A qualitative study exploring the experience of ‘relating therapy’ that aims to modify distressing relationships with voices: Perspectives from voice hearers, therapists, relatives and referrers.

by

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Volume I
I certify that any material in this portfolio which is not my own work has been referenced as such and that no material is included for which a degree has previously been conferred upon me.

Elodie Fuller, 2006
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Introduction to the Portfolio for the PsychD in Clinical Psychology

This portfolio comprises two volumes of work completed for the PsychD in Clinical Psychology. Volume I includes the academic dossier, which contains four essays covering the four core training areas; the clinical dossier, which includes summaries of all the placements completed over the three years of training and summaries of five case reports; and the research dossier, which is comprised of the research log checklist, the service related research project and the major research project.

Volume II contains all the written work and documentation concerning the clinical aspect of the course. This includes the five case reports, one from each of the four core placements and one from a specialist placement. Placement contracts, logbooks of clinical experience, and placement evaluations are presented for each of the six placements. Due to the confidential nature of the information in volume II, it will be stored within the Department of Psychology at the University of Surrey.
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INTRODUCTION

In order to discuss to what extent psychotic experiences are understandable and meaningful it is helpful to first clarify the definitions of the most relevant terms. The defining feature of a psychotic experience can be understood as a gross impairment of reality-testing: This may involve a breakdown of perceptual, cognitive and sensorimotor processes that normally enable an individual to determine his or her relationship with the external physical and social environments (Reber, 1995). In this essay, psychotic experiences will include delusions and hallucinations.

Oltmanns (1988) suggests that the definition of a delusion includes a number of defining characteristics (none of which are necessary or sufficient): The belief is held with firm conviction, although the balance of evidence indicates that it is incredible; the belief is not shared by others; the individual is pre-occupied with the belief; it involves personal reference; it is a source of distress or interferes with the individual’s social or occupational functioning; and the individual does not report attempts to resist the belief (as cited in Garety & Hemsley, 1994, p.8-9). A hallucination refers to a perceptual experience (such as auditory, visual or tactile) that has all the compelling subjective properties and impact of a real sensory impression, but in the absence of an appropriate physical stimulus for that sensory modality (Reber, 1995).

It is also important to clarify the present interpretation of the terms understandable and meaningful. For the purposes of this essay, understandable will refer to the notion of psychotic experiences being explicable: For example in terms of the extent to which theories can adequately explain the formation and maintenance of delusions and hallucinations. Broadly, meaningful will refer to the extent to which the content and interpretations of these experiences are telling about the individual’s life, and have an important and meaningful effect on their life.

This essay will argue that psychotic experiences are both understandable and meaningful. First the traditional psychiatric view will be outlined, which suggests that genuine psychotic experiences are not psychologically understandable or meaningful in light of the dichotomy that exists between psychotic and normal experiences. Then
evidence that delusions and hallucinations may be continuous with 'normal' experiences will be presented; which supports the notion that they are understandable and meaningful. A cognitive approach to the understanding of psychotic experiences will be discussed, followed by consideration of maintenance factors. This model offers an understandable account of the formation and maintenance of psychotic experiences. It also highlights the crucial role of personal meaning in the experience of delusions and hallucinations. Implications for treatment will then be explored.

THE TRADITIONAL PSYCHIATRIC VIEW

Historically, psychotic experiences have been regarded as epitomising 'madness' and irrationality. The traditional psychiatric medical model has considered psychotic experiences neither understandable nor meaningful: The suggestion is that they are qualitatively different from non-psychotic experiences, and therefore cannot be explained or understood in terms of 'normal' processes. Within this psychiatric model, it has not been relevant to consider the meaning of psychotic experiences, and instead the emphasis has been on determining whether the experience fulfils the criteria of a delusion or hallucination, and of what disorder it is symptomatic (Chadwick, Birchwood & Trower, 1996).

Jaspers (1913) suggested a distinction between 'primary' and 'secondary' delusions: 'Primary' or genuine delusions are said to originate from an organic pathological experience such as disease, or a personality change. In this way, it is proposed that they are phenomenologically irreducible and therefore not understandable. 'Secondary' delusions or delusion-like ideas are linked to affect, hallucinations or other processes, and to this extent may be interpreted as understandable (as cited in Garety & Hemsley, 1994, p.2). The primary/secondary distinction remains influential in Western Psychiatry; preserving the notion that the development of genuine psychotic experiences (such as delusions) is rooted in organic pathology and is therefore not understandable in psychological terms.

Similarly, traditional psychiatry renders the meaning of psychotic experiences irrelevant. For example, when treating auditory hallucinations, the identity, content,
interpretation and subsequent meaning of the voices to the individual are insignificant from a psychiatric point of view. Berrios (1991) describes the content of delusions as meaningless:

Delusions are likely to be empty speech acts, whose informational content refers to neither world nor self. They are not the symbolic expression of anything. Its 'content' is but a random fragment of information 'trapped' in the very moment the delusion becomes crystallized (p.12).

The suggestion is that the only meaningful interpretation of a delusion or hallucination is as a symptom of underlying pathology; and the focus is on treatment of that pathology (Chadwick et al., 1996).

However, it seems likely that this categorical division between psychotic and 'normal' experiences increases the risk of stigmatisation of clients experiencing delusions and hallucinations: It indicates that he or she is different in a clearly distinct way. This may contribute to lowered self-esteem and increased distress (Kingdon & Turkington, 1994). By portraying psychotic experiences as 'un-understandable' this model may have inhibited the exploration into the possible psychological processes involved in the formation and maintenance of psychotic experiences. Similarly the significance of the personal meaning attached to these experiences has tended to be overlooked, whereas this is crucially important from a psychological point of view. Furthermore, evidence suggests that the proposed dichotomy between those principles that determine ordinary processes and behaviour and those that govern true psychotic experiences may, in fact, be artificial.

### CONTINUITY BETWEEN 'NORMAL' AND PSYCHOTIC EXPERIENCES

The notion of continuity between psychotic and 'normal' experiences suggests a continuum between delusions and normal thoughts; and hallucinations and normal mental imagery. Evidence of continuity includes the demonstration that delusions and hallucinations may arise in some 'normal' individuals in certain situations (including hostage situations, solitary confinement and sensory deprivation, food and water
deprivation and sleep deprivation) (Kingdon & Turkington, 1994). Oswald (1974) conducted an experiment with six medical students who were kept awake for 108 hours. He referred to experiences similar to paranoid delusional thinking, and auditory and visual hallucinations (as cited in Kingdon & Turkington, 1994, p.18).

Zimbardo, Andersen and Kabat (1981) demonstrated that irrational and paranoid beliefs resembling delusions may be provoked in the general population through undetected hearing loss: Partial deafness was hypnotically induced in a sample of college students, without their awareness. Two confederates engaged in a well-rehearsed conversation during which they ‘laughed at an incident mentioned, [and] made a funny face’ (p.1530). As predicted, participants who experienced partial deafness without awareness of its source were significantly more paranoid on the Minnesota Multiphasic Personality Inventory compared to controls. They were also rated by themselves and independent judges as significantly more irritated, agitated, hostile and unfriendly. While recognising the artificiality of this experiment, it seems that this and other studies are consistent with the notion that psychotic experiences may be understood in terms of the processes involved in normal experience. It also demonstrates that delusion-like beliefs have meaningful effects on mood and behaviour.

Evidence also suggests that, like any beliefs, delusions can be understood as varying on a number of dimensions. One of the earlier applications of the multidimensional model of delusions was conducted by Garety and Hemsley (1994). They aimed to describe dimensions or characteristics along which delusions may vary. Fifty-five ‘deluded’ patients (as clinically identified) completed the ‘Characteristics of Delusions Rating Scale’, consisting of eleven belief characteristics derived from the literature on delusions. The authors concluded that the most consistent characteristic of all delusions was high conviction. Two thirds demonstrated high resistance, and over half described their beliefs as extremely worrying and causing unhappiness. The remaining dimensions showed high inter-subject variability. There were very few strong correlations between the items, but a principal components analysis identified four groups of variables: The authors labelled them distress, belief strength, obtrusiveness and concern. Delusions can therefore be understood as
multidimensional. It is interesting to note that the frequency of resistance and subjective distress indicates that many patients were attaching some negative emotional meaning to their delusions.

It is also significant, in terms of establishing the continuity of psychotic and normal experiences, to consider studies of brain activity. Carter (2000) reports that 'hallucinations, imagination, and 'real' seeing are essentially the same thing as far as the brain is concerned' (p.206). She argues that brain scans reveal activity in the same vision and recognition areas of the brain regardless of whether the individual is imagining or actually looking at their bedroom. This indicates that there is some level of continuity between externally-generated sensory experiences and those that are self-generated (e.g. hallucinations). Furthermore, it would seem to suggest that an individual experiencing a hallucination would be inclined to attach as much meaning to that experience as they would in a 'normal' experience.

Therefore it makes sense to consider the psychological processes involved in psychotic experiences on a continuum with 'normal' processes. This highlights the fact that delusions and hallucinations may be just as meaningful as ordinary experiences: And indeed indicates that they are as understandable, for example in terms of some disturbance in normal cognitive functioning.

A COGNITIVE MODEL OF PSYCHOTIC EXPERIENCES

This section will outline a cognitive model of the formation and maintenance of psychotic experiences, which incorporates a number of theories and a range of evidence. The model is presented in order to highlight an understandable account that emphasises the role of personal meaning, rather than as the only explanation of psychotic experiences.

Predisposing Factors and Triggers

Garety, Kuipers, Fowler, Freeman and Bebbington (2001) suggest that the most common route to the development of psychotic symptoms arises through cognitive
and affective disturbances. In the initial phase a triggering event causes a disruption of cognitive processes in a predisposed person. The trigger may be a life event (involving failure, loss or stress) or biological in origin (such as drug misuse). Predisposing factors may include biological vulnerability, social factors (such as trauma, disadvantage or exclusion) and psychological factors (such as schema or cognitive biases).

Garety et al. (2001) propose that life experiences contribute to the formation of negative schematic models of the self and the world, for example ‘the world is a dangerous place’, ‘I am a bad person’. These schema thereby govern the processing of self and social information, and bias interpretation of events. Negative schema may also influence the content of the psychotic experience: For example the former may become manifest in a persecutory delusion (a belief that they’re out to get me), and the latter may determine the content of an auditory hallucination (‘you’re bad’). Even in this early stage of the formation of a psychotic experience, it is clear that the process is understandable within a cognitive framework. Furthermore, it seems that psychotic experiences are significant and meaningful in that they may reflect underlying beliefs about the self and the world.

**Cultural and Ethnic Diversity**

When considering social context and schema, the importance of acknowledging diversity issues in attempting to understand psychotic experiences is clear. Research has consistently found a higher incidence of psychotic symptoms amongst African-Caribbeans in the UK. For example, Bhugra et al. (1997) screened people who made contact with two health districts in London for psychotic symptoms, over a one-year (Whites) or two-year (ethnic minorities) period. Of the 100 people who met their criteria for schizophrenia, the incidence rate was significantly higher for African-Caribbeans than Whites. It was also higher for Asians aged over 30, particularly women. The proportion of African-Caribbeans demonstrating a poor outcome at one-year follow-up (defined as relapse, still in the first episode, or suicide) was two and a half times greater (60%) than that of Whites (24%), and significantly more common than that of Asians (17%).
Garety et al.’s (2001) model would suggest that the higher incidence rate of psychotic symptoms amongst ethnic minorities could be related to the likeliness of these people forming negative schematic models of themselves and the world. Sharpley, Hutchinson and McKenzie (2001) have argued that being the object of racial discrimination is a form of social adversity and contributes to problems with self-perception and identity. Bhugra et al. (1997) examined differences between African-Caribbean, Asian and white people diagnosed with schizophrenia on seven sociodemographic factors. Their study indicated that African-Caribbeans had a significantly higher proportion of unemployment and suggest that this may be a key vulnerability factor for relapse. Bhugra and Bhui (2001) suggest that African-Caribbean people born in Britain are exposed to a social environment in which they suffer exclusion, low social status, and an internalised sense of inferiority and disadvantage. These factors could all be construed as predisposing factors within the framework of Garety et al.’s (2001) model in that they contribute to the development of negative schema which may then influence the processing and content of psychotic experiences.

Cognitive Disturbance and Anomalous Experience

So for a predisposed person, a triggering event may cause a disturbance in cognitive processes; which leads to anomalous conscious experiences. Frith (1992) suggests that anomalous experiences may result from a breakdown in the cognitive processes that govern the monitoring of the intentions and actions of the self and others. The individual does not recognise the ‘sense of effort’ or prior intention that accompanies a deliberate act. They can therefore only monitor their own actions using peripheral feedback (observing the actual consequences of one’s actions or thoughts); which leads to an experience of their thoughts and actions as ‘caused’ and thus alien (p.114). Similarly, they may make incorrect inferences about the intentions of others (p.115). Garety et al. (2001) highlight that this basic cognitive disturbance leads to anomalous conscious experiences (for example, actions experienced as unintended, thoughts experienced as voices, two unconnected events experienced as causally linked). They
report that these cognitive and perceptual changes are experienced as unfamiliar, external and often threatening.

The Role of Emotion

Garety et al. (2001) propose that both the triggering event and these anomalous conscious experiences lead to important emotional changes. Garety et al. (2001) suggest that these emotions influence the immediate processing of the anomalous experiences and thereby impact on the content. For example, a woman who is raped may become anxious and depressed, and this would be exacerbated by an anomalous experience such as hearing their thoughts as voices, which may in turn influence the content of the voices (for example ‘they’re out to get me’, ‘you’re dirty’). Birchwood (2003) reports that depression, social anxiety, distress, fear and anger are commonly associated with the early stages of psychotic experiences. Again it is clear that the meaning attached to one’s experiences plays a central role in the formation of psychotic experiences.

Cognitive Biases and the Search For Meaning

Garety et al. (2001) suggest that the confusing anomalous experiences combined with the emotional changes seem personally significant. This activates a search for an explanation of their cause and for the meaning of the experience. Biased appraisal processes contribute to a judgement that these unfamiliar experiences are externally caused. Garety and Freeman (1999) review literature regarding understandable cognitive biases involved in delusions. There is evidence demonstrating that people with delusions tend to ‘jump to conclusions’: For example, in a probabilistic reasoning task Garety and Hemsley (1994) found that deluded participants required less information before reaching a decision than either non-deluded psychiatric and ‘normal’ controls. Garety and Freeman (1999) reviewed a further fourteen studies and found this bias in eleven of them. They conclude that under certain conditions, this ‘jumping to conclusions’ data-gathering bias may contribute to erroneous inferences. This therefore demonstrates an understandable cognitive bias involved in delusion formation.
Another may be the defensive attribution bias proposed by Bentall and colleagues. They argue that negative or threatening events (for example the anomalous experiences combined with negative emotional changes) evoke external causal attributions evident in paranoid or persecutory delusions (for example 'MI5 are following me'). This is because negative schemata or self-representations are primed by these events, which heighten discrepancies between self-representations and self-ideals (Bentall & Kaney, 1996). The external attribution is defensive or self-protective in that they reduce the person’s awareness of these discrepancies.

Bentall and Kaney (1996) compared scores on the Dysfunctional Attitudes Scale amongst participants who were deluded, deluded and depressed, depressed and controls. As predicted, the depressed and all the deluded participants scored significantly higher. They suggest that these results support the proposal that people with paranoid delusions have negative self-representations or schema, which is consistent with Garety et al’s (2001) model of psychotic symptoms. Garety and Freeman (1999) review a further eight studies and conclude that people with persecutory delusions are most likely to attribute negative events externally to other people when the material is self-referent. These results are therefore consistent with the defensive attribution hypothesis, although Garety and Freeman (1999) emphasise that this hypothesis is not supported in terms of internalising attributions for positive events (p. 136). Yet the evidence does indicate that there are understandable cognitive biases occurring in people experiencing psychotic symptoms. Furthermore, this process highlights the fact that these people are searching for the meaning of their experiences.

It also seems that some form of understandable cognitive bias is involved in the experience of hallucinations. In Bentall’s (1990) integration of research into the cognitive mechanisms underlying hallucinations, he argues that evidence suggests that they result from a failure of metacognitive skills. This failure affects reality discrimination; that is the individual’s ability to discriminate between self-generated and external sources of information. This failure of cognitive processes can be construed as a cognitive bias to the extent that a person may have a tendency to
misattribute internal events to an external source. This is consistent with evidence concerning an externalising bias in persecutory delusions (Bentall & Kinderman, 1998). In his discussion of hallucinations, Bentall (1990) suggests that if the misattributed internal event is inner speech or verbal thought, then the hallucination will be auditory. If it is visual imagery that is misattributed, then the hallucination will be visual. Consistent with Garety and Hemsley’s (1994) findings concerning a ‘jumping to conclusions’ bias leading to erroneous inferences in delusion formation, it seems that rapid and overconfident judgements are also relevant in the formation of hallucinations (Bentall, 1990).

Garety et al.’s (2001) model suggests that in the final stage of the formation of a psychotic experience, the biased cognitive processes reviewed above are worsened by negative emotional states. This culminates in an external appraisal of the anomalous experience, which seems personally significant and meaningful. So for example, an auditory hallucination may arise from an anomalous conscious experience of hearing one’s thoughts as voices, which is appraised as externally generated and threatening; this may heighten anxiety and thus influence the content of the voices, which again may exacerbate the anxiety, and so on. Delusions of being controlled may arise from the external appraisal of the anomalous experience of one’s actions seeming unintended; again the resulting anxiety or fear may perpetuate the symptoms.

**Maintenance Factors**

The cognitive model can also provide an understandable account of the maintenance of psychotic experiences: Underlying negative schema may influence beliefs about psychotic experiences, which shape emotional responses and behaviours, which then serve to confirm the negative schema and beliefs about the experience and therefore maintain the experience.

Evidence suggests that negative schema may influence the interpretation of or beliefs about the psychotic experience. Close and Garety (1998) reported that extremely negative self-appraisals and low self-esteem were common amongst their sample of people with auditory hallucinations. They propose that the voice activates negative
core beliefs about the self, which in turn influence beliefs about the hallucination and seem to confirm the accuracy of abusive voices. Birchwood, Meaden, Trower, Gilbert and Plaistow (2000) found that core interpersonal schema concerning subordination and marginalisation was the key predictor of beliefs about the power and rank of the auditory hallucination. It is crucial to recognise this when considering the formation and persistence of psychotic experiences amongst minority groups who are likely to be exposed to higher levels of subordination and marginalisation.

Beliefs about the psychotic experience may then influence emotional and behavioural responses to the experience. Chadwick and Birchwood (1994) suggest that beliefs concerning the omnipotence, identity and purpose of auditory hallucinations contribute to a belief that voice is either malevolent or benevolent. These beliefs then impact on the emotional and behavioural responses, which seem to confirm the beliefs and thus maintain the psychotic experience. Birchwood and Chadwick (1997) demonstrated that beliefs about voices, rather than voice content, maintained high levels of depression amongst people experiencing auditory hallucinations, which in turn maintained their psychotic experiences.

Other behavioural responses that maintain psychotic experiences include safety behaviours. They are attempts at preventing the occurrence of feared outcomes or beliefs; but actually maintain the belief by preventing its disconfirmation. In a group of twenty-five individuals with persecutory delusions, Freeman, Garety and Kuipers (2001) reported that all had engaged in safety behaviours within the last month: These included ninety-two percent having avoided particular areas or social situations. Sixty-eight percent had used in-situation safety behaviours such as checking locks or wearing a disguise. Three-quarters of the sample believed that their safety behaviours were effective, which is consistent with the notion of these behaviours as maintaining.

Biased cognitive processes previously explored (the ‘jumping to conclusions’ data-gathering bias and biased attribution style) can also be understood as maintaining factors. Garety and Hemsley (1994) offer an example of how the ‘jumping to conclusions’ bias may maintain a delusion: A client reported testing out his belief that aeroplanes were following him and communicating with him:
He would go out to look for any planes that seemed to be following him. This activity resulted in daily confirmation of the belief: Whenever he went out, planes could be seen in the sky, and sometimes they signalled to him, by turning suddenly (p.134).

In this way the cognitive model offers an understandable explanation of the formation and maintenance of psychotic symptoms, and highlights the role of personal meaning in the process.

**IMPLICATIONS FOR TREATMENT**

Considering the evidence that psychotic experiences are both understandable and meaningful, there are a number of implications for treatment. As discussed, the cognitive model suggests that delusions and beliefs about hallucinations result from the individual attempting to make sense of his or her experiences. Therefore the cognitive therapist aims to work collaboratively and meaningfully with the client to ascertain an alternative, plausible, and less distressing account of their experiences: If the client is unable to accept an alternative explanation of their experiences, it may be necessary to identify ways of reducing distress and increasing safety despite the persistence of the delusional belief (Freeman & Garety, 2002).

It is vitally important to develop a therapeutic alliance, particularly as psychotic clients may be paranoid or have difficulties with interpersonal relationships (Chadwick et al., 1996). Engagement may be promoted/assisted by normalising psychotic experiences, drawing on evidence of continuity between psychotic and ‘normal’ processes, and by taking an empathic and nonconfrontational approach. The emphasis is on recognising the client’s perspective, that their experiences are understandable, and have personal meaning in their life. An individualised formulation will be aided by a detailed assessment focusing on subjectively defined problems and psychotic beliefs, their relationship to the individual’s life experiences and core beliefs about the self, others and the world, and maintenance factors such as reasoning and attribution biases, emotional processes and safety behaviours.
However it may be difficult to encourage open discussion, considering the meaning and stigma of psychotic experiences. Romme and Escher (1993) suggest that meeting others to share experiences can achieve empowerment, reassurance and reduction of stigma; for example within the Hearing Voices Network that they set up. Alternatively, clients may be shown videos, such as fellow voice hearers expressing their experiences (Chadwick et al., 1996). As discussed, a client’s relationship to their voices tends to be characterised by powerful beliefs: So in cognitive therapy, it is essential to define these beliefs, concerning the identity, power, purpose and malevolence or benevolence of the voice. The aim is to illustrate that the clients’ responses to their voices are understandable considering these beliefs, and thus that their distress is clearly linked to the subjective meaning of the voices (Chadwick & Birchwood, 1994). It is also helpful to explore the link between delusions or beliefs about hallucinations, and the client’s life history or underlying beliefs about the self, others and the world (Close & Garety, 1998). Romme (1996) suggests that voices may have symbolic meaning, a protective function, or may reflect current or past trauma. This highlights the extent to which these experiences are meaningful to both the client and the therapist.

The understandable processes involved in the development of symptoms that are described in this essay have clear implications for cognitive behavioural interventions. Garety, Fowler and Kuipers (2000) suggest that therapists discuss with clients how events may be misinterpreted as a result of cognitive biases and how internal experiences may be misattributed externally: Links are made to the client’s own biases (such as ‘jumping to conclusions’ or misattribution), and their evidence for the delusional beliefs are discussed and gently challenged. Plausible and meaningful alternative explanations of events and experiences are generated: For example, that the delusion is an understandable response to, and way of making sense of, specific events or experiences. It is also important to consider any safety behaviours that may be preventing disconfirmation of the delusional beliefs. Empirical testing of the validity of the delusion and the alternative may be performed using reality testing through behavioural experiments (Chadwick et al., 1996), or experimenting with dropping safety behaviours. Eventually, clients are encouraged to re-evaluate their beliefs and
interpretations in light of evidence for the delusion or beliefs about the hallucination, and evidence for the alternative explanation.

In treatment of delusions and hallucinations, it is important that the emotional states and negative self-appraisals associated with the experiences are also addressed, as well as reducing the psychotic symptoms. Birchwood and Iqbal (1998) refer to the high rate of depression and suicide amongst people with psychosis. Evidence also suggests that low self-esteem is common amongst individuals with persecutory delusions (Freeman et al., 1998) and individuals with auditory hallucinations (Close & Garety, 1998). It is also likely that anxiety will need to be addressed; particularly in relation to persecutory delusions, which can be construed as ‘threat beliefs’ (Freeman, Garety, Kuipers, Fowler & Bebbington, 2002). In order to promote shared understanding, the connection between psychotic experiences, appraisals and emotional responses should be explored. Standard cognitive approaches to anxiety, depression and low self-esteem can be employed.

CONCLUSION

In conclusion, it seems that the formation and maintenance of psychotic experiences are indeed understandable within a cognitive framework. The cognitive model explains these experiences in terms of cognitive and affective disturbances that are continuous with normal experience. This essay has demonstrated that this account also recognises that psychotic experiences are meaningful, in that they are telling about the individual’s life experiences and have an important effect on their life. For example, underlying schema and emotional disturbance are said to influence the formation and content of psychotic experiences: In this way, psychotic experiences are meaningfully linked to the individual’s life. The model also emphasises interpretations of experiences, appraisals of events and related emotions in the course of experiences becoming ‘psychotic’: These important processes are indicative of the individual searching for meaning, and finding it in an external attribution.

In recognising that delusions and hallucinations are understandably and meaningfully related to an individual’s life experiences, there are important implications regarding
the issue of diversity. Life experiences clearly vary between individuals, but it seems likely that on the whole, minority groups may be more likely to be exposed to some level of social adversity than majority groups; perhaps in the form of discrimination, exclusion, or disadvantage. It is crucial to acknowledge the wider social context in which an individual’s experiences are embedded in order to fully understand and appreciate the personal meaning of that individual’s experiences.

The greatest significance of demonstrating that psychotic experiences are understandable and meaningful lies in the implications for treatment. Firstly, it is important to note that denying that these experiences are understandable and meaningful can actually be seen as counter-therapeutic. The cognitive model, however, provides a framework for the therapist to empathise with the client and develop a shared understanding of the formation and persistence of the delusions or hallucinations. In doing this, the meaning of these experiences to the client, in terms of their interpretations of them and beliefs about them, as well as the emotional and behavioural consequences, will be explored. As a result, their experiences are normalised, and are seen as understandable and meaningful. Treatment focuses on targeting the cognitive biases, emotional distress as well as resulting behaviours. The aim is to develop an alternative, less distressing, but still understandable and meaningful explanation of their experiences.
REFERENCES


How can Bowlby's attachment theory assist us in understanding challenging behaviour in people with learning disabilities?

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INTRODUCTION

In this essay I will argue that attachment theory can assist our understanding of some challenging behaviour in some people with learning disabilities. There is evidence suggesting that people with learning disabilities are more at risk of forming insecure attachments and I will discuss why this might be. Next I will consider the many ways that an insecure attachment pattern may be manifest in challenging behaviour amongst people with learning disabilities, drawing particularly on clinical experiences and case studies. There is also evidence demonstrating a clear link between insecure attachment and disruptive or challenging behaviour in people without learning disabilities. In this way, there is an apparent rationale for the notion that insecure attachment patterns may contribute to our understanding of challenging behaviour in people with learning disabilities. However, throughout this essay I will also recognise the difficulties in measuring the attachment status of people with learning disabilities and applying attachment theory to this population. The clinical value of attachment-related explanations will then be explored, as I consider attachment-based interventions addressing challenging behaviour.

Definitions

It is first necessary to outline a few definitions. Emerson (1995) describes challenging behaviour amongst people with learning disabilities as follows:

Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities (pp.4-5).

In this way, frequent or intense occurrences of non-compliance, hitting or self-injurious behaviour are likely to be considered challenging to a learning disability service. It is estimated that between 10% and 15% of people supported by learning disability services in the United Kingdom may show challenging behaviours (Emerson, 1998).
People with learning disabilities include all people that may require intermittent to pervasive support from learning disability services, and therefore fulfil the criteria of having a significant impairment of intellectual and social or adaptive functioning, acquired before age eighteen (BPS, 2001).

It is also helpful to broadly outline attachment theory. Bowlby (1969/1984) emphasised the biological function of the attachment behavioural system; to protect infants from danger. He suggested that an attachment relationship is defined by the presence of three important features by six months of age. Firstly, the infant demonstrates proximity seeking to the principal attachment figure. Secondly, they will use the attachment figure as a secure base; ‘a springboard for curiosity and exploration’ (Holmes, 1993, p.70). And finally the infant will display separation protest in which anger or distress is triggered by the threat or occurrence of separation from the principal attachment figure.

Bowlby referred to four principal phases during the development of the attachment system: A baby initially orients and signals without discrimination, but by 3 months of age discriminates at least one attachment figure by means of auditory and visual stimuli. At about six months, the infant’s repertoire of responses has increased. He or she can use locomotion and signals to maintain proximity and use the attachment figure as a secure base. In the final phase from about age three, the child and attachment figure develop a reciprocal partnership as the child builds an internal working model of himself or herself and others, based on these repeated patterns of interaction. A secure attachment is promoted by care-giver affection, sensitivity and reliability. Consequently, a securely attached child will develop an internal working model of a loving, responsive and reliable care-giver and of a self that is worthy of love and attention (Holmes, 1993). This internal working model will guide expectations of and evaluations about self and others’ behaviours in subsequent relationships (Bowlby, 1969/1984). Therefore it is suggested that attachment experiences affect individuals throughout their life.
The final area to outline concerns the classifications of attachment status through the use of the Strange Situation (Ainsworth et al., 1978). This measures infants' coping with separations from the attachment figure, and re-union. Broadly, the securely attached child shows some distress on separation but settles easily on re-union. The insecure-avoidant infant demonstrates few overt signs of distress on separation and avoids or ignores the care-giver on re-union. The insecure-ambivalent attachment pattern is indicated by extreme distress on separation, and resistance to comforting on re-union. Main and Solomon (1990) added the insecure-disorganised attachment pattern, which is evident in confused or disoriented behaviour especially during re-union (as cited in Main, 1996).

**Diversity Issues**

Studies have tended to indicate that there are no significant sex differences in the distribution of attachment classifications (van Ijzendoorn et al., 1999). Interestingly, evidence also suggests cross-cultural validity of attachment theory, with most children in any one culture demonstrating secure attachments: It is suggested that there is more diversity in distributions of attachment classifications between different samples within a culture than there is between different cultures (van Ijzendoorn & Sagi, 1999). For example, in North American studies, insecure attachment patterns are more common amongst infants from families with low socio-economic status compared to middle class families (van Ijzendoorn et al., 1999). Most relevant is the evidence indicating a higher incidence of insecure attachment in people with learning disabilities compared to non-clinical samples.

**EVIDENCE OF A LINK BETWEEN LEARNING DISABILITY AND INSECURE ATTACHMENT**

Generally, studies seem to indicate that infants with learning disabilities are more at risk of developing insecure attachment patterns than people without learning disabilities. For example, in a meta-analysis of the distributions of attachment status in clinical and non-clinical populations van Ijzendoorn et al. (1999) reported that amongst children with neurological abnormalities (n=248) there was an overall higher incidence of insecure classification than secure attachments. These six studies
included children with learning disabilities and neurological abnormalities such as cerebral palsy, cranial abnormalities, autism and Down's syndrome. Compared to the normal distribution of security classifications, there were significantly fewer secure attachment patterns, and significantly more insecure-disorganised classifications.

In a study of fifty-three infants with Down's syndrome and their mothers during the Strange Situation and observations at home, Atkinson et al. (1999) confirmed the finding that a minority (40%) of children exhibited secure attachment behaviour. However, of the other 60%, most (47%) were 'unclassifiable'. The authors discuss whether these unclassifiable children are demonstrating insecure attachments or an absence of secure base behaviour. The unclassifiable group had less sensitive caregiving (which is linked to insecure attachment) but also a higher level of cognitive impairment (which could imply an absence of secure base behaviour rather than insecurity). This highlights an important caveat in interpreting evidence regarding the higher incidence of insecure attachment in people with learning disabilities, namely that the measures and classifications used to determine their attachment status may not be appropriate for this population.

A possible reason for mistaken classifications is that the behaviours used to assign an infant to a particular attachment category may be reflecting the infant's learning disability or neurological impairment, rather than truly representing their attachment status. These dual indices are most likely to be present in the coding of insecure-disorganised attachment — the category that has been reported to be over-represented in infants with learning disabilities (e.g. van Ijzendoorn et al., 1999). The dual indices include contradictory behaviours, incomplete and asymmetrical movements, stereotypies, freezing and disorientation (Pipp-Siegel et al., 1999). Each may indeed reflect an insecure-disorganised attachment, or may result from particular neurological symptoms or conditions: For example, tics, dyspraxia, cerebral palsy, focal seizures or a pervasive developmental disorder. Therefore it seems difficult to draw firm conclusions from evidence suggesting a higher frequency of insecure-disorganised attachments amongst children with learning disabilities. In future studies, Pipp-Siegel et al. (1999) have suggested that researchers should obtain medical reports and interview each attachment-figure about their child's typical behaviour in different
contexts. This would help to determine whether behaviour observed in the Strange Situation reflects attachment status or disability.

Another issue concerns infants with more severe learning disabilities and their ability to form attachment relationships. The theory seems to suggest that this requires a certain level of cognitive, sensory, motor and communicative functioning. Even in the earliest phase, Bowlby (1969/1984) refers to the infant using their sensory experiences to recognise their primary attachment figure. Without object permanence the infant would be in a constant state of separation distress (Janssen et al., 2002). Communicative and motor skills are needed to maintain proximity and use the attachment figure as a secure base. The infant requires cognitive flexibility, planning skills and theory of mind in order to achieve a reciprocal partnership with the care-giver. Mental representations are necessary to develop internal working models that are constantly monitored and revised (Bretherton & Munholland, 1999; Cassidy, 1999). Blacher and Meyers (1983) pose the question of whether there is an ‘upper limit’ in attachment stage attainment amongst people with severe and profound learning disabilities. This may seem compelling considering the skills required, but this does not necessarily mean that attachment relationships are not present. Perhaps the child develops an organised but qualitatively different attachment pattern (Atkinson et al., 1999).

**WHY IS THERE A LINK BETWEEN LEARNING DISABILITY AND INSECURE ATTACHMENT?**

Before discussing how insecure attachment styles may become manifest in challenging behaviour, it is important to explore possible reasons why an infant with a learning disability is more at risk of developing an insecure attachment. As indicated above, there are many skills and abilities involved in developing an attachment, and any impairment in one or a few could affect the infant’s ability to express their attachment needs. For example, if an infant is unable to communicate fear, cannot orient or move to the care-giver, or does not understand or respond to the care-giver’s signals, the attachment relationship may be affected (Esterhuyzen & Hollins, 1997). The care-giver may be unable to respond to the infant in an effective, sensitive and
reliable way if he or she cannot read the infant’s needs and desires. Care-giver responsiveness, warmth and closeness are less likely to continue if they are not reinforced by the infant with a learning disability (Blacher & Meyers, 1983). So an infant who cannot display these attachment behaviours may engender a caregiver who interacts less and lacks responsiveness and sensitivity. Evidence suggests that sensitive, responsive care-giving is predictive of secure attachment relationships (De Wolff & van Ijzendoorn, 1997; Isabella, 1993); and thus if a care-giver is less able to read an infant’s signals and respond appropriately and promptly, an insecure attachment style is more likely to develop.

There may be extra stresses and demands resulting from having an infant with a learning disability, which may in turn affect the attachment relationship. Baxter et al. (1995) reported that parents perceive the diagnosis of their child’s learning disability as their most stress-inducing life event (as cited in Janssen et al., 2002). Hollins and Sinason (2000) suggest that it can be considered a trauma. Parents may need to seek further information and support while coming to terms with their child’s disability. Esterhuyzen and Hollins (1997) refer to the stress of providing extra physical care and supervision, perhaps having more laundry to do and disturbed sleep. Parents and siblings may struggle with shame about the child’s differences in appearance, behaviour or development. Or the family may become increasingly ‘child-centred’, hoping to improve their child’s functioning and quality of life, to the extent that parents may become isolated or other family members neglected. Financial worries may be present from the start, as may be concerns about their child’s future. All of these difficulties and extra pressures may leave the primary attachment figure feeling tired, stressed and anxious - all of which may have detrimental effects on their relationship with the child. The care-giver may start resenting or rejecting the infant, or find it increasingly difficult to maintain the level of sensitivity and responsiveness that is so important in the development of secure attachment (De Wolff & van Ijzendoorn, 1997; Isabella, 1993).

Insecure attachments may be linked to the loss and grief that is felt by some parents at the birth of their child with learning disabilities:
Families may be faced with how to grieve for what was hoped for and is now lost: often referred to as ‘the perfect child’ (Goldberg et al., 1995, p.267).

When experiencing loss and grief, parents may respond with shock, denial and disorganisation (Parkes, 1972; as cited in Esterhuyzen & Hollins, 1997). This grief may be re-evoked at each transitional stage of the family life-cycle when parents are reminded of lost hopes and expectations. Starting school, adolescence, leaving school and planning for the future may all generate different decisions, stresses and difficulties for the family (Vetere, 1993). This grief may affect the thoughts, feelings and behaviour of the primary attachment figure towards the infant, which might affect their role as a secure base or hinder the provision of reliable and sensitive care-giving that is central in secure attachment.

Esterhuyzen and Hollins (1997) document how parents may feel guilty about their real or imagined role in causing their child’s learning disability. They suggest that this guilt or the above described stresses, worries and grief may contribute to over-protection of their infant. This might lead to an insecure and ‘over-anxious’ attachment pattern where there is a failure to separate physically and emotionally from the parents. Parents may not initiate distancing, nor encourage independence and sexual maturation, so the normal ‘fading’ of attachment behaviours in later life may not occur.

Adults with learning disabilities may have moved into institutional care at an early age. This can cause a major disruption to the attachment relationship (Janssen et al., 2002). In the past, institutions minimised emotional development and security (Clegg & Lansdall-Welfare, 1995). In current residential care, there are multiple carers and staff turnover affects continuity of carers. If a child does not view their attachment figures as available and responsive (in terms of the child’s expectations as well as physical presence or absence) the child is likely to become insecure (Kobak, 1999).

Evidence has consistently indicated that people with learning disabilities are more at risk of maltreatment, neglect and particularly sexual abuse (Brown et al., 1995). Van IJzendoorn et al. (1999) presented a meta-analysis including five studies (n=353)
demonstrating the link between parental maltreatment and insecure attachment, particularly insecure-disorganised attachment. The combined effect size was medium-large ($r = .41$). It is therefore probable that the higher incidence of maltreatment in people with learning disabilities leads to a corresponding higher incidence of insecure attachments in this population.

**HOW MIGHT INSECURE ATTACHMENT BECOME MANIFEST IN CHALLENGING BEHAVIOUR?**

Having argued that people with learning disabilities are more likely to develop insecure attachment, I will now explore how this might assist our understanding of challenging behaviour. In an interesting report of three attachment-based interventions with people with learning disabilities, Clegg and Lansdall-Welfare (1995) draw on their theoretical knowledge and clinical experience to outline a number of indicators of attachment-related challenging behaviour. In doing so they emphasise that it is a sub-group of people for whom attachment theory offers a clinically useful explanation. There are often cases when the most useful formulation would not be attachment-related. It is very important to recognise the functional diversity of challenging and disruptive behaviour (Waters *et al.*, 1993) in order to offer the most effective intervention.

Clegg and Lansdall-Welfare suggest that an attachment-related intervention may be useful when a person with a learning disability demonstrates separation difficulties. Bowlby (1973) described the consequences of separation as protest, despair and detachment. These may be manifest in challenging behaviour. Clegg and Lansdall-Welfare suggest that separation anger or distress is likely to be intermittent and in selected settings, such as when the individual is feeling particularly vulnerable, or when certain individuals arrive or leave. In a case example they describe a woman with an insecure-ambivalent attachment to her mother and challenging behaviour when travelling away from home, including aggression and incontinence. Her parents made a special tape of familiar music linked by her mother talking to give to the driver, which initially helped. In this way, an attachment formulation would assist an understanding of her challenging behaviour as separation distress.
Clegg and Lansdall-Welfare also describe challenging behaviour that can be understood as difficulties using a secure base. They suggest that attachment theory can offer a clinically useful explanation of resistance to physical and intellectual exploration. A member of the team in which I work described a client who became aggressive when encouraged to take day trips away from home. This behaviour can be considered attachment-related in terms of the insecure individual being unable to use a secure base or ‘self-soothe’ effectively. A person with an insecure attachment may also have difficulty exploring intellectually. Clegg and Lansdall-Welfare document a case example of a woman with a moderate learning disability whose intellectual assessments indicated a temporary but significant drop in her cognitive functioning, after she started at a day centre.

In insecurely attached people with learning disabilities may also present challenging behaviours related to proximity-seeking. Bowlby (1973) described how anxious attachment can cause ‘clinginess’ and over-dependence on one attachment figure. In my clinical experience, some people with learning disabilities may become fixated on a particular member of staff, resulting in jealousy and aggression when the staff member interacts with others. Clegg and Lansdall-Welfare (1995) refer to a man with a severe learning disability and a history of enmeshed family life and anxious attachment. This attachment pattern was repeated in ‘obsessional’ attachments to staff members, characterised by physical attempts to stop them interacting with others. Yet in the presence of these attachment figures, his insecure-ambivalence was often evident in his extreme anxiety and aggression towards the staff member.

Anxious attachment may encourage the family or staff team to become over-protective of the individual with learning disabilities. This can hinder the normal ‘fading’ of attachment behaviours at adolescence and lead to secrets and ‘protection’ or exclusion from mortality, sexuality and disability issues (Esterhuyzen & Hollins, 1997). Challenging behaviour might be linked to these experiences of exclusion. For example, Esterhuyzen and Hollins refer to a young woman’s challenging behaviour after starting menstruation. Discussions with the family revealed that the daughter was challenging her dependence on her mother for sexual safety and physical care, and
challenging her mother’s attempts to deny her sexuality and prevent her from meeting men (through insisting that her respite care and day-centre trips were in women-only groups). The daughter’s main wish however, was to have a boyfriend.

