DOCTORAL PORTFOLIO IN COUNSELLING PSYCHOLOGY

by

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DECLARATION

The research dossier or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated).

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Dedications

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All work throughout this portfolio has been appropriately anonymised and all identifiable information removed, so no participant can be identified.
Preface: An Introduction to the Portfolio

This portfolio contains a selection of work completed for the Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton. It contains three dossiers: Academic, Therapeutic Development and Research.

The Academic Dossier contains papers that were submitted for the following modules: ‘Introduction to the Psychodynamic Approach’ and ‘Issues and Ethics’. The Therapeutic Dossier contains an essay exploring three years of placements (‘Supervised Practice’) and an essay reflecting on my professional development (‘Professional Issues’). Finally, the Research Dossier contains a literature review, a research report and critical appraisal.

Confidentiality of clients, research participants and their families has been protected throughout the portfolio. Individuals’ names and places have been changed and any potentially identifying information has been omitted or anonymised. Client studies, process reports and all raw data (including interview transcripts) are available in the Confidential Attachment that has been submitted separately and is not available to the public.
The following paragraphs discuss my journey becoming a counselling psychology trainee and the content of the portfolio and the different pieces of work included in the three dossiers. Each piece was specifically selected as it represents part of my academic and personal journey that has shaped the professional that I have become to date.

I have been interested in psychology for many years. I worked as an administrator in an NHS speech and language therapy department. I was really interested in reading the reports that the educational and clinical psychologists wrote about the clients on our caseload. At this time I was undertaking a business studies degree part time at Wolverhampton University which I went on to complete. I then went to work in a further education college and began teaching basic skills to students who struggled with reading and writing. Whilst working in this job I met a great cross section of society and as the college’s ethos was one of inclusion many of the students that I met had come from very difficult backgrounds. One group, in particular, that I worked with will stay in my memory. They were a group of students who had been expelled from school. I remember vividly the stories they told me about their lives and the difficult backgrounds they came from. I got on well with the group and they engaged well with me because I respected them and listened to them. After having had my three children I decided that I had lost something of myself and decided that maybe this was the time to do something different with my life. It was then that I decided to pursue my interests in psychology and I undertook the undergraduate degree. This was a life changing event for me. The third year of the degree was especially interesting as a more critical stance was taken by many of the lecturers. It was then that I was introduced to the counselling psychology module which opened up a whole new area of interest for me. It was this module that
introduced me to auditory verbal hallucinations and the effect they had on people.

The essays contained within the Academic Dossier reflect some of the issues that counselling psychologists face in their professional work. All of the modules I have undertaken as part of this course have introduced me to new ways of working with clients. I feel strongly about Rogers' core conditions and person centred therapy is the foundation on which I work (Rogers, 1951). When I feel I am struggling I have confidence in that I can go back to the basics and just be with the client. It feels like a safe place to be both for me and for my clients. I had preconceived ideas about cognitive behavioural therapy (CBT). I felt it was too simplistic in nature and did not really get to the core of the person’s problems. I was quite surprised, therefore, that I came to rely on its techniques with many of my clients. I felt that the integration of person centred therapy and CBT worked well. These were our mainstay therapies in our first year of the course. We spent a great deal of time practicing the techniques in session with each other and I became confident quite early on in using them both together with clients. Some clients worked really well with CBT and would do their homework and stick to it rigidly; others however were not so keen. Other approaches were also interesting such as life span theory which was something I had not come across before but now which is present in my thinking about all clients that I work with. The psychodynamic module was of particular importance to me. The essay on the essential features of the psychodynamic approach was an important piece of work as in writing it I realised the importance of what I had learnt from the module. This approach had always been something that I found interesting but that I felt was too complicated for me to use in my everyday practice. I had been introduced to it on my undergraduate degree but had never really had the opportunity of applying it to practice. I have found
the features of the psychodynamic approach to have had the most profound impact on
my work with clients as it has enabled me to understand how issues of transference and
countertransference can muddy the waters of therapy. It helped me particularly in the
working with one client who had a diagnosis of personality disorder as it enabled me to
understand how she related to others through her relationship with me. I came to realise
that some of the emotions that I thought were mine during therapy sessions were
actually those of clients. This was a real turning point in my training as I felt it gave me
a greater insight into clients’ worlds. Why did I feel angry when some clients sat in the
room with me? If I felt angry did other people feel angry in their company? I feel that
the power of transference and countertransference is immense. The skill is in being able
to disentangle what are my own emotions and what are the clients. I remember always
feeling extreme fatigue with one particular client and I thought at first that this may
have been due to the time of day that I arranged appointments with him. In changing
the appointment time I realised that it was not the time of day. Through undertaking the
psychodynamic module I realised that I was actually feeling his tiredness, the fatigue he
felt because of his continual anxiety. This is how it left him feeling and I had an insight
at that point into how difficult he found doing everyday activities that I just couldn’t
comprehend before. There is something about the features of this approach that have
become fundamental to me as both a professional and as a person. It has also led me to
think about how I can integrate the psychodynamic principles more in my every day
clinical practice and how they help me in my everyday life.

