental changes of its members (Sam’s attempts to assert her right to a sexual life). However, during such changes, systems seek ‘homeostasis’ or a return to the status quo (Goldenberg & Goldenberg, 2001). Thus I hypothesised that, the wider societal pressures and attitudes about LD and sexuality were impacting the ability of the system to adapt to Sam’s developmental changes.

Outcome and Follow Up
At follow up Sam reported that her relationships with her mother and Jan had improved. Sam had been able to implement alternative ways of relating which we had practiced in our sessions, although she continued to feel that it was sometimes difficult to articulate her point of view to them.

Following recommendations to carers and Sam’s care manager, about her capacity to give informed consent and to make choices about dating, carers at the home negotiated a risk management plan with Sam (i.e. carrying a mobile phone, letting them know what time she would be home, meeting in daylight etc). Sam was happy to utilize these strategies. Sam’s care manager also sought a support worker to assist Sam in accessing lesbian services.

Critical Evaluation of the Work
There is a lack of research and ‘praxis’ in relation to sexuality and LD, beyond simple manualised sexuality assessments. I took care not to make assumptions about Sam’s abilities prior to meeting her, and not to necessarily utilise this simple and structured approach because of her LD label. The work was beneficial to Sam as demonstrated by the changes
following the work, however in light of the systemic reformulation, it may have been more beneficial to work directly with the carers in the home to address their views and concerns.
References


Older People Case Report Summary

Summary of Clinical Case Report

Older People:

Cognitive behavioural intervention with a 65 year old lady presenting with fear of falling

All identifying details of services, service users and their families have been removed. Some details have been changed to preserve anonymity

Year 3

October 2006
Referral of the Problem
Jenny is a 65 year old woman of white-British origin. Since a car crash 10 years ago in which acquired a brain injury, she has lived in residential care. She was referred for psychological assessment by her GP for fear of falling (FoF).

Presenting Difficulties
Jenny uses a wheelchair, but has the ability to stand and walk short distances with a frame. Jenny reportedly experienced high anxiety when attempting to stand. Therefore attempts to mobilise with a frame posed a safety risk and she was hoisted for all transfers. Due to Jenny’s acquired brain injury she had some cognitive impairment.

Initial Assessment of the Problem
I met with Jenny for two one-hour face-to-face assessment sessions. Jenny gave a detailed account of her personal and social history, her current life circumstances and her medical history. However, exploration of the referral issue was difficult as Jenny reported that she was not anxious about standing, possibly due to memory difficulties.

I gained information from previous physiotherapy reports and Jenny’s physiotherapist about the development of the current difficulties. I also arranged to observe a physiotherapy session as recommended by Childs & Kneebone (2002). During the session Jenny initially denied her FoF. However she became highly anxious on attempting to do so. During this session we were able to elicit associated thoughts and feelings, such as “I am going to fall”, “my legs are too weak”.

Older People Case Report Summary
I also administered the Visual Object and Space Perception Battery (VOSP; James & Warrington, 1991) in order to determine if there were any specific visuo-spatial deficits contributing to her fear. Results showed no deficits in this area.

Risk Assessment
Physical risks associated with standing were monitored by the physiotherapy and care home staff. Jenny did not present as low in mood and denied any symptoms of depression.

Initial Formulation
There was no known trigger incident for the FoF. However, studies have shown that relevant vulnerability factors include being female, poor self-perception of physical health and cognitive status (Vellas et al, 1997). Childs and Kneebone’s (2002) cognitive behavioural model explained the maintenance of Jenny’s anxiety (Figure 1).

Action Plan
Friel et al, (2004) suggest that cognitive-behavioural approaches can provide long-term improvements in FoF. One cognitive behavioural approach with a proven record in treating fears in health settings is graded exposure (Emmelkamp et al, 1992; Edelmann, 1995). Several case studies have reported success when using graded exposure techniques for FoF (Tinetti and Powell, 1993; Jeans and Orrell, 1991; Riley & Holding, 2000).

The aim of the graded exposure CBT intervention was to reduce Jenny’s FoF in order to improve her ability to mobilise more independently. It
was expected that reducing Jenny’s FoF would increase her confidence and help to challenge her negative beliefs about herself and future.

**Figure 1. The development and maintenance of Jenny’s FoF**

<table>
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<th>Immediate Risk</th>
<th>Long Term Risk</th>
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<td>Within physiotherapy</td>
<td>1999 - referral</td>
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</table>

**Worry about falling**

- **Negative thoughts**
  - ‘I’m too tall’
  - ‘My legs are weak’

- **Bodily awareness**
  - Increased muscle tension
  - Breathless

- **Negative thoughts**
  - ‘I’m getting worse’
  - ‘I’ll never stand again’

- **Reduced activity**
  - Withdrawal from sessions
  - Use of hoist for all transfers

- **Distraction**

- **Stiffening**

- **Poor self-perception**

- **Lowered body strength**

**Increased risk of falling**

**Intervention**

The intervention took place over four fortnightly sessions. These were held jointly with the physiotherapist to aid Jenny’s memory and to allow the physiotherapist to develop psychological strategies to use during intermediate sessions. Due to her cognitive impairment a simplified diagrammatical formulation was discussed with Jenny and together we
Older People Case Report Summary

expanded this using her idiosyncratic thoughts and panic symptoms. A graded exposure hierarchy was then developed by the physiotherapist based upon the steps Jenny would need to take in order to stand well. A therapy diary was used as memory aid, which we filled in together at the end of each session. Treatment components of sessions are outlined in Figure 2.

**Figure 2. Cognitive-behavioural structure for fall-related anxiety management (Childs & Kneebone, 2002)**

<table>
<thead>
<tr>
<th>Treatment Component</th>
<th>Example of ways of increasing control in an anxiety provoking situation</th>
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<tbody>
<tr>
<td>Physical</td>
<td>Relaxation and breathing exercises</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Help them to have pre-prepared responses to negative thoughts and/or self coping statements i.e., 'there is a risk of falling, but if I relax and concentrate it is less likely'</td>
</tr>
<tr>
<td>Behavioural</td>
<td>Have a reminder list (prepared in conjunction with a physiotherapist) of 'what I need to do to walk well', i.e., how to look ahead, breather properly, lift frame etc</td>
</tr>
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</table>

**Outcome and Follow up**

Jenny initially made good progress with the graded exposure tasks. Her anxiety level in sessions reduced markedly and she was able to stand and take up to three steps with the assistance of a frame. This was reported by the physiotherapist to be a significant improvement on her presentation over the previous 3 years.
Older People Case Report Summary

Unfortunately following our fourth session, Jenny’s leg ‘gave way’ whilst standing. Jenny was lowered to the ground with assistance and was not hurt. However, she experienced this as catastrophic, as it appeared to confirm her beliefs about her inability to stand. It also appeared to reactivate beliefs such as “I am useless” and “I am so terrible”. She therefore declined to continue with the programme of graded exposure. Jenny agreed to attend a further session with me, in which we discussed her feelings about her perceived failure. Jenny was offered further sessions to explore these issues, but declined.

Jenny’s physiotherapist planned to continue to offer her a cycling programme in order to maintain her muscle strength and felt that he could use the psychological strategies learnt in future sessions.

Reformulation
A CBT model served to understand Jenny’s presenting difficulties. As she chose to terminate the therapy it was unnecessary to reformulate using a different model.

Critical evaluation of the work
The CBT intervention was initially effective in decreasing Jenny’s FoF. Following her set back and termination of therapy it seemed that deeper level cognitions about herself had presented more of a barrier to mobility than had been initially identified. However, it is unlikely that these beliefs would have been readily available to Jenny’s awareness, unless triggered by a ‘critical incident’. Also, CBT addresses the client’s negative automatic thoughts directly relating to the goal they have set for themselves, and does not begin with identification of ‘deeper level
cognitions'. Therefore, an intervention which explored core beliefs initially would not have been based upon the current best-evidence.
Older People Case Report Summary

References


Service Related Research Project

An audit of clinical psychologists', nurses' and social workers' satisfaction with the provision of clinical supervision within five Community Mental Health Teams, and the extent to which this meets Trust and local government guidelines

Year 1

July 2005
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Abstract

**Aims:** I. To audit the provision of clinical supervision (CS) for nurses, social workers (SWs), clinical psychologists (CPs) and counselling psychologists (CoPs) in five community mental health teams (CMHTs) against their respective local CS policies; II. To explore employees satisfaction with CS; III. To test the hypothesis that clinicians’ satisfaction with their CS varies between professions.

**Method:** A questionnaire was used to assess the extent to which policy guidelines were being met and clinician satisfaction with CS. Nurses, SWs, CPs and CoPs working in five CMHTs in a Mental Health NHS Trust were sampled.

**Results:** The majority of CS policy standards were being met across all four professional groups. Areas where standards were not met were ‘contracting’ for all professions; ‘quantity’ of CS for SW, CPs and CoPs; discussion of personal issues for CPs; choice of supervisor for CoPs; and record keeping and confidentiality issues for nurses. The present audit provided evidence in support of the hypothesis that satisfaction with CS varied between professions. CoPs were most satisfied with their CS, followed in order by CPs, Nurses and SWs.

**Conclusions:** It is recommended that: a) a multidisciplinary CS policy, interdisciplinary consultation regarding policies or interdisciplinary CS be considered; b) CS is prioritised where clinicians are not receiving the minimum required CS; c) CS contracting is reviewed across professions, particularly regarding explicit clarification of confidentiality issues; d) further explication of the reasons for the dissatisfaction identified in this study is sought in order to target areas for change in current policies/practice.
Acknowledgements

I would like to thank my project and field supervisors and the CMHT, for their help and guidance with the development, conduct and evaluation of this project.
Introduction

Clinical Supervision (CS) was defined by the Department of Health (DoH) as: "A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. It is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self assessment and analytical and reflective skills" (DoH, 1993).

The importance of CS in the mental health professions has grown rapidly due to an increased Governmental emphasis on lifelong learning (DoH, 1998), greater clinical accountability (Wampold et al. 1997) and promotion of self regulation within the professions (Lambert et al. 1987).

Several authors highlight the benefits of supervision for the well being of individual clinicians (Walsh, et al. 2001); for improving patient outcomes and maintaining standards of care (Butterworth & Woods, 1999); and for promoting professional development (Ronnestad, 1993). The professional regulatory bodies of mental health professionals (Nursing & Midwifery Council; General Social Care Council; British Psychological Society) now clearly recognize the importance of CS, and research suggests that clinicians largely concur with this opinion (Gabbay et al. 1999; Milne, 1998).

Despite this widespread agreement regarding the need for CS, there is less clarity about how CS should be provided. Multiple definitions and models of this complex activity have been developed across professions,
each embodying their own understanding of the purpose, functions and modes of delivery of CS.

In a review of the literature across professions, Kilminister et al. (2000) found general agreement that CS has three functions (educational, supportive and managerial), reflecting the influential work of Proctor (1987) in the UK and Kadushin in the US (1976). However, others argue that there is no consensus about the guiding principles (Simms, 1993), that CS, 'like love, cannot be taught' (Scott, 1999) and that there is great variation in emphases and priority of CS according to professional ethos (Kilminster et al. 2000).

Davy (2002) proposed that supervision has developed differing narratives across professions, contrasting 'progressive empowerment and self justification of upper and middle class professions' (psychology/psychotherapy) with 'the control and monitoring of (mainly) working class women working in public services, focussing... on public protection' (nursing and social work). Thus, currently there exists a wealth of literature around CS, most of which is narrative and philosophical in content, with little or no empirical testing of theoretical models (Kilminster et al. 2000).

Whilst professional guidelines highlight the responsibility of individual employees to actively engage in CS as part of continuing professional development and professional self regulation, it is also the responsibility of mental health employers to provide their employees with effective CS opportunities. This is seen as critical to efficient clinical governance processes (Butterworth & Woods, 1999).
With the lack of clarity around CS and professional guidelines that take the form of general principles rather than prescriptive policy, mental health service managers face a significant challenge when attempting to provide CS opportunities which will benefit employees, maintain standards of care and improve client outcomes.

This may be particularly difficult within multidisciplinary services such as Community Mental Health Teams (CMHTs). Here, frontline staff\textsuperscript{16} working with the same client groups\textsuperscript{17} and with similar case-load responsibilities may have different experiences of supervision, due to the variation in emphases and priority of CS according to professional ethos. CS provision may also differ as policies are devised by local government social care departments for social workers and Trust departments for nurses and psychologists.

Currently all clinicians within CMHTs in one Mental Health Trust should receive supervision in line with Trust and local Government CS policies. It was felt by the management of one CMHT that:

I. There is a need to audit the provision of CS in CMHTs in the locality against Trust/local Government policies as part of effective clinical governance processes

\textsuperscript{16} Front-line staff are described as "those in contact with high-risk patients at high-risk times, including both community and ward staff" (DoH, 1999b, p.84)

\textsuperscript{17} The CMHTs audited in this study accept referrals for adults aged 16-64. The catchment area covers a mix of urban and semi-rural areas. The area is generally affluent, with low levels of socio economic deprivation although the principle regional town has high rates of substance misuse and homelessness.
II. There is a need to explore employee satisfaction with CS in order to develop CS policy and practice which is responsive to local need

III. Current provision of CS varies between professions due to each profession having their own CS policy, and thus clinicians' satisfaction with their CS may vary between professions
Method

2.1 Design
Trust and local government CS policies for nurses, SWs, CPs and CoPs were scrutinised for required standards (summarised in appendix A). A questionnaire was devised (appendix B) which would assess the extent to which these guidelines were being met. Additionally a 5 item, likert scale measure of satisfaction with current CS provision was included.

2.2 Sample
Nurses, SWs, CPs and CoPs working in five CMHTs making up one locality in a Mental Health NHS Trust were sampled.

2.3 Procedure
Questionnaires were distributed at each of the CMHT meetings by the researcher. Participants were asked to complete questionnaires and return them through the internal mail in envelopes provided. Additional copies of questionnaires were left with team managers for those team members not present at these meetings.

2.4 Ethics
Ethical approval from the NHS or university committees was not required for this project as it was audit, rather than research (see appendix C). It was made explicit in the instructions on questionnaires that completion was voluntary and anonymous and that participants would not be identifiable in the write up of the audit.

2.5 Analyses
Descriptive statistics were utilised to explore data.
3.1 Aim 1: To audit the provision of CS for nurses, SWs, CPs and CoPs against their respective local CS policies.

Standards from CS policies and the extent to which these were being met are reported for each profession. CMHT managers were unable to provide specific information about staff numbers due to having high staff turnover and locum staff in the service; therefore it was not possible to determine response rates.

Clinical Psychology
Five CPs responded to the questionnaire (mean years practising = 16.4, range = 12-25). The CP practicing for the longest period did not receive individual CS. Thus percentages reported in the table for standards 2-8 exclude this person. Missing data from unanswered items were excluded from percentage calculations.

The amount of CS received by each CP reported in the table refers to individual CS. Four CPs also received 1.5 hours group supervision per month, in a group of 6 CPs (equating to 15 minutes allowable CS time per attendee, as per Trust policy). Thus, even including group CS, standards 1 & 2 were unmet in 100% of the sample.
<table>
<thead>
<tr>
<th>Trust Policy Standards</th>
<th>n Meeting Standard</th>
<th>%</th>
<th>n Not Meeting Standard</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Receive minimum 1.5 hours CS per month</td>
<td>0</td>
<td>0</td>
<td>3 (1 hr per month)</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 (1 hr 2 monthly)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 (never)</td>
<td></td>
</tr>
<tr>
<td>2 For most staff substantially more</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>3 Have separate CS and caseload supervision</td>
<td>4</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4 Supervised by experienced clinician in same tradition</td>
<td>4</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 Supervisor does not have line managerial responsibility</td>
<td>1</td>
<td>25</td>
<td>3</td>
<td>75</td>
</tr>
<tr>
<td>6 Supervision contract in place</td>
<td>1</td>
<td>25</td>
<td>3</td>
<td>75</td>
</tr>
<tr>
<td>7 Choice of supervisor from a pool of senior staff</td>
<td>2</td>
<td>67</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>8 Opportunity to disclose personal issues in CS</td>
<td>2</td>
<td>18</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

It is recommended in Trust policy (standard 7) that there should be a choice of supervisor from a pool of senior clinicians. Whilst 67% of the sample indicated they had a choice of supervisor, all CS opportunities were with peers, thus not necessarily a ‘senior clinician’. For the CP who had a CS contract, all standards in the Trust guidelines pertaining to contracting were met.

18 Information in brackets indicates the level at which respondents agreed the standard was met.
Counselling Psychology

Three CoPs completed the questionnaire (mean years practising = 6, range = 2-10). The most experienced CoP was being supervised by 2 Consultant CPs.

Table 2. Number of CoPs meeting Trust requirements for CS

<table>
<thead>
<tr>
<th>Trust Policy Standards (see appendix A)</th>
<th>n Meeting Standard</th>
<th>%</th>
<th>n Not Meeting Standard</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive minimum 1.5 hours CS per month</td>
<td>1 (2 hrs per month)</td>
<td>67</td>
<td>1 (1 hour per mth)</td>
<td>33</td>
</tr>
<tr>
<td>For most staff substantially more</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Have separate CS and caseload supervision</td>
<td>3</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supervised by experienced clinician in same tradition</td>
<td>2</td>
<td>67</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>Supervisor does not have line managerial responsibility</td>
<td>3</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supervision contract in place</td>
<td>1</td>
<td>33</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>Choice of supervisor from a pool of senior staff</td>
<td>1</td>
<td>33</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>Opportunity to disclose personal issues in CS</td>
<td>1 (completely)</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2 (somewhat)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mental Health Nursing
Seventeen nurses completed questionnaires (mean years practicing = 15.3 years, range = 1 - 30). One nurse was not receiving CS, and commented that it had “recently ceased due to staff leaving”. Therefore percentages reported for standards 2 - 11 exclude this person.

Table 3. Number of nurses meeting Trust requirements for CS

<table>
<thead>
<tr>
<th>Trust Policy Standards (see appendix A)</th>
<th>n Meeting Standard</th>
<th>%</th>
<th>n Not Meeting Standard</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 All nurses will have CS</td>
<td>10 (1hr per month)</td>
<td>94</td>
<td>1 (never)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>3 (1hr per 6 weeks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (1hr as requested)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Supervised by experienced practitioner</td>
<td>16</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 Conducted in private</td>
<td>15 (always)</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1 (mostly)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Free from interruption</td>
<td>12 (never interrupted)</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4 (rarely interrupted)</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 CS contract in place</td>
<td>10</td>
<td>62</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>6 Utilize guided reflection</td>
<td>8 (completely)</td>
<td>94</td>
<td>1 (not at all)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7 (somewhat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Develop skills</td>
<td>3 (completely)</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>13 (somewhat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Identify targets for achievement</td>
<td>1 (completely)</td>
<td>71</td>
<td>4 (not at all)</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>9 (somewhat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 A summary of sessions will be kept</td>
<td>8</td>
<td>50</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>10 Summary signed and agree by both parties</td>
<td>3</td>
<td>23</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>11 Explicit discussion of Confidentiality</td>
<td>8</td>
<td>50</td>
<td>5 (no)</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>3 (unsure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Content of sessions controlled by supervisee</td>
<td>7 (supervisee)</td>
<td>93</td>
<td>1 (no one)</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>7 (jointly)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Work

Nine SWs completed the questionnaire (mean years practising = 9, range = 1-30). Two SWs did not have CS and three provided comments suggesting CS was sporadic. Therefore, percentages reported for standards 2 - 20 exclude the 2 SWs not receiving CS. Missing data were excluded from percentage calculations.

Table 4. Number of SWs meeting local government requirements for CS

<table>
<thead>
<tr>
<th>Local Government Policy Standards (see appendix A)</th>
<th>n Meeting Standard</th>
<th>%</th>
<th>n Not Meeting Standard</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Monthly CS</td>
<td>3 (once per mth)</td>
<td>33</td>
<td>2 (never)</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 (every 2 months)</td>
<td></td>
</tr>
<tr>
<td>2 CS 1 - 2 hours long</td>
<td>4 (1 hour)</td>
<td>100</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (1.5 hours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Supervision contract In place</td>
<td>3</td>
<td>43</td>
<td>4</td>
<td>57</td>
</tr>
<tr>
<td>4 Contract signed by both parties</td>
<td>3</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 Contract reviewed annually</td>
<td>1</td>
<td>33</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>6 CS only cancelled in exceptional circumstances</td>
<td>3 (never)</td>
<td>80</td>
<td>1 (frequently)</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>1 (rarely)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 CS planned in advance</td>
<td>4 (mostly)</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>3 (always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Conducted in private</td>
<td>7</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9 CS conducted without interruption</td>
<td>5 (rarely Disturbed)</td>
<td>71</td>
<td>1 (always disturbed)</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>1 (mostly)</td>
<td></td>
<td>1 (mostly disturbed)</td>
<td></td>
</tr>
<tr>
<td>10 CS structured and focused</td>
<td>1 (always)</td>
<td>71</td>
<td>1 (never)</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>4 (mostly)</td>
<td></td>
<td>1 (rarely)</td>
<td></td>
</tr>
<tr>
<td>11 Access to CS between sessions</td>
<td>5</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12 Content recorded by supervisor</td>
<td>7</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Summary

I. Four out of eight standards were met in the majority of cases for the CP sample. These related to the opportunity to have separate caseload and clinical supervision and who provided CS. Standards not being met (1, 2, 6, 8) related to amount of CS, contracting and ability to disclose personal issues.