Challenging behaviour may be triggered by transitional periods in families with unresolved loss and insecure attachments. At life-cycle transitions, re-evoked grief is likely to affect attitudes and behaviour towards the person with a learning disability. If this person interprets these as negative or is aware of their origin, these transitions could initiate challenging behaviours such as aggression or self-injurious behaviour. My own clinical experience has included work with a family who were referred following the son’s challenging behaviour after his father’s death from a heart attack. The mother described how she had always resented her son’s disability, and how this had affected their ability to bond. The family were not only grieving about and adjusting to their loss, but his death had also re-evoked intense feelings of grief and anger on the part of the mother about her son’s mild learning disability. The son interpreted this as blame for his father’s death, and his distress was communicated in verbal and physical aggression towards his mother. This demonstrates an attachment-related explanation of an individual’s challenging behaviour within a systemic framework.

A final attachment-related explanation of challenging behaviour in people with learning disabilities is Janssen et al.’s (2002) stress-attachment model. They use Lovallo’s (1997) model of psychological stress in which people first evaluate events for their threat value, then appraise their coping resources. They propose that people with learning disabilities are likely to perceive life events as less under their control and therefore as more threatening, and perceive their coping resources as less effective. They argue that people with learning disabilities are more often insecurely attached, and highlight the link between insecure attachment and difficulties coping with stress (e.g. Schore, 2001). They therefore suggest that people with learning disabilities are more at risk of frequent and intense stress which might become manifest in challenging behaviour. They outline evidence of the link between learning disabilities and increased stress, and cite evidence of insecure attachment and
difficulties coping with stress, but as yet there does not seem to be any direct evidence of this stress-attachment model.

There seems to be little research investigating the link between insecure attachment and challenging behaviour in people with learning disabilities. It is unclear if this is because most studies have failed to demonstrate a significant relationship and thus have been subject to the publication bias. Alternatively, this research may not have been conducted, perhaps because most literature concerning the application of attachment theory to learning disability populations is fairly recent and as yet there is no valid and reliable measure of attachment status for this population.

Clegg and Sheard (2002) report evidence of a link between insecure attachment patterns and challenging behaviour. Although this study demonstrates clearly that participants categorised as showing secure attachment were significantly less likely to show challenging behaviours, there are a number of limitations. The study analysed existing data from a study on bullying by Sheard et al. (2001). As a result, participants were deemed insecure on the basis of a single item rather than on a number of measures of insecurity. They were considered challenging on the basis of their carers' responses to the remainder of the survey, which was originally designed to investigate experiences of bullying. This limits the reliability and validity of this study, and the results do not necessarily indicate a causal relationship. However, as the authors argue, it adds support to the contention that some challenging behaviour may be linked to attachment style.

INSECURE ATTACHMENT AND CHALLENGING BEHAVIOUR IN NON-LEARNING DISABLED POPULATIONS

Although there is little evidence confirming the link between insecure attachment and challenging behaviour in people with learning disabilities, there is some relevant research demonstrating that insecure attachment patterns predict later disruptive behaviour in people without learning disabilities. These disruptive behaviours can be conceptualised as paralleling challenging behaviour, or as increasing the risk of challenging behaviour to some extent. For example, studies have reported a link
between insecure attachment and aggression at school; non-compliant behaviour (Lyons-Ruth, 1996); suicidal ideation and behaviour (Adam et al., 1996); psychopathology including conduct disorders and personality disorders (Rosenstein & Horowitz, 1996) and mental health problems in adulthood (Main, 1996).

Van Ijzendoorn et al. (1999) conducted a meta-analysis of studies on insecure-disorganised attachment, including twelve studies concerning disruptive or problematic behaviour in 734 children. They reported a significant relationship between disorganised attachment and aggression at school, with an overall moderate effect size of $r = .29$. However, considering the variety of methodologies employed in the different studies, van Ijzendoorn et al. concluded that their meta-analytic evidence is correlational rather than indicative of a causal relationship between attachment and disruptive behaviour. This seems to be a consistent limitation amongst these predominantly retrospective studies.

The proposed mechanisms mediating the link between insecure attachment and difficult behaviours include problematic stress management (van Ijzendoorn et al., 1999), cognitive disorganisation (Adam et al., 1996), difficulties regulating emotions (Waters et al., 1993) and problematic conflict resolution (Erdman & Caffery, 2003). It seems helpful to assume some degree of continuity between the processes that might contribute to challenging behaviour in people with and without learning disabilities, particularly considering the concept of learning disability as being on some point of a continuum of intellectual, social and adaptive functioning. This would indicate that the same processes are just as likely to occur in people with learning disabilities who are on the milder end of the spectrum as they are in ‘normal’ populations.

However, there could be difficulty replicating these studies with people with learning disabilities. In these retrospective studies, the participant completes the Adult Attachment Interview to classify their attachment status. This measure was developed by Main and colleagues using non-clinical samples (Main, 1996). Participants are asked for descriptions and evaluations of childhood attachment relationships, including the impact of separations and losses. Attachment classifications are derived from discourse analysis, and correspond to the four categories of infant behaviour in
the Strange Situation. For example, a lack of coherence, clarity and relevance is likely to indicate classifications corresponding to insecure attachments (Main, 1996). However, there may be difficulties using this measure amongst people with learning disabilities considering the emphasis on narrative discourse and reflection, and the need for conversational skills (Smith & McCarthy, 1996). Smith and McCarthy have developed a more appropriate measure of attachment experiences for this population, but acknowledge that more research is needed, and its reliability and validity is far from confirmed.

IMPLICATIONS FOR INTERVENTIONS

In summary, it seems that attachment theory can assist our understanding of some challenging behaviour in some people with learning disabilities. It is also important to examine the clinical value of this framework by considering the implications for attachment-based interventions. Firstly it is necessary to identify when challenging behaviour is attachment-related. This might be achieved by recognising the manifestations of insecure attachment in challenging behaviour that I outlined above.

A therapist might work directly with the client presenting with challenging behaviour. Therapy provides a safe place for the client to ‘act out’ their insecure attachment style. The secure boundaries of therapy are designed to ‘hold’ the client, so that they may become more secure in their relationship to the therapist (Esterhuyzen & Hollins, 1997). Using the therapist as a secure base from which to explore, the client can begin to examine their attachment relationships and how these link to their challenging behaviour (Clegg & Lansdall-Welfare, 1995). Eventually, the client can re-organise their internal working model to enable more healthy ways of relating to people. They can then develop more secure attachments to important people in their life, so that insecurity is no longer expressed as challenging behaviour (Esterhuyzen & Hollins, 1997). This process is consistent with the cognitive approach of exploring and modifying dysfunctional schemas (e.g. Beck, 1995).

The intervention might involve indirect work with family or carers. Esterhuyzen and Hollins highlight the importance of helping families cope with the diagnosis and long-
term implications of a learning disability, at an early stage. This can be construed as preventative work, reducing the chance of challenging behaviour by promoting conditions that foster secure attachment. Later work may be around challenging behaviour at transitional periods when grief for the 'perfect child' is re-evoked. Family therapy aims to allow families to grieve their past, current and future losses to enable them to break unhelpful patterns of behaviour and progress through the transition (Goldberg et al., 1995). If challenging behaviour has been triggered by over-protection and secrets, family therapy can help family members achieve a balance between separateness and attachment (Vetere, 1993) by aiding the natural 'fading' of attachment (Esterhuyzen & Hollins).

Clegg and Lansdall-Welfare (1995) outline guidance on working with ambivalent staff who might have become enmeshed with clients showing challenging behaviour. The work aims to develop an understanding of their relationship to the client, particularly focusing on their own responses and how these may affect interactions, boundaries, and the client's behaviour. Or the intervention might involve staff training and support to recognise the signs of enmeshed relationships and inappropriate attachments to prevent this escalating to challenging behaviour. These systemic approaches highlight the relational and contextual components of attachment-related challenging behaviour.

My own clinical experience indicates that people with challenging behaviour may benefit from involvement in an intensive interaction group. Intensive interaction is a form of interaction developed for people with severe learning disabilities and communication difficulties. Often these people are more likely to show challenging behaviour (Emerson, 1998). The approach aims to achieve interactions that are similar to parent-infant interactions that are normally developed during the first year of an infant's life. Essentially, intensive interaction encourages attachment behaviours; promoting sensitivity, responsiveness, proximity, exploration and the development of sociability and communication skills. These attachment behaviours contribute to the client learning that their behaviours are important, and therefore that they are important and 'good to be with' (Hewett, 1999). This process can be likened to the development of secure internal working models.
CONCLUSION

In conclusion, I have demonstrated how Bowlby's attachment theory can assist us in understanding some challenging behaviour in some people with learning disabilities. I have explored possible reasons why people with learning disabilities are more at risk of developing insecure attachments, and how this may become manifest in challenging behaviour. I have also considered the implications of this for attachment-based interventions with people with learning disabilities.

Although I have argued that attachment theory may offer a useful framework for understanding challenging behaviour, I have also acknowledged its limitations. Firstly there seems to be a lack of conclusive evidence demonstrating a link between the presence of a learning disability, insecure attachment and challenging behaviour. Yet I have outlined compelling case examples from the literature, which are consistent with some of my own clinical experiences and those of my colleagues. Secondly, there may be difficulties using the Strange Situation and Adult Attachment Interview to assess the attachment status of people with learning disabilities. However, I have outlined Pipp-Siegel et al.'s (1999) suggestions of ways to overcome neurological dual indices, and recommended further development of more appropriate assessment tools such as that proposed by Smith and McCarthy (1996).

I have also recognised the functional diversity of challenging behaviour, and argued that attachment theory cannot assist our understanding of all challenging behaviour shown by all people. There are certainly times when challenging behaviour would be better understood within an alternative framework, such as the behavioural model proposed by Emerson (1995). Yet there are times when an explanation and intervention based on attachment theory could assist, and I have suggested ways of identifying when this is the case. Therefore I would maintain that attachment theory does assist our understanding of challenging behaviour, as it offers an additional explanatory model that can guide interventions for behaviours that are very distressing for the client and their carers.
REFERENCES


‘Divorce is bad for children’: Critically discuss with reference to the literature on the psychological effects on children of divorce and parental conflict.
INTRODUCTION

Most of the literature concerning the effects of divorce on children comes from the United States. Schoen and Standish (2000) suggest that between forty and fifty percent of marriages in the United States will end in divorce (as cited in Amato, 2001). Of these divorces, an estimated sixty-five percent of women and over seventy-five percent of men remarry and rates of cohabitation are high in those who do not remarry (Bumpass & Raley, 1995). These figures mask some diversity in rates, for example Castro-Martin and Bumpass (1989) indicate that African Americans are more likely to separate and divorce and less likely to remarry than non-Hispanic white people. In a comparison of rates of divorce in European countries, Muncie and Sapsford (1997) conclude that the United Kingdom has the highest rate in Europe, with over fifty percent of marriages ending in divorce. Land (1997) estimates that three fifths of all divorces in the United Kingdom involve dependent children, and that one in four children will experience the divorce of their parents before their sixteenth birthday. Haskey (1994) reports that one in twelve British children live in stepfamilies.

Divorce cannot be understood as a discrete event when considering its impact on children, but rather it is a process of change. This process of marital transition may begin many years before the separation, and the separation and legal divorce set in motion a number of possible transitions post-divorce. This may include remarriage and reorganisation into stepfamilies, and many of these children will experience further divorces (Hetherington et al., 1985). In this way there are multiple pathways through marital transitions that interact with the vulnerability and resiliency of the individual child, which contribute to the diversity of outcomes in children’s psychological adjustment and well-being (Hetherington et al., 1993). Therefore it seems unlikely that children would be affected by divorce per se, but rather by their own individual experience of the changes and transitions involved in the process by which their family divorces.
Diversity in outcomes

Many cross-sectional and longitudinal comparisons of children from divorced families with children from continuously married families indicate an overall higher incidence of negative outcomes amongst children from divorced families: These include measures of psychological well-being, behavioural problems, academic difficulties and social relationship problems (e.g. Amato, 2001). Some have argued that these problems persist into adulthood (e.g. Amato & Keith, 1991b; Wadsworth et al., 1990). There is, however, a high level of variability in outcomes, with some children demonstrating remarkable resiliency and others showing severe adjustment problems. This is because during the process of divorce there are a number of possible factors that may affect a child’s well-being, such as economic and social resources, parental absence, parental conflict and adjustment, the parenting environment, the characteristics of the child and further marital transitions. These factors can be understood as contributing to the child’s individual configuration of stressors and resources at any one point in time. This essay will focus on these factors and their varying effects on children, before outlining the ways in which children’s adjustment can be promoted. A thorough exploration of the possible long-term effects of the transitions associated with divorce is beyond the scope of this essay.

FACTORS CONTRIBUTING TO DIVERSITY IN OUTCOMES

Economic and social resources

It has been argued by many that the economic decline associated with single parenting may account for some problems in some children of divorce. In the vast majority of cases of divorce in the States, the mother is awarded custody of the children (Hetherington et al., 1993). This is likely to be accompanied by a decrease in earnings, and possibly financial hardship if the father was previously the sole earner. Economic decline may influence the general standard of living, for example less access to educational toys, books and home computers that may facilitate academic success (Amato & Keith, 1991a). Reduced economic resources may also lead to dependence on welfare, changes in the residential parent’s employment, and possibly a move to
poorer quality housing and schooling (Hetherington et al., 1989). These transitions and changes may disrupt a child’s health, adjustment and academic performance or may contribute to a loss of social support from the child’s peer group, extended family, and the parent’s friends. This might leave the parent and child feeling isolated and unsupported, and thereby hinder the parent’s ability to support their child through these transitions at a time when they most need support. Some evidence suggests that social support is positively associated with adjustment, especially amongst adolescents (e.g. Silitsky, 1996).

The accumulation of these types of economic and social stressors may contribute to the negative effects of divorce on children. In a meta-analysis, Amato (1993) reviewed studies that investigate associations between the number of stressful environmental changes that have occurred and the adjustment of children to divorce. He concluded that most studies, especially those that are more methodologically sound, provide support for this hypothesis by demonstrating significant correlations between the number of stressors and poorer outcomes on child measures of academic achievement, behaviour problems, psychological adjustment and self-esteem. In a Norwegian qualitative investigation, Moxnes (2003) reported that approximately one third of the children had experienced a decline in income and had to move house following the divorce. These children indicated that finding new friends and becoming included in the new community were most significant in contributing to their difficulties. It is important to note that this study recruited a sample of fifty-two Norwegian children who had experienced many changes following the divorce, which limits the extent to which the results can be generalised.

**Absence of the non-residential parent**

Another factor that may contribute to a child’s adjustment to divorce concerns the absence of one parent. Traditionally, it has been assumed that a family with two parents living in the same household is better for the child. This makes sense from the perspective that two parents can potentially offer more support, supervision and guidance, and can serve as role models of social skills. Evidence suggests that following a divorce the quality and quantity of contact with the non-residential parent,
usually the father, does decrease (e.g. Seltzer, 1991). However, in a meta-analysis of the effects of reduced contact with the non-residential parent, Amato and Keith (1991a) concluded that there is minimal support for the notion that this may lead to poorer outcomes for children. It seems that it is not the quantity of contact with the non-residential parent that affects children's adjustment, but rather the quality of the child's relationship with the absent parent. Contact with a rejecting, nonauthoritative or abusive non-residential parent is more destructive for a child's psychological adjustment (Hetherington & Stanley-Hagan, 1999). Furthermore, continued contact can have detrimental psychological effects on a child when the parents have a highly conflicting relationship and the child ends up feeling caught in the middle. This will be explored further below.

**Conflict and parenting**

Conflict is likely to be high amongst families who later divorce, and often disputes and arguments continue long after the separation. Parental conflict is a consistent predictor of poor outcomes amongst children and adolescents, in both continuously married and divorced families (e.g. Buehler & Gerard, 2002; Fauber et al., 1990).

Some research concerning the impact of parental conflict on children uses samples from continuously married families. This research is useful in considering the links between conflict and children's adjustment in families prior to the separation. However, the nature of parental conflict following a divorce may be qualitatively different from that during marriage. Many additional issues are pertinent: Children may be caught in the middle of arguments over parenting, child support and other economic issues, contact with the non-residential parent, or other legal disputes. Parents may openly criticise, blame or punish each other or ask the child to take sides. Or a parent may seek the child's support and thus trigger a role reversal in which the child is encouraged to parent the parent (Moxnes, 2003).

Marital discord and post-divorce conflict may affect a child's behaviour and psychological adjustment directly through the process of modelling aggressive or hostile ways of coping with relational problems, or by shaping the child's feelings,
cognitions and perceptions (Davies & Cummings, 1998). Parental conflict might also interfere with the child’s attachments bonds (Emery, 1982), increasing feelings of emotional insecurity (Davies & Cummings, 1994). From a systemic perspective, Minuchin et al. (1978) suggested that parental conflict may encourage ‘detouring’, whereby the child develops problematic behaviour with the function of distracting the parents from their own conflict (as cited in Fauber et al., 1990). High parental conflict in the aftermath of divorce may leave children feeling caught in the middle of the parental conflict and this is associated with higher depression, anxiety and deviant behaviour amongst adolescents (Buchanan et al., 1991). A child may feel a sense of loss or even exploitation in their relationships with their parents who are most responsible for ensuring their welfare. Some feel that they are not allowed to love the ‘guilty’ parent and others feel guilty for hating that parent (Moxnes, 2003). This is likely to be stressful for the child and threaten their self-esteem as well as increasing anxiety, low mood and problematic behaviours (Wallerstein, 1991).

Parental conflict prior to and following a divorce may also indirectly affect a child’s psychological adjustment and behavioural outcomes, through its impact on the parenting environment and parent-child interactions. Fauber et al. (1990) investigated the mediating role of three aspects of parenting practices in the relationship between parental conflict and adjustment problems of young adolescents from continuously married and divorced families. Multiple regression analyses demonstrated that much of this relationship can be explained through various aspects of parenting behaviour. They reported that perceived rejection and withdrawal by the parent were most commonly associated with higher levels of internalising and externalising adjustment problems within the divorced sample.

As well as the mediating role of withdrawal and reduced parental involvement, Buehler and Gerard (2002) provided evidence that marital conflict is also associated with greater use of harsh parental discipline and more frequent parent-adolescent conflict: This in turn is associated with higher levels of maladjustment in children and adolescents as measured by the Child Behaviour Checklist. Consistent with this, Almeida et al. (1999) demonstrated that on the day after marital conflict, parents are fifty percent more likely to have tense and conflicting interaction with their children.
Parental conflict may lead some parents to become increasingly stressed, angry and hostile, which may reduce their tolerance of their child’s behaviour. Others become absorbed by their problems and less available to their children. If conflict and disruptions in the parenting environment increase child behaviour problems, this is likely to contribute to parental stress and conflict, and thus may exacerbate the cycle (Emery, 1982). There must be some caution in interpreting these research findings as both Buehler and Gerard (2002) and Fauber et al. (1990) used a cross-sectional design, which presents limitations in making causal inferences.

Separation may sometimes signal the end of exposure to parental conflict or abusive relationships and therefore may be a relief to children and promote psychological adjustment (Gorell Barnes et al., 1998). Or some divorced parents manage to move from conflict to co-operation in their parenting following a divorce (Moxnes, 2003). In these cases, children are no longer exposed to the psychological effects of living with hostile and conflicting parents. In this way, children are better off psychologically and behaviourally in a harmonious, low conflict divorced or single parent family than in a high conflict distressed marriage: The poorest outcomes are associated with exposure to continuing high conflict between divorced parents (e.g. Amato et al., 1995).

Parents’ adjustment and parenting

Another issue that is important when considering the diversity of children’s outcomes concerns the parent’s adjustment following divorce. This can be understood as relating to the stressors to which they are exposed (similar to those discussed for children), their attitude towards and meaning attributed to the divorce and protective factors such as their personal and social resources (Amato, 2000; Wang & Amato, 2000).

Following separation or divorce, parents are at increased risk of anxiety, depression, irritability, emotional lability and disruptions in identity (Hetherington, 1989). Kiecolt-Glaser et al. (1987) also provided evidence that marital disruption can alter the immune system which may lead to health problems (as cited in Hetherington et al., 1993). This is important for children because they may be experiencing an altered
parent at a transitional time when they most need stability and support (Hetherington et al., 1993). If parents are feeling ill, stressed, anxious, depressed or vulnerable, this may compromise their ability to be responsive and sensitive to their children and provide an appropriate parenting environment (Hetherington & Clingempeel, 1992). Evidence supports this view, as the well-being of children is positively associated with the post-divorce psychological adjustment of the residential parent (Amato, 1993).

The relationship may be cyclical, as a distressed or demanding child may heighten the stress of parents, thus contributing to parents’ difficulty meeting their child’s needs (Hetherington et al., 1989). These associations between divorce, parental maladjustment and child problems must be interpreted with caution: Although it seems likely that the process of divorce would affect the well-being of parents, it is also possible that parents who are psychologically maladjusted are more likely to divorce and have children with similar problems (Amato, 1993).

**Children’s characteristics**

Research exploring the impact of age and developmental level on the effects of divorce on children and adolescents has yielded mixed results. In a meta-analysis of the effects of divorce, Amato and Keith (1991a) reported larger effect sizes for children at primary and secondary school on measures of psychological adjustment and conduct problems, compared to pre-school children and older adolescents. However, this result is difficult to interpret as the age of the sample was recorded rather than the age at divorce. In a review of the limited literature concerning the effects of divorce on children under five, Leon (2003) argued that preschoolers’ thought is often egocentric, so they are more likely to blame themselves for their parents’ divorce and have difficulty understanding why their parents are divorcing. They are also likely to have less access to support outside the family and fear total abandonment (Hetherington & Stanley-Hagan, 1999). Due to limited behaviour regulation and verbal abilities, young children are more likely to express stress through externalising behaviour problems than through other ways (Leon, 2003).
Evidence is inconsistent regarding sex differences in adjustment to divorce. In a longitudinal study, Hetherington et al. (1985) concluded that divorce has more adverse long-term effects on boys. This study only used white middle class American families. Amato and Keith’s (1991a) meta-analysis did not indicate any sex differences, other than boys showing slightly more difficulty adjusting socially than girls. A more recent meta-analysis demonstrated a significant difference in effect sizes on the measure of conduct, with boys showing more externalising behavioural problems than girls (Amato, 2001). These meta-analyses provide some modest support for the notion that boys are more strongly affected than girls. Hetherington et al. (1993) reported that boys are more likely to be exposed to parental conflict and for longer periods than girls, which may partially account for any sex differences.

There is some evidence of differences in outcomes depending on racial background and socio-economic status. For example, the difference in adjustment between children from divorced and intact families in African-American families is smaller than that of white Americans. Similarly, the difference in adjustment between children from divorced and intact families is smaller for low socio-economic status families than it is for middle class families (McLanahan & Sandefur, 1994).

Some evidence suggests that temperamentally difficult children with an external locus of control may have more problems adjusting to divorce compared to those with an easy temperament and an internal locus of control (e.g. Hetherington, 1989). A more difficult child is arguably more likely to elicit and be the target of anger, criticism and anxiety by parents, and have less coping resources to manage these aversive responses: If this exacerbates behaviour problems a temperamentally difficult child may contribute to marital problems and thus be more likely to experience divorce (Hetherington et al., 1989).

Remarriage and stepfamilies

Considering the high rates of remarriage amongst divorced adults, it is important to briefly explore how reorganisation into stepfamilies may influence a child’s adjustment. Research has yielded mixed results, and this may in part be due to the fact
that the stepfamily is a very complex and diverse form of family, and it is likely that a child’s adjustment to remarriage will also be affected by their experience of all the other transitions and changes associated with divorce (Gorell Barnes et al., 1998).

Amato and Keith’s (1991a) meta-analysis indicated that children in stepfamilies score significantly lower on measures of psychological adjustment than do children in single parent families. Five studies offered the tentative conclusion that effects may vary when considering the sex of the child in relation to the stepparent: Boys living with stepfathers compared to single-mother families demonstrated improved overall well-being. Other studies suggest that girls may generally find it harder adjusting to remarriage than boys and stepfather-daughter relationships are often reported to be the most conflictual and negative amongst adolescents; possibly as this may disrupt the very close relationship that divorced mothers and teenage girls are likely to form (Hetherington et al., 1985).

Evidence also suggests that the age of the child affects adjustment to remarriage. Younger children may be more able to form an attachment with a competent stepparent and accept their parenting role (Hetherington et al., 1989). Hetherington and Clingempeel’s (1992) study indicated that adolescents find it harder to adjust and are more likely to experience difficulties in family relationships. Using a life story method, Gorell Barnes et al. (1998) concluded that because adolescents are older and bigger, they can argue and fight much more powerfully, between each other and with adults in stepfamilies. This may contribute to their apparent problematic adjustment to remarriage.

In a qualitative study, Moxnes (2003) reported that all fifty-two children found the introduction of a stepparent a stressful process, but that the vast majority considered it a gain with time. Children with a residential stepparent seemed to adjust better than those with a non-residential stepparent. This emphasises the importance of the process through which the stepparent was introduced, as children were always involved in negotiating and building a relationship with residential stepparents before they moved in, whereas most children did not even meet the non-residential stepparent before they moved in with the non-residential parent.
Many children who experience reorganisation into stepfamilies may also experience further marital transitions: Over half of all second marriages in the United Kingdom end in divorce (Walker, 1993). Additional parental divorces seem to be more stressful for children than first divorces (Amato & Booth, 1991). Arguably this may be partly due to increased exposure to parental maladjustment, marital conflict and the other stresses associated with divorce. This highlights that when considering evidence concerning the impact of remarriage on children, it is essential to recognise that children only arrive in stepfamilies through a series of crucial transitions: These may have also contributed to cumulative stress, which in itself may lead to adjustment problems (Gorell Barnes et al., 1998).

FACTORS PROMOTING ADJUSTMENT TO DIVORCE

Considering all the possible factors that may be associated with divorce and the diversity in outcomes for children, it is clear that negative outcomes are by no means inevitable. A number of important implications have emerged for facilitating adjustment to divorce.

What can parents do to help?

As previously discussed, there are a number of ways in which the processes involved in divorce may negatively affect the parenting environment. Authoritative parenting by the residential parent, however, is associated with positive adjustment in children and may negate many of the detrimental effects of other risk factors (Hetherington & Clingempeel, 1992). Authoritative parenting is characterised by high levels of warmth, support, communication and sensitivity, and firm, consistent positive discipline and monitoring (Bray & Hetherington, 1993). Younger children particularly benefit from a predictable, controlled and responsive environment, and the psychological adjustment of older children and adolescents is promoted when parents do not give excessive responsibility or make inappropriate emotional demands (Hetherington et al., 1989). This style of age-appropriate authoritative parenting can act as a buffer or protective factor to help children cope with the other possible
transitions associated with divorce, such as economic decline and associated stresses, parental absence or parental ill health. Authoritative schools that provide structured and responsive environments can also help contribute to children’s adjustment (Hetherington et al., 1993).

The relationship between divorced parents can potentially promote children’s adjustment. Although parental conflict and anger is common and understandable throughout the process of divorce, there is clear evidence that this can affect children negatively. Therefore it is important that parents try not to involve their children in or expose them to their own, sometimes legitimate, battles. This involves parents clearly separating their ongoing parenting roles from their marital roles that have ended (Emery & Dillon, 1994). Divorce often leaves parents with self-doubt and uncertainty, having lost their sense of self-efficacy in their role as a good husband, wife or parent. However they can aim to re-gain a sense of self-efficacy in their role of parent by performing it successfully, through co-operation rather than conflict with their ex-spouse:

People in highly conflicted relationships cannot be lovers or enemies or friends, but perhaps they can become partners in the business of parenting their children (Emery & Dillon, 1994, p.3).

This may involve parents setting clear rules and boundaries around communication with each other and who has what responsibility for which parenting decisions and tasks. If parents are in conflict then it is important that children are not encouraged to form hostile alliances against the other parent and do not get caught in the middle of parental acrimony (Hetherington & Stanley-Hagan, 1999). This type of conflict makes co-operative or even parallel parenting very difficult to maintain and heightens the risks to children’s psychological adjustment.

As previously implied, it is the quality and conditions of contact with the non-residential parent that is important for children’s adjustment, rather than the quantity. It tends to be helpful if the residential parent accepts the child’s relationship with the non-residential parent and if parents encourage the child to retain a constructive and
meaningful relationship with both of them, if that is what the child desires (Emery & Dillon, 1994). Clearly this ideal is often difficult to attain when there is continuing conflict between parents or when the relationship has ended bitterly (Walker, 1993). The child’s adjustment can be promoted by including them in discussions around contact and by ensuring that contact is planned, clearly defined and consistent, for example by following schedules. Emery and Dillon (1994) emphasise that what can seem like flexibility to a parent may often be construed as uncertainty by a child.

This highlights the crucial role of the process by which transitions and challenges are understood and negotiated between parents and children. In Moxnes’ (2003) qualitative study, children adjusted and coped well when parents involved them in open and honest discussions around the problems, prioritised the child’s understanding and concerns, and worked with the child to minimise the negative impact of these problems. In this way, the challenges and changes were construed as shared family problems and as nobody’s fault, rather than as personal problems for the children to cope with alone. While it is important that children do not assume too much responsibility at an early age, the feelings of powerlessness associated with protective exclusion from family upheaval are likely to be detrimental to a child’s psychological adjustment (Gorell Barnes et al., 1998).

If parents are considering remarriage, evidence suggests that younger and older children tend to adjust better than adolescents (Hetherington & Clingempeel, 1992). Yet any child facing reorganisation into stepfamily life will be at less risk of maladjustment if their parents have taken steps to avoid earlier negative outcomes in the ways described above. Children and adolescents also benefit from other protective factors such as social support from siblings, stepsiblings, peers, extended family and school (e.g. Amato, 2000). Furthermore, the way in which relationships are formed and new family roles are established can promote positive adjustment to remarriage. For example, involving the child in decisions about the process of building a relationship (Moxnes, 2003) and encouraging a positive, friendly relationship with the stepparent before they assume the role of disciplinarian (Hetherington & Clingempeel, 1992). Gorell Barnes et al. (1998) emphasise that the experience of a positive marital relationship can in itself promote psychological adjustment.
Interventions for post-divorce adjustment

Considering the range of challenges and problems that children may potentially experience throughout the process of divorce, there is a clear rationale for exploring the interventions that may be used to help alleviate post-divorce adjustment problems. Broadly, these include child-focused interventions, parental programmes and family-focused approaches.

Child interventions often consist of group programmes targeting children’s thoughts and feelings about the divorce, promoting behavioural adjustment and increasing their coping skills and problem-solving strategies (e.g. Bornstein et al., 1988). Leon (2003) highlights the importance of recognising the child’s developmental level. However, methodologically sound research examining the efficacy of these interventions is relatively scarce. In a methodological and substantive review of outcome studies, Lee et al. (1994) concluded that there is only modest evidence of any changes in children’s adjustment, behaviour and coping skills. Overall, they reported a mean effect size of 0.27. Considering the crucial role of parent’s adjustment, behaviour and parenting in predicting child outcomes, it is not surprising that child focused interventions have limited efficacy (Grych & Fincham, 1992).

Interventions for parents tend to comprise community based programmes that may address individual adjustment, parenting issues or coping with the transitions and stresses associated with divorce. Outcomes for these programmes depend largely on the goals of the intervention and Lee et al. (1994) reported that those addressing depression or distress yield the most effective results on measures of parental adjustment. The mean effect size was 0.80. Interventions that target parenting behaviour may include psychoeducational programmes to reduce conflict between parents (e.g. Shifflett & Cummings, 1999) or broader issues of relationships, discipline, conflict and contact with the non-residential parent (e.g. Hipke et al., 2002). Research is beginning to indicate more conclusively that these interventions can improve child adjustment and outcomes (e.g. Wolchik et al., 2000). However, interventions do not benefit all parents and children, and recent research aims to
identify those factors that promote long-term programme benefits; for example, high self-regulatory skills amongst children and parental mental health (Hipke et al., 2002).

Family approaches often focus on relationships, intimacy and power, by helping children to express feelings and needs to parents, reinforcing generational boundaries, reducing parental conflict and promoting communication and co-operative parenting (Emery & Dillon, 1994). Systemic approaches offer a way of conceptualising and understanding complex sets of relationships in terms of their patterns, rules and beliefs. This approach can be useful in working with stepfamilies, using genograms to explore relationships, closeness and distance, and intergenerational patterns: Difficult and conflicting relationships can be understood within the wider system, promoting less blaming and overwhelming accounts of the experiences of life in a stepfamily (Gorell Barnes et al., 1998).

Mediation services are often used as an alternative to settling disputes within the legal system, to minimise conflict between parents and promote co-operation in decision-making. However some evidence suggests that mediation does little to improve parental relationships and thus the adjustment of children (Walker, 1993).

**CONCLUSION**

In conclusion, I would argue that divorce in itself is not ‘bad for children’, although there are many possible challenges and transitions associated with the process of divorce which may potentially have negative effects on children’s psychological and behavioural outcomes. There is great variability in children’s responses to divorce, which I believe reflects the fact that there is no one single pathway through the course of shifts in the marital relationship, the separation, and post-divorce transitions and challenges. In this way, negative outcomes are certainly not an inevitability of divorce, and I have outlined the protective factors which contribute to promoting psychological adjustment. Many of these focus on the role of parents in helping their children cope with their divorce, particularly regarding parental conflict and the parenting environment. This highlights the need for caution in interpreting much of research evidence on this fairly controversial topic, and the need to be careful not to
attribute blame to parents, in both clinical settings and at a policy level. My view is that many of the ideas about ways in which parents can help their children cope with divorce are only relevant for children experiencing their parents' divorce, but many are important for the well-being of children generally, regardless of whether their parents are divorcing.

In considering future directions, it is important to note that there are a number of methodological limitations in much of the research to date regarding post-divorce adjustment in children. Quantitative research would benefit from a focus on longitudinal studies to advance our understanding of the factors discussed that contribute to variability in outcomes and particularly protective factors. Much of the research has used restricted clinical or nonrepresentative samples, with single informants and often only white middle class families. Future research could broaden our understanding of cultural, ethnic, racial and religious differences in the process and meaning of divorce, and its impact on children. Many children experience multiple marital transitions, and further research is needed to investigate the risk and protective factors that contribute to the adjustment of children to complex stepfamily relationships and multiple divorces. More studies using qualitative methods would be useful to enhance our awareness and understanding of the diverse developmental trajectories that affect children's adjustment to marital transitions. Finally, future research could further investigate the outcomes and efficacy of different types of interventions that aim to promote post-divorce adjustment.
REFERENCES


Child and Family Essay


What psychological models, theories and practices are helpful to clinical psychologists when working with instances of suspected and/or actual abuse of older people?
INTRODUCTION

Before considering what psychological theories and practices are helpful to clinical psychologists working with instances of suspected and/or actual abuse of older people, it is useful to outline a few definitions. Firstly, ‘older people’ tends to refer to people over the age of sixty-five, or in some cases sixty. This arbitrary cut-off point is used for many purposes, including most psychological research and practice (Britton & Woods, 1996). The issue of what constitutes abuse is more difficult, with varying terms and definitions across different research and literature. I will refer to the recent definitions of abuse of vulnerable people from the Department of Health (2000) guidelines *No Secrets:*

Abuse may consist of a single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it (p.9).

In this way, there are six main forms of abuse which I will briefly outline: Physical (such as hitting, misuse of medication, restraint) sexual (when the person has not or cannot consent), psychological (including threats, humiliation, isolation) financial or material, neglect and acts of omission (ignoring care needs or not providing access to appropriate services) and discriminatory abuse. These acts may be perpetrated as the result of deliberate intent, negligence or ignorance. It is interesting that these definitions seem to include ‘unintentional abusive acts’ that may be linked to inherent ageist attitudes or a lack of knowledge or training. For example, ‘restraining’ an older person in a chair out of which they cannot get up, which may be ‘isolating’ them from other people due to its positioning. It also implies that any sexual contact with someone who does not have capacity to consent (such as some people with dementia) is abusive (Hagerty Lingler, 2003). In this essay, I will use the term abuse to cover all these types of abuse and neglect, unless otherwise stated.
Due to the problems in defining and detection, it is difficult to clarify prevalence rates of abuse. However, some attempts have been made across many different countries. Kingston and Reay (1996) summarise these random sample population studies and conclude that rates in the UK, USA, Canada, Finland and Australia are surprisingly similar, with rates of all types of abuse between 3-6%. Rates of different types of abuse vary, as do the categorisations of types of abuse. Abuse may occur within families, by outsiders (such as crime within the community), or within institutional care: Pillemer and Moore (1989) demonstrated significant levels of self-reported abuse by staff in UK nursing homes.

**Challenges in Assessment and Detection**

As well as the difficulties in clearly defining abuse, detection may be complicated by other factors that may present as ‘symptoms’ of abuse or may mask actual cases of abuse. For example, psychological abuse can cause confusion or failure to thrive, but so can dementia or chronic illness (Hudson, 1986). A fall might lead to bruising and acute stress reaction, as can physical assault (Papadopoulos and La Fontaine, 2000). This highlights the importance of a thorough multi-disciplinary assessment in cases of suspected abuse.

Detection is also linked to rates of reporting. Recognition and disclosure of abuse may be complicated by delusions, memory problems, immobility, shame (due to individual or cultural beliefs) or fear. For example, older people might fear that disclosure will lead to further and more severe abuse, to the withholding of care, or to the removal from their home or a reliance on services that they view negatively (Papadopoulos & La Fontaine, 2000). Professionals or other family members may believe that reporting colleagues or family may result in punitive rather than protective outcomes (Hudson, 1986). It is helpful for clinical psychologists working in this area to be mindful of these possible challenges and how they may affect the assessment process and any attempts to explore what the older person perceives as abusive.
HELPFUL PSYCHOLOGICAL PRACTICES

There are a number of psychological models and theories that are helpful to clinical psychologists working with instances of suspected and/or actual abuse of older people. These will be discussed below. Firstly, I will briefly outline those practices that are particularly relevant when working in this setting. In any work with older people, it is helpful to be aware of how clinical practice may need to be modified in response to a client's possible sensory difficulties (e.g. Dick et al., 1996). Reflective practice is also an essential psychological practice that is particularly pertinent when working with such an emotive issue as abuse. This involves identifying one's own experiences, context and values that may impact on the process of assessment, formulation, building a therapeutic relationship and intervention. Lavender (2003) outlines the importance of reflection in action, reflection on action (for example in supervision) and self-reflection (promoting awareness and development).

The psychological 'practices' of sensitivity, active listening, non-leading questions, and non-judgemental, collaborative approaches are also helpful when working with people who are distressed and may be involved in legal proceedings (Papadopoulos & La Fontaine, 2000). Person-centred practice is also significant, such as the Rogerian psychological practices of genuineness, acceptance (or 'unconditional positive regard'), warmth and empathy (Rogers, 1959). Person-centred practice is also recommended by government guidelines for working with older people in this setting such as No Longer Afraid (Department of Health and Social Services Inspectorate, 1993) and the National Service Framework for Older People (Department of Health, 2001). Furthermore, this highlights the importance of clinical practice that is consistent with government policies. Evidenced-based practice is also vital to clinical psychologists, emphasising the need to acknowledge the quality and quantity of research regarding different theories of and interventions for abuse of older people. In this way, I will try to be mindful of research during discussions of the useful psychological models and theories.

Another helpful practice adopted by psychologists is to recognise cross-cultural variation, for example in the nature and extent of abusive behaviour, and to identify
those factors that may influence this diversity in individual cases. So it is helpful to acknowledge religion, culture and other contextual factors that may affect the experience of abuse. For example, accepting responsibility for elderly relatives is central to the philosophies of Islam and the Sikh religion. However, ethnic minorities in Britain are arguably subject to the triple oppression of old age, discrimination (which may be understood as abuse in itself) and lack of access to services (George, 1994). These factors may lead to increased stress and conflict in minority families, which may heighten the risk of abuse, or these factors may prevent the reporting of abuse. Many of the issues that contribute to this diversity will be discussed below, particularly in the context of systemic theory.

HELPFUL PSYCHOLOGICAL THEORIES - INTRODUCTION

The psychological practices of assessment and formulation are vital to clinical psychologists in gaining an understanding of the origins and maintenance of abuse, and in guiding the development of intervention plans. In light of this, I will discuss a number of psychological models and theories in terms of how they may help clinical psychologists during their assessment, formulation and intervention. Firstly, I will briefly outline three psychosociological models that many authors have suggested are helpful in understanding abuse of older people (e.g. Biggs et al., 1995): The situational stress model, social exchange model and symbolic interactionist model. Then I will discuss how other psychological theories may be helpful to clinical psychologists working with instances of suspected or actual abuse of older people: Systemic theory, Attachment Theory, psychodynamic theory, and cognitive behavioural approaches.

TRADITIONAL PSYCHOSOCIOLOGICAL MODELS

Situational Stress Model

The situational stress model (e.g. Phillips, 1986), which highlights the situational context of the abusive relationship, may be helpful to clinical psychologists. The basic premise is that situational factors (such as dependency, financial difficulties or social
isolation) contribute to increasing caregiver stress which may become manifest in abuse as a means of immediately alleviating stress (Papadopoulos & La Fontaine, 2000). Whilst this theory makes sense on the surface, it is helpful if clinical psychologists utilise evidence-based practice and recognise that in a matched case-controlled study, Pillemer (1986) reported that the dependency of the older person and financial problems, two factors thought to be associated with caregiver stress, were not significant risk factors for abuse. Furthermore, it is helpful if clinical psychologists remain aware of the issues around retrospective research; that is, that many abusers of older people might be stressed, but that many stressed carers do not become abusive.

**Social Exchange Model**

Social exchange theory might be helpful to clinical psychologists by emphasising the power dynamics within caring relationships (e.g. Dowd, 1975). This model proposes that social interaction consists of exchanges of rewards and punishments, which by degree govern whether the exchange will continue or stop. A long-term perceived imbalance of exchanges is likely to lead to either conflict or avoidance (Phillips, 1986). Neglect might therefore arise when the carer attempts to avoid the intolerable situation altogether. Abuse may be understood as arising from perceived unacceptable losses of rewards and an attempt to regain control on the part of the abuser, or as a function of the powerlessness or dependency of either the carer or the older person (Biggs *et al.*, 1995). Historically the emphasis has been on the power imbalances associated with (physical or emotional) dependency of the older person on the carer as a risk factor for abuse (e.g. Eastman, 1989). However evidence suggests that it is the dependency of the caregiver on the older person, particularly for financial support and housing, that increases the risk of abuse (Pillemer, 1986). A clinical psychologist may find this model helpful in guiding an intervention aimed at reducing dependency and increasing the cost of abuse or neglect (Biggs *et al.*, 1995).