When I began writing the essay on ethical issues I felt quite demoralised by the dryness
of the subject. I always feel that ethics is something that we read about because we
have to cover ourselves by codes of conduct. However, what I realised whilst doing the
research required for writing the essay was the wider implications of ethics in clinical practice. I decided that I would focus on the ethical implications of working with clients of a different culture. This came about mainly as a result of a discussion I had with my clinical supervisor about the low incidence of ethnic minorities accessing psychological services. Writing this essay made me think of how, as a counselling psychologist, it is my aim to help all clients who are experiencing psychological distress, however, in this attempt I may be working outside of my own limits of competence. This is especially true when working with clients of a different culture as it is important that preconceived ideas are not made about as person because of their ethnicity or culture. As an NHS practitioner I would not be considered to be ethical if I refused to see a client because of their culture, however, from a beneficence perspective I may well be doing my best for the client by refusing to work with them! What this indicates is that there is the constant need for questioning my ability and my knowledge and it highlights the important of continuing professional development in working with clients from different backgrounds.

The essays contained within the therapeutic dossier relate to my growing identity as a professional working within the context of the NHS. My ‘Supervised Practice III’ essay details my journey through my clinical placements and documents my growing confidence and autonomy. It details my changing supervisory needs and how these were managed. Throughout my career to date I have focused on working with adults, and my placements have been adult focused. I have worked with clients with a range of issues from depression and anxiety through to psychoses. I have a particular interest in psychosis and the way in which it is constructed through diagnosis. My placement with an early intervention team afforded me the opportunity to work with many individuals
who had been diagnosed with schizophrenia which has enabled me to see first hand the
impact that both the illness and diagnosis and treatment has on their lives. I have been
lucky enough to be able to apply many of the therapeutic techniques that I have learnt
from the course in an integrative way in working with clients with psychotic symptoms.
As my research is also in this area it has been beneficial for me to have first hand
experience of the issues that professionals experience in working in this area.
Supervised practice has been possibly the hardest yet the most enriching experience I
have ever had, excluding motherhood. I have learnt so many things as a result of this
part of my training. However, most of all I have learnt that I do not, and will not, ever
know everything and that there is always room for improvement!

My ‘Professional issues’ essay details my growth as a professional. It was a very useful
piece of work as it made me document my complete journey, taking me way back to
when I first became interested in psychology through to the fairly recent present, where
I was working as a professional and being respected as one in a team of mental health
professionals. It reminded me of why I had decided to undertake the training and I
found that it came at the right time as I was beginning to doubt myself, and my motives
for putting myself through the stress of the course when I also have a family to look
after. It reminded me of a conversation that I had with my research supervisor when she
said that she felt that I had chosen my research topic because of my passion about
fighting injustice. I remember back to my undergraduate course when I was shown a
video about people that hear voices and the impact that this had on me. I have read a lot
about the subject since then and attended conferences and seminars run by the Hearing
Voices Network. I also did some training with Rethink to become an advocate. I
always knew that any research I would undertake as part of this course would be in
relation to hearing voices. Hearing voices is considered to be a major symptom of psychosis and in my research and work I have come to find this area fascinating. The more I read and the more I experience, the more I question the validity of the construct of psychosis. Research and writings by authors such as Bentall (2006), Boyle (2007) & Ross (2007) amongst many have informed my questioning of the label of psychosis.

The research dossier presents a different aspect of me as a professional; it represents me as a researcher. This identity took more time to develop. I prefer people to paperwork; therefore I knew from an early stage that my research would probably be qualitative in nature. I have spent too long sitting at my computer and I yearn to get back into my client work. Yet, what has surprised me is that I want to develop my research skills further, mainly because I believe that clinicians are the best people to be doing research and not enough is done because clinicians generally prefer people to paperwork and don’t have the time to undertake research. As I prefer people and as what seemed lacking in the research in this area were the voices of the people most affected by hearing voices were the clients I felt that a qualitative approach was the best way in illuminating important issues. As it was people’s subjective experiences I was interested in it seemed obvious that Interpretative Phenomenological Analysis (IPA) would be a good methodology to use. We were introduced to different forms of methodology in our first year and I had felt at this stage that IPA sounded exactly right. In discussing the subject with one of the lecturers who I approached to be my supervisor, he too felt that the methodology would meet my research aims. I had never used or studied this methodology and had never even heard of IPA before this initial introduction as it had never been discussed at undergraduate level. Prior to starting my analysis I read books, found previous articles that had used IPA and attended
conferences to ensure I knew what I was doing. However, the more I read, heard and learnt the more aware I was becoming that there is no right or wrong way to do IPA which was both daunting and liberating at the same time! Most experts encouraged you to find your own way of conducting the analysis. This scared me because how did I know I was doing it correctly. IPA is also based on a double hermeneutic which means that the analysis is based on my interpretation of the participants’ interpretation of their experience. My interpretation will be influenced by many things such as my past experiences, my family values and my cultural background, for example, are unique to me. This made me doubly careful in my analysis to the point where I got so worried that the themes I had elucidated were from my own preconceived ideas that I hit a block, which my supervisor helped me climb over!