II. Five out of eight standards were met in the majority of cases for the CoP sample. These related to the opportunity to have separate caseload and clinical CS, who provided CS and the content of CS sessions. Standards not being met (2, 6, 7) related to amount of CS, choice of supervisor from a pool and contracting.
III. Nine out of twelve standards were met in the majority of cases for the nursing sample. These related to amount of CS, who provided CS, practical arrangements, content of sessions and contracting. Standards not being met (9, 10, 11) related to summarizing sessions and explicit discussion of confidentiality.

IV. Seventeen out of twenty standards were met in the majority of cases for the SW sample. These related to the length of CS sessions, practical arrangements, structure of sessions and record keeping. Standards not being met (1, 3, 5) related to frequency of CS and contracting.

3.2 Aims II & III: To explore employees' satisfaction with CS & to test the hypothesis that this varies between professions- respondents' endorsements of 5 satisfaction statements are reported graphically by profession below.
Figure 1. Overall satisfaction with CS

"Overall I am satisfied with the CS I receive"

<table>
<thead>
<tr>
<th></th>
<th>Definitely Agree</th>
<th>Moderately Agree</th>
<th>Neither Agree Or Disagree</th>
<th>Moderately Disagree</th>
<th>Definitely Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2. Perception of CS as beneficial

"Utilising CS has been beneficial to me"

<table>
<thead>
<tr>
<th></th>
<th>Definitely Agree</th>
<th>Moderately Agree</th>
<th>Neither Agree Or Disagree</th>
<th>Moderately Disagree</th>
<th>Definitely Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 3. Perception of CS as addressing issues important to the supervisee

"CS addresses the things that are important to me as a clinician"

Figure 4. Perception of CS as supportive

"I feel well supported in my profession through CS"
Figure 5. Perception of CS as contributing to effective practice

"The CS I receive helps me to be an effective practitioner"

- Counselling Psychologist
- Clinical Psychologist
- Nurse
- Social Worker

Scale:
- ☑️ Definitely Agree
- □ Moderately Agree
- □ Neither Agree Or Disagree
- ■ Moderately Disagree
- ☐ Definitely Disagree
Discussion

4.1 Overview

It is clear that the majority of CS policy standards were being met across all four professional groups in the CMHTs sampled. It is also evident that there is large variation between each profession’s CS policy in terms of both quantity and content of the standards. SW supervisors have considerably more prescriptive standards to meet than the other professions, pertaining to both the process and content of CS.

Importantly, CS provision for CP, CoP and SW groups did not meet standards relating to amount of CS. One CP, one nurse and two SWs were not receiving any CS. All those receiving CS reported that it was rarely cancelled and only in the event of sickness, except SWs who said that supervisor’s duties and caseload demands were prioritised over CS. Therefore, in the case of CP and CoP it appears there is a problem with the amount of CS being arranged, rather than that CS is being cancelled due to unexpected issues arising.

Another area where standards were not met for the CP, CoP and SW samples was contracting; the majority of clinicians from all three professions did not have a contract. It has been suggested that the mutuality of the dialogue occurring within the contracting process is essential, underlies cooperation and enhances the likelihood of successful outcomes (Cottrell, 2002) and thus this is an area of concern for the CMHTs involved in the present study.

Results indicated that 50% of nursing staff either had not, or were unsure if they had, explicitly discussed the meaning of confidentiality within the
context of the supervisory relationship; thus not meeting Trust guidelines. Surprisingly (given its importance to CS) explicit discussion and documentation of confidentiality within CS is not a standard in other professions' policies. Responses in the present study suggest that there was some ambiguity about this in all professions. Only 47% of nurses, 60% of CPs, 22% of SWs and 67% of CPs said they had explicitly discussed and clarified the meaning of confidentiality within the supervisory relationship with their supervisor. Cottrell (2002) reports that this can contribute to a situation where supervisees develop resistance to CS (conscious or unconscious), being unsure as to the nature of the information the supervisor passes on about them.

As hypothesised, there was an apparent difference in satisfaction with CS between professions, although it was not possible to test the statistical significance of this due to small sample size. On all measures SWs were least satisfied, the majority believing that CS is not beneficial. SWs particularly disagreed that their CS was supportive or enabled them to be more effective practitioners.

A possible explanation for this is the apparently low priority given to CS in the SW sample. Whilst low levels of CS could also reflect resistance from supervisees, given their dissatisfaction with what it has to offer, SWs comments suggest that dissatisfaction was with current CS provision, rather than with the concept of CS per se. SWs also acknowledged that supervisors themselves were dissatisfied with the status quo; one respondent stated that their supervisor wanted 'desperately to supervise' but was unable to do so due to time demands, their own large caseload and a lack of support. The difficult decision facing some supervisors when
attempting to balance providing CS with other demands was highlighted. One SW respondent commented that their supervisor had to prioritise dealing with their own clients over providing CS as they were directly accountable for their own practice and not that of their supervisees.

Another reason for SWs' dissatisfaction was that CS did not address the issues important to them. These appeared to be emotional and psychological aspects of the work; SWs reported 'very little supervision on the clinical aspect' and that supervision 'takes no account of how working with chronic mental illness may affect them'.

This focus reflects the ethos of the SW supervision policy, which states that supervision should have a managerial function, as part of the hierarchical structure of accountability. This appears to have resulted in what Cottrell (2002) terms the 'suspicion position', where the links between managerial and clinical supervision create anxiety, mistrust and thus dissatisfaction.

Nursing ratings of overall satisfaction and comments indicated that this group were generally satisfied with the CS they received. Nurses expressed more ambivalence (selecting 'neither agree nor disagree') about the supportive function of CS and the focus on issues which they considered to be important, however, this was a minority of cases.

CoPs emerged as the group most satisfied with their supervision, 100% of the sample agreeing with all satisfaction measures. All CPs endorsed all satisfaction statements, although CoPs agreed more strongly than CPs on 3 measures. This may reflect that whilst CPs value CS, no clinicians in the
sample were receiving the 1.5 hours of CP required for a minimum caseload.

These results indicate that the CS philosophy and policy for psychology within the CMHTs was more congruent with supervisee satisfaction than those of nursing and social work. However, there may be other factors influencing CPs and CoPs expressed satisfaction. The predominant culture in the training and development of psychotherapy is that supervision is integral, important and beneficial, making it difficult for psychologists to stand back from foundational myths and the rhetoric of CS within the profession (Davy, 2002).

4.2 Recommendations for the Service

It appears, as expected, that satisfaction with current CS provision varied across professions. The results from the present audit indicated that this may be associated with each profession having a different CS policy, reflecting their respective professional ethos and managerial strategy.

Whilst it is recognized that within a MDT, clinicians' practice is underpinned by specific philosophies and bodies of knowledge that can be seen as distinct from those of other professions, all health and social care workers are likely to practice 'listening' and basic counselling skills as a form of 'therapy' (Beasley et al 2003).

Therefore, it may be appropriate to consider the development of a MDT supervision policy, consultation between professions regarding current CS policies and strategies or interdisciplinary CS. Gabbay et al. (1999) found that peer group supervision particularly, was valued highly and this may
be a viable option alongside individual intra-professional CS opportunities.

It is recommended that the priority given to CS be reviewed, particularly in SW, CP and CoP where clinicians were not (or only marginally) receiving the recommended amount of CS. Particularly, those clinicians not currently receiving Cs should be identified and CS opportunities provided in line with professional practice guidelines and local policies.

Several respondents in the current audit suggested that they would welcome initiatives such as these and it is possible that more flexible approaches to CS may lead to 'a co-ordinated approach to staff development, skill-mix and skill sharing' which is required for the effective integration of health and social care in mental health services (DoH, 2003).

It is also recommended that supervisors and supervisees review their CS contracts, as this is an important facet of CS and an area where current policy standards are not being met in the majority of cases. Contracts should explicitly clarify the meaning of confidentiality within supervisory relationship.

It was found in the present audit that between 33 and 57% of all clinicians were not aware of their local and professional body CS policies or guidelines. Therefore, it is important for the effective negotiation of CS contracts, that these documents are made explicitly available in the workplace and that employees are required to read them. It may also be beneficial to arrange supervision awareness training for each of the
professional groups in order to increase understanding of guidelines, entitlement and potential benefits of CS.

The reasons for satisfaction and dissatisfaction with current CS provision in the Trust should be explored further as there was a lack of qualitative data provided in the current audit. This may further elucidate areas to target for change in CS policy and practice.

Please see appendix D for a discussion how the results were fed back to the service.

4.3 Limitations
Many respondents had completed a questionnaire regarding supervision recently as part of an audit (which was not completed due to methodological problems). Also, concurrently to the present study, another clinician within the Trust was completing an audit of supervision for psychologists. These factors are likely to have reduced willingness to complete questionnaires and may account for the lack of qualitative responses provided by participants.

Whilst the findings of the current study highlight that some groups are relatively dissatisfied with particular aspects of their CS, the lack of detailed, comprehensive models and empirical research to date mean that recommendations of how to remedy the situation are somewhat speculative. Furthermore, reported satisfaction may not necessarily be due to good supervision and might not affect clinician’s performance or improve client outcomes.
References


Appendix A: Clinical Supervision Guidelines for Clinical Psychologists, Counselling Psychologists, Social Workers and Mental Health Nurses

Clinical and Counselling Psychology

<table>
<thead>
<tr>
<th>Trust Policy Standards from: 'Supervision and continuing professional development guidelines for clinical psychologists, counsellors and psychotherapists'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards set out in this policy document have been summarised and re-ordered below to aid the completion and write up of this report.</td>
</tr>
</tbody>
</table>

1. Minimum requirement of 1.5 hours per month, whether full or part time

2. In most areas of the Trust, staff will need substantially more supervision than the minimum standard

3. All staff need separate clinical and caseload management supervision

4. Supervision should be provided by an experienced professional who works in the same tradition as that of the supervisee

5. Supervisors should not have management or professional responsibility for the service the supervisee provides

6. There should be a supervision contract which clearly identifies:
   - the limits of confidentiality within the supervisory relationship
   - roles and responsibilities of the supervisor and supervisee
   - times
   - format
   - how the contract will be regularly reviewed

7. Staff will have the opportunity to choose who provides their supervision from a range of opportunities provided by a team of senior staff

8. Clinical supervision should provide the privacy and confidentiality to disclose personal issues
Mental health Nursing

**Trust Policy Standards from:** 'Clinical Supervision Guidelines for Nurses' (2001).

Standards set out in this policy document have been summarised and reordered below to aid the completion and write up of this report. Numbers in brackets refer to paragraphs in policy document.

1. All qualified nurses will have the opportunity to experience clinical supervision

2. Clinical supervision will be carried out by experienced practitioners with supervisory skills

3. Venue will be conducive to the success of the clinical supervision session

4. Will be free from interruption

5. There will be a contract agreed by both parties covering: format of the session; confidentiality; roles and responsibilities of both parties (7.1)*

6. Guided reflection will take place

7. With the aim of continuous improvement of clinical skills

8. Practitioners will measure their practice against the ability to deliver care at the required standard (5.2)

9. There should be a summary of each session (7.2)

10. The summary should be jointly agreed between supervisor and supervisee (7.2)

11. It is essential that both parties are clear about the meaning and implications of confidentiality within the arena of supervision. Discussion should be clear and unambiguous (7.5)

12. Content of sessions should in principle be controlled by the supervisee (7.6)
Social Work

**Local Government Policy Standards from: 'Adults and Community Care Supervision Policy- Supervision Standards and Code of Practice' (January 2004).**

Standards set out in this policy document have been summarised and re-ordered below to aid the completion and write up of this report. Numbers in brackets refer to paragraphs in policy document.

| 1. Supervision should be monthly (9) |
| 2. Supervision sessions should usually be for a period of one to two hours (26) |
| 3. The supervisory relationship between supervisor and supervisee is set out in a contract (2) |
| 4. Signed by both parties (2) |
| 5. The supervision agreement should be reviewed yearly (14) |
| 6. Supervision should only be cancelled in exceptional circumstances (9) |
| 7. Supervision sessions should be planned in advance (9) |
| 8. Supervision should take place in private (10) |
| 9. Supervision should take place without interruptions (10) |
| 10. Sessions should be focussed and structured (4) |
| 11. Supervisors should be available between formal supervision sessions to provide support on urgent or anxiety provoking issues (11) |
| 12. All supervision sessions should be recorded by the supervisor (5) |
| 13. Record to be signed by both parties (5) |
| 14. To be done within one working week (5) |
| 15. During supervision, areas covered MUST include monitoring of targets; Workload; Review of current work which is raising issues; Personal issues which impinge on work; Personnel matters (28) |
| 16. Workload; |
| 17. Review of current work which is raising issues; |
| 18. Personal issues which impinge on work; |
| 19. Personnel matters (28) |
| 20. The agenda and discussion should reflect the priorities of both parties (4) |
Appendix B: Questionnaire

I would like to invite you to participate in an audit of clinical supervision provided for nurses, social workers and psychologists working in CMHTs in the ****Trust. I am conducting this audit on behalf of the Trust in line with their aim to annually review the supervision you receive and listen to your comments.

The purpose of undertaking this audit is to establish:

- Whether the supervision currently provided by the trust meets Trust, local government and professional -body guidelines
- Whether you are satisfied with the supervision you get
- Any suggestions you have about how supervision could be improved

If you choose to participate:

- The questionnaire will take approximately 10 minutes to complete
- In order to preserve anonymity and enable you to be honest in your responses, the questionnaires can be sealed in the envelopes provided and returned directly to me
- Please read the instructions carefully before completing the questionnaire

Thank you for your time.
Throughout this questionnaire the term 'clinical supervision' refers to formal, one-to-one consultative support, which may be defined as 'supervision', 'clinical supervision' or 'professional supervision' depending on which profession you are from.

Please underline/circle the appropriate response for each item

1. What is your profession?
- Nurse
- Clinical Psychologist
- Social Worker
- Counselling Psychologist

2. How many years have you been practising? ..............

3. Do you have separate clinical supervision and caseload-management supervision?
- Yes
- No
- Don’t know

4. How often do you have individual clinical supervision?
- Never
- Once a week
- Once a fortnight
- Once a month
- Once every 6 weeks
- Other (please specify)

5. How often do you have caseload-management supervision?
- Never
- Once a week
- Once a fortnight
- Once a month
- Once every 6 weeks
- Other (please specify)
6. Who provides your clinical supervision?

More experienced clinician from same profession
   More experienced clinician from other profession *(please specify)*
   Other *(please specify)*

7. Does your clinical supervisor have any line managerial/managerial responsibility for the clinical work that you undertake?

Yes  No  Don’t know

8. Did you have a choice of clinical supervisor from a ‘pool’?

Yes  No  Don’t know

9. a) How often is clinical supervision cancelled by you?
   Never
   Rarely
   Frequently
   More often than not

   b) For what reasons?

10. a) How often is clinical supervision cancelled by your supervisor?
    Never
    Rarely
    Frequently
    More often than not

    b) For what reasons?

11. How long is the session in hours? .............
12. Are your clinical supervision sessions pre arranged with enough time for adequate preparation?

Never  Rarely  Mostly  Always

13. Are sessions conducted in private?

Never  Rarely  Mostly  Always

14. Are sessions interrupted?

Never  Rarely  Mostly  Always

15. a) Do you have a supervision contract/agreement?  Yes  No

b) Is this documented and signed by both parties?  Yes  No

c) Does it outline the roles and responsibilities of the supervisor and supervisee?  Yes  No

d) Does it outline the format sessions will take?  Yes  No

e) Does it outline the meaning and implications of confidentiality within supervision  Yes  No

f) Is the contract reviewed at least annually?  Yes  No

16. Have you attended the trust 'supervision awareness training'?

Yes  No

17. Who sets the agenda for each session?

You  Supervisor  Jointly  no one
18. Are sessions adequately structured and focussed to meet your needs?

Never Rarely Mostly Always

19. a) Is a record documenting discussions/action points from each session kept? Yes No

b) Who keeps the record? You Supervisor Both

c) Is the record signed by both parties? Yes No

d) Is this done within one week? Yes No

20. Can you access supervision between sessions if necessary? Yes No

21. a) Are you aware of procedures for making complaints/resolving disputes between you and your supervisor? Yes No

b) If you have used these, have they been effective? Yes No

22. Do you feel your supervision in confidential in a way which allows you to be open and honest in sessions?

Never Rarely Mostly Always

23. Have you and your supervisor explicitly discussed the meaning and implications of confidentiality within the arena of supervision?

Yes No Unsure
24. Please indicate the extent to which you cover each of the following items in clinical supervision. If you cover any item elsewhere (i.e., managerial/caseload/group supervision) please specify

- Identify targets for achievement and performance?
  Completely  Somewhat  Not at all  Elsewhere

- Monitor progress?
  Completely  Somewhat  Not at all  Elsewhere

- Discuss workload?
  Completely  Somewhat  Not at all  Elsewhere

- Discuss current work which is raising issues?
  Completely  Somewhat  Not at all  Elsewhere

- Discuss personal issues that affect work?
  Completely  Somewhat  Not at all  Elsewhere

- Identify training needs and address CPD?
  Completely  Somewhat  Not at all  Elsewhere

- Discuss team/service issues?
  Completely  Somewhat  Not at all  Elsewhere

- Discuss attitudes/feelings towards clients?
  Completely  Somewhat  Not at all  Elsewhere

- Develop your skills?
  Completely  Somewhat  Not at all  Elsewhere
• Reflect on practice with a skilled supervisor?
  Completely  Somewhat  Not at all  Elsewhere

• Have an opportunity to discuss all aspects of professional practice?
  Completely  Somewhat  Not at all  Elsewhere

• Receive support in undertaking research?
  Completely  Somewhat  Not at all  Elsewhere

25. Please rate the extent to which you agree with each of the following statements:

a. Overall I am satisfied with the supervision I receive
  Definitely agree  Moderately agree  Neither agree nor disagree  Moderately disagree  Definitely disagree

b. The supervision I receive helps me to be an effective practitioner
  Definitely agree  Moderately agree  Neither agree nor disagree  Moderately disagree  Definitely disagree

c. I feel well supported in my profession through supervision
  Definitely agree  Moderately agree  Neither agree nor disagree  Moderately disagree  Definitely disagree

d. Utilizing supervision has been beneficial to me
  Definitely agree  Moderately agree  Neither agree nor disagree  Moderately disagree  Definitely disagree
e. The supervision I get addresses the things important to me as a clinician

<table>
<thead>
<tr>
<th>Definitely agree</th>
<th>Moderately agree</th>
<th>Neither agree nor disagree</th>
<th>Moderately disagree</th>
<th>Definitely disagree</th>
</tr>
</thead>
</table>

26. Are you familiar with the Trust, council or professional body guidelines for clinical supervision for your profession?

Yes No Unsure

27. Please use this page to briefly outline any further suggestions/comments about the clinical supervision you receive.
Appendix C. Ethical scrutiny form

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.

Name of Field/Placement Supervisor: [Redacted]
Signature of Field/Placement Supervisor: [Redacted]

Name of Trainee: Nicky Hartigan
Title of SRRP: An audit of nurses’, psychologists’ and social workers’ satisfaction with the provision of clinical supervision and the extent to which this meets Trust and local government guidelines.

Date: 11th July 2005.
Appendix D: Feedback of Results to the Service

The report of these findings has so far been submitted to the team manager, nursing supervisor, social work supervisor and clinical psychology supervisor from the main CMHT involved in this project. There are plans to send out the report to the managers and supervisors from the 4 other CMHTs involved. The report has also been submitted to the audit committee at the main hospital site for all 5 CMHTs involved, with details of who will take which actions forward and when the audit should be re-done.

The findings of the report were also presented to the main CMHT’s team meeting, attended by all social workers, nurses and psychologists, their supervisors and the team manager. The team manager praised the audit, stating that it had been something which had needed doing for a long time but they had been unable to support someone undertaking it. Members of the team also praised the fact that the audit had been completed and stated that they felt clinical supervision within the team needed to be looked at in a systematic way.

Presentation of the results promoted a large discussion between the professional groups about what they would gain from a more interdisciplinary approach and many people were in favour of such initiatives. Following the presentation and discussions, the team manager, and the supervisors from the three professional groups agreed a time to meet to discuss how these ideas and recommendations can be taken forward.
Several members of the team commented that it had been helpful that someone had gone through the clinical supervision policy documents (which were in some cases long and confusing) and identified the standards in each of these. As it was clear from the audit that many people were not aware of these standards, copies of appendix A were circulated at the meeting and will hopefully inform supervises when negotiating their supervision contracts.
Hi Nicky,

Yes I do recall your service related research project on supervision. I also recall that you presented your findings to the team in one of our 'Learning and Development' lunch hour slots. You did a very good presentation and stimulated a lot of discussion, to which you responded appropriately. You also gave us a copy of your project for our Clinical Governance folder, which collates audits, research etc within the Locality.