**Symbolic Interactionist Model**

Symbolic interactionist theory is another psychosociological perspective that may be helpful to clinical psychologists in understanding abuse of older people (e.g. McCall
Interactions are seen as symbolic in the sense that they are based on (socially constructed) perceived images and expectations of the self and others. A clinical psychologist using this theory would consider how previously stable role expectations and identities might have changed in the system as the person became older, and the associated mismatches in perceptions and understandings between social actors (Biggs et al., 1995). For example, if challenging behaviour is perceived as being intentional rather than linked to disability or illness, an older person might be blamed and punished through abuse. Significant role changes might contribute to infantilisation and other forms of psychological abuse.

This theory emphasises both the cognitive processes of social interaction such as perceptions, expectancies and personal meanings, as well as systemic contextual factors like cultural beliefs and norms around ‘ageing’ (Phillips, 1986). Therefore it draws on cognitive and systemic perspectives, both of which are familiar to clinical psychologists in understanding behaviour. A psychologist may therefore find it helpful to consider personal meanings and changing role identities in abusive interactions, and how these might be challenged to foster self-validating identities and non-abusive relationships (Biggs et al., 1995). This might include, when preventing or working with abuse of an older person with dementia, educating the carer about aspects of the illness so that behaviours can be re-interpreted in a less negative way (Eastman, 1989). However, the scientist-practitioner would need to be mindful of the difficulty in empirically testing this theory, due to the inaccessibility of symbolic meanings, and its current lack of predictive power (Phillips, 1986).

**SYSTEMIC THEORY**

**Assessment and Formulation**

Clinical psychologists may find it helpful to use systemic theory during the assessment stage of clinical practice, to focus not only on the suspected abusive behaviour, but also on the context within which it is occurring. Hagerty Lingler (2003) demonstrates the importance of assessing contextual and relationship factors in her paper on distinguishing appropriate sexual activity from sexual maltreatment among
women with dementia. She proposes that clinicians must conduct contextual relationship-centred assessments regarding the nature and history of the relationship between the suspected abuser and the abused. With suspected sexual abuse the clinician should assess whether the older person has ever dissented or expressed fear or discomfort, and whether the potential abuser is only able to engage them in such an activity due to aspects related to their cognitive state (such as passivity, or impaired decisional capacity). Kosberg and MacNeil (2003) suggest that in assessing suspected abuse between generations, it is helpful to consider the quality and commonalities of intergenerational relationships. They propose that those families who do not demonstrate solidarity through affection, shared values and positive contact are more at risk of serious conflict and potentially abusive behaviour towards the older generations.

A systemic model can offer a framework for understanding and formulating about instances of abuse and neglect of older people. From a family systems perspective, abuse may be seen as symptomatic of a family’s wider difficulties or as the family’s ‘solution’ to their problems. These problems may be linked to the family’s structure, dynamics, inter-relationships, life cycle stage or cultural context. For example, a clinical psychologist working with a family that has recently re-located to a community with different social, cultural and political standards might understand abusive behaviour as symptomatic of the stresses the family are facing in adjusting to new circumstances (Papadopoulos & La Fontaine, 2000). Transitions associated with later life (such as retirement or the need for care) contribute to important changes in families’ hierarchies and boundaries, resulting in changes in relationships and roles. This is expected as families undergo various changes in the course of its development through the family life cycle (Carter & McGoldrick, 1989). However, if individuals within the family system have problems with role flexibility or accepting new boundaries (because they perceive them as compromising their status or identity within a relationship or culture), conflict may ensue and the family’s problems may emerge as abusive behaviour towards the older person (Neidhardt & Allen, 1993).

Using a family systems perspective, Kosberg and MacNeil (2003) suggest that factors that contribute to grandparents taking custody of grandchildren might heighten the
risk of intergenerational conflict. For example, children who have been abandoned or were inadequately cared for by their parents may develop emotional or behavioural problems that manifest in aggression, conflict or abusive behaviour towards the grandparent. The adult children may have had to relinquish care to their parents due to substance misuse or mental health problems, which have been suggested to be risk factors for abusing older parents (Pillemer, 1986). The transitions associated with taking custody of grandchildren significantly affect roles and relationships in all parts of an older person’s system, and may bring about other lifestyle changes in work, social life, finances and health. All of these personal and contextual changes may contribute to intergenerational tensions or conflicts that may lead to abuse of custodial grandparents. Boxer et al.’s (1986) study demonstrates that psychologists working with cases of intergenerational conflict and abuse should remain aware of generational location and gender differences in shaping the perception and expression of conflict.

Nahmiash (2002) also presents a systemic model that may be helpful to clinical psychologists in understanding abuse. This model emphasises how diverse contextual factors (such as history, gender, culture, social context and relationships) may lead older people and caregivers into positions of powerlessness that culminate in maintaining abuse. Nahmiash describes a woman whose experience of the Holocaust and learned gender role led to beliefs that she must preserve and protect her family at all costs, which included ‘surviving’ sexual abuse from her son. Extracts from physically abused females also demonstrate the link between perceived cultural expectations of gender roles and duties, previous experiences of violence, and the shame associated with ‘family secrets’ such as abuse, that result in the ‘protection’ (or non-reporting) of abusive family members in order to preserve family life. Another example highlights how an Indian man who moved to Canada struggled with the clash between his cultural values and expectations and those of his new Canadian wife and stepchildren, who were able to financially and psychologically abuse him.

The issue of powerlessness also seems pertinent to understanding abuse of older people in institutional settings. Older people in nursing homes and hospital may have suffered some losses prior to their admission, such as financial losses, loss of a partner or loss of health due to disability or dementia. As a result of their move to institutional
care they may have lost their home, their independence, and their social and community contacts. In this context, staff have the power to control many aspects of residents’ or patients’ lives, and often impose routines for the good of the institution over those of any individual (Papadopoulos & La Fontaine, 2000). In addition, staff may perceive that they are in a challenging yet poorly paid and undervalued role, which may heighten frustrations and lead to dehumanising and abusive practices.

Work by Kitwood (1997) emphasises that lack of knowledge and insensitivity may also contribute to the depersonalisation and dehumanisation of older people with dementia. Considering the nature of institutions as ‘closed’ communities, this may render older people vulnerable to abusive practices (Papadopoulos & La Fontaine, 2000).

Interventions

A systemic formulation guides an intervention that focuses on the system within which the abuse is occurring. Clinical psychologists may find systemic interventions particularly helpful in cases of abuse, as the older person is not viewed as the problem, but rather relationships and problematic interactions become the focus (Kingston & Reay, 1996). Neidhardt and Allen (1993) summarise the goals of family intervention in these cases as firstly identifying and reducing those factors of the system that support the abuse, secondly developing appropriate coping skills that do not lead to abuse, and thirdly eliminating family interactions that precipitate abuse. They suggest that methods such as joining (engaging the family), positive connotation and exploring alternative possibilities (e.g. circular questioning) may facilitate the development of alternative (non-abusive) patterns of behaviour and congruent communication.

Systemic theory may also be helpful to clinical psychologists in preventing or intervening in cases of abuse within institutions. This theory is helpful as it highlights the need to respond at many levels of the older people’s context. For example, at an organisational level, Papadopoulos and La Fontaine (2000) suggest that care home managers need to promote the attitude that their function is to provide high quality care to older people, rather than just running a business. This might involve helping staff to feel empowered to achieve practices that maintain dignity, privacy,
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independence and choice. This includes fostering anti-ageist attitudes and person-centred practice that considers the individual’s abilities, tastes and values (Kitwood, 1997). Training might be required so that staff have more knowledge of health needs and more skills in conflict resolution and stress management. To minimise losses associated with institutionalisation, staff should include family members at all stages of admission and care, and enable older people to maintain links with their community and networks (Papadopoulos & La Fontaine, 2000). Comijs et al. (1999) demonstrated that abused older people with higher levels of social support (such as emotional support and visiting) showed less psychological distress.

ATTACHMENT THEORY

Assessment and Formulation

Bowlby’s Attachment Theory (1969/1984) may be helpful to clinical psychologists in assessing and formulating about abusive behaviour within families. Bowlby emphasised that the nature of a child’s attachment affects the development of their internal working model that then guides their expectations of and evaluations about self and others’ behaviours in subsequent relationships. Evidence has reported a link between insecure attachment and later aggression (Lyons-Ruth, 1996), mental health problems in adulthood (Main, 1996) and problematic conflict resolution (Erdman & Caffery, 2003). Furthermore, evidence has suggested that these types of psychological and emotional difficulties are risk factors for abuse towards older people (e.g. Pillemer, 1986). In this way, it is clear that attachment may have significant effects on the relationship between an older person and their adult child, and the likelihood of the adult child displaying abusive behaviour (Kosberg & MacNeil, 2003).

Cicirelli (1986) suggests that when an older parent becomes ill or incapacitated, the adult child may feel their attachment bond is threatened. So the adult child will provide help and caregiving to maintain the survival of and attachment with the parent. Cicirelli (1983) demonstrated that adult children’s negative feelings and parent-child conflict are more likely when parents have high dependency, require frequent helping behaviours and when the adult child’s attachment feelings are not
strong and attachment behaviours are infrequent. Furthermore, if the adult child’s attachment is not strong, they are less likely to respond to cultural norms and expectations regarding help to aging parents. This model indicates that adult children in a caregiving position for an older parent who do not have a strong secure attachment are more likely to find themselves in a cycle of conflict. In addition, Steinman (1979) indicates that insecurely attached adult children are more likely to manage conflict in a caregiving situation by ‘actively avoiding’ caregiving or ‘vacillating’ between caregiving and avoidance (as cited in Cicirelli, 1983). These situations may end up in neglect of the older parent.

**Interventions**

Attachment Theory is helpful to clinical psychologists as it emphasises the history of the relationship between the parent and child in contributing to the adult child’s response to conflict with their parent in a caregiving situation. Interventions may therefore aim to strengthen existing attachments by helping to resolve conflicts between parents and adult children. This is likely to involve exploring both new conflicts and those that are continuing or are reactivated from earlier life (Cicirelli, 1986). However, considering the importance of evidence-based practice, it is helpful if clinical psychologists remain aware that the evidence of a link between attachment and later problems is correlational rather than causal, and that there is a need to empirically test the link between attachment and abuse of older people.

**PSYCHODYNAMIC THEORY**

**Assessment and Formulation**

Papadopoulos and La Fontaine (2000) suggest that the psychodynamic notion of projection may be helpful to clinical psychologists in understanding some cases of abuse within families. For example, an individual’s early experiences of abuse, neglect or loss may have contributed to repressed feelings of fear or anger. If a spouse has an illness like dementia, these feelings may be triggered by the multiple losses within the current relationship, such as loss of intimacy, loss of valued roles and loss
of access to leisure or spiritual experiences. These repressed feelings may be projected onto the older person and become manifest in abusive behaviour. Working in institutions for older people requiring nursing care may evoke anxieties in staff about their own mortality and possible loss of independence, or anger at the older people for ‘failing to improve’ (Zagier Roberts, 1994) Staff may develop unconscious psychological defences against these feelings that could increase the chance of abusive practice: Devaluing and depersonalising older people, treating them like objects, and seeing them as inherently different from themselves may become the accepted norm.

**Interventions**

Psychodynamic theory may be helpful when intervening with victims of abuse: The clinical psychologist would aim to lessen the psychological impact of the abuse through exploring and working through distressing feelings and emotional conflicts in the context of the relational dynamics that occur between the client and psychologist (Papadopoulos & La Fontaine). With perpetrators of abuse, the clinical psychologist would facilitate the exploration and expression of repressed feelings with the aim of resolving emotional conflicts and developing a fulfilling and meaningful life. To prevent or respond to abuse in institutions, reflective practice would also be encouraged to enable acknowledgment of negative feelings so that the need for defences and abusive practice is reduced (Zagier Roberts, 1994).

**COGNITIVE BEHAVIOURAL THEORY**

**Assessment and Formulation**

The cognitive behavioural model may be helpful to clinical psychologists in assessing and formulating about abuse of older people. This approach might include a functional analysis of abusive behaviour, in terms of the links between triggers, cognitions, emotional responses and behaviour. It may be possible for the perpetrator to use an ABC diary of antecedents (triggers), behaviour (what happened), and consequences, but on a prospective basis, so as not to expose the older person to further abusive
incidents (Papadopoulos & La Fontaine). An ABC ‘diary’ and in-depth assessment interview may contribute to a cognitive behavioural formulation. For example, triggers might include increasingly challenging behaviour of the older person and stressful life events, which may lead to an interpretation of the situation as threatening and that the older person is intentionally demanding: These cognitions would cause feelings of anger and fear, which may result in aggressive behaviour towards the older person, punitive measures or withdrawal from the caring role. These acts of abuse or neglect may fulfil the function of controlling the older person’s behaviour while alleviating the carer’s stress, which may increase the chance of repeating this abusive behaviour under similar circumstances (Papadopoulos & La Fontaine, 2000).

Interventions

Cognitive behavioural interventions may be helpful to clinical psychologists working with perpetrators of abuse. Evidence suggests that people who abuse older people are significantly more likely to be rated by the older person as having psychological problems or substance misuse problems than a control group (Pillemer, 1986). While this study may not demonstrate a causal relationship and does need to be replicated using more reliable measures, it suggests that cognitive behavioural therapy may be useful in addressing the perpetrators’ difficulties. The overarching aim might be to help them generate alternative coping strategies (to abusive behaviour) that are realistic and ethical. This might include challenging negative thoughts, interpretations and beliefs (through ‘reality testing’, reframing or psychoeducation), and the identification of more positive or helpful self-talk that promotes more positive feelings and behaviours (Papadopoulos & La Fontaine, 2000). Behavioural techniques such as distraction or problem-solving may also be employed. In an overview of four hundred and seventy-three strategies used by a Canadian health and social service agency, individual therapy to reduce abusers’ anxiety, stress or depression were rated by the team as amongst the most accepted and successful strategies (Nahmiash & Reis, 2000).

Reay (1995) outlines a cognitive behavioural therapy plan for perpetrators of physical, sexual or verbal abuse in terms of anger management (as cited in Kingston & Reay,
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This approach includes self-report monitoring using diaries, psychoeducation regarding causes and consequences of anger, generating coping self-talk for use before, during and after anger situations, relaxation to address physical tension and behavioural techniques such as assertion training and time out. Eastman (1989) highlights that these approaches would be particularly helpful to clinical psychologists working with perpetrators who perceive the older person's dependant or challenging behaviour as 'deliberate'.

Evidence suggests that older people who have been abused or neglected are at risk of becoming depressed (e.g. Comijs et al., 1999). Cognitive Behavioural Therapy (CBT) has been found to be effective in the treatment of late-life depression (e.g. Dick et al., 1996), although these studies have not involved older people who have been abused.

Once a thorough assessment has been conducted and a therapeutic alliance developed, the basic strategies involved in CBT may include behavioural activation, identifying and challenging cognitive distortions, and relaxation techniques and possibly assertiveness training (Dick et al., 1996). Cognitive restructuring may be focused on challenging distorted beliefs about the legitimacy of abuse towards them (Papadopoulos & La Fontaine, 2000), and behavioural techniques may facilitate the older person in regaining some sense of self-efficacy. Comijs et al. (1999) demonstrated that higher levels of mastery and perceived self-efficacy were associated with less psychological distress in victims of abuse.

CONCLUSION

In this essay I have demonstrated how a number of psychological models, theories and practices are helpful to clinical psychologists when working with instances of suspected and/or actual abuse of older people. This has included discussions of general psychological practices relevant in cases of abuse, psychosociological models that have been used to explain abuse of older people, systemic theory, attachment theory, psychodynamic theory and the cognitive behavioural model. In doing so, I have highlighted how these psychological theories can help clinical psychologists assess and formulate about the origins and maintenance of abuse of older people. These theories also offer guidance on a range of therapeutic interventions in a variety
of contexts with abused older people, with perpetrators of abuse, and in preventing abuse. Clinical psychologists would acknowledge that no single theory can sufficiently explain all abuse of all older people, but rather that different theories may be more or less helpful depending on the issues that emerge in a particular case (Biggs et al., 1995).

However, in my opinion, it seems that systemic theory and cognitive behavioural models offer the most useful frameworks for understanding abuse of older people and for developing interventions. Systemic theory emphasises to psychologists the importance of situating abuse of older people within the context of relationships, transitions and the wider social and cultural context. This perspective is also helpful as it highlights that abuse is likely to affect many members of a family or institutional system, and it helps psychologists to consider how interventions can target many aspects of an older person's system. Cognitive behavioural approaches offer a clear framework for understanding abusive behaviour, and may be particularly helpful to psychologists working with perpetrators of abuse who have mental health problems.

I have illustrated that many psychological theories and models may be helpful in cases of abuse of older people. However, it is important to acknowledge that abusive behaviour is complex and multifaceted. Therefore it is likely that many professional disciplines and social support structures will need to be incorporated in a thorough multi-disciplinary assessment of abuse and in planning a global intervention. Yet this essay has demonstrated that psychological models, theories and practices have a lot to offer in understanding, treating and preventing abuse of older people in a variety of contexts.
REFERENCES


Clinical Dossier
Summaries of Placement Experience

Core: Adult Mental Health Placement
Setting: Community Mental Health Team / Day Centre
Trust: Surrey Hampshire Borders NHS Trust
Dates: 15th October 2003 – 26th March 2004

Clinical assessment: Assessment interviews with individuals, family members (including carer’s assessment) and professionals. Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), CORE, Wechsler Adult Intelligence Scale-III (WAIS-III), Wechsler Memory Scale-III (WMS-III), National Adult Reading Test, SCHONELL.

Clinical interventions: Predominantly cognitive behavioural therapy (CBT), integrating systemic ideas and some psychodynamic formulation; with individuals and a couple. Presenting problems included anxiety, depression, phobias, anger problems in the context of M.S., eating disorder, borderline personality disorder and self harm, alcohol problems, relationship difficulties, and problems associated with cognitive difficulties.

Group work: Co-facilitated weekly confidence building group (CBT) with inpatients and clients attending the day centre. Co-facilitated weekly anxiety management group (CBT) with clients attending the day centre.

Other experiences: Observation of multi-disciplinary team members/ward round (on acute ward), case presentation, attended journal club, conducted Service Related Research Project.

Core: People with Learning Disabilities Placement
Setting: Community Team for PLD / Challenging Needs Service
Trust: Kingston Primary Care NHS Trust
Dates: 7th April 2004 – 24th September 2004

Clinical assessment: Assessment interviews with individuals, family members and professionals, including functional assessments of challenging behaviour. Symptom Checklist, General Health Questionnaire, dementia assessment (Oliver & Crayton), Adaptive Behaviour Scale, WAIS-III.
Clinical interventions: Behavioural approaches, CBT, and systemic interventions (including family therapy with reflecting team); with individuals and families from diverse backgrounds (including work with an interpreter), and indirect/consultation work with residential staff. Presenting problems included challenging behaviour, transitional issues, family issues, anxiety, grief and loss—all in the context of mild to severe learning disability (including Autistic Spectrum Disorders, Downs Syndrome and Aperts Syndrome).

Group work: Contributed to Intensive Interaction group for people with severe learning disabilities.

Other experiences: Observation of multi-disciplinary team members and other agencies, visits to supported accommodation/residential homes, presentation to psychology department, training to staff at residential home on bereavement, regular team meetings, compiled Oliver & Crayton dementia assessment pack, attended training e.g. 3 day physical intervention training.

Core: Child and Family Placement
Setting: Community Child and Family Consultation Service
Trust: Blackwater valley & Hart NHS Trust
Dates: 13th October 2004 – 24th March 2005

Clinical assessment: Assessment interviews with individuals, family members and professionals, and observations of children. BAI, Locke assessment, Gillberg Aspergers criteria, Merrill Palmer, Wechsler Intelligence Scale for Children-III, WORD, visual memory tests (BAS).

Clinical interventions: Predominantly cognitive behavioural therapy integrating systemic ideas, and some behavioural interventions; with individuals, parents and families. Presenting problems included anxiety, travel phobia, vomit phobia, self-esteem issues in the context of diabetes, trauma, family issues, difficulties associated with Autistic Spectrum Disorders, and queried learning difficulties.

Group work: Co-facilitated weekly group for young people with OCD (CBT oriented).

Other experiences: Observation of multi-disciplinary team members (e.g. ADHD clinic, EMDR clinic), visits to schools (mainstream and special) nurseries and
children's wards, consultation to team members, regular peer supervision and team meetings, attended training e.g. 2 day child protection training.

**Specialist:** Forensic  
**Setting:** Maximum Security Special Hospital  
**Trust:** West London Mental Health Trust  
**Dates:** 6th April 2005 – 23rd September 2005


**Clinical interventions:** CBT and systemic/narrative interventions with individual patients from diverse backgrounds, and indirect/consultation work with ward staff e.g. initiating life story work. Presenting problems included gender identity difficulties, transitional issues (e.g. supporting transfer to medium security), anger management, relapse prevention for alcohol misuse – all in the context of offending behaviour and complex mental health problems e.g. personality disorder, psychosis, dual diagnoses.

**Group work:** Co-facilitated weekly interpersonal relationships group with young men with a diagnosis of personality disorder, using systemic/narrative approach, integrating some CBT ideas.

**Other experiences:** Compulsory 6 day induction including risk management/ CPR/Mental Health Act/breakaway, observation of ward meetings/admissions panel/CPAs, regular peer supervision and team meetings, supervision from specialist psychologists e.g. neuropsychologists, joint work.

**Core:** Older People Placement  
**Setting:** Community Physical Rehabilitation team / Stroke Unit / (medical) inpatients and day hospital  
**Trust:** Surrey and Borders NHS Trust  
**Dates:** 12th October 2005 – 24th March 2006

Clinical interventions: Predominantly CBT, some narrative and life story/reminiscence work; with individuals and indirect/consultation work with ward and residential staff. Presenting problems included grief and loss, adjustment issues, depression, anxiety, fear of falling, management of memory problems - often in the context of physical health problems e.g. head injury, vascular dementia, stroke.

Group work: Facilitated one session on confidence building in Falls Group, facilitated two sessions in Parkinsons Group (coping with Parkinsons and relaxation).

Other experiences: Observation of multi-disciplinary team members, visits to residential/nursing homes and day services, regular team meetings/special interest groups, weekly case presentation/discussion using audiotaped sessions, attended PSYRIS (stroke) training day.

Specialist: Continuing Needs Service
Setting: Rehabilitation and Recovery team, Assertive Outreach team, inpatients
Trust: Surrey and Borders NHS Trust

Clinical assessment: Assessment interviews with individuals and professionals, use of Knowledge about Schizophrenia Interview and Family Questionnaire with relatives, risk assessments, BPRS, BAVQ.

Clinical interventions: Predominantly CBT and relapse prevention (for alcohol/psychosis), some narrative work, mindfulness and psychosocial interventions; with individuals and indirect/consultation work with professionals. Presenting problems included paranoia, delusions, voices, anxiety, low mood, obsessive thoughts and alcohol misuse – all in the context of psychosis (schizophrenia, bipolar disorder) and often dual diagnoses.

Group work: Co-facilitated (every 2 weeks) Coping Skills group (CBT oriented) within rehabilitation unit, for inpatients and day attenders.

Other experiences: Observation of MDT members/CPA/ward round, visits to day centres/supported accommodation, meeting with service-user co-ordinator, regular AMH and psychology meetings, 3 assessments with relatives of service-users.
Adult Mental Health Case Report Summary

**Title:** Cognitive behavioural therapy with a 33-year-old man presenting with social anxiety and depression.

**Presenting Problem:** Daniel was referred to the CMHT by a private hospital. The presenting problems included low mood and social anxiety, and associated problems at work and within his relationship with his wife. Daniel reported feeling sensitive to stress and criticism, and self-conscious in many social situations. He was avoiding social contact as much as possible, and this had contributed to increasing conflict with his wife.

**Assessment Procedure:** The assessment included reviewing previous reports, two assessment interviews, and completion of the Beck Depression inventory (BDI) and Beck Anxiety Inventory (BAI).

**Formulation:** Daniel’s problems were conceptualised within a cognitive behavioural (CBT) framework. The formulation outlined the links between Daniel’s early experiences and the formation of negative core beliefs. These beliefs were activated by a stressful occurrence at work and difficulties in his relationship with his wife. This culminated in a cycle of depressive thoughts, low mood, withdrawal and social avoidance, and conflict with his wife. In addition, the role of self-focused attention was highlighted as maintaining anxiety within social situations.

**Intervention:** Daniel and I agreed to meet for twelve sessions of cognitive behavioural therapy, with a focus on social anxiety at Daniel’s request. The intervention involved challenging negative thoughts and beliefs (aided by the use of thought diaries as homework), relaxation training, graded exposure to avoided social situations with a reduction in safety behaviours, and basic social skills training (with the use of role-play).

**Outcome:** Daniel seemed to gain a greater understanding about the origins and maintenance of his difficulties. His BDI score remained unchanged, but his BAI score
reduced significantly. He reported feeling more confident in social situations, at work and within his relationship with his wife. He reported that on the whole his mood had improved, as the number of ‘good days’ now tended to outweigh the ‘bad days’.

**Critical evaluation:** Daniel and I formed a collaborative therapeutic relationship, and he socialised to the CBT model with ease. However he struggled with the use of homework, so may have benefited from a more explicit explanation of its benefits and further exploration of the obstacles to his use of this. In hindsight it would have been helpful to introduce the basic social skills training and role-play earlier on. Issues around the role of his wife in maintaining his social anxiety were dealt with sensitively and from a neutral position.
People with Learning Disabilities Case Report Summary

Title: Systemic family therapy with a 24-year-old man with mild learning disabilities and his family.

Presenting Problem: Gary, his mother and sister were referred to the family therapy and reflecting team service by the CTPLD. Prior to the first session, his mother completed a short questionnaire that asked ‘what are the current difficulties’, to which she wrote ‘Gary’. Gary was described as aggressive and argumentative. The presenting problems seemed to include family difficulties around resolving conflict, blame, and the death of Gary’s father two years earlier.

Assessment Procedure: The family therapy team (consultant psychiatrist, clinical psychologist, trainee clinical psychologist and I) reviewed Gary’s case notes, and discussed the referral and initial hypotheses. We met the family for an initial assessment, involving an interview by the psychiatrist (observed by the reflecting team), then we reflected on the session, and finally the family were invited to comment on our reflections. All sessions followed this format.

Formulation: The family’s difficulties were understood within a systemic framework using narrative ideas. This highlighted the role of loss, grief and anger in the formation of the family’s dominant stories (including ‘Gary is the problem’, and ‘it’s hopeless’). The family’s bereavement may have re-evoked feelings of loss, grief and anger, which widened the divisions between Gary, and his mother and sister. The family system became ‘stuck’ in a cycle of negative interactions and meanings, which maintained the dominant stories.

Intervention: We met the family for seven sessions of systemic family work involving narrative interventions. This included circular questioning, externalising the problem, identifying unique outcomes (that contradict the dominant stories) and reframing and positive connotation to challenge the family’s perception of the problem and identify new solutions.
**Outcome:** The intervention enabled the family to consider some of their difficulties from a more positive, hopeful and less blaming perspective. The dominant stories were challenged to help generate new descriptions of their situation, for example forming a picture of Gary as a young man facing numerous challenges, yet remaining positive about achieving his goals. By the final session, the family demonstrated more shared humour, eye contact and a greater ability to explore family concerns.

**Critical evaluation:** There were a number of issues associated with working with a person with learning disabilities within this therapeutic model. For example, an important role of the reflecting team was to ensure that Gary’s voice was heard and valued, and that our interventions did not contribute to further disempowerment of him. This was achieved by using repetition and Gary’s own language, offering few opinions, and normalising some of the family’s worries. This therapeutic model seemed to have advantages over a cognitive behavioural approach that might have perpetuated the family’s beliefs about the problem (being located in one individual). Issues around the measurement of outcome were discussed.
Title: Cognitive behavioural therapy with a 13-year-old girl with a phobia of vomiting.

Presenting Problem: Sarah was referred to the CAMHS by her GP. The presenting problems included a long-standing phobia of vomiting, worsened by a severe stomach bug six months earlier. Sarah described fears about feeling and being sick, often leading to panic attacks. Triggers included feeling full or bloated from food, feeling unwell, witnessing others feeling sick, and seeing or hearing vomiting. Sarah was avoiding certain foods and particular television programmes and films, and had recently experienced panic in a noisy classroom.

Assessment Procedure: The assessment was conducted over two sessions with Sarah and her parents, and also involved discussion with Sarah’s school teacher. The Beck Anxiety Inventory (BAI) was completed, and a standard risk assessment suggested no significant risk issues.

Formulation: Sarah’s difficulties were understood within a cognitive behavioural (CBT) model of panic and phobia. Early experiences were seen as contributing to a predisposition to panic and worries around sickness. The stomach bug triggered her beliefs about the threatening nature of sickness and her fears about losing control. Hypervigilance to internal and external triggers contributed to a cycle of panic, involving catastrophic thoughts and anxious feelings. Avoidance and protection by her family was preventing Sarah from disconfirming her beliefs.

Intervention: The intervention involved ten sessions of cognitive behavioural therapy to address her phobia of vomiting by reducing avoidance and increasing coping skills. This included relaxation, controlled breathing, distraction, and challenging negative thoughts and beliefs. Graded hierarchies were created to enable exposure to the feared situations that Sarah felt were impacting on her life most significantly. This included graded exposure to film scenes of sickness, graded exposure to feeling full from food, and to remaining in the classroom when ‘feeling panicky’. Sarah’s parents and school
were also involved, to support Sarah in the graded exposure and her management of anxiety.

**Outcome:** The BAI demonstrated a clear decrease in Sarah’s anxiety, which was supported by her own accounts and those of her parents. She described less daily preoccupation with sickness and more confidence in coping with bloated feelings and witnessing sickness. Her panic attacks had reduced in frequency.

**Critical evaluation:** I reflected on issues associated with working with a young person such as differential power, and the strategies used to promote empowerment and collaboration: For example, emphasising Sarah’s role in setting goals and making decisions (for example about the extent of her parents’ involvement). There was an ethical issue regarding the ratings of the films used during exposure. This was resolved with reference to the British Board of Film Classification’s recommendations, discussion with Sarah, her parents and my supervisor.
Forensic Case Report Summary

**Title:** Extended assessment: A psychological admission assessment of a 35-year-old man in a forensic setting.

**Presenting Problem:** Patrick was remanded to prison in 2004 after being charged with the murder of his partner and her adult son. Following reports of persecutory delusions and auditory hallucinations, he was transferred from prison to secure hospital under Section 48 of the Mental Health Act 1983 for a multidisciplinary assessment. The psychological component of the assessment aimed to understand the links between the development of his psychosis and the offence, in the context of his personality style, relationships with the victims and his history.

**Extended Assessment:** The assessment consisted of twelve sessions, including interviews with Patrick and the ward team. The cognitive assessment suggested borderline functioning with most difficulty on tests of executive functioning. The personality assessment included the Millon Clinical Multiaxial Inventory (MCMI-III) and the Young Schema Questionnaire (YSQ-L2). Patrick’s profile (and the interview material) indicated a personality style characterised by dependence, paranoia, mistrust, emotional inhibition and subjugation. At the CPA meeting, the multi-disciplinary team agreed that Patrick seemed to be experiencing paranoid schizophrenia and that a Hospital Order (to medium security) would therefore be recommended by his RMO at his trial.

**Extended Formulation:** A cognitive model of psychosis was presented. Vulnerability factors may have included early attachment issues and later drug use. The onset of psychosis was in the context of Patrick’s relocation to England from the Caribbean, his experiences of perceived discrimination, and increasing drug use. His relationships with the victims were likely to have been conflicted: His personality profile suggested a need for reassurance and protection, yet significant mistrust and a tendency to suppress negative feelings. Core beliefs, heightened arousal, cognitive biases and reasoning problems may have contributed to the formation of delusions around abuse and persecution from his partner and her son. These delusions were reinforced by
hypervigilance to possible evidence of threat and hostility. Patrick’s history, personality style, his relationship context and ultimately his delusions culminated in the commission of the offence. Patrick’s cognitive profile was consistent with a diagnosis of schizophrenia.

**Recommendations:** The recommendations for future psychological intervention included group work (psychoeducation regarding his mental illness and substance misuse), individual therapy (e.g. CBT for psychosis), risk management and relapse prevention, and further assessment. Any interventions that aimed to challenge the reality of Patrick’s beliefs (and motivation for the murders) would need to be sensitively handled, for example to minimise the risk of self-harm.

**Critical evaluation:** The limitations of the findings were discussed, for example, the implications of using measures with British normative data with a Caribbean man. Issues associated with a forensic setting were explored, for example the tension between client-centred work and yet not justifying the offence. Safety management and issues of consent and confidentiality in a forensic setting were discussed.
Older People Case Report Summary

Title: A neuropsychological assessment of memory problems in a 68-year-old woman.

Presenting Problem: Joan was referred to the Physical and Neurological Rehabilitation Services by her GP, for help in managing her M.E. During the initial assessment, Joan reported significant memory problems that were observable in the session. She described short-term memory difficulties and planning problems that were interfering with her daily functioning. She was coping through extensive use of a daily diary and post-it notes, for example a reminder to turn off the gas on the oven. She also described multiple minor physical health concerns attributed to her M.E., for example nausea and tightness in her stomach. Joan had small vessel disease and a history of possible Transient Ischemic Attacks (TIA). She had withdrawn from previously enjoyed activities.

Assessment Procedure: The assessment consisted of a literature review of relevant conditions, discussion with relevant professionals, two interview sessions and six sessions of psychometric assessment. The aim of the assessment was to clarify the nature and extent of Joan’s cognitive difficulties to inform her future care. Joan completed the Wechsler Adult Intelligence Scale-III (WAIS-III), Wechsler Test of Adult Reading (WTAR), Rivermead Behavioural Memory Test (RBMT-II), Hayling and Brixton, Behavioural Assessment of Dysexecutive Syndrome (BADS), Verbal Fluency (VF), Hospital Anxiety and Depression Scale (HADS), and Beck Depression Inventory-Fast screen (BDI-Fast).

Assessment Findings: Joan’s scores on the WAIS-III, VF and WTAR were consistently within the average range. However her profile on the RBMT-II was severely impaired. On tests of executive functioning, Joan’s performance was varied. Her overall score on the BADS was within the average range, but her performance on some subtests (e.g. Zoo Map, Key Search) was impaired. Her scores were also within the impaired range on the Hayling and Brixton. The HADS and BDI-fast suggested
mild anxiety and depression (which is commonly under-reported and characterised by somatic complaints in older people).

**Discussion:** The assessment suggested significant memory problems and some executive difficulties in the context of otherwise average cognitive functioning. Given the extent of these problems, it seemed unlikely that they were due to fatigue, anxiety or depression alone. As these focal deficits were in the context of small vessel disease and possible TIA, a vascular potentially deteriorative process might be indicated. However, without global cognitive deficits, a diagnosis of vascular dementia was not appropriate.

**Recommendations:** Joan was referred to the community mental health services for older people, for further support in managing her memory problems and likely depression and anxiety. It was recommended that Joan remained supported in her attempts to find sheltered accommodation and to increase her social network. The assessment was not intended to be diagnostic, and if Joan wanted further clarification she was advised to request a referral to neurology in the future (e.g. for an MRI scan). This assessment would be informative in future diagnostic investigations.

**Critical evaluation:** I highlighted the strengths and limitations of the assessment. I recognised the need for ecologically valid measures of specific skills, rather than relying on global measures to screen for deficits. Limitations included the lack of availability of information from someone who knew Joan well, and some difficulties obtaining reliable information from Joan in the context of her memory problems. Issues around minimising anxiety during the assessment, and the ethical issue of gaining consent from people with cognitive impairment were discussed.
Research Dossier
Assessing Client Satisfaction with Groups at a Day Treatment Centre

Service Related Research Project

June 2004

Year 1

Word Count: 2990
Abstract

The aim of this research was to explore to what extent service users are satisfied with groups run at the Day Treatment Centre, and their views about different aspects of the groups. The design was a non-experimental cross-sectional survey using a questionnaire that I designed. The results indicated that 52.6% of participants were very satisfied with their group, 40.4% were fairly satisfied, and no one rated themselves as not at all satisfied with their group. Overall service users had generally positive views of the groups. Most participants rated their group as very helpful, interesting and supportive with very approachable staff; that it was fairly relevant to their individual needs; that the length and pace of group sessions were about right; as were the difficulty of sessions and the amount of homework (if any was given). Just over half the participants rated that it was fairly or very difficult being in a group of people. Design and methodological limitations are discussed.

Acknowledgements

I would like to thank all members of staff at the Day Treatment Centre who helped with the design and distribution of the questionnaire, in particular the senior occupational therapist whose advice and support was greatly appreciated. I would also like to thank my university research supervisor for her guidance and time. Finally thanks to the participants in this study.
Introduction

The National Service Framework for Mental Health (DoH, 1999) states that service users should be involved in the planning and delivery of care that they receive. Satisfaction surveys are an important means of evaluating quality and outcomes in mental health services, and emphasise the essential role of service users in the assessment and development of services. Service users’ views are vital as they may influence treatment outcome, for example whether the client attends regularly or drops out, or the extent to which they engage with or participate in treatment. In this way, Lebow (1982) has proposed that minimal satisfaction or acceptability is a necessary condition for treatment success, and should therefore be considered a goal of treatment, even if it is not accepted as the ultimate goal. Feedback from service users can also be a valuable source of information in the development of effective services. Recognition of service users’ preferences and views can offer guidance in the planning and provision of health care (Fitzpatrick, 1991a).

Service users have unique views about how appropriate and satisfactory they consider the nature and process of treatment, which may not necessarily match those of service providers. In the context of the Day Treatment Centre (DTC) this was highlighted in an audit using the Camberwell Assessment of Need tool in March 2002. Ten service users and their respective care co-ordinators were interviewed. The results indicated that overall there was a slight discrepancy between client and staff views in terms of the percentage of needs each considered were being met (77% and 81% respectively). Of a total of 81 cases of identified needs, there were 48 (59%) instances of mismatched needs. They reported that 7 of the 10 clients interviewed were satisfied overall with their treatment at the DTC, 2 clients were not satisfied, and 1 client did not know. However, as only ten clients were interviewed, they were understandably cautious about their ability to generalise about the views of all DTC users.

In this context the service were keen for a satisfaction survey targeting a greater number of clients at the DTC. They also felt that gaining insight into the views of clients could offer guidance and suggestions for ways of improving the content or process of group sessions or courses held at the DTC. Finally we agreed that involvement in a survey
that could directly influence the running of future groups could empower clients and encourage open feedback about groups on a more informal and regular basis.

The relevant literature discussed above, combined with dialogue with staff at the Day Treatment Centre and particularly with the senior occupational therapist, contributed to the formation of the research questions:

- What are service users’ views and perceptions about different aspects of the groups?
- Overall, to what extent are they satisfied with the groups run at the DTC?
- What aspects of the groups do they find most helpful?
- What are their suggestions for improvements?
Service Related Research Project

Method

Design
The design of this research was a non-experimental cross-sectional survey of service user satisfaction, through the use of a questionnaire that I designed.

Setting
The setting was a day treatment centre that currently runs 25 different groups within 30 slots each week. There are two to four groups co-running each morning and afternoon, facilitated by a total of six members of staff: a senior occupational therapist, an occupational therapy technician, a community nurse, a group worker, a physiotherapist and a gym instructor. As one member of staff was off sick when the questionnaires were distributed (the O.T. technician), only nineteen groups were being run. These nineteen groups are categorised by the service as demonstrated in table 1. Some are closed groups in that entry to the group is through referral only and most of these have a structured six to eight week course, but most groups are open and ongoing.

See appendix 1 for a list of the six groups that could not be included in this research due to staff sickness.
Table 1: Groups at the DTC

<table>
<thead>
<tr>
<th>Group category</th>
<th>Group</th>
<th>Percent of participants</th>
<th>Number of participants</th>
<th>Open/Closed</th>
<th>Ongoing/Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Skills Groups</td>
<td>4</td>
<td>20.2</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managing Depression</td>
<td>7.0</td>
<td>8</td>
<td>Closed</td>
<td>Course</td>
</tr>
<tr>
<td></td>
<td>Managing Anxiety</td>
<td>3.5</td>
<td>4</td>
<td>Closed</td>
<td>Course</td>
</tr>
<tr>
<td></td>
<td>Confidence Building</td>
<td>3.5</td>
<td>4</td>
<td>Closed</td>
<td>Course</td>
</tr>
<tr>
<td></td>
<td>Health and Well-being</td>
<td>6.1</td>
<td>7</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Support Groups</td>
<td>2</td>
<td>9.6</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women’s Group</td>
<td>4.4</td>
<td>5</td>
<td>Closed</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Problem Solving</td>
<td>5.3</td>
<td>6</td>
<td>Closed</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Activity Groups</td>
<td>4</td>
<td>28.1</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Art and Craft</td>
<td>5.3</td>
<td>6</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Sewing</td>
<td>4.4</td>
<td>5</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Sculpture and Clay</td>
<td>7.0</td>
<td>8</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Quiz and Games</td>
<td>11.4</td>
<td>13</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Expressive Groups</td>
<td>5</td>
<td>25.4</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poetry and Literature</td>
<td>5.3</td>
<td>6</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Art</td>
<td>3.5</td>
<td>4</td>
<td>Closed</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Creative Writing</td>
<td>7.9</td>
<td>9</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Drama Workshop</td>
<td>7.0</td>
<td>8</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Discussion Group</td>
<td>1.8</td>
<td>2</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Physical Groups</td>
<td>2</td>
<td>8.8</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Keep Fit and Relaxation</td>
<td>5.3</td>
<td>6</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Gym</td>
<td>3.5</td>
<td>4</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Cognitive Groups</td>
<td>2</td>
<td>7.9</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Media Group</td>
<td>4.4</td>
<td>5</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Memory and Concentration</td>
<td>3.5</td>
<td>4</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>100.0</td>
<td>114</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participants

Targeted participants were all individuals attending the day treatment centre; a total of 68 clients when the questionnaire was distributed. As the aim of the project was to investigate satisfaction with the different groups, individuals were asked to complete one questionnaire for each group that they attended. So the demographic data is a repeated measure to the extent that some individuals may have completed more than one questionnaire, but always about different groups. Overall 114 questionnaires were completed. Missing data in returned questionnaires has been reported.
The demographic data is presented in tables 2 to 5 below.