My research is by no means perfect but I believe that I have uncovered some very important and interesting issues that impinge on clients. I felt it important to interview both clients and professionals in an attempt to gain some insight into how professionals’ perspectives can impact on clients’ care. The research process highlighted my difficulties in integrating research with practice as I struggled somewhat with what the client participants talked of, mainly because I felt they had not had the best experience with their care. The tension of clinician/researcher, I feel, is a difficult one because as a clinician it is possible to perceive avenues for exploration that would benefit the client but it is not appropriate or ethical. I wanted to undertake what I felt was real research with clinical populations and professionals on the front line of mental health care. It was an ambitious endeavour and one I have cursed myself for undertaking many times but I feel that I can look myself in the mirror and feel proud that no matter what, I have done my best by both the clients and the professionals in my research study.
Throughout my training and clinical placements I have always taken a critical stance. As I reflect on my research strategy, I am aware that it has been influenced by the philosophical perspective that I have developed during the pursuit of finding out more about hearing voices which has then led me on to finding out more about illnesses such as schizophrenia. I have had to be very careful when analysing the data from my interviews that I did not draw too many assumptions about my issues with the medical model and psychiatric diagnosis. I have tried my utmost to be as open minded as I can in my analysis of the data and in my writing of the research report. As a counselling psychologist I see myself as an integrative practitioner, heavily influenced by the postmodern/constructionist philosophical thinking. I believe that there can not be any objective and absolute “truth” about what it means to be a fully functioning human being. There are only different perceptions and ways of seeing, constructions of reality. (Gergen, 1997; Rorty, 1999). In my critical stance throughout my studies in psychology I have always been sceptical of the medical model and the way in which psychiatrists diagnose clients with illnesses. I have felt angered by the injustices that clients suffer as a result of the stigma that is attached to mental illness, purely because they have experienced adverse situations in their life. The unfairness of this makes my blood boil, yet through my research I have come to an understanding that I didn’t have before. In interviewing psychiatrists I have developed a better understanding of the challenges that they face in working with people with serious mental health problems and I have met some psychiatrists who have the same opinion that I have of the medical model. I have met some lovely people, professionals that really do care about their clients but who are restricted by the systems in which they work. I also have come to understand that although the DSM may not be the best system for diagnosing clients that it has its uses
in helping professionals categorise and make some sense of the myriad of problems that clients present with. My belief is that we seriously need a new system of diagnosis but I am not knowledgeable enough to know what this should be. All I know is that the more that a professional learns about a client the more able they are to make informed decisions about why they are ill. In simplistic terms, we need to collect more information on clients’ backgrounds to ascertain why they may be behaving in the way they are. I feel that there are a massive amount of clients that are falling ‘through the net’ of misdiagnosis and are therefore not being treated appropriately for their issues. These people end up in the mental health system for life. This is unfair and this is the reason that I aim on undertaking more research in this area. This is my first attempt at qualitative research and I hope it adds to the knowledge that we have on diagnosing and treating clients who hear voices.
References


Academic Dossier
Identify the essential features of the psychodynamic approach to counselling psychology with examples of expression within your clinical practice.

Counselling psychology is committed to recognising and establishing the value of the three major traditions in psychology of phenomenological and psychoanalytic/psychodynamic traditions alongside the cognitive behavioural tradition (Strawbridge & Woolfe, 2003). The psychodynamic approach to counselling psychology has its roots in the theories of Sigmund Freud, and was initially developed in the 1940s. His studies focused on the belief that our emotions, thoughts and behaviour stem from the unacceptable thoughts from childhood that we allow to influence our current thinking. These repressed thoughts and feelings eventually manifest as depression, fears and conflicts. The approach is based on a number of key analytical features including Freud's ideas about psychosexual development, defence mechanisms, free association and the therapeutic techniques of interpretation, including that of transference, defences and dreams. Counselling psychologists place great emphasis on the importance of establishing and maintaining a strong therapeutic alliance and the idea of therapy being a shared exploration, “a process of mutual discovery into which the helper brings his or her own personal emotional baggage” (Strawbridge & Woolfe, 2003). It is argued that psychodynamic concepts, such as transference, counter-transference and defences can be used by the counselling psychologist to help understand and manage certain difficulties that arise within the therapist-patient relationship (Goldberg, 2000) and that such concepts can even be used as therapeutic tools (Grant & Crawley, 2002). Within this essay I aim to identify how transference, countertransference and defences, as concepts or features, can be useful...
when working therapeutically with a client and in order to do this I will be using expression from my own clinical practice. I shall use pseudonyms in doing so instead of clients’ real names for the sake of confidentiality (BPS 2002).

In my training as a counselling psychologist I have only recently been introduced to the psychodynamic model. I have previously been trained to work using the person centred model and the cognitive behavioural model and these models have underpinned my clinical work to date. Having been introduced to the concepts of the psychodynamic model, I now am beginning to understand some of the complexities of the therapeutic relationship that I was struggling to make sense of before. I have found the concepts of transference and counter-transference have held much resonance with me in my thinking about how my relationship with the client can affect my therapeutic work.

Jones (2004) describes transference as an unconscious transferring of experiences from one interpersonal situation to another. It is concerned with revisiting past relations in existing circumstances. Thoughts and feelings about significant others from one's past are projected onto a therapist, or others, and influence the therapeutic relationship. Sudbery and Winstanley (1998) identify occasions when the role of transference within counselling should be considered. For example, situations of emotional distress, when ‘comforting’ is required may have its roots when as a child he/she needed 'holding' from an adult but did not find the comfort or reassurance needed. This need may to be met in an appropriate form by the counsellor.

I have been working with ‘Mark’ for 6 months. He was referred to the psychology department because of social anxiety. There have been a few times with Mark when I
have felt an overwhelming urge to comfort him, even though he was not visibly upset, and although I have felt this urge with other clients this feeling was really strong and I have, on some occasions, wondered whether it was sexual attraction that I was feeling which initially caused me a great deal of anxiety. In one session when I was feeling a strong urge to comfort Mark, he was talking about his mother and how he couldn’t remember her comforting him and how he felt isolated by the fact that no human being ever touched him. I realised at this point that it was not sexual attraction that I was feeling towards Mark, it was more about wanting to mother him. From a psychodynamic perspective I can see that Mark may be transferring his needs for motherly love and comfort on to me.