Hope this is sufficient information. If not, please let me know.

Best wishes

Dr
Consultant Lead Clinical Psychologist
Locality
Qualitative Research Project Abstract

Year 2

May 2006
Abstract

With the increasing involvement of psychologists in a host of 'reality TV' programmes that have pervaded our culture in recent years ethical dilemmas and other issues have been highlighted by qualified clinical psychologists. However, less is known about the opinions of trainee clinical psychologists who are developing as professionals within this climate. Six trainee clinical psychologists participated in a focus group to explore their perspectives. Interpretative phenomenological analysis (IPA) was used to analyse the data. Five main themes emerged: public views; credibility; accessibility; professional identify and ethics/responsibility. The emerging themes reflected some of the concerns of qualified practitioners which have implications for individual practice and for the profession as a whole.
Major Research Project

Relationships with and beliefs about voices: A 12-month longitudinal study with clinical and non-clinical voice hearers

Year 3

July 2007
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Abstract

Aims: To explore changes occurring in interrelating between voice and hearer and beliefs about voices over a 12-month period, in a clinical and non-clinical sample. Associations with changes in level of distress experienced were explored.

Method: Prospective, longitudinal within-participants and correlational designs were used. 18 clinical and 9 non-clinical voice hearers were assessed at baseline and at 12-months follow-up using the: Voice Relating Interview; Psychotic Symptoms Rating Scale; Voice and You; and Beliefs about Voices Questionnaire.

Results: There were no significant changes in styles of interrelating in either sample. However, in the clinical sample there was a significant positive association between change in Hearer Distance and change in level of distress experienced. In the non-clinical sample there was a significant negative association between change in Hearer Dependence and change in level of distress experienced, and a negative association between change in Hearer Distance and change in level of distress experienced.

In the clinical sample, there were no significant changes in beliefs about voices’ malevolence and omnipotence. However, clinical hearers believed their voices’ to be significantly less benevolent at 12-month follow up. This change was not associated with any change in level of distress. There were no significant changes in beliefs about voices’ in the non-clinical sample.

Conclusions: The study provided preliminary support for the notion that interrelating and beliefs about voices are relatively stable in the absence of specific psychological intervention. Further, it provided tentative support for the association between styles of interrelating and distress.
Major Research Project

Introduction

1.1 Overview
I will begin this thesis by orienting the reader to my motivation in looking at the experience of voice hearing. I will then outline the history of current perspectives on voice hearing, including the ‘illness’ paradigm and alternative non-medical views. I will then detail recent theoretical and clinical approaches to voice hearing, in particular the cognitive and interpersonal perspectives. Finally, I will discuss the relatively few studies which have looked at the experience of voice hearing longitudinally, and outline the aims and hypotheses for the current study.

1.2 Personal Reflections
Prior to commencing this training, I worked as a Mental Health Nurse. During this time, the majority of people I worked with were voice hearers. What struck me during this period was that this experience was often explained away as a random symptom of a mental ‘illness’ by professionals. Due to this predominating view, I was encouraged to distract people from their voices and make it clear that I did not accept them as ‘real’. This avoided ‘colluding’ with or providing evidence for the person’s ‘unreality’. Aside from giving psychotropic medication, no alternative methods of working with or thinking about voices were offered to me as a professional. This appeared to me to send the message that talking about voices was unacceptable, leading to shame and secrecy.

I have since learned that my professional experience was not an uncommon one and that this approach still predominates in mental health services (e.g. Coffey et al, 2004; Leudar & Thomas, 2000; Romme & Escher,
Major Research Project

2000; Deegan 2006). Most voice hearers who come into contact with mental health services will attract a diagnosis of psychiatric illness (usually schizophrenia) and be treated primarily with drugs, however these are ineffective for most people (Curson et al., 1985 in Vaughan & Fowler, 2004).

This highlighted to me the need for mental health professionals to find new ways of thinking and talking about voice hearing, if health care services are to be helpful, rather than harmful, to those who are distressed by their experiences. Therefore, the basis for this thesis is to build upon recent cognitive and interpersonal research, which has begun to explore new ways of conceptualizing and working with voices.

1.3 The Voice Hearing Experience

There is no doubt that hearing voices can often be an intense, intrusive and extremely distressing experience, having no apparent outside source, whilst seeming to come from someone or something else (Romme & Escher, 1993). Voices can significantly disrupt people's lives and many hearers turn to mental health services in an attempt to alleviate distress. The content of voices can vary greatly but common themes include questions, comments, commands and criticisms (Beck & Rector, 2003). People often report hearing derogatory utterances such as "loser" or commands; these range from the mundane, such as "go for a walk", to extremely frightening instructions, for example, to self harm (Beck & Rector, 2003). Others report hearing their voices as a running commentary on their behaviour. The frequency with which voices are heard ranges from almost continuously to very infrequently (Beck & Rector, 2003).
1.4 Conceptualisations of Voices

The classification of voice hearing as a symptom of a biological mental illness, unlike voice hearing itself, is a relatively recent phenomenon. Accounts of voice hearing date back several millennia, including those of Socrates, Nietzsche, Moses, Jesus, Mohammed and Joan of Arc to name a few (Simonton, 1994). In fact, it has been theorized by American Psychologist Julian Jaynes (1976) that as recently as Ancient Greek times, self reflective consciousness had not evolved, and therefore 'hallucinating' voices (which were experienced as coming from Gods), was the universal, normal mode of thinking.

However, voice hearing only began to be seen as a sign of an underlying disease process, which is categorically distinct from 'normal functioning' with the writings of Kraeplin and Bleuler in the late 1800s (Bentall, 2003). This approach was then accepted with gusto for a variety of cultural, theological, political and professional reasons within psychiatry and society (Boyle, 2007). This paradigm remains dominant today, despite the fact that to date there has been no scientifically convincing evidence that an illness underlies these experiences (Moncrieff, 2007). As Maitland (2007) writes "In the days of Joan of Arc, a whole range of options were advanced about why she was afflicted by voices. That range is dead. Now, if you hear voices, you're a loony."

Since the 1960s a growing movement of professionals and service users have identified this 'illness' approach as unhelpful, and the resulting services as potentially more distressing than the voices themselves (Campbell, 2007). In response to this, a number of professionals, academics and an international group of voice hearers, the Hearing Voices...
Major Research Project

Network (HVN), are challenging the notion that voices must be lived and experienced as signs of disease and illness. They seek a return to a more emancipatory approach (Blackman, 2001) which acknowledges voices as an understandable human experience, rather than as a pathological one.

In support of this approach, a considerable body of evidence demonstrates that a significant minority of people, who have never had contact with mental health services also hear voices (Bentall, 2007) prompting the suggestion that there is continuum of voice hearing within the whole population (Strauss, 1969). A number of surveys conducted within Western cultures with sample sizes ranging from 18,000 to 375 appear to consistently suggest a prevalence rate of voice hearing in the 'normal' population between 5-15% (e.g., Society for Psychical Research, 1894, cited in Bentall, 2003; Posey & Losch, 1983; Bentall & Slade, 1985; Young et al 1986; Tien, 1991; Barrett & Etheridge, 1992; Van Os et al, 2000).

Also, in many non-Western cultures today hallucinatory experiences are not understood within an illness paradigm, being seen as an accepted and valuable part of ritual practice (Bourguignon, 1970; in Bentall, 2004). This reflects culturally embedded beliefs about the boundaries between imagination and reality (Al-Issa, 1995). These findings suggest that hearing voices does not in itself have to be a distressing experience (Birchwood et al, 2004) and cannot be considered a sign of 'illness'.

Romme and Escher, who work closely with the HVN, have been instrumental in reframing voice hearing within this normalising framework, addressing this continuity of experience. In several studies exploring the experiences of voice hearers (Romme & Escher, 1989, 1996, 2000; cited in Escher et al, 2004) Romme & Escher found that the onset of
voices was precipitated by a traumatic experience in 70 % of cases. Similarly, others have reported voice hearing following adversity such as bereavement, sexual abuse, and torture (Kingdon & Turkington, 1994; Ensink, B., 1993; Read, et al 2004). This indicates that voices can be understood as meaningful within the context of the person’s life (Romme & Escher, 2000).

However, the question may be asked, if hearing voices is understandable, and not inherently pathological or distressing, why do some people find the experience so debilitating and struggle to cope, whilst others do not? In order to explore this question and elucidate the factors which impact upon distress and coping, Romme et al (1992) and others (Honig et al., 1998; Davies et al., 2001; Johns et al, 2002; Jones et al., 2003) have compared the experiences of clinical and non clinical hearers19.

1.5 Comparisons of Clinical and Non-Clinical Voice Hearers
Romme et al, (1992) compared the experiences of 97 clinical and 76 non-clinical voice hearers and found little difference in voice characteristics. However, they found factors distinguishing the two groups were that non-clinical hearers had more social support and communicated more about their voices. Also those who perceived themselves as weaker and less powerful than the voice and could not set boundaries with it felt less able to cope.

Leudar et al, (1997) compared the experience of 14 clinical and 14 non-clinical hearers. They found no significant difference between the two

19 Throughout this study the term clinical voice hearers will be used to represent those people who hear voices and are in contact with mental health services. The term non-clinical refers to those who hear voices and are not receiving mental health services.
groups in terms of whether voices were experienced only once or recurrently, or in whether the voices were 'aligned' (identifiable as someone in the hearer's social world) or 'incognito' (unidentifiable). However, non-clinical hearers reported voices which sounded like family members or themselves significantly more frequently than clinical hearers. Clinical hearers reported voices which sounded like public figures, acquaintances or supernatural characters significantly more often. Also, 100% of the clinical group had experienced voices which directed them to carry out specific actions, compared with only 38% of non-clinicals (a statistically significant difference). Further voices in the clinical group more often instigated violence and were more often abusive than those in the non-clinical group.

Further Honig et al, (1998) compared voice hearing experiences in a clinical (n=33) and non-clinical (n=15) sample. Clinical hearers regarded the content of the voices to be significantly more neutral or negative, were more afraid of the voices and felt their voices controlled them, causing disruption to their daily life. Non-clinical hearers reported feeling able to keep their voices under control possibly because the voices were predominantly positive and non-threatening (Honig et al, 1998).

Taken together, the evidence from these studies indicates that there are few differences in the form of voice hearing experience between clinical and non-clinical hearers. However, there are differences in terms of negative content, ability to cope and levels of distress. This then supports the assertion that voice hearing cannot be seen as categorical, or as unequivocally associated with distress, but as lying on a continuum of experience (Johns et al, 2002). Consequently it is suggested that it may be
the framework within which the individual understands the voice that influences the degree to which it is construed as negative and distressing, and subsequent contact with services (Jackson & Fulford, 1997; Jones et al, 2003).

As outlined, there is evidence that the meanings and beliefs attached to voice hearing experiences vary greatly between Eastern and Western cultures, which appears to impact the degree of distress experienced. Close & Garety (1998) suggest that in Western societies being given a 'mental illness' label and a medical framework within which to understand voices may lead to distress because of stigma and prejudice. Also, within Western society, sub-cultures can significantly impact the way experiences are understood. For example, Jackson & Fulford (1997) and Davies et al, (2001) found that voices understood as spiritual in origin were perceived to have adaptive and life-enhancing consequences, whereas those seen as psychotic led to lead to negative social and behavioural consequences. Davies et al, (2001) suggested that the difference was explained by religious groups' access to organised belief-validation and social-support; giving positive meaning to the voices, decreasing associated distress, fear and stigma.

Thus it seems that it is the interpretation of voice hearing experiences, mediated by individual, cultural and sub-cultural beliefs which dictate emotional and behavioural responses (Jackson & Fulford, 1997; Davies et al, 2001; Jones et al, 2003; Thomas et al, 2003). It is hypothesised that this influences the likelihood that people will seek, or be identified by others as requiring, help from mental health services.
1.6 Beliefs about Voices- The Cognitive Model

The above evidence clearly suggests that the emotional and behavioural response to voice hearing is mediated by beliefs and appraisals of the voices, rather than solely the form, topography and content. The question this posed to researchers was “how are the content and form of the voices, and the person’s cognitive, affective and behavioural responses connected?” (Chadwick & Birchwood, 1994). Several studies have explored this question with clinical voice hearers (Chadwick & Birchwood, 1994; Birchwood & Chadwick, 1997; Close & Garety, 1998).

Chadwick & Birchwood (1994) applied Beck’s (1976) cognitive model of depression to the experience of voice hearing, proposing that emotional and behavioural responses to voices cannot be understood solely in relation to form and content. Rather, they derive from the beliefs individuals construct in an attempt to understand and make sense of the experience. Utilising this theory with 26 voice hearers, Chadwick & Birchwood (1994) identified the importance of beliefs about power; hearers who perceived their voices to be more powerful than themselves experienced more fear and distress than those who felt their voices to be less powerful than themselves. Specifically, it was suggested that four types of belief were of importance: beliefs about the voice’s identity; its intent (malevolent or benevolent); its power (or omnipotence); and the consequences of obedience and disobedience.

Birchwood & Chadwick (1997) conducted a further investigation of this model with 62 clinical voice hearers, using the Beliefs about Voices Questionnaire (BAVQ; Chadwick & Birchwood, 1995). In line with their
proposed model, beliefs about voices were shown to have a significant impact on affective responses. Those who believed their voice to have benevolent intent were significantly less distressed than those who believed their voices to be malevolent. Also, beliefs about the voices' omnipotence and malevolence were found to be associated with feelings of depression and helplessness.

Also in line with their 1994 model, beliefs about voices were demonstrated to impact upon behavioural responses; voices believed to be malevolent were resisted significantly more than benevolent voices, which were more often engaged with. Furthermore, as in their 1994 study, in the majority of cases, beliefs about the voice's intent (malevolent, benevolent or benign) could not be directly understood by the content of the voices; that is positive or neutral voice content did not always result in beliefs that the voice had benevolent intent. This then provided further evidence to support the hypothesis that the form and content of voices alone was not sufficient to account for distress and behavioural responses in most peoples' experience.

With the incongruity between voice content and beliefs about the voices' intent found by Chadwick & Birchwood (1994) and Birchwood & Chadwick (1997), other factors appeared to be influencing whether the voice was conceived of as benevolent or malevolent. Birchwood & Chadwick (1997) suggested that, as highlighted by Benjamin (1989) voice hearing is essentially interpersonal, involving a relationship with the voice. Therefore it is likely that a person's 'core beliefs' or schemata regarding relationships and interpersonal functioning generally, may influence beliefs about the voice's power and intent. These schemata are
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hypothesised to originate in early life experiences (particularly early attachments) which then impact upon future relating experiences (i.e., Blatt & Zuroff, 1989, cited in Birchwood & Chadwick, 1997), including those with the voice.

Close & Garety (1998) attempted to replicate the work of Birchwood & Chadwick (1997), however in their interviews with 30 clinical voice hearers, they found only partial support for the earlier findings. Unlike Birchwood & Chadwick (1997), Close & Garety (1998) found a direct relationship between the content of voices and beliefs about their malevolence or benevolence. Further, Birchwood & Chadwick (1997) had found that affective responses of distress and depression were associated with the belief that the voice had malevolent intent. However, contrary to these findings, Close & Garety (1998) found that the voice hearing experience sometimes led to negative affect, even when the voice was perceived as benevolent. It was hypothesised by the authors that this finding may be linked to the hearer being unable to control the experience, regardless of the fact that the voice may be believed to have benevolent intent.

In their study, Close & Garety (1998) also extended the work of Birchwood & Chadwick (1997) by examining the role of self esteem. They hypothesised that behavioural and emotional responses to voices are not only mediated by the beliefs a person holds about the voice but also the appraisal of the voice in relation to the self. They suggested therefore that self esteem, in addition to the factors identified by Birchwood & Chadwick (1997) would be responsible for mediating emotional and behavioural responses. In line with this hypothesis, they found that of the majority of
participants (93%) who experienced negative emotions in response to the voices, 76% were classified as having low self esteem and 82% demonstrated negative appraisals of themselves.

Therefore, Close & Garety (1998) proposed a revision to the cognitive model devised by Chadwick & Birchwood (1994) to include the influence of these negative self appraisals. They suggested that voice hearing may trigger negative core beliefs about the self (such as ‘I am useless and worthless’), which lead to affective and behavioural responses (fear, anxiety, distress, withdrawal) which then work reciprocally to strengthen the negative core beliefs.

Van der Gaag et al. (2003) attempted to reconcile the differences found in previous studies (Chadwick and Birchwood, 1994; Birchwood & Chadwick, 1997; Close and Garety, 1998) regarding whether or not voice content determines beliefs about the voices’ malevolence or benevolence. Van der Gaag et al. (2003) suggested that disagreement between these earlier studies stemmed from the fact that voice content had not been rigorously assessed. Therefore, they assessed voice content using two raters and data was only included when there was agreement from both as to nature of voice content. Beliefs about voices were assessed using the BAVQ (Chadwick & Birchwood, 1995).

Their findings offered partial support for Chadwick and Birchwood’s (1994) cognitive model in that beliefs about the voices identity and malevolence were related to distress, anxiety and depression and attempts to resist the voice (Van der Gaag et al., 2003). However, with regard to voice content, their findings were in agreement with Close & Garety (1998)
in that voice content was demonstrated to be predictive of beliefs about the voices malevolent or benevolent intent. Van der Gaag et al (2003) reported that it was rare for voice content and beliefs about the voice to be unrelated, although they did find that where voice content was neutral, people tended to hold mixed beliefs about the voice’s intent. Unfortunately, this study did not utilise the revised BAVQ-R (Chadwick et al, 2000) to assess beliefs, which includes more response items and is psychometrically more robust than the earlier version used.

Taken together, the results of these studies investigating cognitive aspects of voice hearing provide support for the idea that beliefs about voices’ intent are involved in mediating emotional and behavioural responses to the experience. The studies also advanced this idea further, highlighting the role of the hearer’s core beliefs about the self, beliefs about the self in relation to the voice and previous relating experiences. Therefore, more recent research has examined this interpersonal nature of the voice hearing experience in more detail.

1.7 Interpersonal Aspects of Voice Hearing

Research has demonstrated that many hearers view the voice as having a stable identity and personality, distinct from themselves or their own thoughts (Leudar & Thomas, 2000; Romme & Escher 1993). Leudar et al, (1997) found that among 28 voice hearers (both clinical and non-clinical) most of their voices were gendered, had a determinable age and were aligned with individuals they knew.

Benjamin (1989) was one of the first researchers to directly explore voice hearers’ relationships with voices. She interviewed 30 clinical hearers
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using the Structural Analysis of Social Behaviour measure. Benjamin (1989) found that hearers could easily conceptualize their voice as though it was another person and that the voices commonly reflected interpersonal experiences with people in the hearer’s social world. She concluded that voice hearers had ‘integrated, personally coherent relationships with their voices’, which served an adaptive function by helping to define the self in more satisfying ways than was apparent in reality.

Similarly, Nayani and David (1996) interviewed 100 voice hearers and found that voices were personified and many were identified as someone from the hearer’s social world. They also identified that individuals felt a sense of intimacy with the voice, arising from their knowledge of the voice and reciprocally, the voice’s knowledge of them. The authors likened this to the omniscience (all knowing) concept described by Birchwood and Chadwick (1994). Also, those who engaged in dialogue with their voices described increased personal intimacy and were significantly less likely to experience distress.

As described earlier, Leudar et al., (1997) investigated the characteristics of voices with 28 hearers, both clinical and non-clinical. Consistent with Nayani and David’s (1996) study, they found that the majority of voices were personified and aligned with others in the social world. Voices often initiated dialogue; however hearers from the clinical group were significantly less likely to engage with the voice than the non-clinical group. It was found that withdrawing from the voice in this way was associated with increased negative repetition by voices. More recently, Garrett & Silva (2003) found evidence that voice hearers made
interpersonal attributions about voices, perceiving it as a 'real' person. They suggested that this construal of the voice as 'human-like' facilitates the development of emotional, interpersonal relationships (Garrett & Silva, 2003).

Taken together these studies highlight the reciprocal and relational nature of the voice hearing experience. Therefore, having previously identified the importance of perceptions of power (Chadwick & Birchwood, 1994; Birchwood & Chadwick, 1997), Birchwood et al (2000) further explored this concept within a relational framework, using social ranking theory (Gilbert & Allen, 1998).

1.8 The Application of Social Ranking Theory
Social ranking theory suggests that hierarchical positions (or ranks) within society are formed through a process of comparison with others, for example as more or less powerful. These comparisons are based upon a person's interpersonal schema (or core beliefs), which then determine affective and behavioural responses to others. Gilbert & Allen (1998) state that stimuli perceived to be of relative power and threat will activate defensive responses such as submission or withdrawal, and associated feelings of entrapment and defeat. In contrast, stimuli perceived as safe will lead to cooperation and possible dependence.