Table 2: Sex

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14.0%</td>
<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>77.2%</td>
<td>88</td>
</tr>
<tr>
<td>Missing</td>
<td>8.8%</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 3: Age

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 or under</td>
<td>2.6%</td>
<td>3</td>
</tr>
<tr>
<td>20-29</td>
<td>27.2%</td>
<td>31</td>
</tr>
<tr>
<td>30-39</td>
<td>16.7%</td>
<td>19</td>
</tr>
<tr>
<td>40-49</td>
<td>21.9%</td>
<td>25</td>
</tr>
<tr>
<td>50-59</td>
<td>18.4%</td>
<td>21</td>
</tr>
<tr>
<td>Over 60</td>
<td>1.8%</td>
<td>2</td>
</tr>
<tr>
<td>Missing</td>
<td>11.4%</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 4: Ethnicity (categories from Commission for Racial Equality website)

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>84.2%</td>
<td>96</td>
</tr>
<tr>
<td>White Irish</td>
<td>4.4%</td>
<td>5</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1.8%</td>
<td>2</td>
</tr>
<tr>
<td>Missing</td>
<td>8.8%</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 5: Self-reported mental health problems in order of descending frequency

<table>
<thead>
<tr>
<th>Mental Health Problem</th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>28.9%</td>
<td>33</td>
</tr>
<tr>
<td>Anxiety and Depression</td>
<td>27.2%</td>
<td>31</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7.0%</td>
<td>8</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3.5%</td>
<td>4</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>3.5%</td>
<td>4</td>
</tr>
<tr>
<td>Psychosis and Depression</td>
<td>1.8%</td>
<td>2</td>
</tr>
<tr>
<td>PTSD and Depression</td>
<td>1.8%</td>
<td>2</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.8%</td>
<td>2</td>
</tr>
<tr>
<td>Anxiety and Eating Disorder</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>Depression and Paranoid Ideation</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>OCD</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>Personality Disorder and Depression</td>
<td>0.9%</td>
<td>1</td>
</tr>
<tr>
<td>Missing</td>
<td>20.2%</td>
<td>23</td>
</tr>
</tbody>
</table>

Outcome measure

I designed a questionnaire investigating clients' views of and satisfaction with the groups. Discussions with staff indicated that they agreed with the literature that this would be the most straightforward and direct means of accessing views amongst this population whilst maintaining anonymity and reducing 'interviewer bias' (Lebow, 1982; Fitzpatrick, 1991).

In order to generate items, I discussed the notion of 'satisfaction' with the senior occupational therapist, exploring important aspects or features of the groups about which clients were likely to have views or levels of satisfaction. I also consulted relevant literature discussing the dimensions of satisfaction (Lebow, 1982; Fitzpatrick, 1991). From this, I designed a short questionnaire to distribute to all available staff at the day treatment centre, asking for their ideas and comments about the seventeen listed items and the response format, and any suggestions for further items (see appendix 2). Six questionnaires were completed by staff during this expert sampling process, so there were multiple judges of content validity confirming that thirteen of these seventeen items were relevant and representative of 'satisfaction with groups'. These items were therefore included in the questionnaire for service users.
The staff also suggested that to promote ease of completion and encourage people to respond, a tick-box response format should be used, with three possible responses for each item. They felt that using five response options or using a Likert scale might be too confusing or time consuming for some clients, which could reduce the probability of responses or bias the results. In addition we decided to include three open-ended questions at the end (as well as comments sections next to each question) to encourage participants to indicate any further comments or suggestions. Although Oppenheim (1992) has highlighted the risk of contextual effects, it was felt that it would be most helpful to start with easier questions and again this would encourage responses. Demographic questions were asked at the end of the questionnaire.

As some people may define satisfaction as ‘a minimum level of acceptability’ and others as ‘near perfection’ (Lebow, 1982, p.247), we agreed that it would be most helpful to ask direct questions about features of the groups, rather than use a satisfaction scale for each question. Lebow (1982) has suggested that it is useful and appropriate to include items that do not explicitly focus on satisfaction in a consumer satisfaction survey, as long as such items are kept conceptually separate from satisfaction items in the analysis1.

The questionnaire for service users can be found in appendix 3.

Procedure
Questionnaires were distributed over a two-week period that coincided with the final sessions of the closed groups. Over the two weeks I went into as many groups as possible at the end of the sessions. I distributed questionnaires to each present group member and asked for a volunteer to collect completed questionnaires, put them in the envelope provided (on which the name of the group was written) and post the envelope in the sealed box in the lounge along with any unused questionnaires. If participants wanted to take away the questionnaire and post it at a later time, they were asked to write the name of the group at the top of the questionnaire.

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1 It is interesting to note that the Cronbach’s Alpha of the seven ordinal items scored in the same direction (including item 6 reversed) is 0.7218, which indicates that the internal consistency reliability is adequate.
In the staff office I left envelopes for each group that I did not attend myself, each with enough blank questionnaires inside. Staff agreed to pick up the appropriate envelope for every group they ran over those two weeks, and questionnaires were collected in the manner described above. I collected questionnaires from the box in the lounge at the end of the two-week period.

Ethical considerations
Prior to data collection, I completed a Trust Clinical Audit proposal form for the Clinical Audit and Effectiveness Department with a draft of the questionnaire. Following discussions in their committee meeting, I was informed that my research had been approved and that my project proposal did not require scrutiny from the Ethics Committee.

All participants were given information about the purpose of the research, and informed that participation was entirely voluntary. The information at the top of the questionnaire highlighted that the procedure of data collection ensured anonymity and that all responses would remain confidential. Staff never had access to completed questionnaires, as the box in the lounge was only ever opened by me. At the end of the questionnaire there were details of how to contact me should participants want further information about the research. I will be attending a staff meeting on 14th June 2004 to feedback the results, followed by a short presentation to clients in their morning meeting (see appendix 4). All clients at the DTC will be informed about this presentation.
Results

114 questionnaires were completed and returned. The number distributed is unknown.

Figures 1 to 11 illustrate frequencies of responses to the eleven closed questions. Table 6 compares the frequencies of ratings of how relevant different groups were to individual needs. Table 7 compares the frequencies of different satisfaction ratings for each of the nineteen groups. As these figures and tables indicate, participants were generally positive about groups. Missing data for each question is presented in figure 12.

Descriptive statistics were used rather than further analyses (such as a 1 way ANOVA) for three main reasons: There were small numbers of participants in each group; there was limited possible variance in responses (due to only 3 response options); and it was not possible to assess to what extent the design was repeated measures.

Quantitative Data: Questions 1-11

Figure 1: How helpful was the group?

1. How helpful was the group?

<table>
<thead>
<tr>
<th></th>
<th>0.0%</th>
<th>37.7%</th>
<th>62.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fairly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 2: How interesting was the group?

![Bar chart showing the percentage of responses for how interesting the group was.](chart2)

Figure 3: How difficult was the content of the group?

![Bar chart showing the percentage of responses for how difficult the content of the group was.](chart3)
Figure 4: How approachable were the staff?

![Bar chart showing the percentage of respondents who found the staff approachable.]

- 83.3% found the staff very approachable.
- 14.9% found the staff fairly approachable.
- 0.0% found the staff not at all approachable.
- 1.8% found the staff missing.

Figure 5: How supportive was the group?

![Bar chart showing the percentage of respondents who found the group supportive.]

- 55.3% found the group very supportive.
- 36.0% found the group fairly supportive.
- 3.5% found the group not at all supportive.
- 5.3% found the group missing.
Figure 6: How difficult was it being in a group of people?

Most participants rated the groups as fairly relevant to their individual needs.

See table 6 for a comparison of ratings about different groups.
Table 6: Comparison of ratings of the relevance of different groups to individual needs

<table>
<thead>
<tr>
<th>Group</th>
<th>Percent rating not at all relevant</th>
<th>Percent rating fairly relevant</th>
<th>Percent rating very relevant</th>
<th>Percent missing</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing Depression</td>
<td>12.5</td>
<td>50.0*</td>
<td>37.5</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Managing Anxiety</td>
<td>0</td>
<td>25.0</td>
<td>50.0</td>
<td>25.0</td>
<td>4</td>
</tr>
<tr>
<td>Confidence Building</td>
<td>0</td>
<td>0</td>
<td>75.0</td>
<td>25.0</td>
<td>4</td>
</tr>
<tr>
<td>Health and Well-being</td>
<td>0</td>
<td>71.4</td>
<td>28.6</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Women’s Group</td>
<td>0</td>
<td>60.0</td>
<td>40.0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>0</td>
<td>66.7</td>
<td>33.3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Art and Craft</td>
<td>16.7</td>
<td>33.3</td>
<td>50.0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Sewing</td>
<td>0</td>
<td>100.0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Sculpture and Clay</td>
<td>0</td>
<td>37.5</td>
<td>37.5</td>
<td>25.0</td>
<td>8</td>
</tr>
<tr>
<td>Quiz and Games</td>
<td>7.7</td>
<td>46.2</td>
<td>46.2</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Poetry and Literature</td>
<td>0</td>
<td>16.7</td>
<td>33.3</td>
<td>50.0</td>
<td>6</td>
</tr>
<tr>
<td>Therapeutic Art</td>
<td>25.0</td>
<td>0</td>
<td>75.0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Creative Writing</td>
<td>0</td>
<td>88.9</td>
<td>11.1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Drama Workshop</td>
<td>0</td>
<td>62.5</td>
<td>37.5</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Discussion Group</td>
<td>50.0</td>
<td>50.0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Keep Fit and Relaxation</td>
<td>16.7</td>
<td>33.3</td>
<td>50.0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Gym</td>
<td>0</td>
<td>25.0</td>
<td>50.0</td>
<td>25.0</td>
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</tr>
<tr>
<td>Media Group</td>
<td>0</td>
<td>80.0</td>
<td>20.0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Memory and Concentration</td>
<td>0</td>
<td>50.0</td>
<td>50.0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>All groups</td>
<td>5.3</td>
<td>50.0</td>
<td>37.7</td>
<td>7.0</td>
<td>114</td>
</tr>
</tbody>
</table>

*The percentages in bold highlight the most frequent response(s) in each group.
Figure 8: How was the pace of the sessions?

<table>
<thead>
<tr>
<th>Pace of Sessions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>too slow</td>
<td>9.6%</td>
</tr>
<tr>
<td>about right</td>
<td>79.8%</td>
</tr>
<tr>
<td>too fast</td>
<td>5.3%</td>
</tr>
<tr>
<td>missing</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

Figure 9: How was the length of the sessions?

<table>
<thead>
<tr>
<th>Length of Sessions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>too short</td>
<td>6.1%</td>
</tr>
<tr>
<td>about right</td>
<td>83.3%</td>
</tr>
<tr>
<td>too long</td>
<td>5.3%</td>
</tr>
<tr>
<td>missing</td>
<td>5.3%</td>
</tr>
</tbody>
</table>
Figure 10: How was the amount of homework?

Most participants were very satisfied with the groups they attended, although many were only fairly satisfied.

See table 7 for a comparison of ratings of satisfaction between all nineteen groups.
Table 7: Comparison of overall satisfaction with each group

<table>
<thead>
<tr>
<th>Group</th>
<th>Percent not at all satisfied</th>
<th>Percent fairly satisfied</th>
<th>Percent very satisfied</th>
<th>Percent missing</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing Depression</td>
<td>0</td>
<td>50.0*</td>
<td>50.0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
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<td>50.0</td>
<td>50.0</td>
<td>0</td>
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<tr>
<td>Confidence Building</td>
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<td>75.0</td>
<td>25.0</td>
<td>4</td>
</tr>
<tr>
<td>Health and Well-being</td>
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<td>57.1</td>
<td>42.9</td>
<td>0</td>
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<tr>
<td>Women's Group</td>
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<td>60.0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
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<td>66.7</td>
<td>33.3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Art and Craft</td>
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<td>66.7</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Sewing</td>
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<td>60.0</td>
<td>40.0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Sculpture and Clay</td>
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<td>50.0</td>
<td>37.5</td>
<td>12.5</td>
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<tr>
<td>Quiz and Games</td>
<td>0</td>
<td>61.5</td>
<td>38.5</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Poetry and Literature</td>
<td>0</td>
<td>0</td>
<td>33.3</td>
<td>66.7</td>
<td>6</td>
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<tr>
<td>Therapeutic Art</td>
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<td>0</td>
<td>100.0</td>
<td>0</td>
<td>4</td>
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<tr>
<td>Creative Writing</td>
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<td>Keep Fit and Relaxation</td>
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<td>Media Group</td>
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<td>60.0</td>
<td>40.0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Memory and Concentration</td>
<td>0</td>
<td>25.0</td>
<td>50.0</td>
<td>25.0</td>
<td>4</td>
</tr>
<tr>
<td>All groups</td>
<td>0</td>
<td>40.4</td>
<td>52.6</td>
<td>7.0</td>
<td>114</td>
</tr>
</tbody>
</table>

*The percentages in bold highlight the most frequent response(s) in each group.
Figure 12: Comparison of missing data for each question
Qualitative Data: Questions 12-14 and Comments

74 (65%) of the 114 respondents wrote comments.

**Question 12: What was most helpful about the group sessions?**

- 35.1%\(^2\) (26 responses) referred to support from other group members through discussions, listening, sharing and teamwork.
- 25.7% (19 responses) referred to the therapeutic effects of the sessions, such as reducing anxiety, improving mood, increasing concentration, and creative expression.
- 21.6% (16 responses) referred to enjoying company, relaxing and having fun.
- 10.8% (8 responses) referred to gaining knowledge and skills.
- 1.4% (1 response) referred to the staff.

**Questions 13 and 14: Is there anything else you would have liked included in the group sessions? Do you have any suggestions of how the group could be improved?**

23.7% (27 responses) of all completed questionnaires and 36.5% of those with comments suggested ways to improve the group.

- 7 responses suggested more activities, questions or tips.
- 5 responses suggested more encouragement of discussion and interaction.
- 4 suggested longer sessions.
- 2 responses suggested more one-to-one help.
- 1 suggested that group members are introduced in every session.
- 1 suggested a longer course.
- 1 suggested a smaller group.
- 1 suggested a larger group (quiz).
- 1 suggested a break (women’s group).
- 1 suggested improved ventilation (keep fit).

\(^2\) The percentages are of the 74 questionnaires that offered comments.
• 1 suggested a larger room (keep fit).
• 1 suggested background music (drama workshop).
• 1 suggested more resources and materials (sculpture).
• 1 suggested free coffee!

For further example comments see appendix 5.
Discussion

Research Questions:

- What are service users’ views and perceptions about different aspects of the groups?
- Overall, to what extent are they satisfied with the groups run at the DTC?
- What aspects of the groups do they find most helpful?
- What are their suggestions for improvements?

Overall, participants in the study were satisfied with each group that they rated. Just over half were very satisfied with the group and the remainder were fairly satisfied. No one rated themselves as not at all satisfied. As table 7 indicates, there was slight variation in ratings between groups. For example, all four therapeutic art group members and four gym group members were very satisfied, whereas the two discussion group members were only fairly satisfied. However, as numbers were small it is difficult to generalise beyond these individuals’ views.

Figures 1 to 11 indicate that most participants rated their group as very helpful, interesting and supportive with very approachable staff; that it was fairly relevant to their individual needs; that the length and pace of group sessions were about right; as were the difficulty of sessions and the amount of homework (if any was given). Just over half the participants rated that it was fairly or very difficult being in a group of people.

The qualitative data presented in the results section demonstrates responses to the open-ended questions. Again however, numbers are too small to indicate that these are anything other than individual opinions. For example, even the most common suggestion of more activities and questions being set was only offered by 7 of 114 responses.

The above conclusions should be considered in light of a number of design and methodological limitations. There are some suggestions of how these could be addressed in future studies.
Future design considerations

Comparisons of the frequency of missing data for each question (figure 12) indicate that more questions were missed as the questionnaire went on. This might indicate that participants became increasingly bored, distracted, tired or irritated as they completed the questionnaire. Perhaps a shorter questionnaire would be more manageable.

Another potential problem was that several service users were in more than one group and may have filled in more than one questionnaire. This could have affected the results through individual biases or through priming effects. Future studies might consider using some means of identifying participants to overcome this problem.

The questionnaire was designed with only three response alternatives at the request of the service, as we agreed that this would keep it as short and simple as possible to maximise the response rate. The service acknowledged that this reduced reliability, limited possible variation in scores and increased the chance of non-normal distribution, which made it inappropriate to use any statistical tests in the analysis. The service agreed that they would rather have higher response rates and descriptive analysis of the data. In future research a five-option response format could be considered.

The questionnaire was designed with the closed questions first followed by open questions then demographics. The service preferred this order as they felt that starting with the simpler closed questions would encourage responses. Oppenheim (1992) has warned of contextual effects so participants were asked explicitly to list any suggestions for improvements (as Barker, 2002, has suggested). A future study could distribute half the questionnaires with open questions first and half with closed first to enable an investigation of any contextual effects.

There are also issues concerning the notion of satisfaction, and what constitutes a ‘satisfaction survey’. The service agreed that they were most interested in general views and perceptions about many aspects of the groups, so I designed the questionnaire asking direct questions about features that may not strictly be components of ‘satisfaction’. However, Lebow (1982) has argued that it is valid to
include 'nonsatisfaction items' in the questionnaire, as long as they are relevant to consumer concerns and kept conceptually separate from the satisfaction items in the analysis, as was done.

Future methodological considerations

One inherent difficulty with satisfaction surveys is that the individuals completing them are obviously participating in treatment to some extent. Therefore, those individuals who have dropped-out and attend infrequently (perhaps due to dissatisfaction) are not targeted. This creates a bias towards those people who are present, motivated and arguably more likely to have some degree of satisfaction with treatment. Of those who are present, there may be differences between responders and non-responders (Oppenheim, 1992). In future studies this could be addressed by attempting to target those individuals who have dropped-out, rarely attend or refuse to participate and comparing their responses with those who are present and do respond.

Another possible bias in responses is that of acquiescence. This was addressed to some extent by emphasising anonymity and asking explicitly about any suggestions for improvements.

Questionnaires are likely to have less 'interviewer bias' than interviews (Fitzpatrick, 1991a). However, demand characteristics are still possible. Also, the 'halo effect' has been noted by many (e.g. Hurst and Ball, 1990), whereby single striking impressions of a member of staff (such as being friendly) or a group shape all other views about them (as cited in Fitzpatrick, 1991a). This was addressed to some extent by asking specific questions about many aspects of the group and staff.

Time constraints meant that the questionnaire was distributed over a two-week period. It was therefore unavoidable that some service users and indeed staff may not be present due to illness or leave. Again this could have potentially introduced some bias, and may have reduced the sample size. Future studies could distribute questionnaires over a longer time period.
In conclusion it seems that this study of service user satisfaction has offered a number of interesting insights and tentative conclusions about service user views and their suggestions for improvements to the service. As noted above, it is important to consider the results in light of the discussed limitations. However, the study remains a valuable contribution to the service as it indicates that overall, service users have predominantly positive experiences and have some useful suggestions for service delivery.
References


Appendices

Appendix 1:

Groups Not Included in the Analysis

<table>
<thead>
<tr>
<th>Group category</th>
<th>Group</th>
<th>Open/ Closed</th>
<th>Ongoing/ Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Skills Groups</td>
<td>Anger Management</td>
<td>Open</td>
<td>Course</td>
</tr>
<tr>
<td></td>
<td>Moving on</td>
<td>Closed</td>
<td>Course</td>
</tr>
<tr>
<td>Support Groups</td>
<td>Men’s Group</td>
<td>Closed</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Activity Groups</td>
<td>Lunch Cookery</td>
<td>Closed</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Physical Groups</td>
<td>Relaxation</td>
<td>Open</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Cognitive Groups</td>
<td>Computers</td>
<td>Open</td>
<td>Ongoing</td>
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</table>
Appendix 2:

Questionnaire for Staff at the DTC

As part of my PsychD in Clinical Psychology, I am required to conduct a small-scale service-related piece of research or audit.

I will be investigating service-user satisfaction with groups run at the Day Treatment Centre. I will be designing a questionnaire to distribute to all patients using the groups, and would like to know your ideas and comments regarding the content of the questionnaire.

The questions on the questionnaire will probably be use a tick box format, with space for additional comments e.g.

Example: Overall, how satisfied were you with the group?

<table>
<thead>
<tr>
<th>not at all satisfied</th>
<th>fairly satisfied</th>
<th>very satisfied</th>
</tr>
</thead>
</table>

Please tick whether you agree or disagree that this should be asked, bearing in mind the groups that are run. Please feel free to write any comments next to the question, and further ideas or possible questions in the space provided.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Comments</th>
</tr>
</thead>
</table>

How satisfied

How helpful

How interesting

How difficult was the content...

How difficult was the group setting (i.e. being in a group of people)...

How challenging

How boring

How supportive

How approachable were the staff...

How irrelevant

How motivating
Pace of the sessions  
Too slow, about right, too fast...........

Length of sessions  
Too short, about right, too long........

Homework  
Too little, about right, too much...

(open ended questions:)  
What was most helpful about the group?

What was least helpful about the group?

Any suggestions of how the group could be improved?

Please write any comments or suggestions of further questions that could be asked in the questionnaire:

Thank you very much for your time and suggestions.  
Please return these forms to
Appendix 3: 

Client Satisfaction Questionnaire

Please take the time to complete this short questionnaire. We are interested to know your views about this group. Your feedback is very important to us, and may directly influence the running of future groups. Please note that completion of this questionnaire is voluntary.

Your responses on this questionnaire are absolutely confidential and anonymous. Any information that may identify you will not be disclosed under any circumstances. Once you have completed this short questionnaire, please post them in the box marked ‘Feedback Forms’ in the lounge.

For the following questions, please tick the box that best reflects your view. Feel free to write any further comments in the space provided. Please tick one box for every question, and answer questions on both sides of the sheets.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all Helpful</th>
<th>Fairly Helpful</th>
<th>Very Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How helpful was the group?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How interesting was the group?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How difficult was the content of the group?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How approachable were the staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How supportive was the group?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments (optional)

---

125
6. How difficult was it being in a group of people?

- not at all difficult
- fairly difficult
- very difficult

7. How relevant was the group to your individual needs?

- not at all relevant
- fairly relevant
- very relevant

8. How was the pace of the sessions?

- too slow
- about right
- too fast

9. How was the length of the sessions?

- too short
- about right
- too long

10. How was the amount of homework?

- too little
- about right
- too much
- no homework given

11. Overall, how satisfied were you with the group?

- not at all satisfied
- fairly satisfied
- very satisfied

12. What was most helpful about the group sessions?

13. Is there anything else you would have liked included in the group sessions?

14. Do you have any suggestions of how the group could be improved?
It is helpful if you provide a little information about yourself, so that we can classify your answers. Again, this information is strictly confidential.

15. Sex:  
- Male  
- Female

16. Your age:  
- 19 or under  
- 20-29  
- 30-39  
- 40-49  
- 50-59  
- 60 or over

17. Which of these ethnic groups best describes you? Please tick one box only.
- White
  - British
  - Irish
  - Any other White background (please specify)
- Mixed
  - White and Black Caribbean
  - White and Black African
  - White and Asian
  - Any other Mixed background (please specify)
- Black or Black British
  - Caribbean
  - African
  - Any other Black background (please specify)
- Asian or Asian British
  - Indian
  - Pakistani
  - Bangladeshi
  - Any other Asian background (please specify)
- Chinese or Other Ethnic Group
  - Chinese
  - Other Ethnic Group (please specify)

18. Please briefly describe the problem for which you have been referred to the Day Treatment Centre. (e.g. anxiety, psychosis, depression etc).

Thank you very much for completing this questionnaire, your views are very important to us.

If you would like any further information about this project, please contact (trainee Clinical Psychologist): I am available on Wednesdays at the Day Treatment Centre.
Appendix 4:

Evidence of feedback to staff and service users.

NHS Trust

June 2004

Dear

Thank you for your presentation on 14th June to staff and patients at the Day Treatment Centre.

The presentation was very informative and will help us develop a more effective service for the patients in the future.

Thanks again for your help.

Yours sincerely

Occupational Therapist
Appendix 5:
Further Qualitative Data: Example Comments

The comments below were mentioned on one questionnaire each.

- Good to know you're not the only one.
- It's made me feel better about myself.
- I was made to feel very safe and happy.
- I felt I could talk to [staff] about anything.
- Staff were really most helpful and kind.
- Staff make you feel very relaxed.
- Staff were very communicative, supportive and helpful.
- [Staff] is very helpful and is always ready to talk.
- I did feel self-conscious in the group.
- It's good to listen to other people, to get support from others and to share.
- Some subjects are hard to think about.
- [Staff] are very encouraging and attentive to individual needs.
- It is helping me to change my thinking.
- Other members of the group support and genuinely want to help each other.
- [Sculpture] is interesting, absorbing and very therapeutic.
- I went home with things to think about.
A qualitative study exploring the experience of ‘relating therapy’ that aims to modify distressing relationships with voices: Perspectives from voice hearers, therapists, relatives and referrers.

by

Elodie Fuller

Major Research Project

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Word Count: 19,976

July 2006

Department of Psychology
School of Human Sciences
University of Surrey

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ABSTRACT

Objectives
Current psychological models of voice hearing emphasise the personal meaning that individuals attribute to the voice hearing experience. Recent developments in theory and research have pointed to the importance of the relationship between the hearer and the voice. This study aims to contribute to this area of research, by exploring the experience and usefulness of a new form of 'relating therapy' that aims to modify distressing relationships with voices.

Method
Semi-structured interviews (designed for this study) were conducted with ten participants with views on the experience and usefulness of the 'relating therapy' pilot. This included three therapists and three voice hearers involved in the therapy pilot, two relatives of voice hearers involved in the therapy pilot, and two referrers of voice hearers to the therapy pilot. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

Results
Five themes that emerged from the analysis are presented for discussion. These include the process of engaging with the therapeutic model, the significance and impact of the therapists' approach to therapy, the process of developing a new relating style, challenges and obstacles to change, and how change is described and defined by participants.

Conclusions
This study is consistent with the growing body of theory and research that highlights the interpersonal nature of the voice hearing experience. It also offers tentative support for a therapeutic framework that aims to modify distressing relationships with voices as a means of bringing about positive change. Clinical implications and areas for future research are outlined.
INTRODUCTION

Overview of introduction

In this introduction, I will briefly outline the shift from the traditional psychiatric approach to voice hearing, to psychological models that emphasise the personal meaning of the voice hearing experience. I will then discuss the development of theory and evidence for understanding voice hearing within an interpersonal framework, and how this might guide interventions. My study concerns a recent therapy pilot that uses a modified version of Birtchnell’s theory of human relating (1996, 2002b). Birtchnell’s theory and the few studies regarding its subsequent application to voice hearing will therefore be outlined. I will then consider previous research regarding the views of service users and providers about the experience and process of therapy. The introduction will culminate in a rationale for my current research.

The shift from psychiatric to psychological approaches to voice hearing

The traditional psychiatric approach conceptualises voice hearing (or ‘auditory hallucinations’) as symptomatic of serious mental pathology (such as schizophrenia). This framework therefore focuses on establishing diagnoses (e.g. ICD-10, WHO, 1992), and eradicating voices through pharmacological treatment. However, over the last fifteen years, research has challenged the assumptions of the medical approach to voices (e.g. Romme & Escher, 1993). There has been a shift towards understanding the personal experience and meaning of voice hearing, and how this, rather than voice hearing per se, might mediate the relationship between voice activity and voice hearers’ emotional and behavioural responses (Byrne et al., 2006). Many such mediators have been understood within cognitive frameworks.

Cognitive models suggest that an individual’s beliefs about the voices’ power, identity and intent mediate the link between voice hearing, and distressing affect and

---

1 This report will be written in the first person to facilitate my reflection on my position, values and beliefs and how this might influence the research process.
behaviours. For example, voices believed to be powerful and malevolent are associated with distress and resistance (e.g. Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994). It follows that cognitive behavioural therapy (CBT) might reduce individuals' distress by weakening conviction in these beliefs, for example through questioning evidence and behavioural experiments (e.g. Byrne et al., 2006; Chadwick et al., 1996). CBT is currently the psychological treatment of choice for psychosis (National Institute for Clinical Excellence, NICE, 2002) based on studies that support its efficacy and cost-effectiveness (e.g. Gould et al., 2001).

The interpersonal nature of voice hearing

The development of cognitive models

In recent years, cognitive models of voice hearing have recognised the importance of the interpersonal nature of the voice hearing experience. Birchwood et al. (2002) highlighted that an individual's personification of the voice (as an interpersonal 'other') and beliefs about the voice can be conceptualised in terms of a perceived relationship with the voice. They argued that their previous research (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994) had emphasised the role of interpersonal appraisals of power and malevolence, in accounting for emotional and behavioural responses to voice activity.

Birchwood et al. (2002) proposed that social rank theory (e.g. Gilbert, 1992) is an appropriate framework for conceptualising these connections, as it provides a framework for understanding how individuals may respond to power, dominance and entrapment by another. This theory suggests that individuals appraise their social rank through social comparison within social hierarchies. It emphasises the differing positions of superiority (and threatening, intimidating behaviour) and subordination (humiliation, low self-esteem and submissive behaviour). These positions are pertinent when attempting to understand responses to negative powerful voices, and can be conceptualised as falling within the dimension of interpersonal power.

Birchwood et al. (2002, 2004) suggested that beliefs about voices reflect core beliefs about self-worth and interpersonal relationships. Consistent with cognitive models of
schema (e.g. Beck, 1976), they suggested that life experiences of interpersonal relationships contribute to the development of core beliefs that shape expectations and interpretations of subsequent events or interactions. They argued that a core self-perception of low social rank might be reinforced by the general experience of psychosis. This might include stigma, and loss of status or social rank within relationships to the family and wider community. In this context, voice activity is understood as an event or interaction that activates these core interpersonal beliefs, which in turn influence the meaning of the voice to the individual and ultimately their relationship to the voice. The voice hearer’s subsequent responses (e.g. humiliation and submissive behaviour) are then likely to strengthen the core interpersonal beliefs (e.g. Close & Garety, 1998) and maintain the power relationship with the voice. This model indicates that an individual’s relationship with the voice might reflect a general relating style (linked to core interpersonal schema), evident in their social world.

Birchwood et al. (2000) tested this model with fifty-nine voice hearers, using measures of social rank and power in relationships with the voice, and with significant others. They reported a significant association between subordination to voices and subordination and marginalisation in other social relationships. Birchwood et al. (2004) further validated this model with one hundred and twenty-five voice hearers using covariance structural equation modelling. They demonstrated that powerlessness, shame and subordination in the relationship with the voice tend to mirror external social relationships, and significantly contribute to distress and depression. This research is consistent with the notion that core interpersonal beliefs and appraisals of social power and rank (from earlier interpersonal experiences) underlie appraisals of the voice and subsequent emotional responses.

**CBT within an interpersonal framework**

These studies suggest that CBT might usefully focus on modifying interpersonal beliefs and appraisals of social status and power, both within the relationship with the voice and in social relationships. Birchwood et al. (2002) used three case studies to illustrate the process of an adapted form of CBT that incorporates the application of social rank theory to the voice hearing experience. The interventions aimed to modify interpersonal activating events (such as interactions with family or the experience of
stigma), dysfunctional interpersonal beliefs (concerning low social rank) and unhelpful patterns of emotional and behavioural responses. For example, Altaf was described as experiencing subordination in key social relationships and within his relationship with the voice. The intervention included family work to facilitate Altaf’s opportunities for empowerment, control and autonomy within the family. At the same time, his belief about the voice’s omnipotence was challenged using more traditional CBT techniques. This intervention was reported to reduce the frequency of family crises and enabled Altaf to develop more positive interpersonal beliefs, on the basis of improving his social status, self-esteem and the relationship with the voice.

Byrne et al. (2003, 2006) similarly developed a form of CBT in accordance with the principles of social rank theory, for use with command hallucinations. These interventions aim to directly modify the power relationship with the voice, by challenging beliefs about the voice’s omnipotence and the consequences of non-compliance with commands. Their randomised controlled trial (2006) of thirty-eight voice hearers suggested that CBT was associated with a significant reduction in beliefs about the voice’s power, and a reduction in compliance behaviour and distress (compared to treatment as usual). When the effect of the power beliefs was statistically controlled, the treatment effect disappeared, suggesting that beliefs about voices contributed to changes in behaviour and distress. The authors concluded that this is consistent with social rank theory, which suggests that a reduction in the power differential will lead to reduced distress and compliance.

Limitations of studies regarding the cognitive model
In Birchwood and colleagues’ studies (e.g.1997, 2000, 2004), participants were asked to identify their most powerful voice when completing assessment measures. This may have biased their results, as voice hearers are arguably more likely to rate voices as powerful when they have been asked to consider their most powerful voice. The ethnicity of participants was not specified throughout Birchwood and colleagues’ work, and the sex was either not mentioned or was predominantly male. Their samples included participants who have heard voices for a minimum of two years, but further details were not reported or there was substantial variation. These issues might contribute to bias in their research, considering that the experience and prevalence of
psychosis is likely to vary across ethnicity (Bhugra et al., 1997), sex and age (Tien, 1991) and over time (e.g. Close & Garety, 1998).

Many of the studies regarding the application of social rank theory to the cognitive model made conclusions based on correlational designs which cannot specify the direction of causality; for example between beliefs, emotions and responses (e.g. Birchwood & Chadwick, 1997; Birchwood et al., 2000; Chadwick & Birchwood, 1994). Research regarding the use of CBT within an interpersonal framework has used small samples and case study design (e.g. Birchwood et al., 2002; Byrne et al., 2003, 2006), which limit the extent to which the results can be generalised.

Further support for the interpersonal nature of voice hearing
The value of the application of social rank theory to cognitive models of voice hearing lies in the recognition that the voice is perceived in relation to the self, and that interpersonal beliefs and appraisals mediate emotional and behavioural responses to the voice. Interventions have therefore focused on modifying interpersonal beliefs with regards to power and social rank. There is further theory and research outside the cognitive domain that supports the importance of the perceived relationship with the voice, and points to other variables (such as intimacy) that may be important in understanding this relationship and reducing distress.

Benjamin’s (1989) research was one of the first direct explorations of the nature of voice hearers’ relationships with voices. She interviewed thirty psychiatric inpatients using the validated Structural Analysis of Social Behaviour (SASB). This model quantifies interaction in terms of interpersonal focus, love-hate, and enmeshment-differentiation. She found that voice hearers had ‘integrated, personally coherent relationships with their voice’ (p.308) and that voices commonly reflected interpersonal experiences, consistent with Birchwood et al.’s (2000, 2004) research. Benjamin’s (1989) study was important in recognising that relationships with voices may vary on a number of dimensions, and that therapy might therefore usefully address interactions and relationships. However, the SASB model is lengthy and somewhat complicated, which arguably limits its utility as a framework for understanding relationships with voices.
Nayani and David’s (1996) survey of one hundred voice hearers also illuminated relational aspects of the voice hearing experience. Voices were described as ‘personified’, and many were attributed to people within the individual’s social world. High levels of distress were associated with perceived uncontrollable and frightening voices. Individuals who responded to voices, including conversing with them (dialogical engagement), were significantly less likely to experience distress. This was described as personal intimacy, portrayed in the individual’s knowledge concerning the voice, and the voice’s knowledge of the individual. The authors likened this to the omnipotence described by Birchwood and colleagues (e.g. 1994). Nayani and David suggested that intimacy was linked to the extent to which voice hearers engaged in dialogue with the voice. Although intimacy was associated with less distress, this correlation does not stipulate the direction of causality.

Research by Leudar et al. (1997) further investigated the pragmatic properties of voices through interviews with twenty-eight voice hearers (half of which had a diagnosis of schizophrenia and half were not users of psychiatric services). Consistent with Nayani and David’s (1996) study, their analysis indicated that sixty-four percent of the overall sample heard voices that were personified through alignment with significant others in the voice hearer’s social world. Twenty-five individuals reported that their voice talked to them, or less frequently, about them and voices often initiated dialogue. Voice hearers with a diagnosis of schizophrenia were significantly less likely to engage dialogically with the voice. Less dialogical engagement was associated with more negative repetition by voices. Overall this research emphasised the inherent reciprocity in relationships with voices, and suggested the importance of intimacy or engagement in dialogue with voices.

Davies et al. (1999) outlined a case study in which the relating style of the voice hearer was modified so as to facilitate engagement in dialogue with the voice. The voice hearer was encouraged to situate her ‘self’ in the interaction with the voices, and introduce a moral perspective to mediate the voices’ commands. This involved discussion and rehearsal of responses, and recording her interactions with the voices. The intervention was reported to empower the voice hearer, as her self-esteem grew.
by taking more responsibility for her actions and responses. This was paralleled by a
reduction in the voice hearer’s reports of subjective distress. This single case study is
consistent with the notion that increasing intimacy through new dialogues and ways of
relating is associated with a reduction in distress. However, this study cannot specify
the direction of causality and, as a single case study, further replication is required to
broaden the generality of the conclusions.

The findings from these research studies are consistent with the notion that voice
hearers develop relationships with their voices, and that these relationships may
contribute to their emotional and behavioural responses, and subsequently distress.
Despite their limitations, these studies suggest that issues of both power and intimacy
may be important in understanding the relationship with the voice. The interpersonal
models that integrate social rank theory, offered by Birchwood et al. (2000, 2002)
and Byrne et al. (2006), do not acknowledge the significance of intimacy or dialogical
engagement with the voice. In this way, it seems that a different interpersonal theory
that recognises both power and intimacy might add to our understanding of
relationships with voices.

Birtchnell’s theory of interpersonal relating

Birtchnell (1996, 2002b) provided a framework for understanding positive and
negative relationships in the social world, within the dimensions of power (upper or
lower) and proximity (distance or closeness). Birtchnell (1990) suggested that each of
these four positions reflect innate predispositions to relate in certain ways to achieve
relational goals: Upperness (attaining advantage over others), lowerness (seeking
protection or help from others), distance (escaping threat of others and ensuring self-
survival) and closeness (seeking proximity and closeness). These four positions are
represented at the poles of two intersecting horizontal (proximity) and vertical (power)
axes, with four intermediate positions of upper close, lower close, lower distant and
upper distant. Each one of the eight positions in the ‘interpersonal octagon’ is termed
a ‘state of relatedness’, and, as evolved dispositions, each one may facilitate an
individual, in relation to another, to meet their relating needs (Birtchnell, 2002a).
Birtchnell's (1996, 2002b) theory distinguished between positive and negative relating within each of the eight octants (see figure 1), and the distinction is based on relating competence. An individual has relating competence if they have had positive experiences in each of the eight positions, and has thereby developed 'versatility' in moving between the positions as interactions require. This emphasises that an individual may relate differently to different people, and differently to the same individual over time. Relating competence is associated with 'interrelating', that is the combination of relating, and being related to (Birtchnell, 2001). If an 'unversatile' interpersonal other denies or thwarts a positive position, or forces the individual into a negative position, this interrelating style will compromise the individuals' confidence and competence in positive relating and distress will ensue.

Birtchnell (2001, 2002b) outlined the manner in which this theory may be useful in therapy for individuals, couples and families. Broadly, the 'relating therapy' aims to lessen negative relating and increase tolerance of others' negative relating styles, with individuals, couples, or pairs of family members. This might be achieved through observation and recognition of the negative relating styles, exploration into the origins and maintenance of negative interrelating, and discussion about the impact of modifying negative relating or interrelating. This is consistent with the principles of other interpersonal theorists' approaches to therapy (e.g. Benjamin, 1987; Gorell Barnes, 1994). The modification of negative relating might focus on the relationship between the client and therapist, the client and a particular other's interrelating, or on the client's general social relating (Birtchnell, 2001).
Figure 1: The interpersonal octagon: Positive (upper diagram) and negative (lower diagram) forms of relating

(Based on Birtchnell, 2002a)

UC = upper close, LC = lower close, LD = lower distant, UD = upper distant
The application of Birtchnell’s model to voice hearing

Vaughan and Fowler (2004) used Birtchnell’s (1996) model to explore the link between the perceived relationship with the voice and distress. They used modified versions of Birtchnell’s (2001) measures of the relating of couples (called the Hearer to Voice, and the Voice to Hearer) with thirty voice hearers. They hypothesised that ‘negative’ styles of relating between the voice hearer and the predominant voice would be associated with distressing emotional reactions to the voice, independent of depression and of appraisals of malevolence/benevolence. The results demonstrated that two styles of relating were independently associated with distress: Perceived dominating and insulting voice relating (voice uppmess) and voice hearer suspiciousness and lack of communication (hearer distance).

Vaughan and Fowler’s (2004) findings are consistent with other research (e.g. Birchwood, 2004) that has suggested the importance of power relationships in determining distress in response to voices. However, the results indicate that perceived negative relating styles, rather than beliefs about the voice’s malevolence, contribute to distressing affect. Their research also supports previous findings (e.g. Nayani & David, 1996) that intimacy or proximity is important. Distancing behaviours, such as resistance or lack of engagement with the voice was associated with negative emotional reactions. Interestingly, voice hearer submissiveness was associated with less distress. Vaughan and Fowler therefore reported that voice hearer lowemess can at times be functional, particularly if the hearer perceives the voice to be benevolent. Overall, their research supports the application of Birtchnell’s (1996, 2002b) model to voice hearing.