Freud (1940) argued that one of the advantages of transference “is that in it the patient produces before us with plastic clarity an important part of his life-story, of which he would otherwise have probably given us only an insufficient account. He acts it before us, as it were, instead of reporting it to us”. In understanding Mark’s transference I have gained more insight into the depth of his feelings about his neediness for love from his mother than any words could have expressed. Before this realisation I had been seeing Mark as someone that had anxiety about being with people and although he had talked about his relationship with his mother being difficult I had not comprehended the level of Mark’s distress.

Freud (1940) described transference as something that occurred on a regular basis and that the information about personal motives that a person's transference activity revealed about him or her could be used as a therapeutic tool to promote self-understanding and healing. Grant & Crawley (2002) argue that through the analysis of transference can in itself be an effective therapeutic tool. They describe transference as
a normal organizing process that helps individuals make sense of interpersonal experiences. They believe that therapists can use features such as transference and projection as ‘mirrors to the self’, reflections of a client’s internal structure and core ways of relating to other people. In understanding the concept of transference in the context of working with Mark it has been possible to bring Mark’s feelings towards his mother into therapy and this has shifted the focus of therapy away from Mark’s social anxiety, which appears to be a symptom of his real issues, to his childhood feelings of emotional neglect.

Jacobs (2004) describes countertransference as the counterpart to transference in that it is the feelings evoked in the counsellor by the client. Countertransference refers to a consequence of transference and is complex in that it has different meanings. For example, the term is used to describe not only a direct personal reaction to transference but also the entirety of experiences in response to another person and is used in current practice as a way of monitoring what is going on between the client and the counsellor. The counsellor’s feelings of countertransference may be as a direct result of the relationship with the client or as feelings that belong more appropriately to another part of the counsellor’s life. For example, I am wondering whether, when I am with Mark my feelings of needing to comfort him are more related to my own need to be motherly, after all I have children of my own and I sometimes feel more comfortable in this role than I do of that of a therapist. I sometimes feel the urge to give Mark advice and this too could be more to do with my own need to have control of my children than Mark’s transference of needing a motherly figure. This, I believe, is where the two concepts of transference and countertransference can become difficult to disentangle and that it is only possible to do this through therapist reflection and supervision.
I believe that I have also experienced countertransference where feelings are a direct consequence of being with the client.

“Anne” has a diagnosis of borderline personality disorder (BPD). She was referred to psychology because of depression and self-harming behaviours. She has been in service for approximately 20 years being supported by members of the community mental health team who have labelled her as manipulative. Anne was emotionally neglected as a child and sexually abused by a neighbour in her teens. In sessions Anne talks of another part of herself called “Annette” and we have worked out that Annette is Anne when she was 15 years old, the age that Anne was when she was abused. I believe this can account for some of Anne’s outbursts and tantrums. Initially sessions were fairly positive and Anne made good progress, however, a few sessions in Anne became increasingly negative. In one session I felt that Anne was being particularly difficult and I began to feel extremely anxious to the point where I felt that I couldn’t breathe. I sat there quietly holding the anxiety feeling not sure what to do with it when Anne had an almighty outburst of rage and starting shouting at me saying I didn’t understand her and I had no idea how bad her life was. At this point I realised that what I was actually feeling was a reaction to Anne’s rage and I felt calmer and more in control as I realised that Annette’s transference was affecting me as Anne was acting like a teenager having a tantrum. I have also over time dreaded my sessions with Anne and have often hoped that she would not turn up. I have had to prevent myself from discharging her at various points in time. I have felt dreadful about this and have found it difficult to admit to anyone. On understanding more about the psychodynamic approach I have come to understand that these feelings are possibly related to countertransference as a result of Anne’s transference about being neglected as a child maybe I am feeling like the parent that neglected her.
I understand that I have been experiencing a great deal of countertransference with Anne and it has enabled me to understand how the team have come to be so frustrated with her which has made me less annoyed with them. It has also given me some insight into how Anne affects other people in her life and why she has become isolated and lonely. I have mentioned this in one of our reflective moments whilst undertaking the psychodynamic module and the tutor gave me an idea that possibly the best way forward with Anne would be to use the therapeutic alliance as a tool as it may be possible to use our relationship as a way of demonstrating to her the affect she may have on other people using the concepts of transference and countertransference.

Clarkin, Kernber & Lezenwerger (2007) believe that the key issues that cause the symptoms of BPD are related to dysfunctional relationships in childhood that continue to impact adolescent and adult relationship functioning. The theory is that through interactions with caregivers in early childhood, we develop a sense of self, as well as mental representations of others. If something goes wrong during this development, we may have difficulty forming a solid sense of self, or have problems in how we relate to other people. Because the symptoms of BPD include significant problems in relationships and instability in sense of self, some experts have proposed that BPD needs to be treated by building healthier relationships through the use of transference. Anne’s emotional neglect in childhood and her abuse continue to affect her adult relationships. In working from a psychodynamic perspective I am now working with Anne on the transference and countertransference between the two of us in an attempt to build a positive relationship that can provide her with a model of how she can build on relationships with other people around her for the future.