Birchwood et al, (2000) therefore proposed that voice hearers reporting distress in response to a powerful voice, would have interpersonal schema which predisposed them to negative social comparisons and subordination to others. They also hypothesised that there would be an association between social relationships and relationships with voices in
terms of power and subordination. Supporting this hypothesis, Birchwood et al, (2000) interviewed 59 voice hearers and found that the perceived power difference between self and others in the social world was a main predictor of that between voice and hearer. Also, as predicted in social ranking theory, those who perceived themselves to be more subordinated to the voice, were more likely to experience distress and depression.

Birchwood et al, (2004) found further evidence to support this model through a study of 125 clinical voice hearers. It was found that participants commonly appraised the voices as powerful and dominant and themselves as subordinate and powerless, and that distress was positively correlated with degree of subordination. In line with their previous study, experiences of relating to voices mirrored experiences of social relationships. It was also found that appraisals of power and subordination were independent of mood linked appraisals. Through the use of structural equation modelling Birchwood et al (2004) were able to conclude that interpersonal schema or 'core beliefs' affect subsequent appraisal of the voice as powerful and malevolent, which in turn dictate the hearer's emotional and behavioural responses to the experience.

Therefore, studies utilising social ranking theory and earlier studies by Chadwick & Birchwood (1994) and Close & Garety (1998), highlight the importance of interpersonal power structures within the voice hearing experience. However, it has been suggested that focussing on the dimension of power within the relationship with the voice does not reflect the complex nature of interpersonal relating (Hayward, 2003) and that other dimensions are likely to be influential. One such influential factor
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highlighted by several authors is that of intimacy (Birchwood & Chadwick, 1997; Leudar et al, 1997; Close & Garety, 1998; Nayani & David, 1998). A theoretical framework which addresses dimensions of both power and proximity (likened to intimacy) is Birtchnell’s theory of relating (1996; 2002).

1.9 Birtchnell’s Theory of Interpersonal Relating

Birtchnell (1996; 2002) provided a framework for understanding ways of relating socially, based upon the two dimensions of power and proximity. In this model proximity describes the distance that exists between two people and therefore can be understood as the degree of intimacy. Power describes the amount of influence that one has over another. These two dimensions are represented as two intersecting axes; the horizontal proximity axis (with endpoints Distance and Closeness) and the vertical power axis (with end points Upperness and Lowerness), as represented in Figure 1.

The endpoints of each of the 2 axes represent the four main relating positions, with four intermediate positions (Upper Close, Lower Close, Lower Distant and Upper Distant), the characteristics of which are a combination of those positions on either side of them. Birtchnell termed this structure the Interpersonal Octagon.
Birtchnell proposes that each of the positions within the octagon (termed 'states of relatedness') is potentially desirable and advantageous, depending upon the situation. For example, we may need to adopt a different power and proximity position in relation to a colleague, than we would with a parent. We may also need to vary the way we relate to the same person at different times. Birtchnell states that those competent in relating have had positive experiences in each of the eight positions throughout their childhood development, and have thereby developed 'versatility' in moving between the positions. This is defined as positive relating (see Figure 2).
However, if childhood relating experiences have been more negative and limited, the person may be unable or unwilling to achieve these positive states of relatedness. This unversatile form of relating is defined by Birtchnell as negative relating (see Figure 3). In addition to early relating experiences, relating competence is also dependent upon the process of 'interrelating', that is, the combination of relating, and being related to (Birtchnell, 2001). Therefore, an 'unversatile' other can impose negative relating or deny positive relating. This will then compromise the
individual’s confidence and competence in positive relating, which may lead to distress.

Figure 3. Birtchnell’s Negative Interpersonal Octagon

Key- UN Upper Neutral; UC Upper Close; NC Neutral Close; LC Lower Close; LN Lower Neutral; LD Lower Distant; ND Neutral Distant; UD Upper Distant.

From this theory Birtchnell & Evans (2004) developed The Persons Relating to Others Questionnaire (PROQ2) which assesses general unidirectional relating of a person, to others in their social world. Birtchnell (2001) also developed the Couples Relating to Each Other
Questionnaire which assesses reciprocal negative relating between couples (both to and from each partner).

1.10 Exploring Voice Hearing using Birtchnell's Framework

Vaughan and Fowler (2004) used Birtchnell's (1996; 2002) model to explore the association between interrelating between the voice and hearer, and distress. Specifically, they hypothesised that 'negative' styles of relating between the hearer and their predominant voice would be associated with distress, independent of depression and beliefs about the voice’s intent (malevolent or benevolent). Two measures of relating were developed from the CREOQ: The Voice to Hearer Questionnaire (VTH) and Hearer to Voice Questionnaire (HTV). Distress was assessed on a 5-point likert scale with end points 'not at all distressed' and 'very distressed indeed'. The BAVQ (Chadwick & Birchwood, 1995) was used to assess the hearer's beliefs about the voices' intent and omnipotence and the Beck Depression Inventory II was used to assess mood. These measures were administered to 30 clinical voice hearers.

The results demonstrated that two styles of relating were significantly associated with distress: Perceived dominating and insulting voice relating (Voice Upperness) and hearer suspiciousness and lack of communication (Hearer Distance). There was also a small but significant correlation between Voice Closeness and distress. Multiple regression analysis suggested that these relating styles were uniquely predictive of distress, independent of beliefs about voices malevolence and benevolence, and mood. However, it has been suggested that, when using multiple regression analysis, 20 times more cases than predictor variables should be used (Tabachnick & Fidell, 2001). Therefore with a sample size of 30 the
use of multiple regression was not methodologically sound and conclusions about the uniqueness Voice Upperness and Hearer Distance in predicting distress must be viewed with caution.

The findings provide some tentative support for the suggestion that styles of relating to and by the voice, with respect to power & proximity, are significant in determining the affective response to voice hearing (e.g. Birchwood & Chadwick, 1997; Leudar et al, 1997; Close & Garety, 1998; Nayani & David, 1998). The results also suggest that resistance behaviour is associated with distress. A further unexpected finding of the study was that Hearer Lowerness (subordination) was significantly negatively correlated with distress. The authors hypothesized that this could reflect a response by the voice hearer, whereby they give up the fight to be 'Upper', arriving at acceptance and thus decreased distress.

Contrary to previous research (e.g. Chadwick & Birchwood, 1994), Vaughn & Fowler (2004) found that not all hearers perceived their voice to be omnipotent, although this was common. It was found that those who believed their voices to have malevolent intent tended to relate from a position of Distance, which was associated with distress. However, there were no significant differences in styles of relating between those who did and did not perceive their voice to be omnipotent. Unfortunately, Vaughn & Fowler (2004) used the BAVQ to measure beliefs about voices, which has been criticised for its lack of sensitivity in detecting variations in beliefs due to its 'yes' or 'no' response options, and its lack of reliability in measuring the construct of omnipotence (Chadwick et al, 2000). This further limits the conclusions which can be drawn from this study.
The authors concluded that their results provide further evidence for the importance of power structures between voice and hearer in mediating distress, as suggested by the cognitive model (Birchwood et al, 1997; 2000). They also proposed that as the associations between relating styles (Hearer Distance & Voice Upperness) and distress were independent of beliefs about voices, it is not simply a hearer’s beliefs about the voice’s power that leads to distress. Rather, they concluded that it is the way in which the voice is perceived to use its power, for example by being intimidating or tyrannising (Vaughn & Fowler, 2004).

Hayward (2003) provided further evidence for the applicability of Birtchnell’s (1996; 2002) theory to the experience of voice hearing, investigating further the hypothesis that ways of relating to the voice mirror patterns of relating socially. Hayward used the HTV, (called the You to Voice in his study) to measure voice relating and the PROQ2 (Birtchnell & Evans, 2004) to measure social relating. In his sample of 27 clinical hearers, Hayward (2003) found that styles of relating socially were correlated with styles of relating to the voice on three of the four scales of relating (the main positions on Birtchnell’s interpersonal octagon). These were the positions of Upperness, Lowerness and Closeness, but not Distance. This therefore provided further support for the hypothesis that voice relating mirrors social relating, which is influenced by core interpersonal schema.

Sorrell (2006) sought to replicate the findings of Vaughn & Fowler (2004) and to further test the hypothesis that negative styles of relating between the voice and hearer are associated with distress and consequent service use. In addition, Sorrell (2006) examined this hypothesis in both a clinical
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(n=32) and a non-clinical sample (n=18) which had not previously been explored.

Sorrell (2006) also attempted to overcome a number of the methodological limitations of the Vaughn & Fowler (2004) study. Firstly she used the Voice & You questionnaire (VAY; Hayward, et al 2005) to measure relating styles. The VAY assesses four subscales: Voice Dominance (corresponding to Voice Upperness), Voice Intrusiveness (Voice Closeness), Hearer Dependence (Hearer Lowerness and Closeness) and Hearer Distance and is considered to be psychometrically and theoretically more robust than the HTV and VTH measures (Hayward et al, 2005), used by Vaughn & Fowler (2004). Sorrell (2006) also utilised the more sensitive and psychometrically sound revised version of the BAVQ (BAVQ-R, Chadwick et al, 2000) to measure beliefs about voices and used a larger sample size.

Sorrell (2006) compared the experiences of the clinical and non-clinical groups in terms of distress, general characteristics, relating styles and beliefs about voices. As predicted from previous work (e.g. Romme & Escher, 2000), Sorrell’s findings showed that the clinical sample were significantly more distressed than the non-clinical sample. In terms of characteristics of the experience, it was found that in the non-clinical sample, voices occurred significantly less frequently than in the clinical group, had significantly less negative content, were significantly quieter, and were significantly more controllable. There was no significant difference between the two groups with regard to voice identity.

In terms of beliefs about voices, Sorrell (2006) found that non-clinical hearers believed their voices to be significantly less omnipotent and
malevolent, and significantly more benevolent than the clinical hearers. Therefore, in line with Birchwood & Chadwick's (1994; 1997) cognitive model, these findings indicate that beliefs about the voices' power and intent are significant in determining distress and service use. In terms of differences in relating styles between the two groups, Sorrell (2006) found that hearers from the non-clinical sample related to their voice in significantly less negative ways than those from the clinical sample, who typically related from a position of Distance.

Further, hearers from the non-clinical sample primarily related from a position of Dependence (a combination of submissiveness and intimacy, and thus engagement), which provides tentative support for the suggestion that increased dialogical engagement with voice reduces distress (Nayani and David, 1996; Romme et al, 1992). Taken together, the comparisons of the styles of relating and beliefs about voices in the clinical and non-clinical sample suggest that negative relating styles and beliefs that the voice is malevolent and omnipotent, may lead to increased distress in response to the experience of voice hearing.

In order to further examine the hypothesis that relating styles are associated with distress Sorrell (2006) conducted correlational analysis on the data, in both the clinical and non clinical sample. In line with the work of Vaughn & Fowler (2004) Sorrell (2006) found support for this hypothesis; in both the clinical and non-clinical sample Voice Dominance (Birtchnell's Upperness), Voice Intrusiveness (Birtchnell's Closeness) and Hearer Distance were positively correlated with distress. These associations were statistically significant in the clinical sample, although
only that between distress and Hearer Distance reached significance in the non-clinical sample.

However, in contrast to Vaughn & Fowler (2004) the associations between relating styles and distress were not independent of beliefs about the voices omnipotence (power) and malevolent intent (Sorrell, 2006), although they were independent of beliefs about benevolence. Therefore, whilst Vaughn & Fowler (2004) suggested the primacy of relating styles in predicting distress, Sorrell concluded that it is a combination of both relating styles and beliefs about voices (specifically malevolence and omnipotence) which determines distress. These beliefs may mediate the association between relating styles and distress, or alternatively, there may exist a circular relationship between these variables (Sorrell, 2006).

1.11 The Current Study
As outlined, a growing body of research demonstrates the significant role of negative styles of relating and beliefs about voices in mediating distress associated with the experience. However few studies have explored these longitudinally.

There have been a number of prospective and retrospective long-term follow-up studies of voice hearing (Garralda, 1984; Poulton et al, 2000; cited in Escher et al, 2004). However there is a gap in the literature around short-term follow-up studies, which are necessary in order to identify factors that influence the short term course of the experience; to date only two studies have utilised this design. The first was carried out by Escher et al, (2002), who explored the experiences of eighty voice hearing children, from both clinical and non-clinical samples, sequentially over three years.
This study identified that voice persistence over the three years was associated with increased frequency and severity of voices, and that the clinical sample tended to use more passive coping strategies (Escher et al, 2002). However, their study did not directly assess beliefs about voices or explore the relational nature of voice hearing. Also, as their study was conducted with children, with a 60% rate of voice discontinuation over the 3 years, the findings cannot be extrapolated to an adult population.

The only other reported short-term sequential follow-up study of voices was carried out by Csipke & Kinderman (2006). This study investigated the short-term course of beliefs about voices’ intent, for clinical hearers over a six-month period. As this was the first longitudinal study of beliefs about voices, the study was exploratory and two competing hypotheses were offered; 1) Beliefs about voices are a symptom of the voices themselves and therefore, as frequency or severity changes, so should beliefs about voices’ malevolent or benevolent intent, or 2) Beliefs about voices will not change in response to changes in frequency and severity of voices.

This second hypothesis was based upon traditional cognitive behavioural models of voices (i.e., Morrison, 1998), similar to the cognitive behavioural model of anxiety. These suggest that beliefs about a voice’s malevolent intent lead to feelings of threat, and consequently, safety seeking behaviours and selective attention. These behaviours then prevent disconfirmation of beliefs, which are consequently strengthened and maintained, regardless of the current frequency and severity of voices. Csipke & Kinderman (2006) also predicted that distress would not change
independently of beliefs about voices, which they proposed to underlie emotional responses.

Forty-six clinical voice hearers were recruited and data was collected at monthly intervals, for six months. Frequency and severity of voices was measured using the Positive & Negative Syndrome Scale (PANSS; Kay et al, 1987) and beliefs about voices using the Longitudinal Auditory Hallucinations Assessment Schedule (LAHAS; designed by the authors for this study). In order to assess beliefs about the voice's intent, the LAHAS asks hearers to self-report on scales of 0-10 whether the voice has intent to help them and has intent to harm them (benevolent and malevolent intent respectively). Those participants scoring four or more on each scale were classified as believing their voice had benevolent/malevolent intent.

At baseline, 19 individuals reported their voice had malevolent intent, eight as having benevolent intent, 14 as having neutral intent and five as having both malevolent and benevolent intent. Due to attrition throughout the study, only 16 voice hearers provided full data-sets across the six months. Within this sample of 16, no significant differences were found over the six time points for the hearers' beliefs about the voices' malevolent or benevolent intent. However, over the 6 months, the frequency and severity of voices decreased significantly across the whole sample.

Therefore, Csipke & Kinderman's (2006) results supported their second hypothesis, that beliefs about voices are enduring and stable, irrespective of immediate frequency and severity of voices. Csipke & Kinderman
(2006) interpreted this as supporting the cognitive-behavioural model of voices proposed by Morrison (1998), suggesting that beliefs about voices do not change without a specific intervention. Further, as predicted by Csipke & Kinderman (2006) distress did not change independently of beliefs about voices. This is in line with the findings of Sorrell (2006), which suggested that beliefs about the voices' intent are significant in determining a person's emotional and behavioural response to the experience.

Csipke & Kinderman's (2006) study has several limitations. Firstly, beliefs about the voices power were not assessed, despite power previously having been shown to be important in determining emotional and behavioural responses (Chadwick & Birchwood, 1994; Chadwick & Birchwood, 1997; Birchwood et al, 2004; Vaughn & Fowler, 2004; Sorrell, 2006). Further, beliefs about voices' benevolent or malevolent intent were assessed using one question each; it can be argued that this lacks sensitivity in picking up variation in different facets of these constructs (for example, the voice may be deemed to be helpful/harmful in some aspects of life, but not in others).

Further, in their cognitive model of the maintenance of the emotional and behavioural response to voices, Chadwick & Birchwood (1994;1997) suggest that beliefs about voices' intent 'are not static and unchanging' (pp.1351) but are likely to change in the context of an unfolding relationship. Therefore, replication of this study is required in order to address these limitations and clarify the findings.
Whilst Vaughn & Fowler (2004) and Sorrell (2006) have provided support for the hypothesis that relating styles are associated with distress, there are no longitudinal studies (either short or long term) which examine the voice hearing experience within a relational framework. However, several studies suggest that relationships with voices are likely to develop and change over time. Nayani and David (1996) gained some sense of developmental trends in the voice hearing relationship over time by comparing those hearers with recent onset of voices (< 1 year; n=13) and the remainder of the sample (>1 year; n=87). They found that the evolution of voices over time appeared to entail increasing intimacy and detailed dialogues with voices, which was associated with decreased distress. This suggests that relating styles may change over time, specifically on the axis of proximity, with the hearer moving towards a position of Dependence. In line with the findings of Vaughn & Fowler (2004) and Sorrell (2006), this suggests that Hearer Dependence is negatively associated with distress.

Chin (2005) conducted a qualitative investigation of ten clinical hearer’s relationships with their voices which provided further support for the existence of these observed trends. Chin (2005) found that developments in the relationship over time were evident for all participants, and that engagement with the voice appeared to facilitate this process. Only by using multiple strategies in interactions with the voice, was the hearer able to move from being paralysed with fear, to developing a more resilient and reflexive approach. However, it is not possible to infer over what period of time these developments may occur as these studies did not employ longitudinal methodology.
In a recent qualitative study Fuller (2006) explored three clinical voice hearers' experiences of a pilot form of 'relating therapy', along with the perceptions of both relatives and carers. One emerging theme from the participant's accounts was that of 'entrenched relating styles', whereby people described being 'fixed' in negative ways of relating with voices. Therefore participants conceived of change in interrelating, specifically a move towards more assertive engagement with the voice, as difficult and unlikely. Factors which participants believed maintained negative patterns of relating included: the idea that voice hearers may have adopted (and been encouraged to adopt) a 'patient' or victim role over the duration of their voice hearing experience; cultural or religious backgrounds where assertive ways of relating are not encouraged or modelled, particularly in females; and the functional role of particular ways of relating, for example serving to dilute a person's sense of shame.

Thus it can be seen that several factors are likely to be associated with the degree to which interrelating between the hearer and voice will change in the way observed by Nayani & David (1996) and Chin (2005). Fuller's (2006) findings support the notion that relating styles are associated with distress, as despite identified barriers to change, clients described positive changes following engagement in relating therapy, including decreased distress. However, it is currently unknown how styles of relating are likely to change over time in the absence of such psychological interventions. Therefore, more specific short-term longitudinal follow-up of interrelating between the voice and hearer is necessary. This will help to determine whether styles of relating between voice and hearer are stable over time, and to clarify the relationship between relating styles and distress.
The research outlined above, which has explored longitudinal aspects of voice hearing in terms of beliefs about voices and relating styles, has looked only at the experiences of clinical voice hearers. However, clinical voice hearers have been shown to differ significantly from non-clinical hearers in terms of beliefs about the voices intent and power (Honig et al, 1998; Sorrell, 2006), with clinical hearers perceiving their voices to be more malevolent and omnipotent.

Also evidence suggests that clinical voice hearers are likely to relate to their voice in significantly more negative ways than non-clinical hearers (Sorrell, 2006). Therefore it is currently unknown whether the stability of beliefs about voices over-time (Csipke & Kinderman, 2006) and developmental trends observed in interrelating (Nayani & David, 1996; Chin, 2005; Fuller, 2006) can be extrapolated to non-clinical voice hearers. Longitudinal research examining beliefs about voices and interrelating in a non-clinical sample is required in order to clarify this issue.

Therefore the current study was intended to:

1) Extend previous research which has applied Birtchnell’s framework of relating to the voice hearing experience (Vaughn & Fowler, 2004; Sorrell, 2006) by undertaking short-term longitudinal exploration of voice hearers’ relationships with their voices, in both a clinical and non-clinical sample.

2) Extend the work of Csipke & Kinderman (2006) in three ways. Firstly by using a measure of beliefs about voices which is sensitive and psychometrically sound (BAVQ-R, Chadwick et al, 2000). Secondly by
assessing hearers’ beliefs about the voices omnipotence, and thirdly by investigating the longitudinal course of beliefs about voices in a clinical and non-clinical sample.

1.12 Aims and Hypotheses

Aim 1
To describe and explore any changes occurring in interrelating between the predominant voice and voice hearer at 12 month follow up, in a clinical and non-clinical sample.

Hypothesis 1
Changes in Voice Upperness, Voice Closeness and Hearer Distance will be positively correlated with changes in level of distress (Vaughn & Fowler, 2004; Sorrell, 2006).

Hypothesis 2
Changes in Hearer Dependence will be negatively correlated with changes in level of distress (Vaughn & Fowler, 2004; Sorrell, 2006).