Hayward (2003) used Birtchnell’s (1996, 2002b) model of relating to explore the extent of similarity between the way that people relate to their voices and their relating to people within their social world. He administered part of the modified version of Birtchnell’s (2001) measure of couples’ relating (the Hearer to Voice), and the Person’s Relating to Others Questionnaire – Revised (PROQ2) (Birtchnell & Evans,
to twenty-seven voice hearers. The results suggested significant correlations between relating to the voice and relating socially on the measures of upperness (dominant relating), lowerness (submissive relating) and closeness (clinginess), after partialling out depression and appraisals of malevolence and benevolence. There was not a significant correlation between voice relating and social relating on the measure of distance (withdrawal).

Hayward’s (2003) results are consistent with Birchwood and colleagues’ (2000, 2004) findings that general patterns of social relating are reflected in the way an individual relates to the voice, and therefore with their conclusion that core interpersonal schema may influence voice relating. Distancing to the voice was not reflected in distancing within social relationships. It seems likely that this is linked to the intra-psychic nature of interactions with the voice. Arguably it is more difficult to withdraw from the voice, so resistance (distancing behaviour) is perhaps more likely. Overall this study offers support for the usefulness of Birtchnell’s (1996, 2002b) model of relating as a framework for understanding relationships with voices, within both the domains of power and proximity.

The implication of these two research studies (in the context of previous research) is that relationships with voices and specific relating styles (voice upperness and hearer distancing) may mediate the association between the voice hearing experience and negative emotional and behavioural responses. There is also tentative support for the notion that social relating shares many characteristics of voice relating (consistent with Birchwood et al., 2000). The psychometric properties of the Hearer to Voice and the Voice to Hearer have been further explored, resulting in the Voice and You (Hayward et al., 2005), which includes the reliable and clinically relevant scales that measure inter-relating.

However this research area is at an early stage. The findings from both studies would be consolidated by replication with a larger sample size. Yet the growing evidence base suggests there is a place for assessment and intervention aimed at understanding and changing relating styles and relationships, either socially or regarding

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3 At the time of Hayward’s (2003) study, this paper was in press. It has since been published.
relationships with voices. In my view, a great strength of these approaches is that it is not necessary to challenge the reality of individuals’ experiences\(^4\). This approach appears to be more respectful and person-centred than other approaches, which may seek to achieve a reattribution of voices from externally to internally generated (e.g. Byrne \textit{et al}., 2006; Haddock \textit{et al}., 1998).

\textbf{Hayward \textit{et al}.'s current therapy pilot}

Hayward \textit{et al}. (M. Hayward, personal communication, 1\textsuperscript{st} May 2005) have piloted a new form of ‘relating therapy’ informed by Birtchnell’s (1996, 2002b) relating theory with a series of single cases. The therapy aims to raise awareness of and modify the negative relating of the hearer towards the voice, with respect to both power and proximity. The therapy has been conducted in at least fourteen sessions over approximately six months, consistent with the NICE guidelines for the treatment of schizophrenia (2002). A range of therapeutic techniques were used to bring the voice into the therapy room and create the possibility of conversing and relating in more positive ways (for example based on assertiveness training) that do not maintain the distressing, often dominant and intrusive relating of the voice. A copy of their therapy protocol can be found in appendix 1.

Hayward \textit{et al}. hypothesised that therapy will lead to a reduction in negative relating within the relationship with the predominant voice (as measured on the Voice and You questionnaire, Hayward \textit{et al}., 2005), and this less negative relationship will be associated with a reduction in distress (as measured on the Psychotic Symptoms Rating Scales, Haddock \textit{et al}., 1999). A further exploratory hypothesis examined whether a reduction in negative relating to the predominant voice is associated with a reduction in negative relating to others in that individual’s social world, as measured by the Person’s Relating to Others Questionnaire (PROQ2: Birtchnell, 2002b). As yet, the results of this study have not been collated or written-up for publication (M. Hayward, personal communication, 2\textsuperscript{nd} June 2006).

\(^4\) This is in contrast to traditional cognitive behavioural therapy, which aims to improve ‘insight’ as individuals “inevitably come to see the voices as self-generated” (Chadwick & Birchwood, 1994, p.199).
Major Research Project

Research into therapy experience and process

The current study aims to explore the experience and usefulness of this ‘relating therapy’ pilot. Research into the experience and process of therapy is relatively rare, perhaps due to the emphasis on positivist approaches that use ‘objective’ and ‘reliable’ quantitative measures of outcome. Unfortunately this means that clients’ experiences of and perspectives on therapy have often been overlooked, when judging the usefulness and efficacy of different therapeutic approaches. I would argue that it is essential to explore how a therapy is experienced and understood, in order to meaningfully evaluate and develop interventions. Qualitative research methods are ideal for gaining such in-depth accounts of subjective experiences, and may be conducted in conjunction with quantitative measures. The importance of involving clients and ‘carers’ in the evaluation and development of services (such as therapeutic interventions) is also highlighted by the Department of Health’s (1999) National Service Framework for Mental Health.

Examples of research

It is helpful to draw attention to some qualitative research that explores and describes the process of therapy from the perspectives of clients and therapists. It is interesting to note their findings, and also to consider the methodological limitations to inform the design and evaluation of my own research.

Campbell (1997) interviewed four families who had engaged in family therapy. The most valued aspects of therapy included being listened to, being respected, considering explanations for their experiences, and gaining specific advice. Kuehl et al. (1990) interviewed thirty-seven individuals about their views of family therapy. Satisfied families were more likely to describe their therapist as caring and able. Most families preferred their therapist to offer suggestions and alternatives, rather than ‘telling us what to do’. Lietaer (1992) used post-session questionnaires to explore

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5 ‘Client’ refers to service users. In my study, it will therefore refer to people who hear voices who have participated in ‘relating therapy’.

6 The word ‘carers’ refers to relatives or friends who regularly provide support or emotional/practical care to people who are experiencing mental health difficulties. In my study, the word ‘relatives’ will be used.
forty-one clients' and twenty-five therapists' accounts of client-centred therapy. Clients valued empathy, acceptance and interpretation by the therapist. Therapists frequently identified facilitation of self-exploration and the experiencing of feelings as helpful processes. This highlights that the same therapeutic process may be experienced and viewed differently from different perspectives. Inclusion of both perspectives arguably facilitates a greater understanding of the therapy as a whole.

Messari and Hallam (2003) used discourse analytic methods to analyse five interviews with voice hearers who had received CBT for psychosis. The analysis focused on the ways in which clients positioned themselves and their therapists, and the resulting power implications. Important themes included 'CBT as a healing process', 'CBT participation as compliance with the powerful medical establishment', 'CBT as an educational process', and 'CBT as a respectful relationship between equals'. There were also two contradictory discourses within three participants' accounts; 'this is truly happening' and 'I am ill'. This paper was part of a larger research study that included interviews with the five therapists who had delivered the CBT. Whilst details of the results for this group are not presented, the authors allude to similarities and differences within the therapist group, and between therapists and clients.

McGowan et al. (2005) explored important factors that contribute to outcome in CBT for psychosis. Grounded theory was used to analyse interviews with four therapists and eight of their clients regarding their experiences of therapy. Each therapist nominated one client who had progressed through therapy, and one who had not. Progress was described as reduced distress or new interpretations of the symptom. Accounts about clients who had progressed suggested that the ability to let go of distressing beliefs about the voices, and move into the therapist's model of reality, was important in bringing about change. Those who did not progress seemed to hold emotional investment in psychotic beliefs, and struggled to think reflectively and recall therapy. Furthermore, accounts about non-progressing clients suggested that there was a lack of a shared task or agenda between the client and therapist.
Limitations and areas for consideration

There may be sampling biases in some of these studies. For example, Lietaer (1992) asked therapists to nominate two clients who would be willing to participate. Clients may have been selected on the basis of most likely positive responses. Messari and Hallam (2003) reported that four clients refused to participate and McGowan et al. (2005) did not report on recruitment rates. Generally, it can be argued that participants who agree to be interviewed are more likely to hold positive views of therapy. Often background context and demographic information about participants was scarce, or not even presented (e.g. the therapists in McGowan et al.'s study). This limits the reader's ability to consider the relevance of the results, for example for their own practice.

Another issue concerns the time at which the research is conducted in relation to the therapy process. Campbell (1997) and McGowan et al. (2005) did not specify, and Kuehl et al. (1990) conducted interviews anywhere between one and thirteen months since the completion of therapy. This might be considered a limitation in gaining meaningful results, as there may be important variation depending on the accuracy of recall, or the time in which participants have had the opportunity to witness outcomes or experience further difficulties. The methods of analysis used by Campbell (1997), Kuehl et al. (1990) and Lietaer (1992) are not clearly specified. This makes it difficult to have confidence in the significance and validity of their results.

Studies using qualitative methods should not neglect the issue of validity when discussing results (Dallos & Vetere, 2005). Yet only two of these studies identified the approaches that they used to establish the validity of their findings. Messari and Hallam (2003) discussed the limitations of their study in the context of credibility, transferability and reliability. McGowan et al. (2005) measured inter-rater reliability of their themes and investigated respondent validity (by asking their participants for feedback about their results). This highlighted to me the importance of being transparent about both my method of analysis and the strategies used to explore the validity of my findings.
Rationale for the present study

The introduction has demonstrated a rationale for the present study. Firstly, my study will add to the growing body of research regarding the interpersonal nature of voice hearing, and more specifically about therapeutic approaches that employ Birtchnell's relational framework. Secondly, it will contribute to meeting the need for more qualitative research that prioritises the perspectives of clients and 'carers' about the experience and process of therapy.

In addition, the novel approach of gaining multiple perspectives (from clients, their relatives, therapists and referrers) will strengthen the validity of the findings (as explained in the method and discussion) and offer further insights into this new form of therapy. This approach is consistent with an important systemic notion that situates the therapy process within a system of relationships that may both influence and be influenced by the intervention. Systemic approaches also advocate that exploring multiple key perspectives enables a more complete overview of the topic under investigation. In this way, my study aims to find out more about the experience and usefulness of this therapy from the experts; the voice hearers and their networks (Leudar & Thomas, 2000).

Research aims
The aim of my study is to explore the experience, process and usefulness of a pilot of 'relating therapy' from multiple perspectives. It is hoped that the findings from this research will add to the growing literature regarding the interpersonal nature of the voice hearing experience and the potential usefulness of interventions that utilise a relational framework.

Research questions
What are the views of voice hearers, therapists, referrers and relatives about the experience and usefulness of a therapeutic approach that uses a relational framework?

a) How is the 'relating therapy' pilot experienced and understood?

b) What aspects of the therapy are important in bringing about change?

c) How is change defined?
METHODOLOGY AND METHOD

Rationale for qualitative methodology

My research aims and questions concern the way that the process and experience of therapy is understood from individuals’ perspectives. Qualitative methodologies are appropriate for this area of interest, as they prioritise the meaning that individuals ascribe to experiences or events. Quantitative methods would not be suitable as they prioritise gaining statistically reliable and valid results over a richer understanding of the details and complexities of individual experience and personal meanings within a small sample.

When selecting a qualitative method, it is crucial to pay attention to the epistemological assumptions that underpin the method, that is the assumptions about what knowledge can be established about the world, and how it may be gained (Willig, 2001). Willig refers to three main epistemological positions; the ‘realist’ position assumes that there is an objective reality that is measurable; the ‘social constructionist’ approach suggests that experience and reality is constructed through language and context (rather than an objective reality); and the ‘critical realist’ position assumes that individuals hold subjective representations of social and psychological phenomena, that can be accessed through conversation – and therefore can be construed as mid-way between the two previous positions on the epistemological spectrum.

Rationale for Interpretative Phenomenological Analysis (IPA)

This latter position of ‘critical realist’ is consistent with Interpretative Phenomenological Analysis (IPA), the qualitative method selected for my research. This methodology and its epistemological underpinnings were considered appropriate because it is a constructivist position (that acknowledges the role of language, culture, context and individual diversity in constructing and interpreting individual experience), but also suggests that individuals do hold relatively stable subjective representations (constructs and assumptions) of reality that can be accessed by a
IPA was selected over other qualitative or constructionist approaches, as its aims and epistemological background are consistent with this study. IPA is appropriate when the researcher is conducting a small-scale study and wants to use their own interpretative activity to understand and represent the experiences and perspectives of participants, in the form of themes (Dallos & Vetere, 2005). IPA was selected over Grounded Theory (Glaser & Strauss, 1967), because my aim was to recruit an identified, purposive sample (of people involved in the therapy pilot) rather than use theoretical sampling. Furthermore I hoped to use the data to make connections across emergent themes, and between themes and relevant literature, rather than to establish new theories (Willig, 2001). Discursive methods such as Discourse Analysis (Potter & Wetherell, 1987) explore the construction of meaning and reality in social contexts relationships and different contexts. This also was not consistent with the aims and epistemological position of my study; that there is some relationship between what a person says and beliefs or constructs that they hold, as discussed above (Smith, 1995). Finally, Dallos and Vetere (2005) also propose that IPA may be used in exploratory comparative studies that involve comparing themes across small groups of participants. Considering the diversity of ‘positions’ within my sample (therapists, clients, relatives and referrers), I felt that this could be potentially relevant to my analysis.

IPA is phenomenological in the sense that it focuses on the way in which individuals make sense of their experiences, for example of a therapy process. It is interpretative as the researcher engages in an interpretative process while analysing the data. This emphasises the importance of the researcher’s own position in interpreting and thereby shaping the analysis of participants’ accounts of their experiences and views. Prior to my data collection, I arranged to be interviewed by another trainee to facilitate my reflections on my position as researcher. The interview was recorded so I could listen back to it, and the content is incorporated into a description of my position as researcher and interpretative stance in appendix 2. In summary, this includes how I believe I developed an interest in psychosis and my reasoning for selecting a project in
this area, my approach to working with people who experience psychosis, my knowledge of the ‘relating therapy’ pilot, and my subsequent assumptions and possible biases that may influence the research process.

**Development of the interview schedule**

Semi-structured interviewing was selected as this provides the opportunity for some degree of structure to guide the researcher’s questioning (to facilitate answering the research question), but is also flexible enough to enable the researcher to respond to the content of each individual’s interview, for example by following-up interesting avenues that emerge (Smith, 1995). This allows each participant to contribute to the direction and focus of the interview and introduce new ideas. This is consistent with the aims of IPA, which seek to explore individual participants’ subjective views and personal meaning of experiences.

The interview schedules aimed to answer the research question:

- What are the views of people who hear voices, therapists, referrers and relatives about the experience and usefulness of a therapeutic approach that uses a relational framework?

The interview schedules were designed with reference to guidelines outlined by Smith (1995) and Willig (2001); for example sequencing the areas of enquiry in a logical order, using open-ended and neutral questions to avoid leading the participant, and considering wording options and different probes and prompts in order to facilitate the participant in answering questions. Relevant literature was also important (as described in the introduction), as was consultation with university supervisors.

Having constructed final drafts of the interview schedules for each participant group (see below), face validity was explored through consultation with two Consultant Clinical Psychologists (with over 30 years of experience working with people with psychosis between them), a service user with a diagnosis of schizophrenia, and a relative of a person who hears voices. Feedback from this consultation led to a few changes to the content, structure and wording of the interview schedules. For example,
an additional question for relatives and referrers regarding how much they know about the voice hearer's experiences.

The interview schedules broadly covered three areas:

- General/scene-setting.
- Experience and views of 'relating therapy'.
- The relational approach and perceived change.

There was an additional fourth section that would have been used had any clients discontinued therapy. As my research was exploring the experience and process of therapy from multiple perspectives, I constructed slightly different interview schedules for the different participant positions\(^7\). Interview schedules were designed for a) clients, b) therapists, c) referrers and relatives of the voice hearer. The main areas of difference were in the 'general questions' section, pertaining to background and scene-setting information, and otherwise were mostly regarding the use of pronouns (e.g. 'you' or 'they').

Copies of the interview schedules are in appendix 3.

**Procedure**

**Ethical issues and approval**

Ethical approval was obtained from the university and an NHS Local Research Ethics Committee (via the Central Allocation System for multi-site studies), and Research and Development (R&D) approval was gained from the committees in all three Trusts in which I was recruiting participants (appendix 4). An outline of the main ethical issues considered in conducting the study is in appendix 5. This includes gaining informed consent, minimising the likelihood of anxiety and distress during the interview, a plan for managing distress and risk, and issues of confidentiality and data protection.

\(^7\) 'Participant position' will be used when making reference to the position of the participant, i.e. as a therapist, client, relative or referrer.
Inclusion/exclusion criteria

Participants in my research fulfilled the following inclusion criteria: They were either:

a) therapists who had delivered 'relating therapy' as part of the therapy pilot,
b) referrers of clients to the 'relating therapy' pilot, who have regular contact with the client,
c) relatives of clients who had received 'relating therapy' as part of the therapy pilot (individuals identified by the clients who are deemed to be presently in an important relationship with the client, involving frequent contact).
d) clients who had received 'relating therapy' as part of the therapy pilot. The inclusion and exclusion criteria for the therapy pilot is provided below:

Table 1: Inclusion/exclusion criteria for clients recruited to the therapy trial

<table>
<thead>
<tr>
<th>INCLUSION CRITERIA</th>
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<tr>
<td>• hearing voices for at least 12 months irrespective of diagnosis</td>
<td>• psychosis due to organic illness</td>
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<tr>
<td>• hearing one or more voices, but should be able to identify a predominant or main voice</td>
<td>• psychosis due to misuse of substances</td>
</tr>
<tr>
<td>• recovered from an acute episode of psychosis, e.g. is not acutely unwell</td>
<td>• acutely unwell</td>
</tr>
<tr>
<td>• have experience of speaking about the experience of voice hearing</td>
<td>• considered by the care team to be incapable of giving informed consent</td>
</tr>
<tr>
<td>• the relationship with the voice will be causing distress</td>
<td>• a lack of English language skills that would preclude therapy based on verbal communication.</td>
</tr>
</tbody>
</table>

My sample of participants had all shared in the experience of this new 'relating therapy' in some way, and were therefore all in a position to offer their views about this therapy. Gaining multiple perspectives on the same topic (i.e. the experience and
usefulness of the therapy pilot) allows a diversity and richness of views, and offers a form of validity check (discussed below).

Recruitment
I was informed, via a university supervisor involved in the therapy pilot, when each therapy process was near completion. At this stage, I approached therapists and offered them written information about my study. Therapists then asked their clients if they might be interested in participating in an interview about their views of the therapy. The clients who expressed interest were given written information about the research and I was informed, via therapists, of their decision about participation. Clients’ care teams and GP were informed of their agreement to participate. Referrers were identified by therapists or clients, and offered written information about the study. Relatives were identified by the client and approached following written consent to contact them from the client.

Copies of the participant information sheets (one for clients, and one for therapists, referrers and relatives) can be found in appendix 6. The consent forms are in appendix 7, including consent to participate, and consent (from clients) to contact a relative.

All therapists, referrers and relatives who were approached agreed to participate. One client declined participation due to ‘worries about meeting a stranger’. I stopped recruiting after conducting ten interviews, which Smith et al. (1999) suggest is an appropriate maximum number to enable the researcher to keep in mind each individual case.

Participants
Ten participants agreed to take part in individual interviews. Important characteristics of the participants are described in table 2 to provide some context of the participant sample. However, pseudonyms will not be provided at this stage so that later examples from transcripts cannot be cross-referenced with these descriptions of individuals (to prevent participants from identifying each other). The information has been organised according to participant position for ease of presentation.
Table 2: Important Characteristics of Participants

<table>
<thead>
<tr>
<th>Therapists x 3</th>
<th>Clients x 3</th>
<th>Relatives x 2</th>
<th>Referrers x 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 x female</td>
<td>1 x male</td>
<td>1 x female</td>
<td>2 x male</td>
</tr>
<tr>
<td>1 x male</td>
<td></td>
<td>1 x female</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 x 40-49</td>
<td>2 x 20-29</td>
<td>1 x 50-59</td>
<td>2 x 50-59</td>
</tr>
<tr>
<td>1 x 40-49</td>
<td></td>
<td>1 x over 60</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>White British</td>
<td>White British</td>
<td>1 x White British</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 x Chinese</td>
</tr>
<tr>
<td>Interview</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-80 minutes.</td>
<td>50-80 minutes.</td>
<td>40-60 minutes.</td>
<td>40-60 minutes.</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 x Clinical Psychologist</td>
<td>All unemployed.</td>
<td>1 x factory work,</td>
<td>1 x Nurse Consultant (and client’s care co-ordinator)</td>
</tr>
<tr>
<td>1 x Clinical Specialist (Psychosocial Interventions)</td>
<td>Previous employment: 1 x building work, 1 x bar work, 1 x registered nurse.</td>
<td>1 x retired engineering manager</td>
<td>1 x Consultant Psychiatrist</td>
</tr>
<tr>
<td>1 x Senior Nurse Practitioner</td>
<td>1 x factory work, 1 x retired engineering manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background information</td>
<td>All working within community settings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of therapy for people with psychosis between 8-15 years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All working within community settings.</td>
<td>All completed ‘relating therapy’ treatment phase (15 to 17 sessions) within last 4 weeks.</td>
<td>1 x father: lives near client, 1 x mother: lives with client</td>
<td>Both working within community settings.</td>
</tr>
<tr>
<td>Hearing voices between 4 and 10 years.</td>
<td>No previous experiences of psychological therapy. All taking anti-psychotic medication.</td>
<td>Both married</td>
<td>Both known clients between 2-4 years.</td>
</tr>
<tr>
<td>All experienced at least 1 hospital admission.</td>
<td>Predominant voices: The Devil, voice of a past school bully, personified voice linked to past abuser.</td>
<td>Both regular contact with client</td>
<td></td>
</tr>
<tr>
<td>Predominant voices heard at least daily, content and intent of voices perceived to be negative.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The 'clusters' of participants refer to participants within the same Trust, so each cluster has one of the three therapists. The rationale for highlighting these clusters is to acknowledge my recognition that, despite therapists closely following the therapy protocol, there may be meaningful differences in experience according to geographical locality, for example due to therapists' individual styles or the context of the service.

Clusters included:

- Cluster one: 1 therapist (T1), 1 referrer (R1).
- Cluster two: 1 therapist (T2), 2 clients (C2a and C2b), 1 relative (F2\(^8\)); (Both C2a and C2b received therapy from T2)
- Cluster three: 1 therapist (T3), 1 client (C3), 1 relative (F3), 1 referrer (R3).

Data collection
Written consent was gained before each interview commenced, including consent to participate and consent to audio-record the interview (appendix 7). All participants were made aware that they could withhold any information or withdraw from the study at any point. A short background information form was completed, to gain brief demographic information about participants (appendix 8). Interviews were conducted at a location and time convenient to the participant, including community team bases and participants' homes. Home visits were conducted in accordance with Trust policy guidelines.

All interviews covered the three general areas described above. The questions asked were guided by the interview schedule rather than dictated by it, to allow me to follow the direction of each participant (Smith, 1995). The aim was to gain information that was both relevant to my research question, and meaningful and significant to the participant (not just prompted by the researcher). I therefore frequently modified the wording of questions or the order of questions, to be responsive to the content and

\(^8\) 'F' refers to family member, or relative.
style of responses. Therefore, whilst all the proposed topic areas were covered, not all questions were asked, nor were they in the same order, for each participant (Smith, 1995).

The interviews were audio-taped so they could be transcribed verbatim and then analysed. The transcribing process involved removing or changing any identifying information to ensure confidentiality and anonymity. Participants were allocated a code which subsequently identified each participant’s audiotape and transcript, again to maintain anonymity.

Analysis

The analysis of the transcripts followed guidelines outlined by Jonathon Smith (e.g. Smith et al., 1999). Smith and colleagues are clear that their guidelines are not intended to be prescriptive, and that the process of analysis should be adapted to suit the personal style of the researcher and their research question (Smith & Osborn, 2003).

The first two interviews that I conducted were within cluster one, so I therefore began with analysis of these.

- The richer and longer transcript was chosen and read a number of times. I noted in the left hand margin anything that struck me as important or significant; for example attempts at summarising, associations and connections, or initial interpretations (Smith et al., 1999).
- The right hand margin was then used to note emerging theme titles that ‘capture the essential quality’ of what I was finding in the text (Smith et al., 1999, p.221). These included some broader summaries of the text from my perspective and more abstract interpretations. Many of the emerging theme titles were recurrent in the transcript. Example extracts from four transcripts with both the left and right hand margin comments are in appendix 9.
- Throughout this process, I kept note of emerging theme titles with line references on a separate sheet of paper. This list of emerging theme titles allowed me to consider the frequency of each, check the interpretations against
what was said, as well as look at connections and associations between emerging themes.

- Tentative connections between themes were then made, looking for clusters of topics or concepts (Smith et al., 1999). These clusters were then allocated superordinate theme titles, resulting in a list of preliminary superordinate themes for that participant. Throughout this process, it was important to check that these themes connected to the transcript to ensure that my interpretations were grounded in the text.

- These steps were repeated for the remaining transcript from cluster one. Throughout this process, I kept in mind previous emergent themes as well as looking for novel and different ideas and themes.

- I then analysed the transcripts from cluster two and three in the same manner. Throughout this process I was mindful of the preliminary superordinate theme titles from cluster one, but tried to be open to new and different ideas and issues. New emergent theme titles were then tested against earlier transcripts, and the superordinate theme lists (for each transcript) were modified as appropriate in the ongoing analysis.

- This process resulted in lists of preliminary superordinate themes for each of the ten participants.

- These lists of themes from all ten transcripts were then amalgamated and redefined into a master list9 of superordinate themes and sub-themes, again checking that the themes were represented in the transcripts (Smith et al., 1999). During this process, some themes were dropped, based on relevance to my research question, the richness of the passage supporting the theme, and the frequency of the theme within and across transcripts (Smith & Osborn, 2003). The process of analysis continued throughout the write-up of the results (Smith, 1995).

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9 The language I have used to describe my themes ('master list' of 'superordinate' themes and 'sub-themes') is consistent with conventions outlined by Smith and colleagues (e.g. Smith et al., 1999).
This process of analysis enabled me to identify similarities and differences within and across participant positions, and within and across the clusters (as I had lists of superordinate themes for each transcript).

**Evaluation and validity**

Traditional methods of evaluating the reliability and validity of quantitative research are not appropriate for qualitative methods, yet it is still important to consider the quality, validity and trustworthiness of studies using qualitative methods. Elliott *et al.* (1999) have provided useful guidelines for evaluating qualitative research, and I will now summarise the ways in which the design and methodology of this study aimed to meet their evaluative criteria.

**Owning one’s perspective**

As discussed above, IPA recognises that researchers engage in an interpretative process during the analysis. It was therefore important to be transparent about my relevant experiences, beliefs and assumptions that may colour the interpretative process, to facilitate my reflexivity (appendix 2). This also allows the reader to consider how my values and beliefs may have influenced the interpretative findings, and remain aware of possible alternative interpretations that may have arisen from a different perspective.

**Situating the sample**

My inclusion of table 2 (outlining participant characteristics, p. 156) enables the readers to evaluate for themselves how relevant or representative the findings might be outside of this study. It was important to achieve a balance between situating my sample and promoting confidentiality as discussed above.

**Providing credibility checks**

I used several methods to check the credibility of my research design, analysis and results. It is important to ensure that the research design is meaningful and relevant to the research population and that it is open to collaborative scrutiny (Dallos and Vetere, 2005). During the design of my study, I therefore involved psychologist colleagues,
therapists who work with people who experience psychosis, a service user who hears voices and a relative of a service user with psychosis.

My analysis was monitored by a university supervisor, through regular meetings and discussion about my interpretations of the data. Independent audit (Dallos & Vetere, 2005) was used to explore the coherence of my analysis and whether my interpretations could be followed. This included giving a group of trainee clinical psychologists involved in qualitative research extracts of two transcripts, with my left and right margin comments. In addition, a university supervisor read a whole transcript with my left and right margin comments, and cross-checked these with that transcript’s list of preliminary superordinate themes. The qualitative research group was also given the master list of superordinate themes and sub-themes, and 24 quotations (from all ten participants), as presented in appendix 10. They were asked to assign the quotes to the relevant sub-theme, or if unable to do so, to the relevant superordinate theme. The outcomes of these credibility checks will be described in the results, and considered further in the discussion.

The process of gaining multiple perspectives can also be considered a form of validity check through triangulation (Barker et al., 2002). Multiple perspectives both enhance understanding, and allow the results to be cross-checked to explore credibility (Dallos & Vetere, 2005).

Elliott et al. (1999) also highlight the importance of grounding interpretations in examples, accomplishing general versus specific research tasks, and presenting results that are coherent and resonate with the reader. These criteria for evaluating validity, and additional issues associated with credibility checks, will be further explored in the discussion.
The study aimed to explore the experience and usefulness of relating therapy from the perspectives of clients, therapists, relatives and referrers. Eight superordinate themes (each with sub-themes) emerged from the analysis of all ten transcripts. The interviews provided a large quantity of rich data, and due to space limitations these themes were reduced down to five superordinate themes for discussion. The master list of superordinate themes and sub-themes to be discussed is in table 3. This table also documents the spread of themes, which will be discussed below. A full list of superordinate themes and sub-themes is in appendix 11.

The results section will provide a narrative account of the experience and usefulness of relating therapy, from multiple perspectives (Smith & Osborn, 2003). It will be grounded in verbatim extracts and passages from participants’ transcripts, to facilitate the description, exploration and understanding of their accounts and the emergent themes.

Overview of themes

The first superordinate theme portrays aspects of the therapy that were important in the process of engaging with the relational framework. The second superordinate theme considers the significance and impact of the therapists’ approach to therapy and in relation to the clients. The third theme reflects the process of bringing about change in voice hearers’ relating styles. This theme highlights this process in terms of developing understanding (about the voice hearing experience), generating ideas for change, and introducing difference. The fourth superordinate theme examines challenges or obstacles to change. The fifth theme explores the impact of change, or how change is defined by the participants.
### Table 3: Master list (and spread) of superordinate themes and sub-themes

<table>
<thead>
<tr>
<th>Superordinate theme</th>
<th>Sub-theme</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>C2a</th>
<th>C2b</th>
<th>C3</th>
<th>F2</th>
<th>F3</th>
<th>R1</th>
<th>R3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaging with the relational framework</td>
<td>1:1 An intuitive model of voice hearing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1:2 Assessment of relating styles</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1:4 Openness and honesty</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Therapists’ approach</td>
<td>2:1 Therapeutic relationship</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2:2 Non-judgemental about psychotic experiences</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Developing a new relating style</td>
<td>3:1 Developing understanding</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3:2 Drawing on positive relating styles</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3:3 Assertiveness training</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3:4 Bringing the dialogue into the room</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Challenges to change</td>
<td>4:1 Perceived risks within therapy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4:2 Entrenched relating styles</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5:2 Acceptance of voices</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5:3 Mental health and perceptions of self</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5:4 Independence-seeking</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5:5 Social relationships</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5:6 Hopefulness and the possibility of change</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**
- T = Therapist
- F = Relative
- C = Client
- R = Referrer
Selection of themes for presentation
My strategy for selecting which superordinate and sub-themes to present was mostly based on the relevance to the research question, as well as the richness of the accounts supporting the theme and the frequency of the theme both within and across transcripts (Smith & Osborn, 2003). Furthermore, I considered the potential significance of the theme, in terms of the links to existing theory and literature, and possible clinical implications. This strategy therefore did not necessarily exclude themes that were represented within only one position.

Additional superordinate themes that are not presented in the results include the individual context (for example onset of psychosis and other experiences of treatment), external factors affecting change, and the ‘carer’ role (which includes client dependency, emotional burden, and ‘secrecy’ to the family). Within the presented superordinate themes, there are a few further sub-themes that will not be presented, for the reasons outlined above. All abandoned themes are presented with example quotations in appendix 11.

Spread of themes
Considering the diversity of perspectives in my study, it seemed useful to provide a summary of the spread of superordinate themes across participants and positions. The box is marked with an ‘X’ if the sub-theme was apparent within the participants’ transcript, either frequently or within very rich passages. Whilst the purpose is not to provide a form of content analysis, it may be helpful to be aware of themes that were more and less widely spread across positions. Issues concerning the spread of themes will be more thoroughly explored in the discussion.

As table 3 demonstrates, it emerged that the superordinate themes tended to be shared across positions; with each superordinate theme emerging in at least three positions. There was more variety across sub-themes (than superordinate themes), and differences between positions will be highlighted in this section, and considered more thoroughly in the discussion.
Throughout the process of analysis I was mindful of possible differences between clusters (geographical localities). However, themes that emerged within only one cluster tended not to be particularly relevant or meaningful in the context of the research question, and, due to the additional issue of space limitations, subsequently were not selected for presentation (see appendix 11 for examples). If themes are represented more within a particular cluster, I have noted this in the results section. Further detailed consideration of the nature and explanation of differences across geographical localities is beyond the scope of this study.

**Theme 1: Engaging with the relational model**

This theme emerged in participants’ accounts of the process of socialising to and engaging with the relational framework. Participants talked about the value of providing an intuitive model for understanding voice hearing, the role of assessment measures in exploring relating styles, and the links between openness and engagement with the therapist and model.

1:1 An intuitive model of voice hearing

Encouraging clients to gain a sense of being in a relationship with the voice was described as ‘intuitively... appealing’ (R1 156), because it offered a conceptualisation of the experience in ‘a ballpark where the hearer has a real sense of knowing the terrain’ (T2 309-10). This was linked to the universal nature of experiencing relationships (e.g. T3 226-30). Participants’ accounts suggested that it was intuitive to consider the experience within a relational framework: Voices were generally described as having a personified identity, knowledge, intent (e.g. malevolence), and a history of interactions and dialogue with the client.

The intuitive nature of the relational framework was reflected in the ease with which participants could compare experiences with the voice to those within social relationships. The concept of disempowerment within both social relationships and the relationship with the voice was common in participants’ accounts (e.g. R3 97): C2a expressed that teachers used to ‘talk about me, and make decisions’ without involving him (348-50). He compared this to the voices; ‘it’s the same sort of thing. They’ve had
a meeting without me, and come to decisions without me' (C2a 366-7). The process of comparing relationships facilitated clients in making sense of their voice hearing experiences: 'being able to see that kind of link as opposed to... I don't understand this but it's happening, I think has been very illuminating for her' (R1 108-11).

Therapists also described the model as normalising and empowering for clients. There was a 'sense of relief' (T1 295) as clients were encouraged to understand their experiences within the 'ordinary domain' of relationships (T2 312) rather than as 'mad stuff' (T2 311). The emphasis on reciprocity in relationships allowed clients to gain 'a sense of... playing an active role in that relationship' (T2 95-6), and recognise that they have 'a choice about... how [to] respond' (T1 318). In this way, clients realised that 'like any relationship, [the relationship with the voice] has the potential to change' (T2 452-3).

1:2 Assessment of relating styles
Therapists talked about diagrams and measures that facilitated clients' socialisation to and engagement with the model. The emphasis was on 'bringing social relating explicitly into the process' of therapy (T2 280). For example, developing a genogram and use of Birtchnell's octagon 'expanded [the client's] understanding and awareness' of their relating styles (T3 416-7). Social relationships and predominant relating styles were also explored through the Person's Relating to Others Questionnaire (PROQ2, Birtchnell, 2002b).

The use of visual diagrams and measures supported engagement (R3 201-3) and enabled a 'shared language' with which to talk about relationships (T1 394). They were described as central to the process of comparing social relationships with the relationship with the voice, as described above (T2 276-9). Clients also regularly completed a brief measure concerning their relationship with the voice (C2a 231-9). C2b noted the importance of repeating measures to monitor change (C2b 273-4), but highlighted that repeated use of a long questionnaire such as the PROQ2 can be demanding (C2b 568).
Many participants described the importance of being open and honest (about voices and social relationships) in engaging with the model and the therapist. Clients and relatives described the cathartic effects of openness and honesty about problems. C2a valued ‘just to get things off my chest’ (C2a 639) and C3 described that she could ‘discuss it and get rid of it’ (C3 507). There was a common view that ‘talking about problems... eases a problem’ (F3 544-5) and that ‘it’s kind of a problem shared, a problem halved’ (C2b 218-9). In this way, ‘getting it out in the open’ (C2b 516-7) was seen as facilitating engagement.

Openness and honesty also supported engagement by contributing to clients feeling understood by the therapist. When asked about helpful aspects of therapy, C2a identified ‘somebody to understand... why I’ve become like this’ (C2a 311-2). T2 emphasised that openness and understanding within therapy were crucial, as ‘other people... actively discouraged her from talking about these experiences... people couldn’t, didn’t hear the mad stuff’ (T2 489-92). This was supported by relatives’ accounts. F3 reported that ‘she can’t explain that to us... the voice swears at her, uses vile language... It’s difficult with parents’ (F3 338-40). F2 felt ‘he’s going through something that I can’t understand’ (F2 384-5).

Theme 2: Therapists’ approach

This theme explores the importance of the therapeutic relationship and the non-judgemental approach of therapists.

2:1 Therapeutic relationship

Most participants talked about valuable aspects of the therapeutic relationship. C2b described feeling respected: ‘to finally meet a therapist who treats you like a person, rather than just like a number that has to be ticked off and made better... it does make you feel better’ (738-40). C3 felt empowered within her relationship with T3: ‘It was more a case of how I was going to deal with my voices, it was me that was going to deal with it, it was me that was going to sort it out... she was giving me, myself the power’ (C3 816-21).
The non-directive and person-centred approach of therapists was also highlighted by participants. One referrer explained how the client valued that the therapist was like 'a coach – she doesn't tell me things, she just suggests various ways that I might look at things' (R1 204-5). R1 likened this to the 'guided discovery' in CBT. T1 described practical ways of giving 'choice and control to the person' (T1 829) and C2b appreciated the therapist saying 'if you want to stop at any time, you can' (C2b 608).

Therapists emphasised the importance of their positioning in relation to the client, in bringing about change: 'I have a real kind of curiosity to learn from them and putting the person in the position of expertise. So I think all those ways of me being and relating to the individual... create a... reasonably solid foundation, upon which... change and different understandings may be developed' (T2 360-4). A strong therapeutic relationship was seen as essential for clients to feel able to experiment with new ways of relating (T3 473-4).

2:2 Non-judgemental about 'psychotic' experiences
Most participants emphasised and valued that therapists approached the voices as genuine and valid experiences. T2 explained '...with this approach you don’t question the experience at all, you don’t look to challenge it, you just acknowledge that the way it is at the moment is a problem' (449-51). This was evident in clients' accounts:

I: Would he sort of question your theories or?
C2a: No, he took them on board, yeah. (C2a 199-200).

C2b: After the sessions I'd always feel a bit happier in general.
I: And what do you think brought about that happiness?
C2b: ...To hear someone talk about them as if they were real, instead of... just telling me that I need more medication or... ‘don’t listen to them, they’re not real’. (C2b, 530-6).

This highlights the difference between this approach and previous experiences of the traditional psychiatric approach, where 'the emphasis is on removing a symptom' (R3
349-50), rather than talking about or to the voice (T1, 103-4). The perception that openness about voices would not result in increased medication or admission to hospital (T1 119-20) was described as a 'huge relief' for clients (T1, 117).

Relatives talked about the importance of therapists being experienced in working with people with psychosis (F2, 318), in enabling them to be non-judgemental about voices. For example, F2 felt that therapists are 'detached emotionally' (328) and that allows clients to be open and honest about their voices:

F2 ... whatever C2a says to them, is not going to shock them or make them upset, which, you know.

I And what do you think the effect of that on C2a is, if they're not getting upset and if the therapist doesn't get shocked?

F2 Because he probably feels free to be able to say what he can say. Whereas within a family you don't tell them everything, do you. (362-7).

Theme 3: Developing a new relating style

Relationships with voices tended to be described as negative and fixed (as discussed in the challenges to change below). In this context, therapists talked about wanting to introduce 'something completely different' in the way that clients respond to the voice (T1 355). This theme explores participants' accounts of the process of modifying clients' relating styles. This involves developing understanding about the voice hearing experience, drawing on clients' positive experiences of relating, learning and practicing assertiveness, and bringing the dialogue with the voice into the therapy room.

3:1 Developing understanding

Developing understanding about underlying issues and connections between experiences was consistently valued by participants. Therapists talked about the importance of developing a 'longitudinal formulation' with clients (T1, 282) to guide the intervention around their voice hearing experience: 'look beneath the surface and get a sense of... what this experience connects to, relationally... and get a sense of the
underlying issues that need to be addressed' (T2 75-8). So for example with one client the underlying issues were around shame (T2 195-8).

The therapy was described as helping clients to 'see a connection between that which they experience and that which is going on in their lives' (R1 276-8). T3 referred to a 'powerful week' (356) where the genogram was used to consider the links between a past abusive relationship and the current voice relationship. C3 agreed that this connection 'became clearer through the therapy' (C3 494) and described the impact on her relationship with the voice: 'I'm much less afraid than I was before. I have more understanding of what's occurring and having that gives me more power against him' (C3 201-3). F3 described this as discussing things that were 'deep down' (F3 83).

Some participants valued the exploration of patterns of interaction, as a means to developing new understandings about relationships. For example, C2b developed a new interpretation that hearing the Devil was a test of faith rather than a punishment, by considering 'why would he do this, what would he be achieving by doing this?' (C2b 441-2). The process of exploring clients' interpretations of relationships was also described as facilitating changes in their views of themselves. C3 explained that 'she [therapist] was working with me on accepting the fact that I hear voices, and that it didn't mean that you were mad or bad' (C3 601-3). These new understandings were seen as facilitating clients in making small changes in their relating styles (T1 787-8).