Nacht (1963) argues that countertransference is at times more important to the
development of the cure than the conscious one and can be used as a therapeutic tool within itself to gain some insight into what is happening in the client’s unconscious. Transference and countertransference can almost be described as clues to what is happening in a client’s unconscious and thus can be used as so. Bott Spillius (1988) argues that much of our understanding of transference comes through our understanding of how clients draw us into their defensive systems and how they unconsciously act out with us in their transference, trying to get us to act out with them too. The use of defence mechanisms can indicate problem areas for a person, as a defence mechanism gives some relief from anxiety producing thoughts and actions at the expense of distorting the real world (Jacobs 2004). Defence mechanisms can take various forms including: denial; repression; regression; reaction formation; projection; rationalisation; intellectualisation; displacement and sublimation. Defences can be used by a person, consciously or unconsciously, to avoid facing aspects of themselves which they feel are threatening. In order to employ such defences effectively a client employs tactics known as resistances. According to Gill (Kahn 1991), the therapist should help the client to identify the defences they are using, make it safe to the client to express them, discuss them in a non-judgemental and non-defensive way, and eventually help the client learn the roots of these. When identifying the client’s core pain / anxiety in relation to its trigger, it is important to consider what the client is capable of managing (Lemma 1996). Lemma suggests formulating the consequences for the client of not using defences, and to think developmentally; consider the client’s level of personality organisation.

Despland, Roten, Despars, Stigler, Perry (2001) argue that the therapist has to choose the appropriate proportion of supportive to exploratory interpretations, giving consideration to the level of defensive functioning as an immediate indicator of
personality organization and ego strength in a given session. The therapist will influence the early development of a positive alliance when there is a positive adjustment of therapeutic interventions to the patient’s defensive functioning, whenever the patient’s defensive functioning is low the therapist must be more supportive, whereas whenever the patient’s defensive functioning is high the therapist should use more interpretive techniques. To be supportive, in general or in response to a patient’s level of defensive functioning may be necessary, but supportiveness alone is not sufficient to contribute to alliance building. Rather, at each level of a patient’s defensive functioning there appears to be some specific range of more exploratory interventions that will be optimal to facilitate growth of the alliance.

Initially in sessions, whenever I attempted to explore Mark’s childhood he appeared to not want to discuss this and whenever I did manage to get Mark to talk about his life as a child he would say that he was privileged to have had a good childhood. I had a feeling that Mark’s defensive functioning was high as he was avoiding this area and he would often attempt to change the subject. When I asked Mark about his childhood he would say that he couldn’t remember a great deal. I was not sure if this was an excuse not to talk about his childhood. I decided that I needed to explore further even though Mark was apparently uncomfortable with this but I had a real feeling that it was getting in the way of therapy. I really didn’t feel that I had a great deal of insight into Mark’s feelings about his childhood as he seemed disconnected from his emotions. In one session I discussed this with Mark and he became quite agitated saying that he was telling me the truth and wasn’t intentionally keeping things from me. I decided that I would use his agitation as the focus of our discussion as this was the nearest I had got to seeing any emotion from Mark at this point. In the next session Mark said that he had thought about this and he felt that the reason he was not talking too much about his
mother was because he was hurt by the way she had treated him over the years and that he felt a great deal of guilt talking negatively about her. He also said that he could honestly not remember a great deal about his childhood and that this concerned him as he wondered if something terrible had happened to him as a child that he had repressed.

It appears that Mark had been using defences both consciously and subconsciously to avoid talking about his childhood, consciously because of guilt and subconsciously as a result of fear. What has been positive is bringing Mark’s defences into consciousness appears to have helped Mark realise that the clue to his problems lie somewhere in understanding his childhood. In later sessions Mark talked about wanting to try and remember more about what happened to him as a child and we have since used photographs and talked a great deal about his childhood as an attempt at this. He appears to have come to the conclusion that maybe there was not a major trauma in his life that may have impacted upon him in adulthood but that his mother’s consistent volatile behaviour and apparent lack of emotional support have created an anxiety in Mark that has almost become a part of who he is. It appears that Mark’s social anxiety is a manifestation of his anxiety that he experiences in relation to his mother and has Mark still lives at home he is reminded of this on a daily basis. We have decided that rather than work on the social anxiety it is necessary that Mark gain more insight into his relationship with his mother using our transference and countertransference to assist with this.

Counselling psychologists are trained in a variety of therapeutic approaches and can therefore have choice in their own clinical approach. Personally I choose to work integratively as I feel that this enables me to adapt to the client’s needs. I have found the psychodynamic approach to counselling psychology has had a massive impact on
my work with my clients and although I can not profess to be fully trained in this approach I feel that I am able to understand the relationship between my clients and myself a great deal better. I also feel that it provides me with a greater insight into their inner worlds. In my opinion the psychodynamic approach is crucial in the training of any therapist. I have found the approach has not only helped me in my clinical work but that it has helped me reflect on my own life and how issues from this can impact on the therapeutic alliance which is essential to being an effective reflexive practitioner. Being reflexive is something that I am becoming better at and in doing so I understand that supervision has an important role. As a trainee counselling psychologist I have supervision on a weekly basis. The psychodynamic approach has enabled me to realise that in order to work through my issues and, as mentioned previously, disentangle issues related to transference and countertransference, supervision is imperative to enable me to understand the complications of my therapeutic relationships. I would argue that, as corny as it sounds, and without any scientific evidence, I have become a more reflective therapist, and person, as a result of being introduced to the psychodynamic approach.
REFERENCES


What ethical issues arise for a counselling psychologist working with a client of a
different ethnic origin? Is it ethical to work with someone of a different culture?