Aim 2
To explore any changes occurring in beliefs about voices’ malevolence, benevolence and omnipotence at 12 month follow up, in a clinical and non-clinical sample.
Method

2.1 Design

The purpose of the current study was to explore the 12-month longitudinal course of i) styles of relating between voice and hearer and, ii) beliefs about voices, in both a clinical and non-clinical sample. A further aim of the study was to examine whether any changes occurring in styles of relating and beliefs about voices were associated with changes in levels of distress.

In order to determine whether there had been a change in the style of relating between the voice hearer and their voice, and a change in beliefs about voices, a prospective, longitudinal within-participants design was used. In order to determine whether any changes in relating styles and change in beliefs about voices were associated with changes in level of distress, a correlational design was used.

2.2 Participants

2.2.1 Selection Criteria & Recruitment

Clinical participants were recruited at Time 1 from adult mental health services in three NHS Mental Health Trusts. The criteria for inclusion in the study were: being aged between 18 and 65 and being in receipt of mental health services and having heard voices for at least six months, irrespective of psychiatric diagnosis. People were excluded from the study if: voice hearing was assessed as likely to be a consequence of substance misuse or organic illness or currently experiencing acute psychosis or distress which meant they were not able to give informed
consent or lacking the English language skills necessary to complete the interviews and questionnaires.

Non-clinical participants were recruited at Time 1 via a radio broadcast, an article in a national newspaper and spiritualist publication, a newsletter for hearing voices groups and a conference dedicated to the experience of hearing voices. The inclusion criteria were being aged over 18 and having heard voices for at least six months and not to be currently using mental health services.

The demographic characteristics and mental health service contact of the participants recruited at Time 1 the original study are presented in Tables 1 & 2 respectively.

**Table 1. Demographic characteristics of participants at Time 1**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole sample n = 50</th>
<th>Clinical sample n = 32</th>
<th>Non-clinical sample n = 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25 (50)</td>
<td>19 (59)</td>
<td>6 (33)</td>
</tr>
<tr>
<td>Female</td>
<td>25 (50)</td>
<td>13 (41)</td>
<td>12 (67)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>47 (94)</td>
<td>31 (97)</td>
<td>16 (88)</td>
</tr>
<tr>
<td>Any other mixed</td>
<td>1 (2)</td>
<td>--</td>
<td>1 (6)</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1 (2)</td>
<td>--</td>
<td>1 (6)</td>
</tr>
<tr>
<td>No response</td>
<td>1 (2)</td>
<td>1 (3)</td>
<td>--</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>44.26 (13.13)</td>
<td>38.1 (11.9)</td>
<td>54.3 (13.15)</td>
</tr>
</tbody>
</table>
Table 2. Mental health service contact of participants at Time 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole sample n=50</th>
<th>Clinical sample n=32</th>
<th>Non-clinical sample n=18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Diagnosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>32 (64)</td>
<td>30 (97)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>no</td>
<td>17 (34)</td>
<td>--</td>
<td>17 (94)</td>
</tr>
<tr>
<td>missing</td>
<td>1 (2)</td>
<td>1 (3)</td>
<td>--</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>21 (42)</td>
<td>20 (62)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>4 (8)</td>
<td>4 (13)</td>
<td>--</td>
</tr>
<tr>
<td>Psychotic depression</td>
<td>4 (8)</td>
<td>4 (13)</td>
<td>--</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>1 (2)</td>
<td>1 (3)</td>
<td>--</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2 (4)</td>
<td>2 (6)</td>
<td>--</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>17 (34)</td>
<td>--</td>
<td>17 (94)</td>
</tr>
<tr>
<td>Missing</td>
<td>1 (2)</td>
<td>1 (3)</td>
<td>--</td>
</tr>
<tr>
<td>Medication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32 (64)</td>
<td>32 (100)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>No</td>
<td>17 (36)</td>
<td>--</td>
<td>17 (94)</td>
</tr>
<tr>
<td>Hospital admission?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28 (56)</td>
<td>27 (84)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>No</td>
<td>22 (42)</td>
<td>5 (16)</td>
<td>17 (94)</td>
</tr>
<tr>
<td></td>
<td><strong>Mean (SD)</strong></td>
<td><strong>Mean (SD)</strong></td>
<td><strong>Mean (SD)</strong></td>
</tr>
<tr>
<td>Number of admissions</td>
<td>2.92 (3.80)</td>
<td>4.53 (3.83)</td>
<td>0.06 (0.24)</td>
</tr>
</tbody>
</table>

2.2.2 Inclusion at Time 2

Twelve months following initial data collection, all those from the Time 1 sample who continued to meet the inclusion criteria and remained able to give informed consent to further participation were included. Of the 50
participants recruited and interviewed at Time 1, 28 agreed to participate at Time 2, an overall attrition rate of 44%. Of the original 32 clinical participants, 18 (56.25%) were re-interviewed at Time 2. Of the original 18 non-clinical participants, 9 (50%) took part at Time 2. Reasons for non-inclusion in the study at Time 2 are presented in Table 3. The demographic characteristics of these participants are shown in Table 4 and mental health service contact in Table 5.

Table 3. Reasons for non-inclusion in study at Time 2

<table>
<thead>
<tr>
<th>Reason for non-inclusion</th>
<th>Clinical n (% of Time 1 sample)</th>
<th>Non-clinical n (% of Time 1 sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withheld consent to be re-contacted at Time 2</td>
<td>3 (9.38)</td>
<td>1 (5.56)</td>
</tr>
<tr>
<td>Re-contacted but declined 2nd interview</td>
<td>1 (3.12)</td>
<td>4 (22.22)</td>
</tr>
<tr>
<td>Unable to make contact/no reply to correspondence</td>
<td>2 (6.25)</td>
<td>2 (11.10)</td>
</tr>
<tr>
<td>Unable to arrange mutually convenient interview time</td>
<td>2 (6.25)</td>
<td>1 (5.56)</td>
</tr>
<tr>
<td>Participant did not attend interview</td>
<td>3 (9.38)</td>
<td>-</td>
</tr>
<tr>
<td>Participant in hospital or unwell</td>
<td>2 (6.25)</td>
<td>-</td>
</tr>
<tr>
<td>Voices had ceased</td>
<td>1 (3.12)</td>
<td>1 (5.56)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14 (43.75)</strong></td>
<td><strong>9 (50)</strong></td>
</tr>
</tbody>
</table>
Of the 18 clinical participants, four (22.22%) were originally recruited from community mental health teams, three (16.67%) from rehabilitation services, five (27.77%) from Hearing Voices groups, four (22.22%) from a therapeutic group for hearers, one (5.56%) from a residential service and one (5.56%) from an article written in the hearing voices groups newsletter.

Of the nine non-clinical participants who were re-interviewed at Time 2, two (22.22%) were originally recruited via the conference, three (33.33%) via an article written by the lead researcher which was published in a national newspaper and four (44.45%) following publication of an article about the research in a newspaper of the spiritualist church community.

Table 4. Demographic characteristics of participants at Time 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole sample n = 27</th>
<th>Clinical sample n = 18</th>
<th>Non-clinical sample n = 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11 (40.7)</td>
<td>9 (50)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Female</td>
<td>16 (59.3)</td>
<td>9 (50)</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>25 (92.6)</td>
<td>18 (100)</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>Any other</td>
<td>1 (3.7)</td>
<td>--</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>mixed</td>
<td>1 (3.7)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Caribbean</td>
<td>--</td>
<td>--</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>No response</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td><strong>Mean (SD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>45.07 (14.25)</td>
<td>39.39 (9.95)</td>
<td>56.44 (15.2)</td>
</tr>
</tbody>
</table>
Table 5. Mental health service contact of participants at Time 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole sample n=27</th>
<th>Clinical sample n=18</th>
<th>Non-clinical sample n=9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Diagnosis? no</td>
<td>9 (33.3)</td>
<td>--</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>13 (48.1)</td>
<td>13 (72.2)</td>
<td>--</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>3 (11.1)</td>
<td>3 (16.7)</td>
<td>--</td>
</tr>
<tr>
<td>Psychotic depression</td>
<td>1 (3.7)</td>
<td>1 (5.6)</td>
<td>--</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (3.7)</td>
<td>1 (5.6)</td>
<td>--</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>9 (33.3)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Medication? yes</td>
<td>18 (66.7)</td>
<td>18 (100)</td>
<td>--</td>
</tr>
<tr>
<td>Medication? no</td>
<td>9 (33.3)</td>
<td>--</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Hospital admission? yes</td>
<td>16 (59.3)</td>
<td>16 (88.9)</td>
<td>--</td>
</tr>
<tr>
<td>Hospital admission? no</td>
<td>11 (40.7)</td>
<td>2 (11.1)</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.67 (4.19)</td>
<td>5.5 (4.3)</td>
<td>--</td>
</tr>
</tbody>
</table>

2.3 Measures
The current study formed part of a collaboration between 4 trainee clinical psychologists. Three trainee psychologists collected data from the participants at Time 1 in order to explore different hypotheses relating to the voice hearing experience. The current study utilised this Time 1 data and sample in order to investigate the experience longitudinally.
At Time 1, participants were administered the You and Others questionnaire (Phillips & Hayward, 2005), which measures reciprocal interpersonal relating styles between a person and others in their social world, in order to test the hypothesis that a person's relationship with their voice would mirror social relating. However, as this was hypothesis was not supported in Time 1 analysis, this aspect of investigation was not pursued longitudinally, and the YAO was not administered at Time 2. Also at Time 1, participants were administered the Beck Depression Inventory II, (Beck et al, 1996). However this was not re-administered at Time 2 as aims in the current study were not related to mood.

All other measures administered at Time 1 were re-administered in the current study. Each measure is described below and copies are found in Appendix A.

2.3.1 The Voice Relating Interview (Tozer & Hayward, 2005)
The Voice Relating Interview is a semi-structured interview assessing a hearer's relationship with their predominant voice. The interview investigates four styles of relating which correspond to the VAY (Hayward et al, 2005); Voice Dominance, Voice Intrusiveness, Hearer Dependence and Hearer Distance. Qualitative responses are analyzed and relating style is scored as 'yes' or 'no' for each of these four domains. The interview also assesses the content of the voices and the impact of the voice on the hearer's thoughts, feelings and behaviour. The face validity of the interview schedule was confirmed by two mental health service users and Tozer (2006) demonstrated that the schedule has good inter-rater reliability and concurrent validity with the VAY. For the purpose of this study, the Voice Relating Interview Schedule was primarily used as a
tool to help people talk about their experiences and thus this data was not used in statistical analysis.

2.3.2 Psychotic Symptoms Rating Scale (PSYRATS: Auditory Hallucinations Scale) (Haddock et al, 1999)

The PSYRATS consists of two scales designed to rate unusual sensory experiences and beliefs (medically termed hallucinations and delusions). In the present study, the auditory hallucinations scale was used to assess the voice hearing experience. This 11 item scale, administered by the researcher, assesses characteristics of voices such as frequency, duration, severity, loudness, location, degree of negative content and controllability. It also assesses the impact of the voice upon the hearer in terms of distress caused, beliefs about origin of voices and disruption caused to the hearer’s life. A five point ordinal scale is used to rate each of the 11 items from (0-4).

The authors report excellent inter-rater reliability (ranging from 0.79-1.0, Haddock et al, 1999). In the current study, data for nine of the items were collected. Data on the location of the voices (item 3) was not collected as this was deemed to be of limited interest within a relational framework (Sorrell, 2006) and has not been explored in the voice relating literature. Data on beliefs about the origin of voices (item 5) was not collected as a richer more detailed narrative pertaining to beliefs about voices could be collected via the interview schedule and BAVQ-R. The main area of interest for the present study was item 9 which asks how distressing the voice is. The researcher is required to rate the voice hearing experience on the following scale (0 = voices not distressing at all, 1 = voices slightly distressing, 2 = voices are distressing to a moderate degree, 3 = voices are
very distressing, although subject could feel worse, 4 = voices are extremely distressing, feels the worse he/she could possibly feel) based upon discussion with the voice hearer.

2.3.3 Voice and You (Hayward et al, 2005)
The Voice and You (VAY) questionnaire is a 28 item self report measure of the way in which a hearer relates to their voice, and also the way in which the voice is perceived to relate to them.

The VAY measure derives from two earlier questionnaires, the 'Hearer to Voice' (HTV) and the 'Voice to Hearer' (VTH), which assess the bi-directional relating between the voice and hearer. These measures were developed by Vaughan & Fowler (2004) from Birtchnell's measure of relating between couples, the CREOQ, based upon his interpersonal theory (Birtchnell; 1996, 2001). Therefore the HTV and VTH each comprised four subscales, representing the endpoints of Birtchnell's two axes; Upperness & Lowerness (power axis) and Distance & Closeness (proximity axis).

Hayward (2003) measured the correlation between each of the subscales on the HTV and found there was a strong association between the Lowerness and Closeness subscales (r=0.73, p<0.01). From this he hypothesised that, despite belonging to different axes, the subscales may be measuring the single underlying construct of Dependence. This was conceptualised as relating from a position of relative submissiveness, but with a fear of being alone. Further, Vaughn & Fowler (2004) found that the internal reliability of the Voice Lowerness and Voice Distance
subscales of the VTH questionnaire were not adequate and they were not hypothesised to be related to hearer distress.

In response to this, Hayward et al (2005) developed the VAY with revised subscales: Voice Dominance (corresponding to Voice Upperness), Voice Intrusiveness (Voice Closeness), Hearer Dependence (Hearer Lowerness and Closeness) and Hearer Distance. The questionnaire has 28 items, each rated on a 4-point likert scale (0-3) ranging from rarely true to nearly always true. Seven items relate to Voice Dominance, five to Voice Intrusiveness, nine to Hearer Dependence and seven to Hearer Distance. The higher the score, the greater the tendency to relate from that negative position in relation to the other.

The VAY demonstrates good test-retest reliability and acceptable internal reliability. The internal reliability (Cronbach’s alpha) of each subscale is as follows: Voice Dominance = .92, Voice Intrusiveness = .87, Hearer Dependence = .81, Hearer Distance = .80.

2.3.4 Beliefs about Voices Questionnaire - Revised (BAVQ-R; Chadwick et al, 2000)

The BAVQ-R is a self-report measure of a person’s beliefs, emotions and behaviour in response to voices, and was adapted from the original BAVQ (Chadwick & Birchwood, 1995). The 35 item questionnaire forms five subscales: beliefs about the voice’s malevolence (six items), benevolence (six items) and omnipotence (six items), and emotional resistance (four items), emotional engagement (four items), behavioural resistance (five items) and behavioural engagement (five items) with the voice. Each item is rated on
2.3.5 Qualitative Information

In addition to the measures described, further qualitative information was collected regarding whether participants believed that their relationship with their voice had changed over the 12 month period. If so, this was explored further and the hearer's explanation of why this had happened elicited. This data was collected in order to qualitatively enrich the questionnaire data, allowing causal influences to be explored. Participants were also asked if they had received any interventions for their voice hearing (i.e., hearing voices groups, individual or group therapy) and whether any psychotropic medication had been changed over the last 12 month period.

2.4 Power analysis

An a priori power calculation was conducted prior to Time 1 data collection, in order to inform the minimum number of clinical participants required (G*Power; Erdfelder et al, 1996) to explore various aspects of the voice hearing experience. This was based upon detecting a medium effect size using correlational analysis and suggested that a sample of 64 was required in order to have sufficient power to minimise the risk of a Type II error (effect size r = .30, alpha =.05, power =.80). No a priori power analysis was conducted for the non-clinical sample due to the exploratory nature of this aspect of the research. However, based on previous studies examining the experience of non clinical voice hearers (Honig et al, 1998;
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Jones et al, 2003), the investigators at Time 1 aimed to recruit 30 non-clinical participants.

Despite various attempts to overcome recruitment difficulties, the sample sizes obtained at Time 1 (clinical n= 32, non-clinical n=18) and following attrition at Time 2 (clinical n = 18, non-clinical = 9), meant that both the comparative and correlational aspects of the study were underpowered. Therefore results are interpreted with caution.

2.5 Procedure

At Time 1, ethical approval was sought and obtained from the Central Office for Research Ethics Committees (COREC) (Appendix B) and the University ethics committee (Appendix C), granting approval for this 12 month follow up investigation. Research governance approval from Research and Development (R & D) committees in the three NHS Trusts was also obtained at this time (Appendix D).

At Time 1, the longitudinal aspect of the study was explained and consent forms were obtained from all clinical (Appendix E) and non-clinical (Appendix F) participants. Each participant was asked whether they consented to be re-contacted by another researcher in six months time regarding being re-interviewed. Of the 50 participants asked, four did not give consent and therefore were not followed up.

For the clinical participants, approximately six months following the original interview date their Care Co-ordinator was contacted in writing (Appendix G) and asked whether there was any reason why the participant should not be re-contacted by the researcher. Two participants
were identified as distressed/currently unable to participate by their care co-ordinator and were not re-contacted. The remaining participants were then contacted in writing (Appendix H) and advised that they would be contacted by telephone in the near future to discuss their continued participation in the study. Participants were then contacted by telephone (or via their Care Co-ordinator/mental health worker where these methods were unsuccessful). For those who consented to be re-interviewed, a convenient time and location was then agreed.

For the non-clinical group, those participants who gave their consent, were contacted in writing (Appendix I) or by email approximately six months following their original interview date. Participants were invited to contact the researcher to discuss their continued participation in the study and advised that they would be contacted by telephone in the near future. For those participants who consented to be re-interviewed, a mutually convenient time and location was agreed. Due to the way in which these individuals were recruited, they came from a wide geographical area. For this reason, 6 interviews were conducted via telephone and 3 individuals were interviewed in person.

All interviews were conducted as close as pragmatically possible to 12 months following the original interview date, within a 10-14 month window. At the interview, the research procedure for clinical and non-clinical groups was identical. Firstly, a distress plan was formulated with the participant as a way of managing any negative feelings arising as a consequence of participation (Appendix J) and demographic information was collected (Appendix K). The Voice Relating Interview schedule was then completed, followed in order by the PSYRATS, VAY and BAVQ-R.
2.6 Statistical analysis

All analyses were conducted using SPSS for Windows V14.0 (SPSS INC, Chicago, Ill.). Data were screened to determine whether they met the assumptions for parametric testing. Using the Kolmogorov-Smirnov test, it was found that a number of variables were not normally distributed (see Appendix L for details). For those variables where data were normally distributed at Time 1 and at Time 2, the difference between these scores was calculated. The distribution of these difference scores were then tested for normality, as recommended by Pallant (2005) and Field (2005) when using a repeated measures design.

Using this method, Hearer Distance (VAY) and Omnipotence (BAVQ-R) in the clinical sample, and Benevolence(BAVQ-R) and Omnipotence(BAVQ-R) in the non-clinical sample met the assumptions for parametric testing. For these four variables, differences between Time1 and Time 2 data were analyzed using paired samples t-tests. Differences between Time 1 and Time 2 data for all other variables were analyzed using the Wilcoxon Signed-Rank test.

Differences between scores at Time 1 and Time 2 on relating variables and beliefs variables were calculated for each participant, to identify the amount of change over 12 months. Correlations were conducted between the amount of change in each of these variables and the amount of change in level of distress experienced. Where correlational analysis was used, due to the small sample size and number of tied ranks (Field, 2005) Kendall’s Tau correlation coefficient was calculated.
Major Research Project

**Results**

3.1 Overview
Analyses to meet the aims described in section 1.11 were conducted and will be described in turn below. Firstly, the participant characteristics and characteristics of the voice hearing experience in the longitudinal clinical (n = 18) and non-clinical (n = 9) samples will be described and compared.

3.2 Participant Characteristics
3.2.1 Demographics
The demographic characteristics of the clinical and non-clinical participants included in the longitudinal analysis are presented in Table 4.

Analyses were conducted to evaluate differences in demographic characteristics between the clinical and non-clinical groups. There were no significant difference in gender \( \chi^2 (1, n = 27) = .940, p = .332 \) and ethnicity [Fisher’s Exact test \( n =27 \) = 3.964, \( p = .103 \)] between the clinical and non-clinical samples. However, there was a significant difference in age between the two groups \( U= 31.5, p<.01, r = -.49 \). The mean age of the non-clinical sample \( (M = 56.44, SD =15.2) \) was significantly greater than the clinical sample \( (M = 39.39, SD = 9.95) \). Comparisons with previous research suggest that the mean ages for both clinical and non-clinical samples are similar to those found by others (e.g. Hayward, 2003; Close & Garety, 1998; Honig et al., 1998).

Analyses were also conducted in order to evaluate differences in the demographic characteristics between those who remained in the study at Time 2 and those who did not. As a whole sample (clinical and non-
clinical) there were no significant differences in gender \[X^2 (1, n = 50) = 1.288, p = .256\], ethnicity \[X^2 (2, n = 49) = 1.699, p = .428\] or age \[U = 307.5, p = .953\] between the two groups.

In the clinical sample alone, there were no significant differences in gender \[X^2 (1, n = 32) = .742, p = .389\] or age \[U = 120, p = .820\] between those who did and did not remain in the study at Time 2. In terms of ethnicity, the whole clinical sample at Time 1 (and thus also at Time 2) classified themselves as White British.