3:2 Drawing on positive relating styles

Therapists highlighted that one way of gaining ideas for introducing difference in the relationship with the voice was by drawing on clients' own experiences of positive relating within 'more functional' relationships (T1 375). Therapists would aim to 'shine a spotlight on times when maybe she's not been the passive recipient of an experience, but she's... taken more active roles in those relationships' (T2 732-4). Therapists might ask how the client would respond to criticism or threat within these relationships (T1 365) and explore the possibility of using these ideas within the relationship with the voice (T1 387-8).
Birtchnell’s octagon was used to record both positive and negative relating, so was important in stimulating discussion about past experiences of positive relating (T3 403). The genogram was also used to explore when and how clients had achieved more positive relating within other relationships (T3 371). These diagrams facilitated the process of identifying ideas for change, and the possible impact of change, in the relationship with the voice (T3 407-9).

3:3 Assertiveness training
The purpose of assertiveness training was ‘to think about the process of learning to relate differently’ to the voice (T2 97-8). Clients were encouraged to be ‘less unquestioningly subservient’ to the voice (T1 211) and, in the context of Birtchnell’s model, to ‘take a more upper position’ (T1 383). Therapists also highlighted that assertiveness training gave clients more choice about possible responses to the voice (T3 895-6). This is consistent with an important aspect of Birtchnell’s model that advocates increasing versatility in relating styles (T1 741-2).

Therapists and clients described the process of learning to relate more assertively to the voice. This involved identifying different relating styles, for example ‘relating passively, aggressively and assertively’ (T2 136-7). C2b and C3 valued using an ‘assertive[ness] book’ (C2b 365) that explained these relating styles (T3 294). Clients were encouraged to explore the possible impact of each relating style on themselves and the relationship with the voice (T1 213-4). It was also important to consider why it might be difficult for clients to be assertive in particular situations (T3 297-8).

Once clients were familiar with the concepts ‘then we tried to figure out assertive answers to the voices’ (C2b 367-8). Frequently this involved challenging the voice in terms of ‘the validity and accuracy of what she’s saying’ (T2 255-6) and whether the voice was being ‘reasonable or unreasonable’ (R3 285). Assertive responses were written down to facilitate clients’ recall of this new relating style, for example on cue cards (T3 310) or keyrings:

C2b we looked at ways of trying to remember how to be assertive and how to respond to the Devil in a better way.
And what were those ways?

C2b...We made little notes on keyrings, it says 'soulmates will never be kept apart', 'show me some proof', 'show me someone who agrees with you', 'I know god's real because he speaks to me' (C2b 429-35).

C3 expressed assertive responses to the whispering voices that she hears: 'you're extremely rude to whisper. If you've got something to say, you say it out loud or I won't pay any attention to you at all' (C3 271-2). She also talked about counteracting the voice with logic (C3 132). For example; 'If he's saying you're stupid, I'll say I'm not stupid because I do group work, I do lecture work' (C3 132-4). C2a described 'trying to reason with it' but felt 'it doesn't work' (76-77).

Therapists likened this process to cognitive behavioural therapy, in which clients traditionally challenge the validity of their own negative thoughts (T2 257). For example, T3 explained 'when we were doing the evidential review of the voice content and its accuracy, that felt very CBT' (T3 639-40). Yet therapists were clear that the approach was always 'underpinned by this interpersonal theory' (T1, 81).

3:4 Bringing the dialogue with the voice into the room

Therapists and clients talked about the process of bringing the dialogue with the voice into the therapy room. Often this took the form of role-play with the therapist saying something that the voice might say (T3 305-6), and asking the client to respond (T1 178-80). One therapist used an 'empty chair' to invite the voice into the room more explicitly (C2a 280, C2b 378): 'I essentially would, with his permission, clear a space on the settee and invite the voice into the room and ask him to converse as if the voice was there, and tell me how he believed that the voice might respond' (T2 142-5).

Bringing the dialogue into the room allowed clients and therapists to gain further understanding of clients' relating styles and unhelpful 'reciprocal roles' within relationships (T2 333). C2a emphasised that the aim for him was also to 'get the voice to understand me a bit more' (C2a 291-2). This process enabled clients to experiment with 'speaking in different ways' to the voice (T1 551-2). T2 explained that the purpose was to demonstrate: 'if [the client] or [voice] threw in something different,
how that could lead to all sorts of different conversations spiralling off of it. So it was creating the opportunity to have a different kind of conversation’ (T2 184-7). This often involved ‘practice and rehearsal’ of more assertive responses (T3 299).

T1 suggested that this process can make the dialogue ‘more real’ and ‘more personified’ (T1 180-1). T2 suggested that this was initially experienced as uncomfortable by C2a, as it ‘brought the experience much closer’ (T2 167-8), but after repeated practice, he ‘began to welcome the opportunity’ (T2 169-70). C2b did not expect the ‘empty chair’ to work because ‘the voices... come from the air... from all around, they’re not going to come and want to sit in one chair’ (C2b 395-7). The ‘empty chair’ seemed to be stressful for C2b as she talked about it triggering a migraine (C2b 382).

Theme 4: Challenges to change

This theme explores the potential challenges and obstacles in bringing about change, including perceived risks of therapy, and the entrenched nature of clients’ relating styles.

4:1 Perceived risks within therapy

Clients and therapists referred to the risks or possible negative consequences from therapy. For example, there was a fear amongst clients about the consequences of being open to the therapist: C3 described ‘in the beginning I was worried that I would open a can of worms that I couldn’t get the lid on’ (C3 674-5). Similarly, C2a expressed that he was reluctant to talk about distressing memories from the past; ‘it opens up a... door on another part of my world’ (C2a 599).

There were worries about the consequences of relating differently to the voice, for example how the voice would respond. T1 said that her client ‘expressed a sense of dread, a sort of a not knowing what would happen if she did it differently’ (T1 235-6). C3 expressed a fear that dealing with the voice ‘face on’ (685) would lead to a loss of control (689). T1 identified her client’s fear that relating differently might ‘make it
much worse’, which could ultimately lead to increased medication or hospitalisation (T1 591-5).

Relatives talked about the risks of change in terms of the consequences of clients becoming more open to their family about their distress and experiences. F2 explained ‘he’s probably trying to avoid telling me too much, because I think he knows that a lot of it upsets me... Because I’m so close as a mother’ (F2 15-7). C3 agreed that ‘with my family then I pretend I’m well, you know when I’m having a bad time. Because I don’t want to upset them’ (C3 442-3). This was a potential obstacle to clients developing a more assertive or open relating style with their families.

For therapists, the perceived risks were associated with delivering a new therapy with novel techniques. For example, T2 reflected on not yet knowing the ‘parameters’ (T2 587) of the therapy: ‘I didn’t know where the process was going, and that felt kind of quite intimidating... there was a genuine sense of discovery’ (T2 574-6). Two therapists chose not to use the ‘empty chair’ technique, which was linked to feeling safer (T1 563) working within their ‘comfort zone’ (T3 280). T1 also identified risks associated with not knowing whether clients might perceive this intervention as ‘odd’ (T1 516), and how this could jeopardise their view of the therapist (T1 522).

4:2 Entrenched relating styles
Therapists commonly referred to ‘entrenched ways of relating’ (T3, 680-1) and the ‘fixed’ nature of negative relationships with voices (T2, 21). This was seen as contributing to clients’ difficulties in conceiving of change: ‘when you’re used to being fairly fixed in your relating positions... maybe it’s quite a difficult concept to take on board, that actually there are these different relating positions that you can come at things from’ (T1 418-22). T2 reported that C2a talked about ‘too much water under the bridge for them to change’ (T2 30).

Therapists and referrers identified how negative relationships with voices may be reinforced by the client’s sense of identity, and as such is an obstacle to developing new relating styles. T3 described difficulty in changing C3’s negative ‘resistant’ relating style: ‘being somebody who resists this... is really quite an important part of
Similarly the ‘patient’ identity was seen as maintaining passive relating; ‘they’re very good at taking... instructions or orders... and so, to actually challenge that is quite difficult’ (T1 358-9). R3 talked about the entrenched nature of the ‘patient role’, and how this maintains the client’s positioning as a powerless ‘victim’ (R3 316-22).

For some clients, cultural and religious factors impacted on their ability to develop new relating styles: ‘the way they perhaps perceive their role within their culture might make it difficult for them to change their pattern of relating’ (T1 243-5). One female client felt that assertive relating was inconsistent with her perception of the role of women within her travelling family background (R1 102-5). Similarly, T3 reported that C3 had a Catholic upbringing, ‘which [C3] identified as... not really being very encouraging of answering back and questioning’ (T3 333-4).

T2 also spoke about the ‘functional role’ of the voice (702) in diluting the client’s sense of shame. In this way, this therapist highlighted that clients ‘not being ready to change’ (699-700) can be a challenge in therapy. Participants also described how the nature of the client group contributed to further challenges in bringing about change: ‘These are... complex clients in tertiary care settings with reasonably chaotic lives’ (T2 741-3). This was evident during the interview with C2a, for example as he struggled to remember the purpose of the therapy (C2a 216-219).

Theme 5: Impact of change

Despite the previously discussed challenges to change, most participants described changes since therapy. This large theme therefore reflects the way in which participants defined change or ‘outcomes’ from the therapy. C2a was the only participant who did not identify positive changes since therapy, so his comments are integrated in the sections below.

5:1 Voice-hearer relationship

Some participants described a change in the relationship with the voice, often with regards to power and sometimes proximity. This was supported by a few descriptions
by therapists of changes in scores on the numerical measures (see appendix 11 for examples). This sub-theme was absent in relatives’ accounts.

Participants described a shift in clients’ relating styles from attempted distancing to more assertive engagement: ‘I’ve been trying to run away from the voice all the time and I’ve learned to stand firm and fight back’ (C3 150-2). C2b also referred to a more ‘assertive’ style (649), and less attempts to ‘escape’ the Devil (152). This assertive relating style was commonly described as involving more engagement with the voice in terms of challenging rather than passively accepting its content (T3 570-2). For C2b, this improved communication with the voice (C2b 24) and ‘we’re not complete enemies anymore’ (C2b 697-8). C3 explained that the voice ‘runs out of steam’ (C3 140) when she responds assertively, then she can disregard him (C3 141).

Initially, clients were positioned as powerless victims in relation to critical, powerful voices (e.g. R3 43-5). Many participants associated assertive relating with an increase in clients’ power, for example feeling ‘slightly more in control, slightly more power, as if the relationship is becoming a slightly more balanced one’ (T2 259-60). This was linked to a parallel decrease in the perception of the voices’ power. Voices became ‘more nuisance than... powerful’ (R3 63), and ‘less important’ to the clients through therapy (T1 905). C3 summed up this parallel, reciprocal process of a shift in power within the relationship; ‘the more power I get, the less he has’ (C3 888). For one client, this shift in power was evident in the client feeling less compelled to comply with the voice’s commands (R1 32-6).

C2a did not express any changes in his relationship with the voice; ‘the voices are still very much the same. So it hasn’t really touched upon it’ (C2a 661-2). He continued to describe the voice as a ‘bully’ (39) with malevolent intent (89-91) and great knowledge (180) and power (184). When asked about his expectations about therapy, C2a said: ‘I thought I would get told about the whole conspiracy behind me. And then they would work with me on the real issues, you know’ (429-30): He described this as ‘the only therapy that I could see that would work’. (626-27) This was linked to the content of his voices: ‘my voices always tell me that... one day you’re going to know about it’ (438-9).
5:2 Acceptance of voices

Participants across all positions referred to the importance of clients coming to accept their voices. This was linked to a common idea that the therapy was novel in its goal to facilitate clients in living with voices (F3 762), rather than an approach that ultimately seeks to eradicate voices. Participants highlighted the role of power and control (R3 231-2) in enabling clients to learn to live with the voice (T3 849): 'with the therapy I've come to the conclusion that I might not be able to get rid of him. But I can control him, and I don't have to be depressed by him' (C3 262-4).

This change through therapy seemed consistent with the goals and views of participants. C2b commented 'there is definitely something good about accepting the voices' (C2b 523-4), 'I don't want to get rid of them, I don't feel like they should ever really die or anything' (C2b 768-9). F2 noted the importance of relatives 'coming to terms' (608) with voices too: 'I've come to the conclusion that it's not just going to be a miracle cure now... I think he's got to live with it' (F2 624-6).

5:3 Mental health and perceptions of self

Most participants identified changes in mental health as important outcomes from therapy. Clients were described as 'no longer as distressed or depressed' (R1 266-7), 'happier' (C2b 217) and showing a new 'brightness' in mood (F3 473). C3 reported that since therapy, she had experienced her longest period of time 'without illness' (C3 573-5). C2a's mother identified that 'he's definitely less paranoid' (F2 83-4) which was evident through him going out more. C2a said there had not been any changes in the way he feels (684).

Many participants talked about changes in clients' views of themselves. C3's therapist explained that 'her confidence seems to have grown' as C3 feels better about herself and her abilities (T3 832-4). Improved self-esteem reinforced changes in the relationship with the voice, as clients came to believe 'I have a right to set a boundary' (R3 309) or 'I don't deserve that' (T1 824). Changes in the relationship with the voice served to strengthen self-esteem: 'that gives me more confidence, more self-esteem, because I think I don't have to be... under the control of the devil
anymore. *I can just try and be myself* (C2b 723-6). Self-respect was described as evident in clients’ improved self-image (C3 860) and care about their appearance (F3 681-2).

Participants also referred to improved self-efficacy, for example the extent to which clients believe they can cope with problems (R3 482). Through therapy, clients developed ‘tools to deal with the voice’ (R3 484) which enabled them to feel ‘more able to deal with the voices when they’re bad’ (C2b 649-50). T2 described an increase in C2a feeling ‘he can change things, he can control things’ (T2 863-4), although this was not supported by C2a’s account.

### 5.4 Independence-seeking

Many participants agreed that therapy supported clients in seeking increased independence and engaging in meaningful activities. This theme was most present and central in the accounts of participants across cluster 3. C3 described a number of times where the therapy had given her the skills to cope with seeking more independence. For example, she previously avoided shopping as the voice told her that people were talking about her. However her new assertive style of relating facilitated her in challenging this idea, which gradually enabled her to start shopping more independently (C3 381-4). F3 also talked about his daughter seeking more independence and taking more responsibility (F3 736-7).

R3 and T3 emphasised that C3 had identified ‘ambitions’ (T3 856) related to teaching and training. T3 linked this to C3 feeling ‘more able to get on with them’ (857-8) as therapy had ‘broadened her repertoire of managing’ the voice (T3 790). R1 similarly related his client’s independence-seeking to increased self-efficacy, through being ‘able to establish a different way of managing the experience’ (R1 318-9).

F2 was pleased to notice her son taking more interest in working on his car; ‘it’s great to see him out there, doing things’ (F2 120). However over the last month ‘he just seems to have lost the interest in it’ (F2 520-21). This highlights the fluctuating nature of psychosis and the slowness of change (see appendix 11 for further examples of these sub-themes).
5:5 Social relationships

This sub-theme emerged in participants' descriptions of how the therapy had affected clients' social relating and subsequently relationships with family, friends and partners. T2 described how facilitating assertive relating to the voice had a 'ripple effect' on social relationships (T2 344) by clients applying the 'guiding principles of our conversations' to their life experiences (532-2). Some participants referred to clients taking more interest in social relationships, for example F2 talked about her son increasing engagement with friends and family (F2 576-9).

Many participants described clients becoming more assertive in their relating to others, and the impact of this on their positioning within social relationships. A significant change for both C2b and C3 was being able to say no within relationships: 'it gives me the power to say no without feeling guilty... I can choose what I want to do more, rather than... let him control me, and just be submissive' (C2b 663-5).

Participants highlighted the importance of being able to say no and set boundaries in relationships (R3 80), while 'feeling ok' and 'without losing the person' (T3 803). C2b added that assertive relating had improved conflict resolution between her and her partner (665-7).

Participants talked about the impact of developing an assertive relating style on their positioning within social relationships. R3 talked about the positioning of clients changing from 'victim and patient' to a more 'ordinary' role (R3 313-4). C2b similarly described a shift with her partner to more 'equal terms' (C2b 674). For F3, this shift in social relationships was about a return to C3's former self: He affectionately described the re-emergence of the 'bossy-boots' (F3 269) and was 'happy with the fact that we're getting my daughter back' (747-8).

Consistent with assertive relating, clients were described as being more open and able to ask for help from their family: 'I've learned to be, with the therapy, to be more honest and ask for help when I need it, rather than wait until its too late and I'm ill' (C3 450-2). F3 talked about C3 being more open about her voices (F3 183) and paranoid worries (562). The impact of openness was that her family could 'try and
point out what the solution is' (F3 195-6) or help her challenge her worries and 'allay her fears' (F3 640).

5:6 Hopefulness and the possibility of change
A further area of change identified by participants was regarding clients' views about the future. C3 felt that therapy had allowed her to 'face the future' more positively by helping her to 'face up' to her traumatic past (C3 521-2). C2b referred to the therapy giving her a 'more positive outlook on life' (752) by helping her use assertive responses to challenge the Devil's pessimism. Some participants associated hopefulness with increased independence seeking (T3 865-66) and self-efficacy (R3 432-3): 'before I thought I had no future. Whereas now I can see that with practice...I can get... [the voice] under control' (C3 737-8).

Therapists described the therapy as 'intrinsically optimistic' about the possibility of change (T1 874). Yet they recognised that, in the context of long-standing negative relationships with voices, clients might struggle to believe that things could be different (T1 873). In this way, strengthening the belief in the possibility of change was seen as a significant outcome from therapy: 'if we, over a space of a few short weeks, can work to a point where maybe change can be um conceived of...maybe that's actually something quite significant' (T2 744-7).

Outcomes of credibility checks

Firstly, the qualitative research group (of six trainee clinical psychologists) were given extracts of two transcripts, with my left and right margin comments. This meeting suggested that my interpretations were understandable and verifiable, and stimulated interesting discussions about connections across themes, drawing my attention to new perspectives on the data. For example, our discussions suggested that the notion of 'seeking independence' was more grounded in the data than my preliminary theme title of 'gaining independence'.

A university supervisor cross-checked a transcript (with my left and right margin comments) with the list of preliminary superordinate themes. My analysis was
described as coherent, as superordinate themes could be meaningfully linked to the transcript account. This process enabled me to consider new ways of defining and connecting categories, not so much introducing new interpretations, but refining my theme titles. For example, improvements in self-efficacy, self-esteem and self-respect were collapsed and redefined as changes in 'perceptions of the self'.

Finally, eight members of the qualitative research group were asked to assign twenty four quotations to the relevant sub-theme, or if unable to do so, to the relevant superordinate theme from the master list (appendix 10). This process revealed that quotations were correctly matched to their sub-theme 82% of the time, and were matched to the correct superordinate theme 90% of the time. We discussed the fifteen occasions on which the quotation was incorrectly matched, and with further description of my themes, the trainees agreed that the quotation was meaningfully linked to the theme.
DISCUSSION

Overview of discussion

I will now discuss the results of the study in the context of the research questions, relevant literature and my clinical experience. I will then critically evaluate the strengths and limitations of my research design and analysis, and highlight areas for future research. Finally, I will consider the clinical implications of my study.

Discussion of results

Research aims and questions
The aim of my study was to further explore the experience, process and usefulness of a pilot of ‘relating therapy’ from multiple perspectives. It is hoped that the results have addressed the research questions by exploring how the therapy was experienced and understood, by outlining aspects of therapy that were important in bringing about change, and by illustrating how change and usefulness was defined by participants.

The results suggest that the therapy can be understood as a process of engaging with the relational model and the therapist (as reflected in the superordinate themes ‘engaging with the relational framework’ and ‘therapists’ approach’), developing understanding, introducing difference (manifested in the superordinate theme ‘developing a new relating style’) and ultimately bringing about change. The results indicate that most participants experienced and understood the ‘relating therapy’ as a helpful and positive process (evident in the superordinate theme ‘impact of change’), despite the ‘challenges to change’ that have been described. The exception was C2a, who did not describe any positive outcomes from therapy, and this will be discussed in the context of relevant literature below.

Not all participants described therapy as unfolding through a sequential or linear process of engagement, bringing about change, and the impact of change (in the context of the therapists’ approach and challenges to change). I interpreted their accounts within this structure, consistent with descriptions of the process of therapy
across varying models (e.g. Byrne et al., 2006; Lemma, 2003). Participants’ accounts frequently connected themes together, and these links between superordinate themes are presented diagrammatically in figure 2.

Figure 2: Diagram of the inter-relationship between superordinate themes

The interpersonal nature of voice hearing
The results of my study are consistent with literature outlined in the introduction that highlights the interpersonal nature of the voice hearing experience. Participants’ accounts suggest that the idea of a relationship with the voice is a meaningful, understandable and intuitive concept. This was reflected in the sub-theme ‘an intuitive model of voice hearing’, and in the way that participants talked about voices as personified entities, with knowledge, intent, and a history of interaction and dialogue that commonly positioned the voice as powerful and intrusive, and the hearer as powerless and distancing. These relational aspects of the voice hearing experience are similar to those described in previous research (for example Leudar et al., 1997; Nayani & David, 1996) and fit with my own clinical experience.

Participants’ accounts about relationships with voices were consistent with Birtchnell’s (1996, 2002b) model of negative relating (within the domains of power and proximity), and his suggestion that ‘unversatile others’ (such as a voice) can cause distress by imposing negative inter-relating or denying positive relating (Vaughan &
Fowler, 2004). Furthermore, the sub-theme ‘an intuitive model of voice hearing’ demonstrates the ease with which participants identified similarities between social relationships and the relationship with the voice. This is consistent with literature presented in the introduction, for example studies by Birchwood et al. (2000: 2004), and Hayward (2003). The study therefore adds tentative support to the meaningfulness and usefulness of conceptualising the voice hearing experience within a relational framework.

Relating therapy
This study also suggests that therapy that aims to modify distressing relationships with voices may be of benefit for some voice hearers. Accounts about the process of bringing about change seem congruent with existing literature that suggests that increased dialogical engagement with the voice can contribute to positive outcomes (for example, Davies et al., 1999; Leudar et al., 1997; Nayani & David, 1996). Participants talked about developing a new assertive relating style, through drawing on positive relating styles, assertiveness training and trying out new responses by bringing the dialogue with the voice into the room (reflected in ‘developing a new relating style’). This process of learning to relate differently promoted assertive engagement with the voice, rather than passive acceptance and subservience, or resistance through shouting, avoiding and attempting to escape (Chadwick & Birchwood, 1994).

In this way, the results of the study are consistent with Birtchnell’s (2001: 2002b) therapeutic framework, which aims to modify negative inter-relating within the domains of power and proximity. Within this framework, the ‘relating therapy’ can be understood as encouraging clients to take a positive ‘upper’ position (within the power domain), that involves less distancing and more involvement and engagement with the voice (within the proximity dimension). As well as modifying relating styles, Birtchnell (2001) also proposed that relating therapy should help clients to tolerate others’ negative relating styles (as described in the introduction). Participants’ accounts within the sub-theme ‘developing understanding’ are consistent with this proposition, as therapy was described as enabling clients to consider new understandings and interpretations of the voice’s negative relating.
Comparison with CBT
At times, therapists' accounts of the process of bringing about change were situated in a comparison with CBT (as reflected in the sub-theme 'therapists' use of the model' outlined in appendix 11). Within the sub-theme 'assertiveness training', therapists compared aspects of assertive relating to the disputation of negative thoughts that is central within CBT (e.g. Padesky & Greenberger, 1995). This is consistent with literature that highlights the similarity between the nature and content of voices, and negative thoughts in depression (Gilbert et al., 2001).

However, therapists' integration of CBT ideas was consistently framed within an interpersonal context. This was evident in their use of relational language and recognition of the inherent reciprocity within the relationship with the voice (for example within the 'bringing the dialogue into the room' sub-theme). This is different to traditional CBT for voices, which may encourage disputation of beliefs about voices (e.g. Chadwick et al., 1996), but does not traditionally value dialogue with the voice. However Chadwick's (2006) new person-based cognitive therapy model goes some way in bridging this divide, by including elements of two-way dialogue within role-plays between the voice hearer and the therapist.

Participants were clear that the process of bringing about change did not necessarily entail challenging the reality of clients' experiences, as reflected in the sub-theme 'non-judgemental about 'psychotic' experiences'. This is in contrast to literature regarding the goals of CBT for psychosis. For example, Chadwick et al. (1996) emphasised that challenging beliefs about voices should inevitably weaken clients' 'delusions' about the identity of the voice (for example a belief that they hear the Devil) and thereby improve 'insight'. McGowan et al. (2005) also highlighted the centrality of challenging the reality of 'psychotic' beliefs and encouraging a new model of reality (consistent with the therapist's). Messari and Hallam's (2003) qualitative study suggested that voice hearers are commonly aware of this 'ultimate agenda' despite therapists not discussing it explicitly with them. In my study, therapists' accounts about this difference to CBT were consistently positively framed, as exemplified by this additional quotation:
'I think it doesn't challenge at all... it stays in that respectful, this is your experience, and doesn't seek to kind of challenge or question it in a way that I would perceive that the cognitive behavioural approaches... would maybe get to the point of being slightly more challenging of the clients' view, and ask them to consider the possibility of changing their view of the experience' (T2 456-64).

How is change defined?
The advantage of this type of qualitative research is that significant outcomes or changes can be defined by the participants themselves. This is in contrast to quantitative research in which the researchers tend to define the outcomes on which change can be measured. For the purposes of clarity, I have presented six sub-themes that represent the differing ways that change was constructed or defined by participants. However, their accounts suggest that these are not discrete 'categories' of outcomes, but rather there are meaningful links and connections between these changes. For example, T3 described the links between the improved relationship with the voice, self-efficacy (perceptions of self) and independence seeking: 'she's doing quite a lot of teaching people now. And that was very difficult for her, because of the stress of standing in front of people I guess, that the voice would start saying the most disruptive, derogatory, off-putting things that it possibly could. And it's broadened her repertoire of managing that I think' (T3 786-90).

Participants' descriptions of the inter-relationships between positive outcomes are illustrated diagrammatically below (figure 3). At the centre of all these outcomes, contributing to each positive change, is the improved relationship with the voice.
It was interesting to note that C2a was the only participant who did not identify positive changes from therapy. As the results suggest, C2a expected or hoped that therapy would validate the reality of his beliefs about a conspiracy against him, and help him deal with the subsequent situation. His therapist T2 talked about being non-challenging of his client's beliefs, but was clear that he understood the task of therapy as facilitating C2a in relating differently to the voice. McGowan et al. (2005) reported that the presence of a shared goal between clients and therapists differentiates between those that do and do not progress through therapy. They also reported that clients who do not progress tend to struggle to recall and elaborate on aspects of therapy. This mismatch in the goals of therapy, and difficulty recalling and describing aspects of the therapy, seem applicable to C2a's situation.

**The therapeutic relationship**

The results also fit with existing research that highlights the link between the therapeutic relationship and positive outcomes from therapy (e.g. Horvath & Symonds, 1991). The superordinate theme 'therapists' approach', and the sub-themes 'openness and honesty' and 'developing understanding', illustrate that participants valued the person-centred, empowering, supportive and empathic approach of therapists, in bringing about change. Collaboration was also emphasised within many
of the themes, for example working together to identify assertive responses. These accounts resonate with my own experience of important aspects of the therapeutic relationship, and are congruent with other qualitative studies that have explored what clients value in therapy, outlined in the introduction (Campbell, 1997; Kuehl et al., 1990; Lietaer, 1992).

There may be additional challenges to engaging people who experience psychosis in a therapeutic alliance, reflected in aspects of the superordinate theme ‘challenges to change’. For example, clients’ accounts about the risks of openness to the therapist may be understood as an obstacle to the therapeutic relationship. Additionally, literature suggests that the prevalence of memory and attention problems within this client group (e.g. Hoff & Kremen, 2003) may affect their capacity to engage with a therapist (Lakeman, 2006). Chadwick (2006) also refers to possible anti-collaborative assumptions (of therapists) that may hamper their ability to build a relationship with people who experience psychosis. Despite these potential challenges, participants’ accounts suggest that therapeutic relationships were formed, and indeed contributed to the process of bringing about change. This is consistent with literature that demonstrates a significant association between the therapeutic relationship and positive changes amongst people who experience psychosis (e.g. Frank & Gunderson, 1990; McCabe & Priebe, 2004b).

Differences across positions
Caution should be taken in comparing differences across positions, due to the small numbers of participants within each position.

The superordinate theme ‘developing a new relating style’ (concerning the process of bringing about change) was not consistently or strongly represented in the accounts of relatives and referrers. It seems likely that this is related to further sub-themes outlined in appendix 11: ‘Therapy is confidential’ emerged as an important sub-theme amongst participants within these positions, and this might account for the apparent lack of awareness of the nature of the therapeutic intervention. In addition, ‘relatives’ understanding of therapy’ highlights that relatives talked about the ‘active ingredients of therapy’ (Dallos & Vetere, 2005) in a fairly superficial manner.
Despite their apparent lack of connection to the therapy process, I feel that it does not take away from the value of involving these positions within my sample, evidenced by their rich accounts within other superordinate themes. Additionally, it raises questions about the extent to which referrers should be in dialogue with therapists about psychological interventions; and the extent to which therapy with people with psychosis should be situated in a broader process of family work. Evidence suggests that families and clients benefit from family interventions during the process of recovery from psychosis (e.g. Pilling et al., 2002; Winefield & Burnett, 1996). Consequently, the NICE guidelines for schizophrenia (2002) recommend that family interventions should be offered when clients are in contact with ‘carers’.

There was a small but interesting difference across positions in the extent to which therapists were positioned as ‘experts’: Relatives talked about the importance of therapists being experienced in working with people with psychosis (i.e. being an expert e.g. F2 219), yet therapists talked explicitly about the significance of positioning themselves as non-expert, and clients valued being given choice, control and empowerment. Based on my clinical experience, it seems possible that relatives’ views of therapists may have been linked to expectations based on contact with medically oriented mental health professionals (who may be positioned as experts). For the purposes of this therapy, I would speculate that the therapists’ ability to be both knowledgeable and curious to learn was important.

**Critical evaluation**

There are a range of limitations and potential biases that may have affected the research process and the utility of the results. These can be linked to issues associated with sampling, data collection, my position as researcher, the selection of themes, and further issues of validity in qualitative research (e.g. Elliott et al., 1999).

**Sampling**

The sample were selected on the basis that they were involved in the ‘relating therapy’ pilot and would therefore have some views about its experience and usefulness. Thus
there was homogeneity within the sample to the extent that all participants were relevant to answering the research questions (Smith & Osborn, 2003). Yet the sample was very broad in that participants varied greatly in positioning, age, employment and other contextual factors. This seems appropriate in an exploratory study that seeks to develop understanding about a novel form of therapy and generate further areas for exploration (Dallos & Vetere, 2005). However this issue, combined with the small number of participants, does reduce the extent to which the results can be generalised beyond this sample.

Clients who agreed to participate in the ‘relating therapy’ pilot may be different to those who did not. Clients had to meet the inclusion criteria for the therapy pilot (table 1 in the method, p.154), so for example their experiences were not linked to organic illness. Perhaps the clients that agreed to participate were more likely to have had positive experiences of contact with mental health professionals. One client refused to participate in my study, which they linked to their anxiety. It might therefore be hypothesised that participants who agreed to take part in my study were more confident or felt more positive about therapy. These hypotheses are speculation, but highlight that recruitment and sampling biases are likely to limit the extent to which the findings can be generalised to other people and contexts (Barker et al., 2002).

**Data collection**
The design of the interview schedule was guided by the research questions, and this inevitably influenced the data that was obtained (Dallos & Vetere, 2005). My interview schedules (appendix 3) included many prompts that were intended to remind me of possible areas for exploration. Often they were not required as participants spontaneously provided relevant information, and I was able to let them guide the discussion. C2a did require more direct questioning and prompting, so I was careful in choosing quotations that had not been overly led by my questioning.

A disadvantage of interview data is that some information may be lost through the process of transcribing, for example body language and tone of voice. Furthermore, participants’ voices were momentarily inaudible an average of three times per transcript. Retrospective interviews also rely on participants’ ability to recall past
events. This issue is perhaps more pertinent when interviewing people who experience psychosis and may be more likely to experience memory problems (e.g. Hoff & Kremen, 2003). However, all clients had completed therapy within the last four weeks, and the advantage of retrospective interviews is that participants can express their impressions and views of the therapy as a whole.

Practical constraints (such as time and word limits) prevented the use of multiple methods of data collection, which may have overcome some of the above limitations. This will be considered in the context of future research below.

My position as researcher
Outlining my position as researcher (appendix 2) facilitated the process of ‘owning one’s perspective’ (Elliott et al., 1999) and my personal reflexivity (Willig, 2001). My positioning as a mental health professional may have impacted on dialogue with participants during interviews. For example I noticed that I used more psychological jargon with therapists and referrers. Their accounts suggested that I was experienced as an ‘insider’, for example in their assumption that I would be familiar with the acronym CBT (R1 145), and reference to ‘Romme’s work’ (T3 626). I also felt that clients’ and relatives’ accounts might have been affected by my positioning as a trainee psychologist. For example, C2a and C2b talked about their experiences as ‘real’ rather than imaginary or ‘illness-related’, and relatives tended to frame professional input in a positive light (appendix 11). Perhaps these elements of the interview content would have been different if I was not positioned as a mental health professional.

The process of interpreting the data was also likely to have been influenced by my positioning, experiences and interests. For example, my theoretical affiliation with CBT might have contributed to me paying more attention to accounts comparing CBT with the relational model. It is also likely that my interest in systemic ideas may have led me to value wider definitions of outcomes from therapy. Another researcher may have focused more on intra-psychic descriptions of change. My familiarity with Birtchnell’s (1996, 2002b) model of relating also contributed to increased sensitivity
to conceptualising the process of bringing about change within this model. However, I was continually mindful of ‘grounding interpretations in examples’, discussed below.

Selection of themes for presentation

The strategy for selecting which themes to present, and which to abandon (as outlined in the results section) will now be critiqued. The issue of judging the extent of relevance to the research question is complex, as most abandoned themes could be argued to be important. In the context of space limitations, I felt that ‘external factors affecting change’ (appendix 11) were less relevant than the superordinate themes that were presented, but clearly another researcher may have appraised this differently.

Abandoning a theme on the basis of the frequency and richness of accounts supporting the theme might be criticised on the basis that I was arguably more likely to follow-up participants’ accounts if I judged them to be relevant to the research question. This may have meant that participants did not have the opportunity to elaborate on areas that may have initially seemed irrelevant (such as ‘other treatments and other professionals’), but may have transpired to be illuminating about therapy (for example by comparing valued aspects of previous treatment to the ‘relating therapy’ pilot). The additional strategy of considering the extent to which a theme could be related to existing literature and clinical experience might be criticised because novel ideas and perspectives (that may be idiosyncratic but could broaden understanding) might be missed.

As is inevitable with qualitative research, the interviews generated a vast amount of interesting data. I therefore experienced the process of abandoning themes as challenging and frustrating. Yet it would not have been possible to present all the themes in enough detail to have done them justice. I therefore used a pragmatic and realistic strategy for selecting which themes to present. Furthermore, I hope that providing a list of all themes in appendix 11 (with example quotations of themes that were not presented) helps readers to consider what may have been lost.
Further issues of validity

Throughout the presentation of the results, interpretations were ‘grounded in examples’ (Elliott et al., 1999) as themes were linked back to quotations from participants’ transcribed accounts. This allows the reader to evaluate my interpretations and consider possible alternatives. The example extracts in appendix 9 should also facilitate the reader in understanding my interpretations and how some of the superordinate themes were identified. Including a whole transcript would have also contributed to this process. However, as this report will be stored within the public domain, it seemed inappropriate due to the risks of participants identifying each other.

The process of ‘providing credibility checks’ (Elliott et al., 1999) contributed to confidence in the validity of my results, and enriched my understanding and development of the themes. The process of matching quotations to themes suggested that my interpretations were meaningfully and understandably linked to the data. Gaining multiple perspectives can in itself be considered a useful approach to exploring credibility, as a form of triangulation (Dallos & Vetere, 2005). There was some degree of consistency in emergent themes across positions (evident in table 3 of the results, p.163), and my understanding of the experience and usefulness of ‘relating therapy’ was certainly enriched by different perspectives on the same phenomenon.

Some authors of qualitative studies ask participants to feedback their views about the themes, a process known as respondent validation (Dallos & Vetere, 2005). However, Henwood and Pidgeon (1992) highlight that such an approach to validation inappropriately suggests that the researcher is aiming to represent an ‘objective truth’. IPA is an interpretative process, so arguably one would expect that different individuals’ analyses would generate differing themes. The credibility checks that I used were more focused on exploring the extent to which my analysis and results were understandable and coherent, rather than investigating whether my interpretations of the data matched those of others. Furthermore, Henwood and Pidgeon emphasise that discussions about results often occur in the context of a power differential between the researcher and researched, which may subsequently influence participants’ feedback.
Yet it is still important involve participants in the dissemination of the results. Following submission, I will post a summary of the study (with findings and implications) to participants who requested it. I will invite them to contact me if they would like further information, or the opportunity to discuss the research.

Elliott *et al.* (1999) also discuss ‘accomplishing general versus specific research tasks’. The specific task of my research was to understand these ten participants’ experiences and views of this pilot of ‘relating therapy’. A more general aim was to add to the growing awareness and understanding of relationships with voices, and to offer some ideas about the experience and usefulness of this type of therapy. I was aware from the start that it would not be possible to generalise the results and conclusions to all voice hearers in all contexts, due to the limitations outlined above.

**Future research**

Research into the interpersonal nature of voice hearing is at a relatively early stage, and this ‘relating therapy’ pilot is the first application of Birtchnell’s (2002b) therapeutic framework to the voice hearing experience. Therefore the first recommendation for future research, which might contribute to addressing issues of validity within this study, is replication of the therapy pilot and current study, using the same methods and design. If similar findings emerged about the experience and utility of this approach, this would strengthen the external validity of the conclusions drawn from this research.

The second recommendation for future research is ‘constructive replication’ of the current study (Barker *et al.*, 2002, p.237). This would involve replication of the therapy pilot, but would use different measures or a different population. Issues and biases associated with the use of interviews in this study might be addressed by using multiple methods of data collection and measures of change. This could include interviews and questionnaires before therapy commences (about expectations, hopes and fears), at different stages of therapy (possibly utilising observation of videotaped sessions), and after therapy is completed (to explore overall views and outcomes). My study has identified potentially important outcomes that could be explored as
hypotheses in future studies. It would be interesting to investigate whether these outcomes would be replicated, and observable on quantitative measures.

Replication with different populations would firstly contribute to further understanding about the range of situations or people to which this therapy might be most helpful. This could involve comparing how meaningful and useful this framework is deemed to be by voice hearers with different characteristics (such as different backgrounds, explanatory frameworks and different voice characteristics). Such an approach would contribute to addressing the issues concerning the broad nature of the sample in the current study. It would secondly assist the investigation of the hypothesis (from this research) that conceptualising the voice hearing experience as a relationship may be normalising, hopeful and helpful for some clients. These types of ‘constructive replication’ would offer more information and understanding about this new form of therapy, and contribute to strengthening the validity of the findings from this study (Dallos & Vetere, 2005).

Clinical implications

Despite the limitations and need for future research that have been outlined, this study does offer some important but somewhat tentative clinical implications. Firstly, the study suggests that conceptualising the voice hearing experience within an interpersonal framework, and indeed within Birtchnell’s (1996, 2002b) model, is intuitive, meaningful and normalising for some. It is not possible to conclude that all voice hearers would benefit from such a framework for understanding their experiences, due to the small sample and limitations outlined above. Furthermore, if there is a mismatch (between therapist and client) in their models for understanding psychotic experiences, this may jeopardise the therapeutic relationship and lessen treatment satisfaction (McCabe & Priebe, 2004a).

The study suggests that an interpersonal understanding of voice hearing may facilitate dialogue between some therapists and some voice hearers, and subsequently the development of shared formulations. This process may be assisted by paying attention to relating styles, and recognising the likely parallels between relationships with the
voice and social relationships. In the context of previous research (e.g. Vaughan & Fowler, 2004), this study adds support to the notion that exploration of the relationship with the voice might be usefully integrated into some assessments of voice hearing, to further inform areas for intervention.

This study offers tentative support for the utility of a therapeutic framework that explores and modifies relationships with voices. It suggests that some voice hearers may benefit from the application of Birtchnell’s (2002b) therapeutic framework, to address negative and fixed relationships with dominating and powerful voices. Clinicians may support voice hearers in increasing dialogue with the voice and developing a new assertive relating style from a position of increased power. Again, it is unlikely that this therapeutic approach would be helpful for all voice hearers. Indeed McGowan et al.’s (2005) study stressed the importance of having a shared therapeutic task between therapist and client. For example, this therapy may not be helpful for voice hearers who wish to eradicate the voices, or challenge the validity of this experience.

This study also highlights that voice hearers are likely to experience disempowerment in many relationships, but may be able to draw on previous positive experiences of relating. This emphasises the importance of therapists acknowledging and utilising clients own resources, while remaining mindful of possible challenges to change. In addition this research implies that clinicians must continue to pay attention to the therapeutic relationship, and recognise that some voice hearers will value a non-judgemental approach that does not challenge the validity of their experiences.

This study points to possible positive outcomes from this therapy. While it is difficult to specify causality, participants’ accounts highlight the centrality of modifying the relationship with the voice, in bringing about and defining positive change. A further clinical implication is that clients (and their networks) should have the opportunity to define meaningful outcomes for themselves. The study suggests that ‘symptom reduction’ was not relevant to these participants, and while a reduction in distress was important, it was observed to occur in the context of a number of other significant changes. This might imply that measures of change that focus on changes in voice
activity and simple measure of distress (e.g. the Psychotic Symptoms Rating Scales, Haddock et al., 1999) may not be sufficient to capture other valued aspects of change.

Finally, at a service level, this study contributes to a growing awareness of the value of moving away from traditional medical conceptualisations of voice hearing, towards more psychological, recovery-oriented and person-centred understandings. The findings are consistent with the view that talking about (and to) voices is likely to benefit voice hearers in a range of ways. A further service implication is that clinicians should remain mindful of, and potentially promote, connection with the family and professionals within the clients’ network of support. Such an approach therefore acknowledges the systemic notion of the ‘inter-subjective nature of human experience’ (Dallos & Vetere, 2005, p.99). This study highlights that relatives and referrers may not feel informed about specific interventions (which may or may not be appropriate depending on individual contexts), yet they may have important views about clients’ experiences, care and management. This study therefore supports the move within the NHS to achieve further involvement of service users and ‘carers’ in evaluating and developing services.