As a professional, the counselling psychologist has prescribed ethical codes of conduct by which “should pervade all professional activity” (BPS, 2009). Ethnic-minority groups, which are growing in number in the UK annually, are still under represented in counselling and therapy (Lago & Thompson, 1996) even though the professional has a choice of over 400 therapies to use with clients (Bergin & Garfield, 1994). Counselling and psychology, in general, remains a predominantly white occupation with relatively few ethnic-minority counsellors or clients (McLeod, 1993). Of the small number of minority clients who seek counselling, there is some evidence to suggest that many are dissatisfied and disenchanted because of its failure to address fundamental issues related to client differences (Bimrose & Bayne, 1995; Sue & Sue, 1990). Many also terminate counselling pre-maturely. Although these findings have not been researched adequately, it seems that there is an argument that the psychology profession is not acting ethically in terms of respecting individual, cultural and role differences of the minority communities. Evidence suggests that these communities are unhappy with the quality of care they are given by the mental health professionals. Included within this group of professionals is the counselling psychologist whose philosophical underpinning is to understand the individual’s inner world and construction of reality. This essay aims to explore the ethical issues that may arise for a white counselling psychologist in working with a client of a different culture.
It is reported that immigration will account for two thirds of population growth in the UK over the next quarter of a century. Approximately 180,000 immigrants arrive in this country every year. The most recent census of the population was carried out in 2001 by the Office for National Statistics and revealed that 9% (5,055,871) of the UK population declared themselves to be Asian, Black, Chinese or of mixed heritage (ONS, 2001). In London alone there are more than 300 languages spoken by children, making it the most linguistically diverse city in the world (National Literacy Trust (2008). Though 71% of the population described themselves as Christian, approximately 15% (7,342,905) of the population belonged to numerous other religious denominations.

Detention rates of people from black communities under the Mental Health Act are now at an all time high. Figures from the government's "Count Me In" Census report on inpatient care show that black people are over 44% more likely to be sectioned than their white counterparts, despite having similar rates of mental ill health as any other ethnic group (The National Mental Health and Learning Disability Ethnicity Census, 2005). This has highlighted the need for services to bring down rates of admission for people from black and ethnic minority communities, by addressing those factors that can help prevent the illness from becoming acute (DoH, 2005). In Western nations, ethnic minority groups have experienced difficulties in gaining access to mental health care (Steel, Mcdonald, Silove, Bauman, Sandford, Herron & Minas; Klimidis, McKenzie, Lewis, & Minas, 2000; Bruxner, Burvill, Fazio & Febbo, 1997).

Relative to the majority population, members of ethnic minority groups are underrepresented among patients receiving mental health services (Minas, 1996) and tend to underutilize mental health services (Meinhardt & Vega, 1987; Padgett, Patrick,
Underutilisation and under representation of ethnic minority groups have been attributed to barriers to initial access to mental health services (Steel, et al., 1998; Klimidis et al., 1999; Minas, 1996) and to early dropout (Sue, Stanley, Fujino, Hu, Takeuchi, Zane, 1991), which have been attributed to a wide variety of factors. These factors include insufficient knowledge of the mental health care system in the ethnic community, clinicians’ failure to recognize mental illness among ethnic minority clients, ethnic minority groups’ association of substantial stigma with disclosure of emotional or psychiatric problems, substantial delays or use of alternative forms of managing mental health problems before seeking psychiatric care, and initial perceptions and experiences suggesting that the mental health system does not provide acceptable or appropriate care for members of ethnic minority groups.

The helping professions, including psychology, have been slow to develop ethical guidelines that specifically address culturally sensitive counselling and psychological services. However, there is considerable counselling literature on defining multicultural competencies for competent cross-cultural practice (Arredondo et al., 1996; Arthur & Januszkowski, 2001; Corey, Corey, & Callanan, 1998; Sue & Sue, 1999). There have been significant calls for professional associations, especially counselling psychology, to include more specific guidelines to address multicultural counselling in their codes of ethics (Casas, Ponterotto, & Gutierrez, 1986; Cayleff, 1986; Ibrahim & Arredondo, 1986; Pedersen, 1989, 1995, 1997a, 1997b; Ponterotto & Casas, 1991; Sue et al., 1992). When particular populations do not receive, or perceive themselves as not receiving competent and ethical services, the question arises, "Are professional codes of ethics relevant for multicultural counselling?"
Pedersen (1995, 1997) believes that codes of ethics generally minimize or trivialise the role of culture in ethical decision-making. He argues that ambiguously stated standards tend to protect the status quo and that the guidelines do not deal with the fundamental ethical issues of bias in the profession but are designed to protect the professional against the culturally different client. The lack of attention to multicultural issues in counselling and the tolerance for violations of the generalized guidelines that do exist demonstrate how principles are violated without consequences. Pettifor (2001) argues that there are forces within both the professions and society generally that can be seen as supporting unintentional racism. In the professionalisation process, psychology has defined its identity, its training, and its scope of practice on a scientist-practitioner model, and has established licensing requirements that are unicultural, and not always conducive to recognising diversity or to developing cross-cultural competencies.

Counselling psychologists are often faced with situations which require sound ethical decision making ability within the parameters of ethical codes that appear to sometimes conflict with each other. Determining the appropriate course to take when faced with a difficult ethical dilemma can be a challenge. The Counselling Psychologist is bound by the British Psychological Society’s Code of Ethic and Conduct (BPS 2000) and the Health Professions Council, Standards of conduct performance and ethics (hpc, 2009). As counselling psychologists it is also important to take into consideration the British Association for Counsellors and Psychotherapists’ Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP 2005).