Likewise, in the non-clinical sample only there were no significant differences in gender \[X^2 (1, n = 18) = .250, p = .617\], ethnicity \[X^2 (2, n = 18) = 2.250, p = .325\] or age \[U = 36.5, p = .724\] between those who did and did not remain in the study at Time 2.

### 3.2.2 Clinical Characteristics

The mental health service contact of the clinical and non-clinical participants included at Time 2 are presented in Table 5.

Analyses were conducted to evaluate whether differences between the two groups were statistically significant. A significantly greater proportion of clinical participants had been given a psychiatric diagnosis when compared with non-clinical participants \[X^2 (1, n = 27) = 21.77, p < .001\], a greater proportion of clinical participants were taking medication \[X^2 (1, n = 27) = 22.69, p < .001\], and a significantly greater proportion of clinical participants had been admitted to psychiatric hospital as a consequence of their voice hearing experience \[X^2 (1, n = 27) = 16.13, p < .001\].
3.2.3 Voice Gender, Identity & Duration of Experience

The characteristics of the voice hearing experiences of the clinical and non-clinical participants included in the longitudinal analysis are reported in Table 6. Description of voice gender applies to the predominant voice.

Analyses were conducted to evaluate differences in voice hearing experiences between the two groups. Participants from the non-clinical sample had been hearing voices for a significantly greater length of time (M=34.44, SD=19.89) than the clinical sample (M=16.50, SD=9.46), [U=31.5, p<.02, r = .49]. Again, this may reflect the difference in inclusion criteria which allowed older non-clinical participants to be involved. There was no significant association between sample and gender of the voice [Fisher's Exact test (n =27) = .301, p = 1] or sample and the identity of the voice [Fisher's Exact test (n =27) = 3.94, p = .154]. Voice gender and identity reported in the current study are similar to those reported in previous studies (Leudar et al, 1997; Hayward, 2003; Vaughan & Fowler, 2004; Sorrell, 2006).
Table 6. Characteristics of the voice hearing experiences of participants at Time 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole sample n=27</th>
<th>Clinical sample n=18</th>
<th>Non-clinical sample n=9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male</td>
<td>13 (48.1)</td>
<td>9 (50)</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>- Female</td>
<td>6 (22.2)</td>
<td>4 (22.7)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>- Unknown</td>
<td>8 (29.6)</td>
<td>5 (27.8)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Voice identity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- personified</td>
<td>10 (37)</td>
<td>8 (44.4)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>- supernatural</td>
<td>8 (29.6)</td>
<td>3 (16.7)</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>- incognito</td>
<td>9 (33.3)</td>
<td>7 (38.9)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Duration of voice hearing (years)</td>
<td>22.48 (15.96)</td>
<td>16.50 (9.46)</td>
<td>34.44 (19.80)</td>
</tr>
</tbody>
</table>

3.3 The Longitudinal Course of Relating Styles
The first aim of the study was to describe and explore any changes occurring in relating styles between the predominant voice and voice hearer at 12 month follow up, in a clinical and non-clinical sample. Analysis conducted on data from the clinical sample will be explored firstly, followed by the non-clinical sample.

3.3.1 Clinical Sample
Scores on the VAY at Time 1 and Time 2 are presented in Table 7.
Table 7. Scores on the VAY at Time 1 and Time 2 in the clinical sample

<table>
<thead>
<tr>
<th>VAY subscale</th>
<th>Time 1 n =18</th>
<th></th>
<th>Time 2 n =18</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (range)</td>
<td>Mean (SD)</td>
<td>Median (range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Voice Dominance</td>
<td>18 (20)</td>
<td>14.83 (7.14)</td>
<td>19 (21)</td>
<td>15.28 (7.36)</td>
</tr>
<tr>
<td>Voice Intrusiveness</td>
<td>10 (13)</td>
<td>9.44 (4.33)</td>
<td>11.5 (13)</td>
<td>9.67 (4.88)</td>
</tr>
<tr>
<td>Hearer Dependence</td>
<td>8 (22)</td>
<td>9.33 (6.47)</td>
<td>8 (24)</td>
<td>8.5 (5.69)</td>
</tr>
<tr>
<td>Hearer Distance</td>
<td>14.5 (19)</td>
<td>13.89 (5.89)</td>
<td>14 (20)</td>
<td>13.22 (6.72)</td>
</tr>
</tbody>
</table>

At Time 1 scores indicated that the clinical participants perceived their voice to relate primarily from a position of Dominance (M=14.83, SD=7.14) and that they related to their voice from a position of Distance (M=13.89, SD=5.89). At Time 2, scores again indicated that participants perceived their voice to relate primarily from a position of Dominance (M = 15.28, SD = 7.36), and that they related to their voice primarily from a position of Distance (M = 13.22, SD = 6.72).

A statistical comparison of interrelating between voice and hearer at Time 1 and Time 2, on each of the four relating subscales was conducted. As the assumptions of parametric testing were not met for the Voice Dominance, Voice Intrusiveness, and Hearer Dependence subscales, Wilcoxon Signed Rank tests were conducted. However, assumptions for parametric testing were met for the Hearer Distance subscale, therefore a dependent samples
A *t*-test was conducted. Results from all four tests were non-significant (see Table 8).

**Table 8. Results of Wilcoxon Signed Rank statistical comparisons of relating styles at Time 1 & Time 2**

<table>
<thead>
<tr>
<th>Relating style</th>
<th>Test Statistic</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice Dominance</td>
<td>Z = -0.713</td>
<td>p = 0.514</td>
</tr>
<tr>
<td>Voice Intrusiveness</td>
<td>Z = -0.582</td>
<td>p = 0.585</td>
</tr>
<tr>
<td>Hearer Dependence</td>
<td>Z = -1.019</td>
<td>p = 0.322</td>
</tr>
<tr>
<td>Hearer Distance</td>
<td>Z = -0.760</td>
<td>p = 0.466</td>
</tr>
</tbody>
</table>

Therefore, the results indicate that over a 12 month period there was no significant change in interrelating between voice and hearer. At Time 2, Clinical hearers continued to perceive their voice as relating primarily from a position of Dominance, and continued to relate to their voice primarily from a position of Distance.

### 3.3.2 Non-Clinical Sample

Scores on the VAY at Time 1 and Time 2 are presented in Table 9. Scores at Time 1 on the VAY indicated that non-clinical participants perceived their voice to relate primarily from a position of Dominance (M = 2.89, SD = 6.49) and that they related to their voice primarily from a position of Dependence (M = 6.78, SD = 6.24). At Time 2, scores indicated that again participants perceived their voice to relate primarily from a position of Dominance (M = 1.33, SD = 3.32), and that they related to their voice primarily from a position of Dependence (M = 6, SD = 5.72).
Table 9. Scores on the VAY at Time 1 and Time 2 in the non-clinical sample

<table>
<thead>
<tr>
<th>VAY subscale</th>
<th>Time 1 n =9</th>
<th>Time 2 n =9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Voice Dominance</td>
<td>0 (20)</td>
<td>2.89 (6.49)</td>
</tr>
<tr>
<td>Voice Intrusiveness</td>
<td>0 (11)</td>
<td>2.11 (3.66)</td>
</tr>
<tr>
<td>Hearer Dependence</td>
<td>3 (16)</td>
<td>6.78 (6.24)</td>
</tr>
<tr>
<td>Hearer Distance</td>
<td>1 (15)</td>
<td>2.67 (4.72)</td>
</tr>
</tbody>
</table>

A statistical comparison of interrelating between voice and hearer at Time 1 and Time 2, on each of the four relating subscales was conducted. As the assumptions of parametric testing were not met for any of the subscales, Wilcoxon Signed Rank tests were conducted. Results from all four tests were non-significant (see Table 10).

Table 10. Results of the Wilcoxon Signed Ranks statistical comparisons of relating styles at Time 1 & Time 2

<table>
<thead>
<tr>
<th>Relating style</th>
<th>Test Statistic</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice Dominance</td>
<td>Z=-1.633</td>
<td>p = .250</td>
</tr>
<tr>
<td>Voice Intrusiveness</td>
<td>Z=-.632</td>
<td>p = .656</td>
</tr>
<tr>
<td>Hearer Dependence</td>
<td>Z=-.511</td>
<td>p = .703</td>
</tr>
<tr>
<td>Hearer Distance</td>
<td>Z=-1.342</td>
<td>p = .375</td>
</tr>
</tbody>
</table>
Therefore, the results indicate that over a 12 month period there was no significant change in interrelating between voice and hearer. Non-clinical hearers continued to perceive their voice as relating primarily from a position of Dominance, and continued to relate primarily from a position of Dependence.

3.4 Hypothesis Testing

3.4.1 Associations Between relating Style and Distress

It was hypothesised that changes in relating styles would be associated with changes in levels of distress. Specifically it was suggested that:

1. Changes in Voice Dominance (Upperness), Voice Closeness (Intrusiveness) and Hearer Distance would be positively correlated with changes in level distress

2. Changes in Hearer Dependence would be negatively correlated with changes in level of distress.

As there were no significant differences between interrelating at Time 1 and Time 2, in either sample, the above hypotheses would suggest that there would be no significant changes in the level of distress experienced. The reported distress at Time 1 and Time 2 for both samples is reported in Table 11. A statistical analysis of distress at Time 1 and Time 2 was conducted in both the clinical and non-clinical sample. As the data did not meet assumptions for parametric testing, Wilcoxon Signed Ranks tests were conducted. Results were non-significant in the clinical sample [Z =
7.95 p = .795] and non-clinical [Z = .577, p = 1] sample, suggesting that there had been no significant change in level of distress over 12 months.

Despite there being no statistically significant changes in interrelating or distress between Time 1 and Time 2, participants' qualitative responses suggested that at the case level, some change had occurred (see section 3.7.3). Also, due to the small sample recruited, there was a risk of making a type II error (not detecting a significant change where one had occurred). Therefore, further correlational analyses were conducted in order to determine whether any associations were detected between changes in styles of relating and changes in level of distress experienced, in both the clinical and non-clinical sample. As data did not meet assumptions for parametric testing, the Kendall’s Tau test was used.

Table 11. Levels of distress reported on the PSYRATS at Time 1 and Time 2 in the clinical and non-clinical sample

<table>
<thead>
<tr>
<th>Time Point</th>
<th>Clinical n = 18</th>
<th></th>
<th>Non-clinical n = 9</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (range)</td>
<td>Mean (SD)</td>
<td>Median (range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Time 1</td>
<td>3 (4)</td>
<td>2.83 (1.2)</td>
<td>0 (3)</td>
<td>.67 (1.12)</td>
</tr>
<tr>
<td>(baseline)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2</td>
<td>3 (4)</td>
<td>2.67 (1.33)</td>
<td>0 (4)</td>
<td>.56 (1.33)</td>
</tr>
<tr>
<td>(12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.4.2 Clinical Sample

In the clinical sample, there was a medium significant positive correlation between change in Hearer Distance and change in level of distress experienced [τ=.458, p (one tailed) <.01]. There were no significant
correlations between change in distress and Hearer Dependence [$\tau = -.151$, 
$p$ (one tailed) $= .221$], Voice Dominance [$\tau = .231$, 
$p$ (one tailed) $= .124$] or Voice Intrusiveness [$\tau = .076$, 
$p$ (one tailed) $= .354$]. The results suggest that 
as predicted, in the clinical sample, an increase in relating from a position 
of Distance was associated with an increase in level of distress 
experienced.

3.4.3 Non-Clinical Sample

In the non-clinical sample, there was a medium significant negative 
correlation between change in Hearer Dependence and change in level of 
distress experienced [$\tau = -.514$, 
$p$ (one tailed) $< .045$]. There was also a 
medium significant negative correlation between Hearer Distance and 
change in level of distress experienced [$\tau = -.639$, 
$p$ (one tailed) $= .026$]. There were no significant correlations between change in level of distress 
and Voice Dominance [$\tau = .350$, 
$p$ (one tailed) $= .145$] or Voice Intrusiveness 
[$\tau = .119$, 
$p$ (one tailed) $= .349$]. The results suggest that in the non-clinical 
sample, as predicted, an increase in the hearer relating from a position of 
Dependence on the voice was associated with a decrease in distress. 
However, contrary to expectations, the results also suggested that an 
increase in Hearer Distance was associated with a decrease in distress.

3.5 The Longitudinal Course of Beliefs about Voices

The second aim of the study was to describe and explore any changes 
occurring in beliefs about voices over a 12 month period, in a clinical and 
non-clinical sample. Analysis conducted on data from the clinical sample 
will be explored firstly, followed by the non-clinical sample.
3.5.1 Clinical Sample

Scores on the BAVQ-R at Time 1 and Time 2 are presented in Table 12.

**Table 12. Scores on the BAVQ-R at Time 1 and Time 2 in the clinical sample**

<table>
<thead>
<tr>
<th>Type of Belief</th>
<th>Time 1 n = 18</th>
<th>Time 2 n = 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Malevolence</td>
<td>13.5 (18)</td>
<td>11.67 (5.95)</td>
</tr>
<tr>
<td>Benevolence</td>
<td>2 (17)</td>
<td>5 (5.88)</td>
</tr>
<tr>
<td>Omnipotence</td>
<td>12 (13)</td>
<td>12 (4.52)</td>
</tr>
</tbody>
</table>

Scores at Time 1 on the BAVQ-R indicated that clinical participants mostly perceived their voice to have malevolent intent (M=11.67, SD=5.95) and to be highly omnipotent (Mean= 12, SD = 4.52). At Time 2, scores indicated that again, participants mostly perceived their voice to have malevolent intent (M = 11.39, SD = 6.28) and to be highly omnipotent (M= 11.11, SD = 4.48). These ratings of beliefs about voices are in line with those found by Chadwick et al, (2000) in a clinical sample.

A comparison of beliefs about voices at Time 1 and Time 2, on each of the three belief domains (Malevolence, Benevolence & Omnipotence) was conducted. As the assumptions of parametric testing were not met for the Malevolence and Benevolence subscales, Wilcoxon Signed Rank tests were conducted. However, assumptions for parametric testing were met for the Omnipotence subscale, therefore a dependent samples t-test was conducted.
Results for the Malevolence subscale \( [Z = -2.129, p = .821] \) and Omnipotence subscale \( [t (17) = 1.471, p = .160] \) were non-significant. However, results for the Benevolence subscale were significant, with a medium effect size \( [Z = -2.129, p < .04, r = -.35] \). Therefore, the results indicate that over a 12 month period in a clinical sample, there were no significant changes in beliefs about voices' Malevolence and Omnipotence. However, at 12 month follow up, clinical voice hearers rated their voices as significantly less benevolent, than at baseline. However, this significant change in beliefs about benevolence did not result in any significant changes in level of distress experienced, or in beliefs about the voices' Malevolence.

3.5.2 Non-Clinical Sample

Scores on the BAVQ-R at Time 1 and Time 2 are presented in Table 13.

Table 13. Scores on the BAVQ-R at Time 1 and Time 2 in the Non-Clinical Sample

<table>
<thead>
<tr>
<th>Type of Belief</th>
<th>Time 1 ( n = 9 )</th>
<th>Time 2 ( n = 9 )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Malevolence</td>
<td>0 (3) .33 (1)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Benevolence</td>
<td>12 (18) 9.89 (6.19)</td>
<td>12 (18) 11 (6.27)</td>
</tr>
<tr>
<td>Omnipotence</td>
<td>7 (9) 5.78 (3.15)</td>
<td>3 (7) 3.89 (2.15)</td>
</tr>
</tbody>
</table>

Although all ratings were lower in the non-clinical sample, scores at Time 1 on the BAVQ-R indicated that participants mostly perceived their voice to have benevolent intent \( (M=12, SD=18) \) and not to be omnipotent \( (M = 5.78, SD = 3.15) \). At Time 2, scores indicated that again, participants mostly perceived their voice to have benevolent intent \( (M =11, SD =6.27) \)
and not to be omnipotent (M = 3.89, SD = 2.15). These ratings were also comparable with ratings reported by Chadwick et al. (2000).

A statistical comparison of beliefs about voices at Time 1 and Time 2, on each of the three belief domains (Malevolence, Benevolence & Omnipotence) was conducted. As the assumptions of parametric testing were not met, Wilcoxon Signed Rank tests were conducted. All results were non-significant: Malevolence [Z = -1.0, p = 1.0]; Benevolence [Z = - .677, p = .568]; Omnipotence [Z = -1.620, p = .133]. Therefore, results indicated that in a non-clinical sample, there was no change in beliefs about voices Malevolence, Benevolence or Omnipotence over a 12 month period.

3.6 Associations between Changes in Beliefs and Distress
Correlational analysis was conducted in order to determine whether the significant change in beliefs about Benevolence in the clinical sample was associated with a change in the level of distress experienced. As with interrelating, participants’ qualitative responses suggested that at the case level, changes had occurred in beliefs about voices over the 12 month period, despite no statistically significant changes being detected. Therefore, further correlational analyses were conducted in order to identify whether there was any association between changes in beliefs and changes in level of distress experienced, in both the clinical and non-clinical sample. As data did not meet assumptions for parametric testing, the Kendall’s Tau test was used.
3.6.1 Clinical Sample

In the clinical sample, there were no significant correlations between change in level of distress and beliefs about Malevolence \( \tau = .184, p \) (two tailed) = .350, Benevolence \( \tau = .262, p \) (two tailed) = .188 or Omnipotence \( \tau = .089, p \) (two tailed) = .653.

3.6.2 Non-Clinical Sample

In the non-clinical sample, there were no significant correlations between change in distress and beliefs about Malevolence \( \tau = .553, p \) (two tailed) = .105, Benevolence \( \tau = .499, p \) (two tailed) = .098 or Omnipotence \( \tau = .076, p \) (two tailed) = .8.

3.7 Additional Analyses

3.7.1 Longitudinal Form & Content of Voices: Clinical Sample

The form and content of the voice hearing experience (as measured by the PSYRATS) at Time 1 and Time 2 are reported in Table 14.

Previous studies have suggested that beliefs about voices remain stable, despite changes in their form and content (i.e., Csipke & Kinderman, 2006). Therefore, further analyses were conducted in order to clarify whether changes in the form and content of voices had occurred over the 12 month period. Wilcoxon Signed Rank tests were conducted in order to determine if statistically significant differences existed between Time 1 and Time 2 ratings of frequency of voices, duration of utterances, loudness of voices, degree of negative content and controllability. All tests were non-significant (see Table 15), suggesting that there had been no significant changes in the form and content of voices of a 12 month period.
Table 14. Characteristics of the voice hearing experience at Time 1 & Time 2 in the clinical sample

<table>
<thead>
<tr>
<th>PSYRATS Subscale</th>
<th>Time 1 (n=18)</th>
<th>Time 2 (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rated 0 – 4</td>
<td>Median (range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Frequency</td>
<td>3.5 (3)</td>
<td>3 (1.15)</td>
</tr>
<tr>
<td>Duration</td>
<td>3 (2)</td>
<td>2.89 (.9)</td>
</tr>
<tr>
<td>Loudness</td>
<td>2.5 (3)</td>
<td>2.67 (1.14)</td>
</tr>
<tr>
<td>Degree of Negative Content</td>
<td>4 (4)</td>
<td>3.44 (1.2)</td>
</tr>
<tr>
<td>Controllability</td>
<td>3.5 (3)</td>
<td>3.06 (1.16)</td>
</tr>
</tbody>
</table>

* Higher score denotes less control

Table 15. Results of Wilcoxon Signed Ranks tests of form and content of voices at Time 1 and Time 2 in the clinical sample

<table>
<thead>
<tr>
<th>PSYRATS subscale</th>
<th>Test Statistic</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Z = -.787</td>
<td>p = .516</td>
</tr>
<tr>
<td>Duration</td>
<td>Z = -1.467</td>
<td>p = .189</td>
</tr>
<tr>
<td>Loudness</td>
<td>Z = -0.486</td>
<td>p = .793</td>
</tr>
<tr>
<td>Degree of negative content</td>
<td>Z = -1.403</td>
<td>p = .266</td>
</tr>
<tr>
<td>Controllability</td>
<td>Z = -0.302</td>
<td>P = 1.00</td>
</tr>
</tbody>
</table>
3.7.2 The Longitudinal Form & Content of Voices: non-clinical sample

The form and content of the voice hearing experience (as measured by the PSYRATS) at Time 1 and Time 2 are reported in Table 16.

Table 16. Form and content of the voice hearing experience at Time 1 & Time 2 in the non-clinical sample

<table>
<thead>
<tr>
<th>PSYRATS Subscale</th>
<th>Time 1 (n=18)</th>
<th>Time 2 (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rated 0-4 (range)</td>
<td>Median</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Frequency</td>
<td>2 (4)</td>
<td>2.11 (1.36)</td>
</tr>
<tr>
<td>Duration</td>
<td>2 (3)</td>
<td>2.33 (1.12)</td>
</tr>
<tr>
<td>Loudness</td>
<td>2 (2)</td>
<td>1.78 (.67)</td>
</tr>
<tr>
<td>Degree of Negative Content</td>
<td>0 (3)</td>
<td>.78 (1.09)</td>
</tr>
<tr>
<td>Controllability*</td>
<td>1 (4)</td>
<td>1.56 (1.51)</td>
</tr>
</tbody>
</table>

* Higher score denotes less control

Further analyses were conducted to clarify whether differences in the form and content of voices had occurred over the 12 month period. Wilcoxon Signed Rank tests were conducted in order to determine if statistically significant differences existed between Time 1 and Time 2 ratings of frequency of voices, duration of utterances, loudness of voices, degree of negative content and controllability. All tests were non-significant (see Table 17), indicating that there had been no significant changes in the form and content of voices over a 12 month period.
Table 17. Results of the Wilcoxon statistical comparisons of form and content of voices at Time 1 and Time 2 in the non-clinical sample.