Personal reflections
I have felt that the process of conducting this research has had an impact on my own clinical work. I have become more aware of disempowerment amongst people who experience psychosis, both in terms of relationships with voices, and in their relationships to wider society. Specifically, the conceptualisation of voice hearing within a relational framework has encouraged me to be more aware of acknowledging the power struggle with voices, helping clients to feel that their experiences can be understood within a normal and meaningful framework, and the importance of drawing on clients own resources and resiliency when developing interventions.
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Appendix 1:

THERAPY PROTOCOL

A STUDY EXAMINING WHETHER A TALKING TREATMENT CAN HELP PEOPLE WHO ARE UPSET BY THE VOICES THEY HEAR

Background & aims

Over the past fifteen years there has been an increasing awareness within the psychosis literature of the patterns of relating between 'voices' (auditory hallucinations) and the individuals who hear them. It has become evident that voices can be related to in ways that are similar to relationships with people within the 'real' world. Understandings of relationships with voices have focussed primarily upon issues of power and dominance, and have lead to the development of new forms of Cognitive Behaviour Therapy (CBT) (Byrne et al, 2003). More recently, a new theory of interpersonal relating (Birchennell, 1996, 2002) has been used to explore issues of proximity (closeness-distance) within relationships with voices (Hayward, 2003; Vaughan & Fowler, 2004). The purpose of this study will be to pilot a new form of cognitive therapy, informed by relating theory, that has the potential to modify the relationship with the voice with respect to both power and proximity. Such changes within the relationship with the voice will be associated with reductions in the voice hearer's level of distress.

PRELIMINARY PHASE

Suitability for the trial.
Voice hearer who has experienced voices for at least 12 months irrespective of diagnosis, excluding organic illness and drug induced psychosis. Participants may experience one or multiple voices but will have a perception of a predominant voice. The relationship with their voice will be causing them distress but the individual will not be acutely unwell and will be deemed capable of giving informed consent. Hearer to have had experience of speaking about their voice hearing. Those individuals with insufficient command of English language skills to undertake a verbally based therapy will be excluded.

Recruitment.

- Obtain permission to proceed with the research project from ethical committees and three trusts involved.
- Liaise with RMO's and Mental Health Care teams in local areas to take necessary steps to make the research and therapeutic process transparent.
Initial referral and recruitment to the trial, via care teams: the teams will identify possible participants and speak with the client. If the client is interested, they will be offered the opportunity to meet with one of the investigators.

Investigator will meet the client to discuss the trial in detail and provide information sheet.

If the client volunteers to participate then informed consent will be obtained after a minimum 48hr period of consideration time.

Plans will be discussed with the participant and their care team to manage risk in the event of increased distress.

Phase A: ASSESSMENT

Preliminary discussion will facilitate identification of the predominant voice that will be the focus of some of the measures and subsequent therapy.

Baseline assessments — to be conducted at two sessions

- Psychotic Symptoms Rating Scale (PSYRATS) Auditory Hallucination sub-scale (Haddock et al 1999) to assess dimensions of voice hearing experience incl. distress, frequency, and duration.

Baseline assessments — to be conducted at one of the two baseline sessions

- Person’s Relating to Others Questionnaire (PROQ2) — revised versions of Birtchnell’s (2002) measure of general (social) relating.
- BAVQ-R (Chadwick et al, 2000). 35 item revised edition of a reliable and validated scale to elicit and measure beliefs about the voice.

Ongoing assessments.

A numbered analogue scale representing Birtchnell’s two axes of relating, developed specifically for the purpose of frequent ratings, ease of completion and user acceptability, will be completed at each session.

The VAY and PSYRATS measures will also be scored on alternate sessions to map changes across the process of therapy.

Following baseline, the scores generated by the VAY and PSYRATS will be assessed to ensure sufficient levels of negative relating and distress to progress to therapy.
Phase B: ENGAGEMENT

Session 1. DEALING WITH FEARS AND DISTRESS
- Explore feelings associated with talking to therapist about the voice – include previous experience of talking about the voice and beliefs about consequences.
- Assess fear associated with relating to the voice differently.
- Safety planning - current forms of coping, relapse signature, what to do in the event of increasing distress.

Session 2. SOCIALIZATION AND GOAL SETTING
- Rationale for intervention - viewing the relationship the person has with their voice(s) as relational, acknowledging the individual’s perceived lack of power in relation to the voice and drawing comparison with, and noting similarities to social relating. Suggest that if relationships in life can change, then so might the relationship with the voice/s.
- Moving away from an illness model, to one of acknowledging the significance and possible benefits of voice hearing, but aiming to reduce the distress of the voice hearing experience by working with the client on the relationship with the voice and/or relationships it may represent.
- Using Birtchnell’s (1994) positive and negative characteristics within the Interpersonal Octagon to show how relationships with the voice/s and people can develop and be maintained.
- Discussion of the process of therapy through its various phases.
- Elicit individual goals for change.

Session 3-4. EXPLORING RELATIONSHIPS
- Use the ‘Cognitive Assessment of Voices’ (Chadwick & Birchwood, 1994) semi-structured interview to create an opportunity for the person to talk in greater detail about their experience of hearing voices.
- Use a genogram to explore individual’s experience of interpersonal relating within the family. Extend exploration to social network, identifying any prominent themes, e.g. abuse, disempowerment, rivalry, etc.
Sessions 5-6. ACKNOWLEDGING THE INFLUENCE OF THE PREDOMINANT VOICE

- Assess fear associated with changing the pattern of relating to the predominant voice e.g. moving away from distant relating to create greater closeness to the voice. What would the hearer like to say to the voice and what would be the consequences of doing so? What is the evidence to support those expectations?
- Acknowledge the likelihood of the voice ‘resisting’ attempts by the hearer to relate to it differently. Reinforce the therapeutic space as a place where hearer can safely try out different responses + be validated in attempts to do so outside this space + be encouraged to persist when initial attempts at change are not successful. Educational aspect regarding the role of the hearer’s relating style in the maintenance of a distressing relationship. Continue to assess influence of the voice within the individual’s life: in relation to spouse, family, neighbourhood, mental health services, etc.
- Begin to develop interpersonally based formulation of voice hearing experience. Develop individualised interpersonal octagons to demonstrate reciprocity of relational pattern, using data from VAY and the genogram.

Phase C: EXPLORING A DIFFERENT WAY

Sessions 7 – 12:

Structure for each session.
- Assess current emotional state and ability to engage in the session.
- Review of the week: focused on voice activity and where relevant using review of homework task.
- Administration of appropriate measures (visual analogue plus alternately VAY and PSYRATS). Consider regular review of goals.
- Recap of the last session (and possible review of VAY results)
- Agenda setting.
- Therapeutic task
  - Working with the voice.
  - Working with a social relationship.
  - Using empty chair or assertiveness techniques.
- Summary of session and homework setting.

Therapeutic task
Bring the voice or its dialogue into the room and explore current responses of the hearer and possible alternatives that are consistent with relating differently. Be mindful of:
- Raising awareness of the meaning of voice utterances as this will need to precede relating differently.
This meaning could possibly connect with previous abuse or unhealthy ways of being related to. Such relationships may then form the focus of therapy and have a subsequent influence upon the relationship with the voice.

Likelihood of the voice ‘resisting’ attempts by the hearer to relate to it differently. Emphasize the value of therapeutic space as place where hearer can safely try out different responses.

Methods for exploring dialogues with the voice may include:

Role-play – use of an ‘empty chair’ that represents the voice or possibly an individual in the client’s life with whom they have or have had a problematic relationship.

Hearer may sit in this seat to role-play the voice and get a sense of the extent to which his/her responses reinforce the dominant and/or intrusive relating of the voice. Also, the potential for exploration of the motives, behaviour and agenda of the voice and the subtle way it encourages responses that maintain its power and scope for intrusion. Hearer can also play themselves and develop a greater awareness of their role in maintaining the fixed and distressing pattern of relating. Possible use of circular questioning to highlight interactional nature of relationship and the possible inaccurate inferences of the voice e.g. ‘What does the voice say that makes you think you are stupid? What would ‘X’ say? If you challenged the voice, who would be the first to notice?/ the most surprised?/ the most worried?’.

Conversations that involve relating to the voice differently can be explored creatively.

Assertiveness techniques – how can the needs of the voice and the hearer be met? Possible role for negotiation. Possibility of piloting these techniques on social relationships. These techniques may need to be explored prior to any dialogue with the voice, in order to reinforce ‘armour’ that may be removed as the protective function of the voice is challenged.

Session 13. WHAT’S CHANGED?

- Re-administration of all measures.
- Review of process and goals.
- Negotiation of ending or continuation of therapy for a maximum of 12 further sessions.

Phase D: FOLLOW UP
Re-administration of stated measures at one month and three months.
REFERENCES


6th January 2005
Appendix 2:
My position as researcher and interpretative stance

I am a 26-year old, female, white British trainee clinical psychologist. I developed an interest in psychosis during my work on an acute psychiatric ward prior to my training. My perception was that people experiencing psychotic phenomena such as voices and visions (hallucinations) and unusual beliefs (delusions) were actively discouraged from discussing these experiences, despite them understandably being a major cause of distress. I felt that this was linked to the traditional medical approach to psychosis, which aims to eradicate these ‘symptoms of mental illness’ through pharmacological treatment. This served to instil a sense in which talking about voices, visions or unusual beliefs was ‘colluding’ with the illness, and thereby preventing patients from ‘getting better’. It seemed to me that this approach was disempowering to service users and contributed to stereotypes and stigma around notions of ‘madness’. I was drawn to these individuals on the ward, wanting to understand the complexities of their experiences. I believe my interest in this area was also strengthened by the experience of a close friend’s sibling who was living with a diagnosis of ‘schizophrenia’. Throughout my training, my interest in working with people with severe and enduring mental health difficulties has grown as the opportunities have arisen. I would describe my approach as empathic, validating, curious and person-centred.

These experiences and attitudes contributed to my selection of a research project that involved gaining understanding of the experiences of people with psychosis. My experiences and views also mean that I entered into the process of data collection and analysis with possible assumptions and biases: For example, perhaps a bias towards noticing positive experiences of the therapy and a particular interest in accounts that describe the therapy as person-centred, validating or accepting. My positioning in relation to each participant was also interesting and potentially important. Individual participants were likely to vary in the extent to which I was perceived to be an ‘insider’ or ‘outsider’. For example, therapists and referrers were more likely to consider me an ‘insider’ in my
Major Research Project

positioning as a mental health professional. Clients and relatives might be more likely to consider me to be an ‘outsider’ in this respect, but perhaps my attitudes towards the importance of advocating service user views would contribute to some degree of ‘insider’ status.

In relation to the theoretical framework on which the therapy is based (e.g. Birtchnell, 1996: 2002b), my position during data collection and analysis was that I had some familiarity with Birtchnell’s theory and the modified therapy protocol used in the pilot with people who hear voices. I did not immerse myself in reading about Birtchnell’s model, as I felt I could then be more open to representing individual participants’ understandings of the approach. Despite this, I recognised that my knowledge of Birtchnell’s model and indeed other psychological theories would colour my interpretation of the interview data. In terms of my theoretical orientation, I have most interest and experience in cognitive behavioural approaches (CBT), but value the integration of systemic ideas and narrative models. Most of my experience of working with people who experience psychosis has been within a CBT framework. However at times I have struggled with the goals of CBT, which ultimately may aim to challenge the reality of individuals’ experiences. Leudar and Thomas (2000) describe this as privileging the therapist’s explanatory framework, in a way that may deny the personal truths of the client.
Appendix 3:
INTERVIEW SCHEDULE - CLIENTS

- Thank you for agreeing to take part in this study
- Have you read the information sheet? Do you have any questions?
- Please read (and ask any questions) then sign the consent form
- Remember that participation is voluntary: so you can request that we stop the interview at any point, or choose not to answer any question(s).
- Complete Background Information Sheet
- Check microphone
- Inform that might need to turn tape over

- In this interview I will start with some general questions about your experience of hearing voices.
- Then I will ask about what you think of the therapy that you have had.
- Finally I will ask about any changes that might have occurred following therapy.

General Questions

1. How many voices do you hear?

2. Which voice have you been working with in therapy?
Prompts: Whose voice do you hear? Name, gender, age etc.
   * How would you like me to refer to the voice / shall I call it by name?
   * When / how often do you hear it?
   * For how long have you heard this voice? Constant presence, or come and gone?

3. How would you describe your relationship to this voice?
Prompts: Does the voice talk about you or to you?
   * What types of things does it say? Command/advice/commentary/hostile
   * How do you respond? [reciprocity – relating vs. being related to]
   * Positive vs. negative? Close vs. distant (proximity)? Upper vs. lower (power)?
   * Is the relationship different since this therapy?

4. How do you manage this experience – what helps and what doesn’t?
Prompt: What do you do / not do to cope?
   * What do you say to your voice / to yourself to help you cope?
   * What do you do that makes things worse/better?
   * Where have these ideas come from (e.g. therapy)?

5. How do you feel talking about the voice?
Prompt: What sort of thoughts/feelings do you have? E.g. powerful, scared, anxious
   * What do you think might happen as a result of talking about the voice?

---

Key Probes
1. Can you tell me more about that? 3. What do you think helped that to come about?
2. What do you think led to that? 4. Can you tell me what happened next?
Experience of Therapy

6. How would you describe the therapy?
Prompts: How is it similar to / different from other treatments?
     What do you understand by the term 'relational' / 'interpersonal'?
     How would you describe the techniques, structure, pace, collaboration?

7. What are you views of this therapy?
Prompts: What sense do you make of focusing on the relationship with the voice?
     What sense do you make of considering the voice hearing experience as interpersonal?

8. What are your views of the therapeutic techniques used?
Prompts: What sort of things did you do in sessions?
     What do you think of what happened in sessions?
     - exploring social relating e.g. genogram and positive/negative octagons
     - comparison of voice relating to social relating (similarities/themes)
     - bringing the dialogue into the room
     - role-plays e.g. empty chair (with voice or individual in life)
     - exploring different ways of relating
     - assertiveness training
     - monitoring e.g. diaries re changing nature of interactions with the voice
Prompts: Was this new? / different from previous experiences of therapy?
     Was this easy / difficult? Why?
     Was this helpful / unhelpful? Why?

9. What did you find (most) helpful? In what way?

10. What did you find (most) difficult / challenging? In what way?

11. How is it similar to or different from other experiences of therapy that you have had?
Prompts: What sense do you make of focusing on the relationship with the voice?
     What sense do you make of considering the voice hearing experience as interpersonal?

12. Do you have any ideas or recommendations about how to improve this therapy?

Key Probes
1. Can you tell me more about that?  3. What do you think helped that to come about?
2. What do you think led to that?    4. Can you tell me what happened next?
The Relational Approach and Perceived Change

13. Do you think that this therapeutic approach was useful? [If no – why not?]

14. What do you believe most facilitated this usefulness?
   Prompts: Making sense of relationship with voice, origins and maintenance
   Stimulating thought/discussions about relationships
   Modifying relationship with voice, in proximity and power
   Normalising, considering social relationships
   Promoting agency e.g. hearer’s relating style
   Particular therapeutic technique(s)
   Relationship with therapist

15. Since you began therapy, what (if anything) has changed? How has this changed and why?

   Prompts: How has your relationship with the voice changed? (e.g. power and proximity)
   Are there positive and negative changes in relating, vs. being related to?

   Prompts: Have there been any changes in social relating? (e.g. power and proximity)
   e.g. Relationships with family, friends, work colleagues, professionals...
   Are there positive and negative changes in relating vs. being related to?
   Are there links between relationships with others and feelings about self?
   Are there links between relationships with others and relationship with voice?

   Prompts: Have there been any changes in the meaning of the voice hearing experience?
   How have your feelings and beliefs about the voice changed?
   How have your views/beliefs about voice hearing changed? E.g. benefits?
   How have your feelings and beliefs about the future changed?

   Prompts: Have there been any changes in the way you feel about yourself?
   How have your feelings and beliefs about yourself changed?
   Have there been any changes in self-image, distress, mood?
   How have your feelings and beliefs about the future changed?
   Are there links between the relationship with voice and feelings about yourself?

16. If I was to ask the voice these questions about changes, how similar or different might the answers be?

   Prompts: If I was to ask the voice how their relationship with you has changed...
   .. how your relationships with others has changed...
   .. how the meaning of the voice hearing experience has changed...
   .. how the way you feel about yourself has changed...

---

Key Probes
1. Can you tell me more about that?  3. What do you think helped that to come about?
2. What do you think led to that?    4. Can you tell me what happened next?
If client has dropped out of therapy

Ask General Questions

6. How many sessions did you attend?

7. Why did you discontinue therapy?
   Prompts: Problems in conceptualising voice hearing experience as interpersonal?
   - Was there any distress associated with the relationship with voice changing?
   - Were there challenges to the therapeutic relationship?
   - What did you think of the therapy process / techniques?
   - Were there other stressors in your life?

8. What (if anything) was helpful?

9. What (if anything) was unhelpful / difficult / challenging?

10. Do you have any ideas or recommendations about how to improve this therapy?

End of Interview

- Turn off tape.
- Feedback on the interview, the study, and being a participant?
- Were there any questions you liked / disliked? Found difficult or uncomfortable?
- Check client knows what to do in case of increasing distress (i.e. care team)

August 2005
Version 5
INTERVIEW SCHEDULE – THERAPISTS

• Thank you for agreeing to take part in this study
• Have you read the information sheet? Do you have any questions?
• Please read (and ask any questions) then sign the consent form
• Remember that participation is voluntary: so you can request that we stop the interview at any point, or choose not to answer any question(s).
• Complete Background Information Sheet
• Check microphone
• Inform that might need to turn tape over

• In this interview I will start with some general questions about you and what you know of X’s experience of hearing voices.
• Then I will ask you what you think about the process of therapy that X has had.
• Finally I will ask about what you think of a relational approach to voices (what sense it makes to you) and any changes that might have occurred following therapy.

General Questions

1. What is your experience of working with people who hear voices?
   
   Prompts: For how many years?
   
   In what types of settings?
   
   What different models of therapy have you used?

2. For how long have you known X [client]?
   
   Prompt: What is your relationship with X?

3. How would you describe X’s relationship to his/her voice[s]?
   
   Prompts: What types of things does it say? - Command/advice/commentary/hostile
   
   How does X respond? [reciprocity – relating vs. being related to]
   
   Positive vs. negative? Close vs. distant (proximity)? Upper vs. lower (power)?
   
   Is the relationship different since this therapy?

4. How do you think X manages this experience – what helps and what doesn’t?
   
   Prompt: What does X do that makes it better / worse?
   
   Do you think this has changed since this therapy?

Key Probes

1. Can you tell me more about that? 3. What do you think helped that to come about?
2. What do you think led to that? 4. Can you tell me what happened next?
Experience of Therapy

5. How would you describe the therapy?
Prompts: How is it similar to / different from other treatments?
   - What do you understand by the term 'relational' / 'interpersonal'?
   - How would you describe the techniques, structure, pace, collaboration?

6. What are your views of this therapy?
Prompts: What sense do you make of focusing on the relationship with the voice?
   - What sense do you make of considering the voice hearing experience as interpersonal?

7. What are your views of the therapeutic techniques used?
Prompt: What do you think of what happened in sessions?
   - exploring social relating e.g. genogram and positive/negative octagons
   - comparison of voice relating to social relating (similarities/themes)
   - bringing the dialogue into the room
   - role-plays e.g. empty chair (with voice or individual in life)
   - exploring different ways of relating
   - assertiveness training
   - monitoring e.g. diaries re changing nature of interactions with the voice
Prompts: Was this new for X? / different from previous experiences of therapy?
   - Was this easy / difficult? Why?
   - Was this helpful / unhelpful? Why?

8. What did you find (most) helpful? In what way?

9. What did you find (most) difficult / challenging? In what way?

10. How is it similar to or different from other experiences of therapy that you have had?
Prompts: What sense do you make of focusing on the relationship with the voice?
   - What sense do you make of considering the voice hearing experience as interpersonal?

11. Do you have any ideas or recommendations about how to improve this therapy?
Prompt: Is there anything you would do differently?

Key Probes
1. Can you tell me more about that? 3. What do you think helped that to come about?
2. What do you think led to that? 4. Can you tell me what happened next?
The Relational Approach and Perceived Change

12. Do you think that this therapeutic approach was useful?
[If no – why not?]

13. What do you believe most facilitated this usefulness?
Prompts: Making sense of relationship with voice, origins and maintenance
Stimulating thought/discussions about relationships
Modifying relationship with voice, in proximity and power
Normalising, considering social relationships
Promoting agency e.g. hearer’s relating style
Particular therapeutic technique(s)
Relationship with therapist

14. Since you began therapy, what do you believe has changed for X?
How do you know this has changed?

Prompts: How has the relationship with the voice changed? (e.g. power and proximity)
Are there positive and negative changes in relating, vs. being related to?

Prompts: Have there been any changes in social relating? (e.g. power and proximity)
e.g. Relationships with family, friends, work colleagues, professionals...
Are there positive and negative changes in relating vs. being related to?
Are there links between relationships with others and feelings about self?
Are there links between relationships with others and relationship with voice?

Prompts: Have there been any changes in the meaning of the voice hearing experience for X?
How have feelings and beliefs about the voice changed?
How have feelings and beliefs about the self changed? E.g. self-image, distress
Have they discovered possible benefits of voice hearing?
How have feelings and beliefs about the future changed?

15. If I was to ask X these questions about changes, how similar or different might their answers be?
Prompts: If I was to ask X how their relationship with the voice has changed...
...their relationships with others...
...the meaning of the voice hearing experience...

16. If I was to ask the voice how the relationship with X has changed, how similar or different might the answers be?

Key Probes
1. Can you tell me more about that? 3. What do you think helped that to come about?
2. What do you think led to that? 4. Can you tell me what happened next?
If the client has dropped out of therapy

Ask General Questions

5. How many sessions did X attend?

6. Why do think that X discontinued therapy?
Prompts: Problems in conceptualising voice hearing experience as interpersonal?
- Was there any distress associated with the relationship with voice changing?
- Were there challenges to the therapeutic relationship?
- What do you think X made of the therapy process / techniques?
- Were there other stressors in X's life?

7. What (if anything) was helpful?

8. What (if anything) was unhelpful / difficult / challenging?

9. Do you have any ideas or recommendations about how to improve this therapy?

10. If I was to ask X these questions, what do you think he/she would say?
Prompts: If I was to ask X why he/she discontinued therapy...?
- If I was to ask what he/she found helpful..?
- If I was to ask what he/she found difficult or challenging..?

End of Interview

- Turn off tape.
- Feedback on the interview, the study, and being a participant?
- Were there any questions you liked / disliked? Found difficult or uncomfortable?

August 2005
Version 5
INTERVIEW SCHEDULE – REFERRERS /RELATIVES

- Thank you for agreeing to take part in this study
- Have you read the information sheet? Do you have any questions?
- Please read (and ask any questions) then sign the consent form
- Remember that participation is voluntary: so you can request that we stop the interview at any point, or choose not to answer any question(s).
- Complete Background Information Sheet
- Check microphone
- Inform that might need to turn tape over

- In this interview I will start with some general questions about you and what you know of X’s experience of hearing voices.
- Then I will ask what you think about the therapy that X has had.
- Finally I will ask about what you think of a relational approach to voices, and any changes that might have occurred following therapy.

General Questions

1. For how long have you known X [client]?
   Prompt: What is your relationship with X?

2. How much do you know of X’s experience of hearing voices?
   Prompts: How often do you talk about the voices?
   What sort of things do you talk about? E.g. experience, distress, therapy, advice?

3. What does the word ‘relationship’ mean to you?
   Prompt: Can you describe a relationship? E.g. its effect, reciprocity etc.

4. How would you describe X’s relationship to his/her voice[s]?
   Prompts: What types of things does it say? - Command/advice/commentary/hostile
   How does X respond? [reciprocity – relating vs. being related to]
   Positive vs. negative? Close vs. distant (proximity)? Upper vs. lower (power)?
   Is the relationship different since this therapy?

5. How similar or different is X’s relationship with the voice to other relationships X has?
   Prompts: Can you describe other relationships X has?
   How is this similar to / different from X’s relationship to the voice?

6. How do you think X manages this experience – what helps and what doesn’t?
   Prompt: What does X do that makes it better / worse?
   Is this different since the therapy?

Key Probes
1. Can you tell me more about that? 3. What do you think helped that to come about?
2. What do you think led to that? 4. Can you tell me what happened next?
Experience of Therapy

7. What do you know of the therapeutic process that X has been through?
   Prompt: How often do you talk about it?
   Who initiates the conversation?

8. How would you describe the therapy?
   Prompts: How is it similar to / different from other treatments?
   What do you understand by the term ‘relational’?
   How would you describe the techniques, structure, pace, collaboration?

9. What are your views of therapy for voices that uses a relational framework?
   Prompt: What sense do you make of focusing on the relationship with the voice?
   What sense do you make of considering the voice hearing experience as interpersonal?

10. What are your views of the therapeutic techniques used?
    Prompt: What do you know of what happened in therapy sessions?
    - exploring social relating e.g. genogram and positive/negative octagons
    - comparison of voice relating to social relating (similarities/themes)
    - bringing the dialogue into the room
    - role-plays e.g. empty chair (with voice or individual in life)
    - exploring different ways of relating
    - assertiveness training
    Prompt: would you consider this new / different from previous experiences of therapy?
    Would you consider this easy / difficult? Why?
    Would you consider this helpful / unhelpful? Why?

11. What do you think X found most helpful about this approach? Why/In what way?

12. What do you think X found most difficult or challenging about this approach? Why/In what way?

13. How is it similar to or different from other models of therapy that you know?
    Prompt: What sense do you make of focusing on the relationship with the voice?
    What sense do you make of considering the voice hearing experience as interpersonal?

14. Do you have any ideas or recommendations about how to improve this therapy?

Key Probes
1. Can you tell me more about that?  3. What do you think helped that to come about?
2. What do you think led to that?    4. Can you tell me what happened next?
The Relational Approach and Perceived Change

15. Do you think that this therapeutic approach was useful?
[If no – why not?]
Prompts: What do you think was most useful /least useful?

16. What do you believe most facilitated this (usefulness)?
Prompts: Making sense of relationship with voice, origins and maintenance
Stimulating thought/discussions about relationships (modifying relationships?)
Modifying relationship with voice, in proximity and power
Normalising, considering social relationships
Promoting agency e.g. hearer’s relating style
Particular therapeutic technique(s)
Relationship with therapist

17. Since X began therapy, what do you believe has changed for him/her?
How do you know this has changed?
Prompts: How has the relationship with the voice changed? (e.g. power and proximity)
Are there positive and negative changes in relating, vs. being related to?
Prompts: Have there been any changes in social relating? (e.g. power and proximity)
  e.g. Relationships with family, friends, work colleagues, professionals...
  Are there positive and negative changes in relating vs. being related to?
  Are there links between relationships with others and feelings about self?
  Are there links between relationships with others and relationship with voice?
Prompts: Have there been any changes in the meaning of the voice hearing experience for X?
  How have feelings and beliefs about the voice changed?
  How have feelings and beliefs about the self changed? E.g. self-image, distress
  Have they discovered possible benefits of voice hearing?
  How have feelings and beliefs about the future changed?

18. If I was to ask X these questions about change, how similar or different might his/her answers be?
Prompts: If I was to ask X how their relationship with the voice has changed...
  ...their relationships with others...
  ...the meaning of the voice hearing experience...

19. If I was to ask the voice how the relationship with X has changed, how similar or different might the answers be?

Key Probes
1. Can you tell me more about that? 3. What do you think helped that to come about?
2. What do you think led to that? 4. Can you tell me what happened next?
If the client has dropped out of therapy

Ask General Questions

6. Why do you think that X discontinued therapy?
   Prompts: Problems in conceptualising voice hearing experience as interpersonal?
   Was there any distress associated with the relationship with voice changing?
   Were there challenges to the therapeutic relationship?
   What do you think X made of the therapy process / techniques?
   Were there other stressors in X’s life?

7. What (if anything) do you think X found helpful / most useful?

8. What (if anything) do you think X found unhelpful / difficult / challenging?

9. Do you have any ideas or recommendations about how to improve this therapy?

10. If I was to ask X these questions, what do you think he/she would say?
    Prompts: If I was to ask X why he/she discontinued therapy...?
    If I was to ask what he/she found helpful...?
    If I was to ask what he/she found difficult or challenging...?
    If I was to ask X about any ideas for improving the therapy...?

End of Interview

• Turn off tape.
• Feedback on the interview, the study, and being a participant?
• Were there any questions you liked / disliked? Found difficult or uncomfortable?

August 2005
Version 5

Key Probes
1. Can you tell me more about that?                  3. What do you think helped that to come about?
2. What do you think led to that?                    4. Can you tell me what happened next?
Appendix 4: Approval letters

Dear Ella

A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Thank you for responding to the Committee’s comments on the above study and submitting revised documents.

Confirmation of ethical opinion

The further information and revised documents have been considered on behalf of the Committee by the Chairman. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documents as revised.

The Committee has agreed that the study is exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

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

i) NHS Application Form, Version 5.0, dated 6 September 2005
ii) Your curriculum vitae, Version 2, dated September 2005
Major Research Project

Research governance approval

You should obtain research governance approval from the Trusts involved before commencing any research procedures. Where a substantive contract is not held with the Trusts involved it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely

JOHN KERSLAKE
Co-ordinator

Enc

Copy to:  Mrs Catherine Ashbee, University of Surrey
           Dr Mark Hayward, University of Surrey
           Dr Victoria Senior, University of Surrey
01 December 2005

Miss Ella Fuller
Department of Psychology
School of Human Sciences

Dear Miss Fuller

A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers (EC/2005/132/Psych) – FAST TRACK

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

Date of confirmation of ethical opinion: 01 December 2005

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

Document Type: Application
Dated: 22/11/05
Received: 23/11/05

Document Type: Insurance Proforma
Received: 23/11/05

Document Type: Approval Letter from The South West Surrey LREC
Dated: 04/11/05
Received: 23/11/05

Document Type: Copy of the NHS Application
Version: 5.0
Dated: 06/09/05
Received: 23/11/05

Document Type: Summary
Received: 23/11/05

Document Type: Consent Forms
Received: 23/11/05
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

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

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

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr M Hayward, Supervisor, Dept of Psychology
Dr A Vetere, Supervisor, Dept of Psychology
Dear Ella

Research Project - WHC 621 A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and others.
Local Ethics No (LREC): 05/Q1909/76

This letter provides the formal Hampshire Partnership Trust approval required for your project to commence. Overleaf are a list of details of information that the R & D Office will require during the period of your research. Your project is now registered on the R&D database with identification number WHC 621. It would be helpful if you could use this number on all correspondence with the R & D Office.

Please note that this trust approval (and your ethics approval) only applies to the current protocol. Any changes to the protocol can only be initiated following further approval from the ethics committee via a protocol amendment; the R&D office should be informed of these changes.

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

Should any of your team require training in the above policies and procedures please do not hesitate to contact us.

Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research

With best wishes

Yours sincerely

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

An NHS Teaching Trust with the University of Southampton
With Southampton City PCT and Southampton University Hospitals Trust
Trust Headquarters, Maples, Horseshoe Drive, Tatchbury Mount, Calmore, Southampton, SO40 2RZ

03 November 2005

Ella Fuller
Trainee Clinical Psychologist
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03 November 2005

Ella Fuller
Trainee Clinical Psychologist
Dept of Psychology
University of Surrey
Guildford
GU2 7XH

Dear Ella

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Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research

With best wishes

Yours sincerely

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

An NHS Teaching Trust with the University of Southampton
With Southampton City PCT and Southampton University Hospitals Trust
Trust Headquarters, Maples, Horseshoe Drive, Tatchbury Mount, Calmore, Southampton, SO40 2RZ
Ms Ella Fuller  
Trainee Clinical Psychologist  
Department of Psychology  
University of Surrey  
Guildford  
GU2 7XH  
24 November 2005

ID: 0628/NOCI/2005 A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Thank you for your application to the Research Approval and Monitoring Committee for approval for this study. The committee considered this study at their meeting on 17th November 2005.

I am pleased to tell you that the study received approval subject to the following condition/s:
- Receipt of LREC approval letter

In addition to the conditions of approval, you are asked to note the following:
- The committee felt that it is in your own interest to keep copies of all consent forms in case of future query or complaint, for a minimum of 10 years, as per MRC Good Research Practice Guidelines (2000).

Please also be aware that the study should not commence until full approval has been confirmed.

Following your amendment/s, the Chairman, acting under delegated authority, will be able to approve the study by 'Chairman’s action’. Please note that this first stage approval is valid for three months from the date of this letter. If the issue/s raised have not been responded to within this time, your application will be considered withdrawn, and you will be required to resubmit your application to the committee.

The committee’s decision was based on the following documents:
* NHS REC form parts A and b (signed and dated 06/09/05)
* NHS R&D form (signed and dated 01/11/05)
* Protocol (version 6 dated September 2005)
* Therapy protocol (no version control dated 06/01/05)
* Lay summary (no version control undated)
* CV for Ella Fuller (signed and dated September 2005)
* CV for Dr. Mark Hayward (unsigned and undated)
* Letter from the University of Surrey re: sponsor (signed and dated 08/10/05)
* Indemnity certificate valid to 31/07/09 (signed and dated 28/07/05)
* Interview schedule referrer/carers (Draft 5 undated)
* Interview schedule Clients (Draft 5 undated)
* Interview schedule therapists (Draft 5 undated)

Please note that any amendments to study documentation may require ethical re-approval. You should check with the relevant REC administrator/s to clarify this.

Yours sincerely

[Signature]

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Dear Ella,

STUDY 05/Q1909/76:
THE EXPERIENCE OF A TALKING TREATMENT FOR PEOPLE WHO HEAR VOICES

I can now confirm the approval of Gloucestershire Partnership Trust for this study to proceed for consolidation by the Gloucestershire Local Research Ethics Committee.

Your project will now be added to the Trust's Research Register, which will identify the following:

- Principal Investigator
- Sponsoring Organisation/Departments
- Host Organisation
- Title of Study
- Proposed completion date

It is important that your research complies with the Research Governance Framework. It also needs to be in compliance with the Health and Safety conditions regarding research. If, as a direct result of your research an IRI form needs to be completed for either patient or staff please notify me directly. During the course of your research, I may need to contact you for further information in relation to your study, and, on completion of your study, you will be expected to produce a summary of the project and an indication of how the results from the study will be disseminated.

I wish you every success with the project.

Yours sincerely,

Carrie Marrow - Trust Lead for Research Governance
Dear Ms Fuller

RE: A study examining the experience of a talking treatment for people who are upset by the voices they hear

I would confirm that I have read through all of the documents forwarded to me and I am satisfied with the research proposal from a Data Protection perspective.

Good luck with the study.

Yours sincerely

Susan O'Connell

Susan O'Connell
Freedom of Information/Clinical Systems and Data Protection Manager
Appendix 5: Ethical issues

Informed consent
Participants were given at least forty-eight hours to consider the information sheets (appendix 6) before providing written consent to participate (appendix 7). Clients were offered an informal meeting with myself to discuss the information sheets, but all declined this offer. The information sheets described the aims and purpose of the research, what the interview would involve, the mechanisms through which confidentiality would be maintained, and what would happen to the information they provide. This written information emphasised that participation is entirely voluntary and that neither participation nor non-participation within the study would affect the clinical care of the clients in any way. All participants had the opportunity to ask questions before signing the consent form. Participants were aware that they could withhold any information or withdraw from the study at any time without giving reason. Information sheets were written using simple and clear language to ensure that potential participants could make an informed choice about participation.

Relatives were contacted once written consent from the client had been obtained (appendix 7). Interviews were conducted at either participants’ homes or at the local care team’s base depending on what was more convenient and comfortable for the participant. All interviews were conducted in line with the local NHS Trust’s policies on lone working and home visits.

Additional ethical issues concerning clients
The involvement of service users who hear voices, who may be considered a vulnerable group, was crucial because the principal aim of my study was to explore and understand the experiences of ‘relating therapy’ that aims to reduce the distress of people who hear voices. If the research had not included these people, it would have been difficult to fully understand the experience and usefulness of this therapy.
It was anticipated that the process of exploring clients' experiences of therapy focused on modifying relationships with voices might be temporarily distressing for some clients. However, the likelihood of distress occurring was minimised by the criteria set out within the ‘relating therapy’ pilot to select participants for their study (M. Hayward, personal communication, 1st May 2005). They considered the following:

- Selection of clients considered by their care teams to be sufficiently psychologically robust for potential distress in therapy.
- Selection of clients from within care teams where caseloads permit additional monitoring, support and liaison within the individual’s care plan.
- Risk assessment and safety planning was an integral part of the therapy with the level of distress being measured quantitatively and qualitatively at each session.
- Only using appropriately trained and experienced therapists.
- Accessing monthly supervision by an appropriately trained and experienced practitioner.

Furthermore, the likelihood of distress arising during my interviews was further reduced by the following:

- Seeking ethical and trust approval for the research.
- Regular (at least monthly) supervision by two qualified and experienced practitioners based at the university.
- During interviews, I was able to use my clinical skills to recognise and approach any anxiety or distress in a containing and sensitive manner.

Anxiety and disclosures of risk during the interview
I anticipated that participants might find the interview situation anxiety-provoking. To address this, I promoted an environment that was relaxed and comfortable for the participant. This included talking informally with participants before starting the interview to build rapport, and emphasising that, as the interview was semi-structured,
participants could lead discussions in such a way that they remained comfortable and relaxed. If, for any reason, a participant had become anxious or distressed during the interview, I would have used my clinical skills to recognise and approach this in a sensitive and containing way. If a client had presented with any difficulties of clinical significance during any stage of the interview, I would have asked permission from him/her to pass on concerns to their Consultant Psychiatrist or relevant service provider.

If participants disclosed information that led me to believe he/she might harm him/herself or others, I would have been obliged to pass on this information. The limits of confidentiality in this respect were made explicit prior to commencement of the interview, for example in the information sheets. These guidelines applied to individuals who consented to and completed the interview, individuals who consented to and subsequently withdrew from the interview and individuals who did not give consent (and consequently did not participate). All participants were free to withhold information or withdraw from the study at any time without giving reason.

All participants described feeling satisfied with the interview process and did not report any feelings of distress or concern during or after the interview. No issues of risk arose.

Confidentiality and data protection

Data Protection Act compliance was gained as part of the Research and Development approval prior to commencement of the research. When participants signed the consent form, they were allocated a code number, written at the top of the consent form. This code was then used to identify the audiotape of their interview, and their transcript. The consent forms included permission to audio-record the interview, so that interviews could be transcribed verbatim for the purposes of the analysis. The audiotapes are stored in a locked filing cabinet at the University of Surrey under the care of a university supervisor and will be wiped after completion of the research project.
The interview transcripts were fully anonymised (all identifying details were removed or changed), and stored on password-protected computers at the University of Surrey Psychology Department during the transcribing stage and analysis. This data was backed up on a regular basis. Printed transcripts (fully anonymised) will be stored in a locked filing cabinet at the University of Surrey under the care of a university supervisor, for a minimum of five years. Confidential data including the consent forms with participants’ names and code number are also stored in a separate locked filing cabinet under the care of a university supervisor. All confidential information will not be accessed by anyone other than the researcher and the two university supervisors.
Participant Information Sheet - Clients

This research is being conducted by Ms. Ella Fuller (Trainee Clinical Psychologist), as part of the Clinical Psychology doctoral training course at the University of Surrey. This research is supervised by Dr Mark Hayward (Clinical Psychologist) and Dr Arlene Vetere (Consultant Clinical Psychologist).

Study title
A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Invitation paragraph

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

Thank you for reading this.

What is the purpose of the study?

This study is trying to find out about a talking treatment for people who hear voices. Specifically, this study aims to find out about a therapy which focuses on the relationships that people develop with their voices. The study is interested in people’s views of this therapy, what the experience is like, what effect the therapy might have, and whether it helps relationships with voices become less distressing.

This study will run from September 2005 until September 2006.

Why have I been chosen?

I am interested in speaking with you because you have taken part in a talking treatment that aims to modify relationships with voices.
In total, approximately 15 people will participate in the study.

Do I have to take part?

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

What would taking part entail?

How much time will it take?

You would meet with the researcher for one interview, which would take no more than one hour to complete. The interview would be about your views of the experience of hearing voices, your views of the therapy, and your views of any changes that have happened as a result of the therapy.

Where would I have to go?

The interview would take place at a mutually convenient location, most likely the place where your therapy was conducted, or at your care team base, your GP surgery or at your home.

Unfortunately your travel to and from the interview cannot be reimbursed due to a limited research budget.

What would happen?

You would meet with the researcher and have the opportunity to ask any more questions. You and the researcher would go through the consent form, which requires that you sign to confirm the following:

- you have read this information form
- you have had the chance to ask questions
- you understand that you are free to withhold any information or stop the interview at any time without giving reason
- you agree to the interview being audio-recorded
- you agree to your Consultant Psychiatrist and your GP being informed that you have agreed to participate
- you agree to participate in the interview

The interview would be audio-recorded so that the researcher can write it up (anonymising all personal information) and use the information in the analysis.
Once the consent form is signed, the interview would then begin. The interview would be about your views of the experience of hearing voices, your views of the therapy, and your views of any changes that might have happened as a result of the therapy. The interview would be at a pace that felt comfortable for you and would be within your control. You would not be required to do anything with which you did not agree. Once the interview is over you would be asked if you would like to receive the results of the analysis of all the interviews.

What are the advantages and disadvantages of taking part?

It is hoped that the knowledge gained from this research will contribute to a greater understanding of hearing voices and talking treatments for voices. In particular this study will help to improve therapies that focus on the relationships that people develop with voices. In this way it is hoped that it will help other people who hear voices.