The British Psychological Society (2009) states that “ethics is related to the control of
power” and suggests that many clients are “disadvantaged by lack of knowledge and certainty compared to the psychologist whose judgement they require”. However, in relation to multicultural counselling, research indicates that it is difficult for the westernised psychologist to make judgements about people of different cultures (Sue & Sue, 1995). Therefore there is an argument that in working with someone of a different culture the professional could in fact be practising unethically. For example, in examining the ethical principle of “competence”, the importance of preserving the ability to function optimally within the recognised limits of knowledge, skill, training, education and experience could be interpreted in such a way that a psychologist may decide that her skills and experience, at this point in time, are not sufficient enough for her to work effectively with someone of a culture that she lacks knowledge of. In this situation would it be more ethical for the professional to refuse to work with that client or would this be interpreted as discrimination, especially if working in an organisation such as the NHS with its policies of equal opportunity and strategies for improving access to psychological therapies (IAPT) (DoH, 2007). In terms of the Health Professions Council ethical guidelines (hpc, 2009), the psychologist may be both contravening the requirement of practising in a non-discriminatory manner at the same time as being expected to act within the limits of her knowledge, skills and experience.

The counselling psychologist may also be a member of the British Association of Counselling and Psychotherapy (BACP), or may feel committed to its ethical principles (BACP, 2005). In this situation the professional may feel that there is a conflict between the principle of beneficence and that of justice. Beneficence being the commitment to promoting the client’s well-being and acting in the best interests of the client based on professional assessment in working strictly within one’s limits of
competence and providing services on the basis of adequate training or experience. Justice being a commitment to fairness requiring the ability to appreciate differences between people and to be committed to equality of opportunity, avoiding discrimination against people or groups contrary to their legitimate personal or social characteristics. It is possible to see here how the counselling psychologist may struggle as she may feel that she does not have the appropriate knowledge or skills to work with a certain client group but at the same time she may be committed to ensuring that there is an equal opportunity for clients no matter what there culture is. Also as Woolfe, Dryden & Strawbridge (2003) states ‘any action or attitude that discriminates on the grounds of race, gender, disability, class, religion, is contrary to the core beliefs of counselling psychology. There is an argument therefore that the ethical codes of practice promote a great deal of conflict for the professional. These are just some examples of the complexity of working within ethical guidelines and the conflicting choice of decisions they raise for the professional.

Thinking about ethics pervades all professional activity including how the professional works therapeutically with a client. It can be argued, therefore, in order for a professional to act ethically it is necessary that they use the most effective strategies that they can in working with clients. Psychologists are increasingly being expected to practice from an evidence base Woolfe et al., 2003). Evidence based practice is based on a body of scientific knowledge about service practices, for example, referral, assessment, and case management or about the impact of clinical treatments or services on the mental health problems of children and adolescents. The knowledge base is created through the application of scientific methods that examine the impact of certain practices on outcomes for the client. Even though there is an increasing demand for
psychotherapy among ethnic minority populations there appears to be little adequate evidence that empirically supported therapies are effective with ethnic minorities.

Sue & Sue (1999) argue that most western psychotherapies share some common therapeutic characteristics which are derived from the profession’s standards of practice and ethical codes of conduct. They are conducted generally in a one-to-one relationship, the primary responsibility for change resides with the person, the medium by which helping occurs is verbal, achieving insight is valued, and clients are expected to self-disclose their most intimate thoughts and feelings.

In behaving in an ethical manner there are certain therapeutic taboos that are present in definitions of the helping role; therapists do not give advice and suggestions (it fosters dependency), therapists do not self-disclose their thoughts and feelings (it is unprofessional), therapists do not barter with clients (it changes the nature of the therapeutic relationship), therapists do not serve dual-role relationships with clients (there is a potential loss of objectivity), and therapists do not accept gifts from clients (it unduly obligates them). Sue & Sue, (1999) argue that these taboos are culture-bound and that although they are present for reasons of safeguarding the clients many of these characteristics are intimate aspects of help giving in other cultures. For example, gift giving in many Asian cultures has a long-standing historical/cultural sanction in the helping relationship (Sue & Zane, 1987); expression of the helper’s thoughts/feelings is seen as evidence of sincerity and humanness, necessary attributes of the helping relationship among many Asians and Africans (Parham, 1997); the giving of advice and suggestions is perceived as a helping characteristic among many Asian groups (Laugani, 2004); and, among many Afro Caribbean’s, multiple-role relationships are often
associated with greater probability of seeking help from the healer (White & Parham, 1990).

It is, therefore, highly possible that different ethnic minority groups perceive the competence of the helping professional differently from mainstream client groups. If that is the case, culturally different clients may see a clinician who exhibits primarily therapeutic skills associated with mainstream therapies as having lower credibility and systemic approach to cultural competence is required. Calls for cultural competence in psychology have been prominent especially in American psychology and have been voiced by many psychologists and groups for more than two and half decades (APA, 1993; Arredondo, Toporek, Brown, Jones, Locke, Sanchez & Stadler, 1996; Council of National Psychological Associations for the Advancement of Ethnic Minorities, 2000; Hall, 2001; Marsella, 1998). Yet, demands for integrating multicultural perspectives into the profession have often resulted in resistance for several reasons: belief in the universality of psychological laws and theories (Sue, Carter, Casas & Fouad, 1998) and the invisibility of ‘ethnocentric monoculturalism’ which depicts the fallacies of Westernised counselling. Sue et al., (1998) argue that according to this concept, the dominant culture, the West, harbours the belief in superiority over the minority cultures and perpetuates this belief through institutions (i.e. through policies, practices, and structures of society). Moreover, as Sue & Sue (1999) explain ‘the West imposes these institutional structures over the minority groups in a pervasive manner, such that they become invisibly imbued in the Western worldview, and thus become the universal truth’.