<table>
<thead>
<tr>
<th>PSYRATS subscale</th>
<th>Test Statistic</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Z = -557</td>
<td>p = .750</td>
</tr>
<tr>
<td>Duration</td>
<td>Z = -1.184</td>
<td>p = 1.00</td>
</tr>
<tr>
<td>Loudness</td>
<td>Z = -1.414</td>
<td>p = .50</td>
</tr>
<tr>
<td>Degree of negative content</td>
<td>Z = -1.633</td>
<td>p = .250</td>
</tr>
<tr>
<td>Controllability</td>
<td>Z = -0.816</td>
<td>P = .750</td>
</tr>
</tbody>
</table>

3.7.3 Participants' Assessment of Change in Relating Styles

In order to elicit participants' own explanations of any change occurring in their experiences, at Time 2 all participants were asked: if they believed their relationship with their predominant voice had changed in the previous 12 months; if they had experienced a change, what did they attribute this to; if they had deliberately tried to change the way they related to their voice; if they had received any interventions for voice hearing; and if their medication had changed. Responses to these questions are presented in Table 18.
Table 18. Participants’ assessment of change in interrelating

<table>
<thead>
<tr>
<th>Questions relating to interrelating over 12 month period</th>
<th>Clinical n = 18</th>
<th>Non-clinical n = 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Has your relationship with your voice changed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (50)</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>No</td>
<td>6 (33.3)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Missing</td>
<td>3 (16.7)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>What is your explanation of the change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decided to engage more with voice</td>
<td>-</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Decided to accept voice</td>
<td>1 (5.6)</td>
<td>-</td>
</tr>
<tr>
<td>Changed beliefs about voice</td>
<td>2 (11.1)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Attending HVG</td>
<td>4 (22.2)</td>
<td>-</td>
</tr>
<tr>
<td>Non-specific therapy</td>
<td>-</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Medication</td>
<td>2 (11.1)</td>
<td>-</td>
</tr>
<tr>
<td>Life event/stressors</td>
<td>-</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>-</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>No change</td>
<td>6 (33.3)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Missing</td>
<td>3 (16.7)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Have you had any voice hearing interventions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (66.7)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>No</td>
<td>4 (22.2)</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>Missing</td>
<td>2 (11.1)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>What type of intervention have you had?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Voices Group</td>
<td>10 (55.6)</td>
<td>-</td>
</tr>
<tr>
<td>Individual Psychology</td>
<td>2 (11.1)</td>
<td>-</td>
</tr>
<tr>
<td>Non-specific therapy</td>
<td>-</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>None</td>
<td>4 (22.2)</td>
<td>8 (77.8)</td>
</tr>
<tr>
<td>Missing</td>
<td>2 (11.1)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Has your medication changed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
Discussion

4.1 Overview

The aim of the current study was to expand upon previous research in the field of voice hearing, which has examined hearers' relationships with, and beliefs about voices.

Firstly, the current study aimed to extend the growing body of research which has applied Birtchnell's (1996; 2002) relating theory to the experience of voice hearing. Using this framework, Vaughn & Fowler (2004) and Sorrell (2006) have demonstrated the importance of styles of interrelating between voice and hearer in mediating the level of distress experienced. However, to date no studies have examined the longitudinal course of styles of relating to and by the voice. The current study addressed this gap in the literature by researching styles of interrelating and their relationship with distress, over a 12 month period in both a clinical and non-clinical sample.

Secondly, the study replicated and extended the work of Csipke & Kinderman (2006), who conducted the only short-term longitudinal study of beliefs about voices to date. They found that beliefs about voices remained stable over a period of six months in a clinical sample of voice hearers, despite changes in the frequency and severity of voices. However, this study suffered several limitations as it did not use a psychometrically robust measure of beliefs about voices; it did not investigate beliefs about voices' power; and it did not investigate the experiences of non-clinical voice hearers. Therefore the current study addressed these limitations.
Major Research Project

In order to determine whether there had been a change in the style of interrelating or a change in beliefs about voices, a prospective, longitudinal within-participants design was used. In order to determine whether any changes in relating styles and change in beliefs about voices were associated with changes in level of distress, a correlational design was used.

4.2 Main Findings

4.2.1 Interrelating between Voice and Hearer

The first aim of the study was to describe and explore any changes occurring in relating styles between the predominant voice and voice hearer over a 12 month period, in a clinical and non-clinical sample. At Time 1 the clinical participants perceived their voice to relate primarily from a position of Dominance and tended to relate to their voice primarily from a position of Distance. At 12-months follow-up these relating styles remained the same; there were no significant changes in interrelating between the voice and hearer in the clinical sample.

In the non-clinical sample at Time 1, participants perceived their voice to relate primarily from a position of Dominance, however their ratings of the voices' degree of Dominance were significantly lower than the clinical sample. At Time 1, non-clinical participants tended to relate to their voice primarily from a position of Dependence. At 12 months follow-up these relating positions remained the same; there were no significant changes in styles of interrelating in the non-clinical sample.
In relation to interrelating between voice and hearer, two specific hypotheses were made based upon the findings of Vaughn & Fowler (2004) and Sorrell (2006). Firstly it was hypothesised that changes in Voice Upperness, Voice Closeness and Hearer Distance would be positively correlated with changes in the level distress experienced by the hearer. Secondly, it was expected that changes in Hearer Dependence would be negatively correlated with changes in level of distress.

Despite there being no statistically significant changes in relating styles over the 12 month period, at Time 2, the majority of participants in the study reported that their relationship with their voices had changed. Therefore, further correlational analysis was conducted in order to explore whether any non-significant changes in interrelating were associated with changes in level of distress experienced. This analysis suggested that there was some degree of change in interrelating, and that this was associated with changes in levels of distress experienced.

In the clinical sample, in line with hypothesis one, there was a significant positive association between change in Hearer Distance and change in the level of distress experienced. That is, an increase in Hearer Distance is associated with an increase in distress, and a decrease in Hearer Distance with a decrease in distress.

In the non-clinical sample, in line with hypothesis two, there was a negative association between change in Hearer Dependence and change in distress experienced. That is, an increase in Hearer Dependence is associated with a decrease in distress, and a decrease in Hearer Dependence would be associated with an increase in distress. However,
contrary to hypothesis one in the non-clinical sample, there was also a negative association between change in Hearer Distance and change in degree of distress experienced. That is, an increase in Hearer Distance was associated with a decrease in distress, and a decrease in Hearer Distance with an increase in level of distress experienced.

4.2.2 Beliefs about Voices
The second aim of the study was to explore any changes occurring in beliefs about voices' malevolence, benevolence and omnipotence over a 12-month period, in a clinical and non-clinical sample. At Time 1 clinical participants predominantly perceived their voice to have malevolent intent and to be highly omnipotent. At Time 2, this remained the same and there was no significant change in beliefs about voices' malevolence or omnipotence. However, at 12 month follow up, clinical voice hearers perceived their voices to be significantly less benevolent than at baseline assessment.

In the non-clinical sample all ratings of beliefs about voices were lower than those of the clinical sample. At Time 1 non-clinical participants mostly perceived their voice to have benevolent intent and not to be omnipotent. At Time 2 there were no significant changes in beliefs about voices; participants continued to perceive their voices to be benevolent and to have little power over them.

As no specific hypotheses were made about the relationship between changes in beliefs about voices and changes in level of distress experienced, correlational analyses were conducted to explore this further. In the clinical sample, the significant decrease in beliefs about the voices'
benevolence was not associated with any change in the level of distress experienced. No other associations were found between changes in beliefs about voices and changes in level of distress experienced in the clinical sample.

In the non-clinical sample there was a medium, but non-significant positive association between change in beliefs about the voices' malevolence and change in level of distress experienced. That is, an increase in the belief that the voice had malevolent intent is associated with an increase in distress and a reduction in that belief is associated with a decrease in distress. Likewise, in the non-clinical sample there was a medium, but non-significant negative association between beliefs about benevolence and levels of distress experienced. That is, an increase in beliefs about the voices' benevolence is associated with a decrease in level of distress experienced, and a decrease in beliefs about the voices' benevolence with an increase in distress.

4.3 Theoretical Implications

4.3.1 Interrelating in the Clinical Sample

In the clinical sample, the finding that hearers perceived their voice to relate primarily from a position of Dominance (on the power axis) is consistent with previous research which has utilised Birtchnell's (1996; 2002) relating theory (Vaughn & Fowler, 2004; Sorrell, 2006). The current study therefore lends further support to the assertion that perceptions of the voice as powerful are influential in determining emotional and behavioural responses to voices and consequently, mental health service use (Chadwick & Birchwood, 1994; Birchwood & Chadwick, 1997; Birchwood et al, 2000; Birchwood et al, 2004; Vaughn & Fowler, 2004).
The finding that clinical hearers tended to relate to their voice from a position of Distance is also consistent with previous findings (Hayward, 2003; Vaughn & Fowler, 2004; Sorrell, 2006). This provides support for previous research which suggests that resisting voices is associated with increased distress, and consequently mental health service use (Leudar et al., 1997).

The finding that styles of interrelating between the voice and hearer did not significantly change over the 12 months suggests that the short-term course of interrelating between voice and hearer in a clinical sample is relatively stable and enduring. There is little previous research which has explored the development of relationships between voice and hearer over time. However, some research in this area provides tentative explanations for the current findings.

Romme et al., (1992), Birchwood et al., (2000; 2004) and Vaughn & Fowler (2004) suggest that appraisals of voices as powerful and dominant may be determined by an individual’s interpersonal schema which predisposes them to negative social comparisons and interrelating. This model would predict that perceptions of the voice as relating from a position of negative power (Voice Dominance) would be unlikely to change over a period of 12 months, as interpersonal power structures or ‘core beliefs’, are by their nature long-standing and extremely difficult to change (i.e., Padesky, 1994). However, the current study did not provide a direct test of this model and thus this suggestion is tentative.
Fuller's (2006) qualitative study of voice hearers who had taken part in 'relating therapy' for voices, along with their therapists, referrers and relatives, also supports the suggestion that styles of interrelating are enduring and "entrenched" (pp, 44) without specific psychological intervention. Fuller (2006) highlights the importance of social and cultural factors which may seek to maintain positions of Hearer Distance and perceived Voice Dominance in clinical samples. These included the perception that voice hearers may have adopted (and been encouraged to adopt) a 'patient' or victim role over the duration of their voice hearing experience; cultural or religious backgrounds where assertive ways of relating are not encouraged or modelled, particularly in females; and the functional role of particular ways of relating. For example, one functional role of seeking distance from the voice, rather than assertively engaging with it, was to increase the hearer's sense of determination by 'not giving in' to the voice.

However, whilst the current study found that relating styles were stable over 12 months in the clinical sample (as measured by the VAY, Hayward et al, 2005), 50 % (n =9) of clinical participants reported that they believed their relationship with the voice had changed over that time. Hearers gave a number of explanations for these changes, however the most common (n=4) reason given was attendance at a Hearing Voices Group. Participants felt this had enabled them to talk about their experiences and to adopt a more positive position in relation to the voice. Similarly, a further participant (who had not attended a HVG) reported that they had decided to accept the voice which had reduced their distress. Two participants associated the change with a change in their medication. A further two participants reported that their perceptions of the voices had
changed (one in relation to voice identity, one in relation to the voice's intent), which had in turn changed the way they interacted with them.

Fuller's (2006) findings may help to explain this discrepancy between participant's perceptions of change and the lack of change detected in the study. Fuller found that clinical voice hearers described several positive outcomes of relating therapy including increased acceptance of voices; improved social relationships; increased hopefulness; improved self perception and increased independence seeking, which were all interlinked with improved interrelating with the voice. Fuller (2006) noted that the qualitative methodology utilised allowed participants to define change for themselves, and that their accounts suggested that change occurred in several of these areas as part of a fluid and interlinked process. Therefore it may be that in the current study, the changes in relationships which participants reported may have been more evident in areas which were not detected by scores on the VAY, but which were apparent to the voice hearers.

The finding in the current study that there was a medium significant positive correlation between change in Hearer Distance and change in level of distress experienced also supports the suggestion that some change had occurred over the 12 month period, as reported in participants' qualitative responses. This supports the work of Leudar et al, (1997), Vaughn & Fowler (2004) and Sorrell (2006) who found that reacting to the voice by distancing oneself acts to increase distress. This positive association also suggests that a reduction in Hearer Distance is associated with a reduction in distress. Further, participants' qualitative explanations
of change suggested that support which encourages acceptance of voices (such as the HVGs) may facilitate such a change.

Nayani & David (1996) and Chin (2005) have provided tentative suggestions that increased intimacy with voices is likely to occur over time, with the hearer moving towards a position of Dependence. However this was not observed in the current study. A possible explanation for this relates to the duration of the voice hearing experience. In Nayani & David’s (1996) study, the trend towards increased engagement and intimacy over time was observed when comparing participants with recent onset of voices (< 1 year duration) with the remainder of the sample who had heard voices for significantly longer. In the current clinical sample the mean duration of voice hearing experience was 16.5 years. Therefore, it may be that the increased intimacy and engagement with the voice observed by Nayani & David (1996) occurs near to the onset of the experience when hearers begin to realise they cannot deny or distance the voice completely. It may be that following this shift, a degree of intimacy and dependence which is tolerable for the hearer is reached, which without intervention remains fairly constant.

4.3.2 Interrelating in the Non-Clinical Sample

The finding that there was no significant change in interrelating between the voice and hearer over the 12 month period, indicates that as in the clinical sample, styles of relating are fairly enduring and fixed. This, as described above, may be due to the relatively long duration of the voice hearing experience (Mean 34.44 years), making the likelihood of the increased level of intimacy suggested by Nayani & David (1996) and Chin (2005) unlikely to occur spontaneously at this stage.
This finding may also reflect the fact that in the non-clinical sample, ratings of distress and negative content of the voices were predominantly extremely low, and participants reported high levels of control over the experience. Thus, presumably their motivation and inclination to significantly change their relationship with the voice would be low. In line with this suggestion, the two non-clinical participants who did report distress in relation to their voice at Time 1, had by Time 2 attempted to change their relationship with their voices through individual therapy and spiritual guidance.

As in the clinical sample, 55.6% (n =5) of the non-clinical participants reported that their relationship with their voice had changed, despite this not emerging as statistically significant on the VAY. This again likely reflects the complex and multi-faceted nature of relating, and the fact that idiosyncratic and subtle changes observed by the hearer may be in areas not directly assessed by the VAY (Fuller, 2006).

Non-clinical voice hearers, like clinical hearers in the present study, continued to perceive their voice as relating primarily from a position of Dominance (although to a lesser degree than clinical hearers). This finding suggests that Birtchnell's axis of Power may be more important for hearers in evaluating the voice hearing experience, as neither sample identified the voice's main relating position on the Proximity axis.

This is in line with the cognitive model of voice hearing (Chadwick & Birchwood, 1994; Birchwood & Chadwick, 1997) which suggests that perceptions of the voice as omnipotent are crucial in determining
emotional and behavioural responses to the experience. However, the current findings provide further support for the assertion that it is not perceptions of the voice's power *per se*, which determine the hearers response, but the way in which the voice is perceived to use the power (Vaughn & Fowler, 2004).

In the current study, 55.6 % (n = 5) of the non-clinical participants understood their voice hearing experience within a spiritual framework, and their predominant voice as being that of God or a 'higher being'. Hearers described these voices as being, by their nature, extremely powerful. However, as this power was used in a positive way (for example through guiding, advising and leading) as defined in Birtchnell's Positive Interpersonal Octagon (1996, 2002; see Figure 2), participants gave low ratings of negative forms of power used by the voice (Voice Dominance as measured by the VAY). The majority of non-clinical participants also reported minimal distress in relation to the voice. This therefore provides further support for the utility of Birtchnell's interpersonal theory in understanding the relationship between perceptions of the voice's power and distress.

In terms of proximity, the finding that Hearer Dependence was the main relating position of the non-clinical sample is in line with the work of Sorrell (2006). Also, this finding and the finding that a change in Hearer Dependence was negatively associated with a change in distress is in line with earlier work (Romme *et al*, 1992; Leudar *et al*, 1997; Nayani & David, 1996; Romme & Escher, 2000; Sorrell, 2006). These authors have suggested that increased intimacy and engagement with the voice may lower distress and thus would be expected to be present in the non service-using sample.
However, the finding that a change in Hearer Distance was also negatively associated with a change in distress in the non-clinical sample was contrary to hypotheses, based upon Sorrell’s (2006) study with a non-clinical sample. This finding was also contrary to the current findings in the clinical sample where a positive association existed between Hearer Distance and distress. This difference between clinical and non-clinical samples may be understood in relation to the work of Birchwood et al, (2000).

They reported that interrelating in clinical samples is characterised by ‘involuntary subordination to a powerful and omnipotent other’ (pp. 338), suggesting that attempts at distance seeking are unsuccessful. It therefore seems likely that the association between Hearer Distance and distress arises from repeated unsuccessful attempts at seeking distance from the voice. However, non-clinical hearers in the present study reported high levels of control, low levels of Voice Dominance and low levels of omnipotence. It could therefore be speculated that attempts at distancing the voice were successful, and consequently, not experienced as distressing. An example of this was one participant who reported taking a step back from the relationship with the voice, and indeed other relationships, in order to create space needed to deal with current life stressors.

This suggestion is in line with previous work (i.e., Honig et al, 1998; Romme et al, 1992) which has found that those who are able to set boundaries and control their voices feel more able to cope. Therefore it may be that distancing in non-clinical samples with high levels of control,
can serve an adaptive function whereas unsuccessful distance seeking in the clinical sample becomes maladaptive and distressing.

4.3.3 Beliefs about Voices in the Clinical Sample

The finding that the majority of clinical participants believed their voice to have malevolent intent is in line with previous research which has shown that clinical hearers typically experience voices as abusive, disruptive, frightening and controlling (i.e., Leudar et al, 1997; Honig et al, 1998; Csipke & Kinderman, 2006).

The finding that there was no significant change in beliefs about voices' malevolence over a 12 month period in the clinical sample offers partial support for the work of Csipke & Kinderman (2006), which is the only other longitudinal study of beliefs about voices in a clinical sample to date. In their six month follow up study, Csipke & Kinderman (2006) found that beliefs about malevolence and benevolence were enduring and stable, despite fluctuations in the frequency and severity of voices.

Csipke & Kinderman (2006) utilised the cognitive-behavioural model of voices proposed by Morrison (1998) to explain their findings. This model asserts that the belief that a voice has malevolent intent lead to feelings of threat and safety seeking behaviours; these behaviours then prevent disconfirmation of beliefs, which are consequently strengthened and maintained. This maintenance cycle is therefore proposed to continue regardless of the current frequency and severity of voices.

However, in the current study no significant changes were observed between Time 1 and Time 2 in the frequency and severity of the voices.
Thus the independence of beliefs from immediate characteristics of the experience could not be assessed and the current study cannot directly test this cognitive-behavioural model.

The finding that at Time 2 clinical participants believed their voices to be significantly less benevolent, contradicts the findings of Csipke & Kinderman (2006) and their suggestion that beliefs about voices' intent do not change without specific intervention. Whilst 66.7 % (n = 10) of the clinical sample were receiving interventions for voices, none of these were cognitive-behavioural interventions aimed at weakening beliefs about voices, and would have been unlikely to focus on reducing beliefs about benevolence. Therefore these interventions seem unlikely to be the cause of this change.

Thus Csipke & Kinderman's (2006) assertion that beliefs about voices' benevolence are stable and enduring was not supported. This is in line with the cognitive model proposed by Birchwood & Chadwick (1997), which suggests that beliefs about the voices' intent are not static and unchanging, but may develop over time in the context of the relationship with the voice. Further, the finding that voice content did not change, but that beliefs about benevolence did, adds further support to the literature which suggests that voice content alone is insufficient in accounting for beliefs about voices (Chadwick & Birchwood, 1994; Birchwood & Chadwick, 1997).

The finding that a significant decrease in beliefs about benevolence was not associated with an increase in beliefs about malevolence suggests that rather than lying at two ends of a continuum, these beliefs represent
separate constructs. It appears possible for both types of belief to exist concurrently, and also that change in one does not necessarily impact upon the other. This is in line with previous findings (Close & Garety, 1998; Vaughn & Fowler, 2004; Csipke & Kinderman, 2006) that some hearers are ambivalent about the voices and believe them to have both malevolent and benevolent intent. This further points to the complexity and interpersonal nature of the voice hearing experience, which as with many social relationships are often not experienced as 'all bad' or 'all good'.