It is possible that talking about the voices you hear and your therapy may cause you some distress in the short term. The researcher is a trainee clinical psychologist who is experienced in helping people cope with distress. She would assist you in finding ways of coping with any temporary increases in distress, should this occur. You would also be free to access help from your care team, should you wish.

If you wanted to stop the interview for any reason, you would be free to do so immediately.

Confidentiality

Your care team including your GP and Consultant psychiatrist will know that you are taking part in the study. The researcher would write to them after the interview just to let them know that you have taken part. The researcher will have no other contact with your Consultant Psychiatrist or care team, unless you say something that leads the researcher to believe that the safety of yourself or someone else is at risk. If this was the case, the researcher would talk to you about how to do this. Other than in this exceptional case, all information given in the interview will remain confidential.

With regard to writing about the research project

When you sign the consent form, you will be allocated a code number. This number would then be used to identify the audio-tape and transcript from your interview. The interview will be written up word-for-word (transcribed) by the researcher. All information will be kept strictly confidential and stored securely. This information will have your name and address removed so that you cannot be recognised from it. Only the researcher and the two university supervisors will have access to this information. The study has been checked to ensure it complies with data protection laws.
**What will happen to the results of the study?**

The information from all the interviews will be analysed through a process called Interpretative Phenomenological Analysis, which involves identifying interesting, important and common themes. The results of this study will be written-up by July 2006 and submitted to the course being undertaken by the researcher at the University of Surrey. You could receive feedback on the results of the study if you would like it. An article about the entire study will be written by the researcher and attempts will be made to publish it in a national psychology journal. No participant will be identified in any part of the write-up or article.

**Who has reviewed the study?**

This study has been reviewed by South West Surrey Local Research Ethics Committee, which has raised no objection to it.

**Contact for further information**

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

Ms. Ella Fuller  
Trainee Clinical Psychologist  
C/o Department of Psychology  
University of Surrey  
Guildford GU2 7XH  
Tel: 01483 689441

If you have any complaints about your participation in this research, in the first instance please contact the Chief Investigator, Ms. Ella Fuller or her supervisor Dr Mark Hayward (contact both at above address). The normal National Health Service complaints mechanisms should also be available to you. You may wish to seek advice from the Patient Advice and Liaison Service [insert contact details for appropriate PALS].

In the unlikely event of you suffering significant and enduring harm as a result of your participation in this research, the University of Surrey (as sponsor of the research) holds no-fault insurance cover which is intended to provide compensation to participants, regardless of liability. The University of Surrey also has public liability insurance, which covers public liability claims.

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

**Version 5**  
27th October 2005
Participant Information Sheet

Therapists, Referrers, Relatives

This research is being conducted by Ms. Ella Fuller (Trainee Clinical Psychologist), as part of the Clinical Psychology doctoral training course at the University of Surrey. This research is supervised by Dr Mark Hayward (Clinical Psychologist) and Dr Arlene Vetere (Consultant Clinical Psychologist).

Study title
A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Invitation paragraph

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

Thank you for reading this.

What is the purpose of the study?

This study is trying to find out about a talking treatment for people who hear voices. Specifically, this study aims to find out about a therapy which focuses on the relationships that people develop with their voices. The study is interested in people’s views of this therapy, what the experience is like, what effect the therapy might have, and whether it helps relationships with voices become less distressing.

This study will run from September 2005 until September 2006.

Why have I been chosen?

I am interested in speaking with you because:
   a) You are a therapist who has taken part in a talking treatment that aims to help relationships with voices OR
   b) You are very close to someone who has taken part in a talking treatment that aims to help relationships with voices OR
c) You have referred someone to a talking treatment that aims to help relationships with voices.

In total, approximately 15 people will participate in the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form (see below). If you decide to take part you are free to withhold any personal information or to withdraw at any time, without giving a reason.

What would taking part entail?

How much time will it take?

You would meet with the researcher for one interview, which would take no more than one hour to complete. The interview would be about your views of the voice hearing experience, your views of the therapy, and your views of any changes that might have happened as a result of the therapy.

Where would I have to go?

The interview would take place at a mutually convenient location like the place where the therapy was conducted, the care team base, at your GP surgery or at your home.

Unfortunately your travel to and from the interview cannot be reimbursed due to a limited research budget.

What would happen?

You would meet with the researcher and have the opportunity to ask any questions. You and the researcher would go through the consent form, which requires that you sign to confirm the following:

- you have read this information form
- you have had the chance to ask questions
- you understand that you are free to withhold any information or stop the interview at any time without giving reason
- you agree to the interview being audio-recorded
- you agree to participate in the interview

The interview would be audio-recorded so that the researcher can write it up (anonymising all personal information) and use the information in the analysis. If you wish to participate you will sign the consent form in the presence of the researcher just before the interview commences.
Once the consent form is signed, the interview would then begin. The interview would be about your views of the voice hearing experience, your views of the therapy, and your views of any changes that might have happened as a result of the therapy. The interview would be at a pace that felt comfortable for you and would be within your control. You would not be required to do anything with which you did not agree. Once the interview is over you would be asked if you would like to receive the results of the analysis of all the interviews.

What are the advantages and disadvantages of taking part?

It is hoped that the knowledge gained from this research will contribute to a greater understanding of hearing voices and talking treatments for voices. In particular this study will help to improve therapies that focus on the relationships that people develop with voices. In this way it is hoped that it will help other people who hear voices.

It is possible that the interview situation might cause some people to feel slightly anxious. The researcher is a trainee clinical psychologist who is experienced in helping people cope with worries and anxiety. She would assist you in finding ways of coping with any temporary increases in anxiety, should this occur.

If you wanted to stop the interview for any reason, you would be free to do so immediately.

Confidentiality

All information given in the interview will remain confidential, with one exception: If you say something that leads the researcher to believe that the safety of yourself or someone else is at risk, this information will need to be passed on to relevant professionals. Before doing so, the researcher will speak with you about how to do this.

With regard to writing about the research project

When you sign the consent form, you will be allocated a code number. This number would then be used to identify the audio-tape and transcript from your interview. The interview will be written up word-for-word (transcribed) by the researcher. All information will be kept strictly confidential and stored securely. This information will have your name and address removed so that you cannot be recognised from it. Only the researcher and the two university supervisors will have access to this information. The study has been checked to ensure it complies with data protection laws.

What will happen to the results of the study?

The information from all the interviews will be analysed through a process called Interpretative Phenomenological Analysis, which involves identifying interesting, important and common themes. The results of this study will be written-up by July 2006.
and submitted to the course being undertaken by the researcher at the University of Surrey. You could receive feedback on the results of the study if you would like it. An article about the entire study will be written by the researcher and attempts will be made to publish it in a national psychology journal. No participant will be identified in any part of the write-up or article.

Who has reviewed the study?

This study has been reviewed by South West Surrey Local Research Ethics Committee, which has raised no objection to it.

Contact for further information

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

Ms. Ella Fuller
Trainee Clinical Psychologist
C/o Department of Psychology
University of Surrey
Guildford GU2 7XH
Tel: 01483 689441

If you have any complaints about your participation in this research, in the first instance please contact the Chief Investigator, Ms. Ella Fuller or her supervisor Dr Mark Hayward (contact both at above address). The normal National Health Service complaints mechanisms should also be available to you. You may wish to seek advice from the Patient Advice and Liaison Service [insert contact details for appropriate PALS].

In the unlikely event of you suffering significant and enduring harm as a result of your participation in this research, the University of Surrey (as sponsor of the research) holds no-fault insurance cover which is intended to provide compensation to participants, regardless of liability. The University of Surrey also has public liability insurance, which covers public liability claims.

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

Version 5
27th October 2005
CONSENT FORM - clients

Title of Project: A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Name of Researcher: Ms. Ella Fuller (Trainee Clinical Psychologist)

1. 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.

2. 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.

3. I give permission for the interview to be audio-recorded, for the purposes of the analysis. I understand that the audiotape will be wiped after completion of the project.

4. I give permission for my GP Dr ........................................ to receive a letter confirming my participation in this study.

5. I give permission for my Consultant Psychiatrist Dr ....................................... to receive a letter confirming my participation in this study.

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

Name of participant Date Signature

Researcher Date Signature

1 for participant; 1 for researcher; 1 to be kept with care team notes

September 05 - Version 3
CONSENT FORM – therapists, referrers, relatives

Title of Project: A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Name of Researcher: Ms. Ella Fuller (Trainee Clinical Psychologist)

1 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.

2 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.

3 I give permission for the interview to be audio-recorded, for the purposes of the analysis. I understand that the audiotape will be wiped after completion of the project.

4 I agree to take part in the above study.

Name of participant Date Signature

Researcher Date Signature

1 for participant; 1 for researcher

September 05
Version 3
CONSENT TO CONTACT OTHERS FORM

Title of Project: A study examining the experience of a talking treatment for people who are upset by the voices they hear. Perspectives from clients, therapists, referrers and carers.

Name of Researcher: Ms. Ella Fuller (Trainee Clinical Psychologist)

1. 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. 

2. I give permission for the researcher to contact my referrer to the therapy pilot .................................................., to ask whether they would like to be interviewed. 

3. I give permission for the researcher to contact a close friend or family member .........................................................., to ask whether they would like to be interviewed.

Address: ........................................................................
........................................................................
........................................................................
Telephone ..............................................................

Your name

Date

Signature

Researcher

Date

Signature

1 for participant; 1 for researcher; 1 to be kept with care team notes

September 05 - Version 3
Appendix 8:

Background Information Sheet

It is helpful if you provide a little information about yourself, so that we know more about the people who have taken part. However, you will not be identifiable in the research report, as this information is strictly confidential.

1. Sex: [ ] Male [ ] Female

2. Your age: [ ] under 30 [ ] 30-39 [ ] 40-49 [ ] 50-59 [ ] 60 or over

3. Which of these ethnic groups best describes you? Please tick one box only.
   a) White
      [ ] British [ ] Irish [ ] Any other White background (please specify)

   b) Mixed
      [ ] White and Black Caribbean [ ] White and Black African [ ] White and Asian [ ] Any other Mixed background (please specify)

   c) Black or Black British
      [ ] Caribbean [ ] African [ ] Any other Black background (please specify)

   d) Asian or Asian British
      [ ] Indian [ ] Pakistani [ ] Bangladeshi [ ] Any other Asian background (please specify)

   e) Chinese or Other Ethnic Group
      [ ] Chinese [ ] Other Ethnic Group (please specify)

4. What is your current job?
   If you are not working, what was your last job? ____________________________

August 2005
Version 5
Appendix 9: Five example extracts from transcripts

Interview with T1 02/12/05

T1 Yeah ok, um I suppose for the majority of what I've been doing with people it's been about um trying to consider the voice as another person really, as another, significant other as it were. Um and that that then is about responding to them in a way that you might with others. Um and so bringing that dialogue if you like, in to the room and being able to say well you know, for example if they were there now, or putting them in this chair or whatever, how would you respond to that. So it's about making it um more real if you like, more personified and being able to have that dialogue. And also I suppose um within that, then assertiveness type stuff about recognising one's own relating patterns and um thinking about there's a different way of being able to do that, that might make both parties feel ok really. Um. I Yeah. How do you go about um finding out about other relating patterns or their general relating patterns?

T1 Well the baseline measures included the Persons Relating to Others Questionnaire, number 2, which is Birchnell's measure. And so from the baseline measure I personally I don't know what the other therapists have done but I sort of map that on to the octagons of relating and then we've used that for looking at um you know, 'you seem to be scoring quite highly in these areas or quite low in these areas' and looking at positive and negative relating. Um although obviously it's more the negative relating that we've focused on so yeah, some use of the information that we got from the baseline really. And also just discussion of relationships in life, which the first
Interview with T1  
02/12/05

5 or 6 sessions of the therapy do, I mean that time is spent on engagement and discussing relationships. Um and so from those discussions in my experience, out came all you know stuff about the relevant social relationships, as well as the um exploration of the relationship with the voice.

So do you have in mind um goals, in terms of where you'd like to see their pattern of relating shifting to?

I didn't personally because this is research and so I you know, because we're still exploring I don't think we know how we want people you know, to think it might be less distressing to relate in this way. Um so no, the answer would be no, I didn't have goals for change in their relating, other than perhaps I suppose it would be fair to say if I'm using assertiveness techniques then perhaps I'm encouraging them to be less unquestioningly subservient. That doesn't necessarily mean to say that they choose to become more assertive but just that they become aware of, you know, what they're doing and how that might be making them feel, and then the choice is theirs as to whether they choose that this is the time they want to change that or not.

Yeah so in some ways it's a case of kind of experimenting with different reactions, is that right, and seeing how that changes...
you have to sort of weigh up those advantages and disadvantages.

And you know, ur think about the time, is this the right time, is this
the time that I want to try and see what might happen if I did it
differently. And for some people it's not the right time, it's too scary,
because it, perhaps that reflects that this is such a new concept you
know, the idea of perhaps being able to relate differently is enough in
itself to kind of be taken on board, without necessarily thinking about
doing it as well.

Yeah. So, I mean, do you have any specific examples of what clients
might be scared of, or what might be getting in the way of them
experimenting with new ways of relating?

Mmm. Mmm. Yes, I think well for one person for example, s/he
expressed a sense of dread, a sort of a not knowing what would
happen if s/he did it differently. Um you know if you're being told to
do this in a certain way at a certain time, and you know you've
always done that, and you've done that for years, then it can be
hugely difficult to think well, god what's gonna happen if I do that
differently? And s/he just described a huge sense of dread and that
not knowing, so it's the fear of the unknown really. Um for other
people I think you know I've come across people where it's a sort of
a maybe part of their culture, that they're not able to, you know the
way they perhaps perceive their role within their culture might make
it difficult for them to change their pattern of relating. Um, and for
other people it might just be the mere idea of, you know of taking -
that idea on board. You know, 'I've never even thought about it like
that so it’s like that, like I was saying earlier, that process of taking that idea on board and settling with that first um so that it’s the mere sort of paradigm shift, if you like, to that that way of thinking that it might be possible to do something different.

So it sounds like that’s kind of one of the more explicit goals in a way, if you see what I mean. That it’s about trying to get people versed and used to the idea of um having a relationship with their voice that is amenable to change.

Yeah. In my experience some people take more easily to that than others. Um. Yeah. I think that some people more easily and more readily see it as a relationship. Um and others have just seen it as perhaps something that’s happening to them, an experience, but not necessarily personified it in any sort of way. So yeah, I guess it would depend where the individual’s is coming from, as to how it easy it might be or what those barriers might be, to thinking that you could do it differently.

Are there any other sort of um therapeutic techniques or interventions that were used?

Um. I think, I mean, without knowing necessarily how to define them I think the kind of coming to view it as ur a more normal or general experience that others can have, beginning to identify it, with, you know, as having similarities to other relationships or situations in life that might have had something to do with it, you know. Um, so I don’t know if there were sort of specific techniques but there are
Interview with C2b

28/04/06

was quite good fun [laughs], yeah most of the time. I had a couple of
bad sessions.

In what way, what makes you say it was quite fun?

Well it just, no-one really wants to talk about god and the devil. I mean
I've tried, to all my friends I used to try and say, oh look god's saying
this now, the devil's saying that now. And no-one wants to hear it. And
my parents don't want to hear it. And so it's just good to get an
opportunity to talk about these things without fear of someone looking
down on you for it.

Yeah, I see. So that's quite a change, that's a new thing [yeah]. And
what do you think the impact of that is on you? Having the opportunity
to

Um [pause] I don't know. I suppose it makes me feel a bit happier, it's
a bit like, if someone else knows what's going on it's kind of a
problem shared, a problem halved kind of thing.

Ok, so prior to that, your experience had been that, people didn't really
want to hear what you had to say [yeah] about what god and the devil
were saying [yeah]. Ok. Are there any other ways that you'd describe
the therapy or the purpose, the aim of it?

Because you said what you imagined the research was about, but from
your perspective what would you kind of say to describe it?

I'd say the therapy was kind of trying to help me get on better with my
voices, not get rid of them, because that's not what I want either, just
try and make me more confident, more happy with the situation.

Yeah, all of the time all the doctors have tried to do, is gave me
medication to try and take the voices away.

Ok, and what's the effect of that on you, this new aim of being able to
live with them?

Well, when we studied, we did a bit of assertiveness, I think I said that
already, um there was, it's really helped. What was the question again,
sorry! [laughs]
Interview with C2b

239 I That's alright. What's the effect, you were saying this new aim of
240 being able to live with the voices rather than trying to get rid of them
241 altogether, I was saying what's the effect of that on you?
242 C2b Yeah it's been good. It has made me be more assertive to my voices
243 and in my normal, everyday life, with my partner.
244 I Ok so you've found ways of being more assertive both with your voice
245 and with social relationships?
246 C2b Yeah.
247 I What's, this is a very broad question, but what are your views of the
248 therapy?
249 C2b Yeah, it was mostly good. I went for the initial meeting, and I was like I
250 don't think I'm suitable for it, and s/he said, no you are. And I was
251 like, that's good.
252 I And why did you think you weren't?
253 C2b Um, I don't know really. Because at the time I must have thought I
254 don't have a specific voice, but as soon as I thought about it, I thought
255 yes I do. And then we talked a bit more about it, and it was good. And
256 then I can't remember what we did the first session we just filled in
257 questionnaires and stuff.
258 I What was that like filling in the questionnaires?
259 C2b Yeah it was quite good fun actually, I quite enjoyed doing those
260 questionnaires [laughs], I like bits of paper!
261 I Yeah [laughs], can you remember what sort of things it was about, or
262 what the purpose was?
263 C2b I think we did the same ones at the beginning and the same ones at the
264 end, to see if there was any difference between the two, and see what
265 the difference, if the therapy had had any effect. But they were about
266 all sorts of things, like the voice and you, how, your social
267 relationships, and there was like a cross that you had to tick four dots
268 on. Like hearer distance, hearer dependence, ur voice intrusiveness,
269 and I can't remember what the other one was. It was quite interesting
270 doing that.
271 I And what was your sort of understanding of the aim of that, what was
272 that about?
Interview with C2b

I think that was just to measure if, um if there was any visible pattern to whether the therapy was working, or whether it was staying the same throughout.

Yeah, was it your impression that the therapy was quite focused on relationships, or the relationship with the devil?

The relationship with the devil yeah.

Ok, and what sense do you make of focusing on relationships with voices?

Um, I think it's really good. I've always tried to respond to my voices, I've never believed that they're just figments of my imagination. I've always thought they were real. And it's good to actually hear someone talking about the devil as if they're real, rather than 'your voices - what are they saying' and just dismissing it, rather than we sort of went into the detail about what he was saying, why would he say that, what would you say back? And I thought that was good.

Right. So was your view about whether [therapist] also felt that the devil and god were real, or did that not really matter? Was it important for you to feel as though s/he was believing in them, as it were?

That was another question, because the first couple of weeks I thought s/he really does believe that I'm, in, you know the god and the devil as well as I do. And that was quite reassuring. And then a couple of weeks later I thought that same thing again, and I thought well no, s/he can't think that [laughs]! So it's just a schizophrenic moment I guess, where you can't, where you have two minds about it.

Yeah, ok. So, because does that matter?

No, I don't think it does. I think it it probably would to a lot of people, but, to me, I know they're real. And if someone thought they're real then great, but if they didn't that's their choice, you know.

So wherever [therapist] would stand on it, it sounds like his approach was very much engaging with that experience as if it's real [yeah], even if his view was that it wasn't.

Yeah, yeah.

So it sound like that was quite a valuable side of it?
Interview with C3

The distance I can put between him and I, is really different to what it was in the past. Plus I'm not, I don't take everything he says personally, where I did in the past. No matter what anybody said to me I just thought it's the [devil's?] voice, and he's going to get me. I've done something really bad somewhere, and it's a punishment.

So do you think that that's something that's grown from the therapy with [therapist]? This idea that you can kind of hear it, but take it differently.

Yes yes. I think I've learned from [therapist] with the therapy that you can [pause] instead of always hanking to be rid of it completely, I think you can just learn to just control it and live with it I think, without it being the end of the world. You know, whereas before the constant bombardment depressed me and once I got depressed I'd get suicidal. And with the therapy I've come to the conclusion that I might not be able to get rid of him. But I can control him, and I don't have to be depressed by him. I don't have to take, or when the whispering comes I can work harder at controlling um where the voices are coming from using logic. And I, from the therapy you have set yourself tasks um it's like homework. And I do it religiously.

And what are the sort of tasks that you might be doing?

Um it might be to tackle the whispering by, one of them was by saying you're extremely rude to whisper. If you've got something to say, you say it out loud or I won't pay any attention to you at all. Um and I just everything was just [inaudible] and I'd just chant that in...
Interview with C3 13/01/06

274 my head over and over, you’re just too rude to listen to, you’re bad mannered. People people who whisper aren’t very nice.

276 I So that does mean that the homework tended to be things where you’d kind of experiment with a new way of responding [Yes]. And then you’d come and feedback how it worked out or whether it was helpful.

280 C3 Yes, whether it was useful, or whether it worked or not. And on each occasion when I would come back from practicing the homework, we would then adjust it perhaps slightly um if it wasn’t as successful, some things were more successful than others. So we would do some adjustment, and I would go away for a practice um.

285 I And how would you sort of decide how to adjust it if you see what I mean? What might be the things that you change?

287 C3 Um, sometimes we had to change how I viewed what was being said. Um because I had problems with the fact that the whispering quite often makes me listen, it’s very distracting. And um when I start to listen, because it’s doing it now because I’ve not been very well and it’s very difficult to flow of conversation.

291 I Well you’re doing remarkably well then I keep I keep wanting to drift off to see what they’re saying. And I want to check if there’s a clock [looks around] luckily there’s none in this room, which is a relief. Because yesterday I had um to talk to the psychiatrist and he had a television and a clock in his room.

297 I So does that make the whispering louder or ur worse?
Interview with C3

298 C3 It makes it worse, that makes it a lot worse. Whereas with [therapist] I've been working, the latest thing we've been working on is having a television in the room with me. Not avoiding the issue, and hiding away from it; seeing that its an inanimate object and can't hold whispering, especially not when it's switched off, which it does.

299 13/01/06

300 We've been practicing with that. I haven't quite kept up. I've still got some more work to do with [therapist] because I haven't quite kept up with getting to have the television on all the time. Um...

301 I've been working, the latest thing we've been working on is having a television in the room with me. Not avoiding the issue, and hiding away from it; seeing that its an inanimate object and can't hold whispering, especially not when it's switched off, which it does.

302 13/01/06

303 We've been practicing with that. I haven't quite kept up. I've still got some more work to do with [therapist] because I haven't quite kept up with getting to have the television on all the time. Um...

304 I've been working, the latest thing we've been working on is having a television in the room with me. Not avoiding the issue, and hiding away from it; seeing that its an inanimate object and can't hold whispering, especially not when it's switched off, which it does.

305 "I'm fat. And when I look in the mirror I see someone who's a size 20. Even though I've lost a lot weight in the past 2 month, I've lost over 2 stone um. But when I look in the mirror I can still see a person that's a size 20, because the whispering tells me I'm fat and grotesque, if I concentrate on what it's saying. When I'm out in public the whispering transfers itself to people that are behind me, I don't like having people walking close behind because I think it's them that's doing the whispering. And [therapist] and I have been working on the fact that it's obviously not them, the people in the supermarket for instance, are working out their own money and their own shopping, and don't have time to whisper about me being a size..."
Interview with F2 27/01/06

aren't you, and somebody who can understand. Because [therapist] has
probably come across people like this before but it's something that's
very very new, to us. (-) Care Burden.

So are you saying that maybe something that's important is that in a
therapy like this, that the therapist is aware of, is kind of experienced in
talking to people who hear voices [yeah] and what do you think is so
important about that? I mean how might that affect how [therapist] is
with Matt?

He knows the right things to say. He's not emotionally involved
[pause].

And do you have kind of ideas about what the right things to say are?
And when you in family, you're not. And you're more likely to react —
about things.

I get upset over things. Because I see a deterioration in my son, you
know. He was such a sort of happy go lucky person. I mean, 5 years
ago, he was a brilliant skateboarder. He was really lively and bouncy,
and he could, he was excellent. And he can hardly skateboard now.

Lack of practice probably, but the agility and everything in him, has
sort of gone.

Yeah. Why do you think that is?

What it's done to him. Well I don't know, whether it's the drugs that's
done it, or the illness, I don't know.

Is he on a lot, did you mean medication or drugs that he took?
Interview with F2

Well I’ve, I think he was smoking and I know he took Ecstasy.

Whether that sparked off all of this, I will never know really.

But it sounds like something you think is quite a strong possibility.

Yeah.

And is he on any medication now? [yeah]. What’s he taking?

He takes, he has an injection. I’ll just put the heater on, it’s getting a bit chilly [laughs].

Do you know the name of the injection he has?

No I couldn’t tell you that. The packet’s sort of often put in the bin but I don’t know.

No don’t worry. Ok. Um so we were talking about your reactions to when he talks about things. And how it’s sort of upsetting to think back to the past.

Yeah.

So I suppose what I’m doing is trying to work out what it is that the therapy offers that is different to that. And you’re saying it’s about the therapist being detached from the situation. So presumably wouldn’t react in the same way that family would. So how might you describe a therapist who’s like that? I mean if they were detached how would they sort of be, if Matt’s talking about things?

Because whatever Matt says to them, is not going to shock them or make them upset, which you know.

And what do you think the effect of that on Matt is, if they’re not getting upset and if the therapist doesn’t get shocked?
Interview with F2 27/01/06

F2 Because he probably feels free to be able to say what he can say. 
Whereas within a family you don't tell them everything, do you.
And so your view is that it's sort of really helpful to be able to be free
to say what's going on.
I I think so yeah.
Why do you think it's so important to be able to talk openly about
what's going on for Matt? [pause] In what way does that help?
F2 It's, it always helps to be able to talk over things, doesn't it. Because if
you keep them within yourself, it's very hard isn't it, to keep
something in. To have somebody come in and be able to talk to, and
understand you. [pause]
So I suppose is it sort of 2 things? Being able to be free to say what's
going on, and the second thing
Without judging
Yeah. and the second thing is feeling understood by the therapist. What
do you think the effect of feeling understood is on Matt? How do you
think that might make him feel or?
That he's not different. That somebody can actually understand how,
what he's going through. Because he's going through something that I
can't understand. And even though [therapist] probably hasn't been
through it himself, he's obviously met up with other people that have
And he knows how, what they're going through. I mean I've got no idea, really. [pause].
Interview with R3

273 experience and the action didn't work. Another member then suggested
that she try a shield. Ur, so every time Sam got really difficult, she
274 could put the shield, and she actually could do that. So it was a way of
275 defending her, but it did nothing about the power. So lots of, there
276 were loads and loads of techniques like this. But it seems, you know,
277 (addressing the power issues seems so the most directly helpful)
278 
279 I So how do you think, or how do you imagine that the power was

281 R3 I imagine it's about addressing June as a person who is ok in her own

right. And I'm hoping it's got something to do with self-acceptance, of

her being a valuable human being. And reinforcing that element so that

284 she feels stronger. And then looking at the voice, seeing whether the

285 voice's demands were reasonable or unreasonable, and should you

286 want to do that or not. That's how I imagined things working, or

287 actually going along.

288 I And is that different do you think, to other approaches that have been

289 taken with June previously?

290 R3 It's not different in content, it's different in um focus, and persistence.

Because we do address those kind of issues, but I think what's

291 happened is that it's been addressed time and time again, and is the

292 focus of each and every session. Whereas if I'm working with her as a

293 care co-ordinator, there are many other things that all impinge on this,

294 that need to be done too. So I think we lose focus time and again.

296 I And from what you've understood of the therapy, does it feel as though

297 it's focused on relationships solely?
Interview with R3  13/01/06

R3 Well I don't know if it's focused on relationships solely, I just know that the outcome is relationship orientated! Because she's more assertive with other people as well as the voice. So I guess it's to do with being assertive.

Mm, ok. What do you think, I suppose you've sort of answered this, but what do you think June's found most helpful about the therapy with [therapist]?

R3 I think it's about her feeling stronger in herself And also um, do you remember that book my Dickson, a woman's right on her own, or something like that. It's about her saying I have a right to be, and I'm ok. And what the voice is saying is unreasonable and I can recognise that. And that I have a right to set a boundary, those are the kind of things.

Ok. What do you think might have been most difficult or challenging for June, during this therapy? Do you have any ideas?

R3 I think it's changing her view from being a victim and a patient, to being an ordinary human being. You think that's been difficult?

R3 I think that's been difficult because there are so many factors that reinforce it. Her income is totally reliant on her taking a patient role. Um her medication is enormous, so it reinforces her illness. The voice is particularly punishing, so it reinforces her feeling of being a victim. Um and much of her day to day experiences of mental health services, or mental illness service really, so that kind of reinforces the patient role.
Interview with R3

I So it was so sort of ingrained in a way, and so reinforced, that that’s probably the most difficult change to achieve, yeah.

R3 Mm, so to be assertive means that she may put all those things aside, which she has been doing. She’s done part time lecturing for instance, which has been very beneficial.

I Um. Again I suspect you’ve mentioned this, but how similar or different do you think this therapy is to other therapies?

R3 I think it’s an extension of typical cognitive behavioural therapy, into relationship-forming stance, rather than just about antecedents, behaviours and consequences. So it’s about clearly seeing the relationship, that’s been the most important part of it. Rather than your thoughts about what’s going on, or you know, the characteristics of the voice. It’s one characteristic of the voice, in the relationship, and looking at that in-depth.

I So would you say there’s some over-lap between an approach that thinks about um your beliefs and thoughts about the voice, and this therapy?

R3 Yeah there is. It’s the focus. And I think philosophically, they’re very similar. It’s the focus that’s different. You know, because it’s one aspect of all the different things that we look at. But possibly the most important. Because these are people with persistent voices, despite huge amounts of medication. So it’s the thing that probably needs addressing the most.
Appendix 10:

1. Engaging with the relational framework
   a) An understandable/intuitive model of voice hearing
   b) Comparison of voice and social relationships
   c) Assessment of relating styles (measures and diagrams)
   d) Openness and honesty to the therapist

2. Developing a new relating style
   a) Developing understanding
   b) Drawing on past (positive) relating styles
   c) Assertiveness training
   d) Bringing the dialogue with the voice into the room

3. Other factors affecting change
   e.g. medication, wider issues

4. Impact of change: how is changed measured?
   a) Acceptance of voices (living with voices)
   b) Mental health and self-respect
   c) Independence-seeking
   d) Return to 'old self'
   e) Hopefulness/possibility of change
   f) Change in voice-hearer relationship
   g) Social relationships

5. Therapists' approach
   a) Therapeutic relationship
   b) Non-judgemental of 'psychotic symptoms'
   c) Therapists' use of the model

6. Challenges to change
   a) Perceived risks within therapy
   b) Pressure of the research process
   c) Entrenched relating styles

7. Therapy is confidential

8. Carer role/burden
   a) Client dependency
   b) Emotional burden
   c) Secrecy to family
Please write the theme number and letter next to the quote!

[Mother] I get upset over things. Because I see a deterioration in my son... He was such a sort of happy go lucky person

[Client] we... covered assertive training sort of thing... I still do it now, if I get a question in my head... well I question it... Try and say ‘what’s your proof’ or whatever.

[Therapist about genogram] Each of the relationships... was explored in terms of relationship development with them. So it wasn’t you know quite the same as doing a regular genogram, there was much more emphasis on inter-relating style.

[Father] ...we’re more happy with the fact that we’re getting my daughter back.

[Client] ...To hear someone talk about them [voices] as if they were real, instead of ...just telling me that I need more medication or... ‘don’t listen to them, they’re not real’.

[Referrer] I think intuitively it’s appealing to think that people would relate to what they think as being an embodiment of something, i.e. the voices, representing some thing or being

[Client] It’s also helped me to face up to what happened to me, and by doing that um, it’s made me ready to face the future... And I feel more positive to what the future will hold.

[Therapist] It felt kind of pressured in a way that we had to stick to the [therapy] protocol... I was also weighed down by the expectation that kind of maybe we needed the data to say something that would feed into the potential efficacy of this approach

[Client] I would only travel with people I knew... whereas with the therapy, I’ve thought no, these people have all been vetted so they’re all safe. And I’ve organised to travel by community transport to give my friends and family a break. And do things on my own.

[Mother] he’s had changes in drugs, you know, different types of drugs they keep trying on him, see if things are improving. So I don’t know which things affect him

[Client] And with the therapy I’ve come to the conclusion that I might not be able to get rid of him [the voice]. But I can control him, and I don’t have to be depressed by him.

[Referrer] she could see that sometimes the voice being particularly punitive or threatening, would in some sense mirror the difficulties she was having.. with her brother

[Client] my parents... they’re elderly, they’re not young anymore. And my son’s my other carer. If I get up during the night with the voices he has to get up and sit and talk to me. He’s got to get up at half past six and go to work
[Therapist] I think her feeling about herself is that she’s got more potential than she’s felt for a very long time. And she’s starting to feel much better about herself and her abilities, and her confidence seems to have grown.

[Me to client] What were some of the things that you did...to try and make the relationships with the voices better?...[Client] Well it was bringing the, bringing the person who’s doing the voice into the room.

[Therapist] look beneath the surface and get a sense of... what this experience connects to, relationally... and get a sense of the underlying issues that need to be addressed.

[Father] ‘Talking about problems... eases a problem’

[Client] I guess that we’re not at each other so much anymore, we’re not complete enemies anymore. There’s something in me he wants to like, and there’s something in him that I can like do for him.

[Therapist] we might kind of look back... and shine a spotlight on times when maybe s/he’s not been the passive recipient of an experience, but s/he’s been kind of more active, and taken more active roles in those relationships.

[Client] ‘It was more a case of how I was going to deal with my voices, it was me that was going to deal with it, it was me that was going to sort it out... she was giving me, myself the power’

[Referrer] many of her friends have mental illness problems and are often very demanding... recently there’s been lots of examples where she’s said... this is when I’m going to help you, after that I won’t be able to help you because I need to look after myself. And that’s quite different from the past.

[Client] in the beginning [of therapy] I was worried that I would open a can of worms that I couldn’t get the lid on.

[Therapist about clients] a lot of people... seem to be very good at being told what to do, they’re very good at taking um instructions or orders um, and so, to actually challenge, that is quite difficult.

[Father] So we weren’t privy to what was being discussed. Not that we wanted to be.
Appendix 11: Full list of superordinate themes and sub-themes

*Individual context

- *Origins, onset, losses, triggers (of voice)  
  T,C,F,R
  'when all this first started 3 years ago... he'd been taking drugs... And he started saying like that there were cameras round the house and he was hearing voices saying horrible things about him' (F2 46-9).

- *Other treatments and other professionals  
  C,F,R
  'In the group everybody was quite helpful as well, because we helped each other, but it had its limitations and ur, there was no real therapy involved, it was just discussion or what do you try?' (C3 178-80) 
  '...there's been so many people coming in, do you know what I mean? Coming in doing all this. I mean it's been good, you know, for me to see it, it's great. But it's perhaps a little over-whelming for him sometimes, you know.' (F2 175-8)

- *Fluctuation – recently became unwell  
  C,F,R
  'unfortunately these last 10 days things have changed again' (R3 50-1). 
  'I've become unwell in the past 7 to 10 days' (C3 693-4)

- *Reality of experiences – 'I know that they're real'  
  Clients only
  'There is a minute part of me that thinks it's an illness... But, no, it's, the coincidences that happen, it's too real' (C2a 569-71). 
  'I've always tried to respond to my voices, I've never believed that they're just figments of my imagination. I've always thought they were real'. (C2b 281-3)

- *Voice content  
  T,C,F,R
  'language-wise, the air is blue with the f-ing, c-ing and b and all the rest of it, telling her how useless she is' (F3 293-4)

- Examples of negative relating  
  T,C,F,R

Engaging with the relational framework

- An intuitive model of voice hearing  
  T,C,F,R

* and bold = sub-theme was not selected for presentation  
* and bold and underlined = superordinate theme was not selected for presentation
Major Research Project

- Assessment of relating styles
  T,C,R

- *Individual differences in engagement process
  Therapists only
  ‘I think that some people more easily and more readily see it as a relationship. Um and others have just seen it as perhaps something that’s happening to them, an experience, but not necessarily personified it in any sort of way’ (T1 257-60).

- Openness and honesty
  T,C,F

**Therapists’ approach**

- Therapeutic relationship
  T,C,R

- Non-judgemental about psychotic experiences
  T,C,F,R

- *Therapists’ use of the model
  T,R
  ‘It throws me back to sort of thinking about individual, different individuals’ understanding of it, and it very much sort of depends on what their understanding is as to where you go with it next, really’ (T1 311-4).
  [Integrative]: ‘I mean obviously there were, there were times when things like CBT crept in. Like when we were doing the evidential review of the voice content and its accuracy, that felt very CBT. I think the homework felt quite CBT and that’s you know, that’s not an intrinsic part of this work, but it fitted well’ (T3 638-42)

- *Therapists’ gender
  Cluster 3
  ‘I think that if people are given therapy we should be asked what gender we want the therapist to be’. (C3 340-2) ‘... it automatically relaxes you, even before you start.’ (C3 345)

**Developing a new relating style**

- Developing understanding
  T,C,F,R

- Drawing on positive relating styles
  T,R

* and bold = sub-theme was not selected for presentation
* and bold and underlined = superordinate theme was not selected for presentation
• Assertiveness training
  T,C,R

• Bringing the dialogue into the room
  T,C,R

• *Homework
  Cluster 3
  [Assertive responses] ‘it seemed natural to say give them a go in the week’ (T3 456).
  ‘you’re occupied with the therapy even when you’re not with the therapist’ (C3 792-3).

** External factors affecting change

• *Medication
  F,R
  ‘he’s had changes in drugs... So I don’t know which things affect him’ (F2 469-71).

• *Wider issues
  C,R
  ‘She’s lost weight... She has been put on a new medication that is less sedating... she’s got this new flat. So these are all confounding issues, and it’s hard to tease out what’s from the therapy’ (R3 489-93).

• *‘Recovery stage’
  T3 only
  ‘[C3 is] further through the recovery process’ (T3 826) during which she is ‘doing things differently and more positively’ (T3 215-6).

Challenges to change

• Perceived risks within therapy
  T,C,F

• Entrenched relating styles
  T,C,R

• *Research process and perceived pressure
  Therapists only
  ‘It felt kind of pressured in a way that we had to stick to the protocol... I was also weighed down by the expectation that... we needed the data to say something that would feed into the potential efficacy of this approach’ (T2 569-73)

* and bold = sub-theme was not selected for presentation
* and bold and underlined = superordinate theme was not selected for presentation
[Supervision] ‘It was really hard to set it up regularly and have enough time to talk through the case work in detail about it. And I think that you know that partly contributed to my struggle to keep the inter-relating stuff in there, the model in there’ (T3 923-6).

**Impact of change**

- *Therapy was ‘very helpful’ etc.*  
  C,F  
  ‘...quite helpful’ (C2a 210-11)  
  ‘I do feel she’s *gained* from it, there’s no doubt about that’ (F3 164)  
  
- Voice-hearer relationship  
  T,C,R  
  
- Acceptance: live with voices  
  T,C,F,R  
  
- Mental health and self-respect  
  T,C,F,R  
  
- Independence-seeking  
  T,C,F,R  
  
- Social relationships  
  T,C,F,R  
  
- Hopefulness and the possibility of change  
  T,C,R  
  
- *Generalising therapy*  
  T,C  
  ‘if I’m very tired... I’ll start to get visual hallucinations. And I use the same logic in that, and tell myself; it’s not there, it’s just my brain sending me signals and interpreting them in the wrong manner’ (C3 214-7)  
  ‘There was almost a sense in which some of the things we were thinking about in terms of change, in terms of how we related to his/her experiences, there’s a sense in which s/he was applying those more generally to his/her kind of psychotic experiences per se.’ (T2 525-8)  
  
- *Scores on measures*  
  Therapists only  
  ‘C3’s perceptions of how powerful the voice was um they dropped a lot. I think she had a rating of 15 at the start of therapy and it was down to 3 at the end. And that seems to be supported by the conversations that we’ve had as well’ (T3 703-6)  

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‘I think for all the people in the trial, omnipotence has reduced in terms of the score on the Beliefs About Voices Questionnaire - Revised’ (T1 685-7).

- *Slowness of change
  Therapists only
  ‘I think maybe there was the beginnings of some process of change in him that would take longer to see in relation to the data’ (T2 711-13)
  ‘I think it’s starting to be useful. I think you know the numerical outcomes have some interesting things in, that indicate that change was on its way’ (T3 693-5).

**‘Carer’ role**

- *Client dependency
  Relatives (F) only
  ‘I think I’m coming to terms with the fact that he’s going to be our responsibility. He can’t survive on his own.’ (F2 608-9)
  ‘For 8 years, I’ve handled her paperwork, basically her son and her paperwork’. (F3 168-9)

- *Emotional burden
  Relatives (F) only
  ‘I get upset over things. Because I see a deterioration in my son, you know. He was such a sort of happy go lucky person’ (F2 332-3)

- **‘Secrecy’ to family – protect from upset/impact on family
  C,F
  ‘when you say these things out loud, first of all what her husband did to her and things, it was like she was frightened to say it to us unless it antagonised us’ (F3 130-2)

- *Relatives’ understandings of therapy – ‘strategies to deal’
  Relatives (F) only
  ‘they apparently were discussing strategies to deal with the voices’ (F3 94-5)
  I: ‘what do you know of the therapy that he’s had?’
  F2: ‘I think um trying to get him to deal with voices’ (F2 149-50)

- *Therapy is confidential – so don’t know about intervention
  F,R
  ‘So we weren’t privy to what was being discussed. Not that we wanted to be. We wanted June to have the freedom that you know, we weren’t listening to whatever her thoughts were or what have you’ (F3 89-92)
  ‘…she’s wanted to keep the work that she’s doing with [therapist], with [therapist]’ (R3 180-1).

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