Csipke & Kinderman (2006) and others (Chadwick & Birchwood, 1994; Birchwood & Chadwick, 1997) have suggested that beliefs about a voice’s intent underlie the hearer’s behavioural (engagement or resistance) and emotional response. However, in the current study, the significant decrease in beliefs about the voices benevolent intent was not associated with a change in level of distress experienced. This suggests that beliefs about the presence of benevolent intent may be less influential in the emotional response to voices than beliefs about the absence or presence of malevolent intent. This suggestion is further supported by the work of Sorrell (2006), who found that beliefs about voices’ malevolence and omnipotence were predictive of distress, whereas beliefs about benevolence were not.

The finding that there was no significant change in beliefs about the voice’s omnipotence (power) over the 12-month period in the clinical sample provides further support for the cognitive model of voices proposed by Birchwood et al, (2000; 2004). These authors suggest that appraisals of the voices power are determined by an individual’s
interpersonal schema which predisposes them to negative social comparisons. This model would therefore predict that perceptions of the voice as powerful would be unlikely to change over a period of 12 months as interpersonal schema or 'core beliefs', are by their nature long-standing and extremely difficult to change (Padesky, 1994). However, the current study did not provide a direct test of this model and therefore this suggestion is tentative.

4.3.4 Beliefs about Voices in the Non-clinical Sample

Due to the exploratory nature of this element of the study, interpretation of these findings should be viewed as tentative. As described above in relation to the clinical sample, the finding that there was no significant change in beliefs about the voices' omnipotence in the non-clinical sample may provide further support for the cognitive model of voices proposed by Birchwood et al, (2000; 2004) and the role of interpersonal schema. However, for the reasons described above in relation to the clinical sample, this suggestion is tentative.

The finding that there were no significant changes in beliefs about the voices' malevolent and benevolent intent in the non-clinical sample is in line with the findings of Csipke & Kinderman (2006) in their clinical sample. This may provide further evidence for the stability of beliefs about the voices' intent over time, and also for the suggestion that the voice hearing experiences of clinical and non-clinical hearers can be viewed as existing on a continuum, rather than as separate and distinct experiences (Johns et al, 2002).
In their clinical sample, Csipke & Kinderman (2006) utilised Morrison's (1998) cognitive-behavioural framework to explain the maintenance of beliefs about voices' (mainly malevolent) intent, through safety seeking behaviours. However, this model has less applicability when explaining the maintenance of beliefs about benevolence. In the non-clinical sample the maintenance of beliefs about the voices' high benevolence and low malevolence could be explained by the finding that over the 12 month period, the voices' content continued to be perceived as non-threatening and predominantly positive and that voices were not perceived to be highly dominating or intrusive.

In addition to this, the majority of the non-clinical participants in the current study understood their experiences within a spiritual framework. Many were actively involved in the spiritualist community, which provided organized belief-validation, social support and positive meaning to voices. Therefore, it is likely that these spiritual understandings and associated beliefs about the voices' benevolence are maintained and reinforced through involvement with the spiritualist community.

The finding that non-clinical hearers in the current study reported low levels of distress would also be explained by previous research which suggests that access to such organised belief validation is associated with less distress and the perception of voices as 'life enhancing' (Davies et al, 2001 & Jackson & Fulford, 1997).
4.4 Limitations

4.4.1 Sample Size and Recruitment

A significant limitation of the current study was the sample size (clinical n = 18, non-clinical n = 9). A post hoc power calculation indicated that the study was under powered. This means that there was an increased risk of making a type II error, that is, the failure to detect an effect which exists. The presence of two medium but non-significant correlations (between malevolence and distress and benevolence and distress in the non-clinical sample) indicates that this may have been the case in at least some elements of the study.

Difficulty with recruitment can be accounted for in several ways. At Time 1, three researchers collaborated in an attempt to recruit 64 participants, in order that the study would have sufficient statistical power. Despite this collaboration recruitment was significantly lower (clinical n = 32, non-clinical n = 18), although comparable to previous clinical samples (i.e. Hayward, 2003; Vaughn & Fowler, 2004) and in excess of all previously reported non-clinical samples. Difficulties in recruitment of the clinical sample included professionals' beliefs that their clients were 'too ill' to be interviewed or that talking about voices represented 'collusion' and was therefore unhelpful.

Also, some potential clinical participants reported not wanting to discuss the experience with a stranger or declined due to having recently taken part in similar research. Further, of those clinical participants who agreed to take part in the study, the majority were attending hearing voices groups. These participants therefore likely represent a biased sample, who
are skilled at thinking and talking about their voices, rather than the full range of clinical voice hearers.

Difficulties in recruiting non-clinical participants into the study may reflect social stigma about the experience and associations with 'madness'. This is likely to be particularly true for those non-clinical hearers who do not have organized belief frameworks for the experience, such as through the spiritualist church. Therefore the self selecting non-clinical sample is likely to be biased towards those people who have integrated and coherent ways of understanding and talking about the experience. This sample may therefore represent an extreme view of non-clinical voice hearing, rather than the true range of experiences which may occur at various points on a continuum between clinical and non-clinical experiences.

At Time 2, after a 12 month period, the attrition rate was 43.75% in the clinical sample and 50% in the non-clinical sample. The reasons for non-inclusion at Time 2 are presented in Table 3. The only comparable longitudinal study of voice hearing was that of Csipke & Kinderman (2006). This study had an overall attrition rate over the 6 month period of 65.22%, reflecting the difficulties of longitudinal follow-up. Thus, the retention rate in the current study was superior to previous work, despite the study being underpowered.

4.4.2 Ethnicity & Diversity

The lack of ethnic diversity in the clinical and non-clinical sample may also affect the confidence with which the results can be generalised. The most likely reason for this being the demographic characteristics of the population served by the NHS Trusts from which clinical participants
were recruited. These demographic characteristics are also similar to those found in previous voice hearing research (Birchwood & Chadwick, 1997; Hayward, 2003; Vaughn & Fowler, 2004). However, this presents a significant limitation when thinking about the applicability of these findings to clinical settings, given that there appears to be a greater prevalence of voice hearing in non-white-British individuals (Johns et al., 2002). This is a potentially area for further research.

4.4.3 The Applicability of the Relational Framework

The focus in the current study on the relationship with the voice is based on previous findings which suggests voices are viewed as interpersonal others (i.e. Leudar et al., 1997; Garrett & Silva, 2003). However, some participants' responses in both the clinical and non-clinical sample suggested that voices were not understood in this way. For example, two participants reported voices being present in the background, but that they were rarely spoken to by, or responded to, the voices. Similarly, several non-clinical participants reported hearing infinite numbers of voices, which were perceived to be those of numerous spirits who were around at the time. Therefore, low ratings on the VAY, particularly in the non-clinical sample, may represent a lack of relating in general, rather than low levels of Birtchnell's negative relating.

Further, the focus on the predominant voice may be a limitation as several participants from both the clinical and non-clinical sample reported that they heard multiple voices. Some participants reported that their voices were quite different and therefore focusing on one voice may have discounted or distorted important information. Similarly, interactions
between the relating styles of several voices and beliefs held about these voices could not be explored.

4.5 Clinical Implications
The results of the current study suggest that styles of interrelating between voice and hearer are relatively stable and enduring, as are beliefs about the voices' malevolent intent and power. The current study also corroborates previous research which suggests that relating styles (specifically Voice Dominance and Hearer Distance) and beliefs about voices (specifically omnipotence and malevolence) are associated with distress in clinical voice hearers. These findings therefore suggest that interrelating and beliefs about voices are potential targets for psychotherapeutic intervention.

The stability of beliefs and relating styles over time suggests that negative relating patterns and beliefs about malevolence and omnipotence may serve as ongoing vulnerability factors for distress. For example, even at times when voices are not present, construal of the voice as dominant and powerful, and beliefs about the voices malevolent intent are likely to remain stable. Thus, any re-emergence of voices is likely to be understood and responded to within this enduring framework, with consequent negative emotional and behavioural reactions. This suggests that psychotherapeutic interventions may be important and successful even in periods where a person is not currently experiencing voices.

Cognitive behavioural interventions for voice hearing has focussed on improving 'insight' into the experience and assisting individuals to alter
their beliefs about voices, for example by re-attributing them as internally generated rather than as 'real' (Chadwick & Birchwood, 1994; Morrison et al, 2004). However, the findings in the current study corroborate previous research (Romme & Escher, 2000; Leudar et al, 1997), which suggests that accepting and engaging with the voices may be adaptive and reduce distress for some hearers, rather than necessarily challenging beliefs about the experience. This approach is in line with therapeutic interventions highlighted by the HVN, Romme & Escher (2000), and Knight (2006). Further, Knight (2006) suggests that seeking to challenge and modify a person's belief system may be construed as disempowering and even unethical.

Therefore, it may be that utilising a relational framework in therapy, within which the therapist accepts the experience, and seeks to explore styles of interrelating, is both more therapeutic and ethical than approaches which aim to challenge and modify hearers' beliefs. Some preliminary work utilising concepts of relating to the voice within psychological therapy (Leudar & Thomas, 2000; Davies et al, 1999) has shown this to be a potentially successful intervention in reducing distress. Hayward et al, (2007) have developed a form of 'relating therapy' for voices, based specifically on Birtchnell's (1996, 2002) theory. This therapy is aimed at raising awareness of the negative relating of the hearer towards the voice, with respect to both power and proximity.

Various techniques are employed to empower the hearer to develop a more assertive and balanced relationship with the voice. For example, the 'empty chair' technique, developed in gestalt therapy, encourages the hearer to directly converse with and question the voice as if it were located
in the therapy room. This enables the hearer to both reduce distance seeking behaviour and experiment with more assertive ways of interacting with the voice. Whilst not directly seeking to challenge the hearer’s beliefs about the voice, adopting a different position in the relationship has the potential to lead to a re-evaluation of the power that the voice has over the hearer. Preliminary evaluation of the usefulness of this approach demonstrated positive results in terms of reducing distress, and also in other areas such as increasing the hearers’ self esteem (Fuller, 2006).

These studies are preliminary and further research will need to be undertaken in order to demonstrate the efficacy of, and further develop, specific ‘relating therapy’. However, the findings of the current study have clinical implications, not only for specific psychological therapies, but also for ‘front line staff’, such as nurses on psychiatric wards.

As described in the introduction to this thesis, traditional clinical approaches and ‘coping strategies’ commonly suggested by professionals include trying to ignore or distract oneself from the voices (Tarrier et al, 1990). This is often based on the premise that voices are meaningless symptoms of an ‘illness’ and that professionals should not encourage or collude with the idea that voice are ‘real’. However, the results of this study contribute to the growing body of evidence which suggests that accepting and engaging with voices may be a more effective coping strategy.

This suggests that professionals need to be more willing to accept and explore the meaning of the voice hearing experience with their clients. The findings also suggest that professionals should explore a range of
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coping strategies with hearers, for example, talking back to the voice assertively. This highlights the need for the dissemination of these approaches amongst 'frontline' professionals and care staff.

4.6 Further Research

Future work should aim to recruit larger samples of both clinical and non-clinical voice hearers. Replication of the current study with a sufficiently powered sample size would help to clarify further whether relating styles and beliefs about voice tend to change over time. A larger sample size would also allow for further investigation of the associations between relating styles, beliefs about voices and distress, through the use of multivariate statistical analyses.

Future research should also aim to recruit a broader spectrum of both clinical and non-clinical voice hearers, rather than those predominantly from HVGs or the spiritualist community. This will help to further clarify the notion that voice hearing exists on a continuum within the population, and that the experiences of clinical and non-clinical hearers are not categorically distinct, as they may appear due to biased samples in the current study.

An important area to further investigate is the notion that changes in relating styles, specifically the development of increased intimacy, occur nearer to the onset of the voice hearing experience. If this held true it could have important implications for the timing of psychological interventions for voice hearers in mental health services. This would require replication of the current study with hearers who had recently
begun to hear voices, and longer-term sequential follow-up (for example at 6 months, 1 year, 2 years etc). This may be possible by recruiting participants from Early Intervention in Psychosis Services, although identifying non-clinical participants for such a study could be extremely difficult.

Given the discrepancy in the current study between the lack of change reported on the VAY and through participants' qualitative responses, it may be beneficial to think about alternative or additional ways of assessing interrelating within Birtchnell's framework. Previous work in the area suggests that qualitative analysis may be necessary in order to capture the fluid and idiosyncratic nature of change in this area (Fuller, 2006; Chin, 2005).

4.7 Conclusions
The current study found that styles of interrelating between voice and hearer are relatively stable over a 12-month period in both clinical and non-clinical voice hearers. Suggested mechanisms by which these styles of relating are maintained include social and cultural factors, the individual's core interpersonal schema, long duration of voice hearing experience and satisfaction with the current relationship. The current study also found support for the notion that negative styles of relating are associated with increased distress, and that increased engagement with voices with a reduction in distress.

In line with previous work, the current study found support for the notion that beliefs about voices power and malevolent intent are stable over a 12 month period in a clinical sample. However, contrary to previous work,
beliefs about benevolence were found to significantly decrease over a 12 month period in a clinical sample. This change was not associated with any significant change in level of distress experienced and it is therefore suggested that beliefs about benevolence are less influential than beliefs about malevolence and omnipotence in determining the emotional response to voices. In the non-clinical sample, there were no significant changes in beliefs about voices over the 12 month period. Suggested mechanisms which may act to maintain beliefs include safety seeking behaviours, core interpersonal power structures and access to organized belief validation.

Clinically it is suggested that these enduring styles of interrelating and beliefs may serve as vulnerability factors for future distress. Therefore it may be appropriate to work psychotherapeutically in these areas even when voices have remitted. It is argued that interventions which promote acceptance of and engagement with the voice may be more appropriate than approaches which seek to challenge a person's belief system. Addressing styles of interrelating with voices within the therapeutic encounter is one such approach.

Despite the methodological limitations described, the current study makes a significant contribution to the literature in several ways. Firstly it investigated the longitudinal nature of interrelating with voices, which was not previously explored. Secondly it replicated and extended previous research which explored the longitudinal course of beliefs about voices by including beliefs about omnipotence, by using a more robust method and by including both clinical and non-clinical hearers. Future work should attempt to recruit a larger, more diverse sample and conduct
longer-term sequential follow up, including those people who have recent onset of voices.
References


Maitland, S. Extracted from "Is there a link between madness and creativity?". The Independent on Sunday, 18th March 2007.


Major Research Project


MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix E. Consent form for clinical participants

**HEADED PAPER OF APPROPRIATE NHS TRUST**

Centre number:  
Participant Identification Number:

**CONSENT FORM**

**Title of Project:** An exploration of the experience of hearing voices within a relational framework

**Name of Researcher:**

I confirm that I have read and understand the information sheet dated □ ................. (version ............... ) 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 withhold personal information or to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.

I understand that sections of any of my medical notes may be looked at by responsible individuals from (Trust name) where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.

I give permission for my GP Dr (insert name of GP) to receive details of my participation in this study.

I give permission for my interview to be audio-tape

Name of participant        Date              Signature

Name of Researcher         Date              Signature

*1 for participant; 1 for researcher; 1 to be kept with care team notes*
Appendix F. Consent form for non-clinical participants

Centre number:
Participant Identification Number:

CONSENT FORM

Title of Project: An exploration of the experience of hearing voices within a relational framework

Name of Researcher:

I confirm that I have read and understand the information sheet dated 11th November 2005 (version 4) 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 withhold personal information or to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.

I agree to take part in the study.

Name of participant Date Signature

Researcher Date Signature

1 for participant; 1 for researcher.
Appendix G. Care co-ordinator follow-up letter for clinical sample

Nicky Hartigan
Department of Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH

Dear (name of Care Coordinator),

Re: (client name)

My name is Nicky Hartigan and I am part of the research group from the University of Surrey which is currently exploring people's experiences of hearing voices. In (date) 2006 my research colleague (name of original interviewer) interviewed (client name) about his/her voice hearing experiences. I would now like to invite (client name) to be re-interviewed approximately 12 months following his/her initial interview. The purpose of this is to help us explore whether or not people's voice hearing experiences and their relationships with their voices tend to change over time.

Please could you contact me if there is any reason why it is no longer appropriate for me to re-contact and re-interview this person. If I do not hear from you within 3 weeks I will proceed with contacting the client. Thank you in advance for your time.

With best wishes

Nicky Hartigan (Trainee Clinical Psychologist)
Department of Clinical Psychology, University of Surrey

Email: nickyhartigan@[email]

Telephone: [number] (please leave a message)

In writing: at the address above
Appendix H. Participant follow-up letter for clinical sample

Nicky Hartigan
Department of Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH

(Participant name)
Address

Date

Dear (participant),

My name is Nicky Hartigan, I am part of the research group from the University of Surrey which is currently exploring people’s experiences of hearing voices. As you may remember, as part of this research my colleague (name of interviewer) interviewed you about your voices on (date) 2006. As I believe (name of interviewer discussed with you at the time, I will be attempting to re-interview all participants 12 months after their first interview. The purpose of this is to help us explore whether or not people’s voice hearing experiences and their relationships with their voices tend to change over time.

I would therefore like to invite you to be re-interviewed about your experiences. If you agree to this I would like to come to (place first interview conducted) to complete the interview. Please could you contact me using the details below, to let me know whether or not you would like to be re-interviewed and if so whether (proposed date) is a good date for you. If I do not hear from you I will try to contact you by telephone. Please may I stress at this point that you are under no obligation to be re-interviewed, although your continued participation would be greatly appreciated. Thank you in advance for your time.

With best wishes

Nicky Hartigan (Trainee Clinical Psychologist)
Department of Clinical Psychology, University of Surrey

Email: nickyhartigan@...com
Telephone: (please leave a message)
In writing: at the address above

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Appendix I. Participant follow-up letter for non-clinical sample

Nicky Hartigan
Department of Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH

(Participant name)
Address

Date

Dear (participant),

Thank you for participating in the voice hearing research we are undertaking at the University of Surrey. You were interviewed by my colleague (name) on (date) this year about your experience of voice hearing. As I believe (name of first interviewer) discussed with you at the time, I would like to invite you to be re-interviewed about your experiences. The purpose of this is to help us explore whether or not people's voice hearing experiences and their relationships with their voices tend to change over time.

I am aiming to re-interview people within 2 months either side of their first interview, which in your case would be between (dates) 2007. Please contact me using the details below, to let me know whether or not you would like to be re-interviewed or to ask any questions you may have. Please may I stress at this point that you are under no obligation to be re-interviewed, although your continued participation would be greatly appreciated. Thank you in advance for your time.

With best wishes

Nicky Hartigan (Trainee Clinical Psychologist)
Department of Clinical Psychology, University of Surrey

Email: nickyhartigan@^Bcom
Telephone: (please leave a message)
In writing: at the address above
Appendix J. Distress plan

Provide person with opportunity to discuss issues with researcher at the end of the session.

If the person experiences further distress outside of interview situation:

1. Is there a family member/friend that they would feel able to talk to? If yes how would they contact this person, what would they do if person was unavailable (e.g. another person or move on to next step)?

2. Health care professional – check person has contact details of relevant health care professional (e.g. key worker) – would they feel able to contact this person if they were distressed.

3. Additional organisations person could contact e.g. Hearing Voices Network confidential help line – 0845 1228642 (Mon-Fri 10-4)

4. Check that person is aware that if they are experiencing extreme distress and are concerned they can contact their GP, or A&E.
Appendix K. Demographics form

Participant number and location for this study, e.g. participant 1

Name:

Age:

Gender:

Duration of voice hearing:

Name/identity of dominant voice:

Current diagnosis (corroborated by clinical notes):

Number of hospital admissions:

Current medication:
1. How would you describe your ethnicity?

(Please choose one section from (a) to (e) then 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
## Appendix L. Kolmogorov-Smirnov test results

### Tests of Normality (Time 1 Data)

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Log of Research Experience
Log of Research Experience

Research Log Checklist

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<td>Devising and administering questionnaires</td>
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<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
<td>Yes</td>
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<tr>
<td>16</td>
<td>Setting up a data file</td>
<td>Yes</td>
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<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
<td>Yes</td>
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<td>18</td>
<td>Choosing appropriate statistical analyses</td>
<td>Yes</td>
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<td>19</td>
<td>Preparing quantitative data for analysis</td>
<td>Yes</td>
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<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
<td>Yes</td>
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<td>21</td>
<td>Summarising results in figures and tables</td>
<td>Yes</td>
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<td>22</td>
<td>Conducting semi-structured interviews</td>
<td>Yes</td>
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<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
<td>Yes</td>
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<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
<td>Yes</td>
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<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
<td>Yes</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
<td>Yes</td>
</tr>
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<td></td>
<td>Log of Research Experience</td>
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<td>27</td>
<td>Producing a written report on a research project</td>
<td>Yes</td>
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<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>Yes</td>
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<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>No</td>
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<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td>Yes</td>
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