Increasingly, however, psychologists are recognising that psychological concepts and
theories are developed from a predominantly Euro-American context and may be limited in application to the emerging racial and cultural diversity in the United States and the United Kingdom (Marsella, 1998). Some have even argued that western psychology may become “culturally obsolete” unless revised to reflect a multicultural perspective (Hall, 1997; Sue & Sue, 1999). The likelihood of this becomes more apparent when examining the population statistics for the next twenty five years.

These arguments are supported by studies in relation to therapeutic practices which have shown that low-income minority ethnic people are less likely to seek and complete mental health treatment (Agosti, Nunes, & Ocepeck-Welikson, 1996) and that where they do; they are more likely to seek therapists from the same ethnic background (Thompson, Bazile, & Akbar, 2004; Sue et al., 1991). Maramba, Hall & Nagayama, (2002) found that although racial matching did not improve treatment outcome, it did increase mental health service utilisation and retention. Sue, Akutsu & Higashi (1987) states that:

“intervention or treatment is more likely to be effective when it matches or fits the cognitive map, life style, or cultural background of clients. That is, ideally the intervention strategy is culturally consistent with the expectations and background of the clients”.

There is a further argument that therapists of the same ethnicity to their clients are likely to have had similar experiences and are therefore more likely to fully appreciate, understand and be able to help their clients with their difficulties (Atkinson & Schein, 1986).
The alternative view, and a more hopeful one for the counselling psychologist, is that the culturally sensitive therapist should be able to overcome the differences in the same way they have to overcome differences that may exist between therapist and the client with regard to religion, sexuality, gender, education and socioeconomic status (Vontruss, 1988). Furthermore there is also the fundamental issue that no matter what the merits of matching clients to therapists are the reality is that, at present, there are too few ethnic minority psychologists to facilitate such practice (Department of Health, 2004; Turpin & Fensom, 2004; Williams, Turpin & Hardy 2006).

The National Health Service and specialist agencies within the UK are striving to ensure that they offer services that are inclusive, accessible and appropriate to all users seeking their services (Tribe, 2009). As such, language interpreters have been used to work alongside health professionals to ensure that service users who are not fluent in the English language can gain full access to health and therapeutic provisions. This potentially brings up issues of its own from an ethical point of view of confidentiality and from a therapeutic point of view in relation to the loss of meaning through the therapist lack of understanding of cultural meanings shared, verbal and non-verbal misunderstandings, the use of cultural symbolism and metaphors (Laungani, 2004).

Pedersen (1995) believes that the dominant culture perspective discriminates against persons and groups from different cultural beliefs and that it is racist to demand that others adjust and accommodate to the majority culture. Sue (2005) goes as far as to say that the professional who lacks awareness of self and awareness of diversity may be unintentionally racist. The western emphasis on individual responsibility, achievement
and decision-making may conflict with cultural values of family, community, interdependence, and collective identity. The emphasis on science and objectivity may deny subjective learning experience. Absolutist concepts of the use of power, definitions of professional identity, training, scope of practice, concepts of the nature of mental health and illness, and prohibition of dual relationships may all be culturally insensitive and discriminatory. For example, assessing the hearing of voices or communicating with the dead as psychotic manifestations or counselling young people to establish full independence from their families may be seen as being racis (Pederson, 1997).

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Pettifor (2001) argues that the belief in scientific empiricism and empirically supported interventions has the potential to exclude the use of culturally appropriate humanistic and spiritual healing experiences. Mental health that is perceived as adjustment to the status quo may deny the need for social activism and social change. Purdey & Banks (2001) believe that the institutionalisation of the profession has brought credibility, recognition, and rewards, but has the potential to limit creativity and flexibility in respecting diversity. They argue that there are also forces in society that may work against respect, understanding, and caring for people who are perceived as different. Today the focus on cost control may restrict the ability to fund programs that assist immigrants from other countries. The deontological ethical principles of respect for the inherent value of human beings may be eroded by the utilitarian principles of the greatest good for the greatest number and the adequate return for the money spent (Pettifor, 2001). It can be argued that budgetary cutbacks, capped funding, managed care restrictions, rationing of services, and other developments have the potential to unintentionally discriminate against diverse groups. What is unintentional is difficult to address because motives are not always obvious. Codes of ethics support the development of self awareness and require professionals to practice within their areas of
competency. However, it appears that self-awareness and competency may be better defined, and developed with professional training, continuing education, and supervision that underpins counselling psychology training. Is there more, however, that counselling psychology training and continuing professional development programmes could provide to bridge the gap between the dominant western culture and other cultures?

Moodey (1999) argues that even though there has been a focus on a multicultural context in counselling training over the past two decades with more training programmes including issues of race, culture and ethnicity there is still the criticism that they remain marginal in terms of convincing the minority communities of their value and effectiveness. The evidence for this is in the premature termination and lack of participation by minorities in counselling and therapy. The chief criticism against counselling throughout this period is that, it has remained essentially Eurocentric, ethnocentric, and individualistic. Culture-sensitive counsellors and counselling within a ‘culture fit’ model have been suggested as a way of making the process more appropriate to a diversity of cultures. Furthermore, this has led to some practitioners strongly advocating the inclusion of socio-economic and political constructs as part of a broader definition of multicultural counselling. For example, the issues of power and influence, cultural hegemony, racism and masculinities are becoming key schemas in cross cultural counselling practices.

Laugani (2005) asks “Can one ever envisage a situation where counsellors, regardless of their own cultural origins and backgrounds, will counsel clients from different social, cultural, and ethnic backgrounds in an ethical manner with the same ease as they would
clients from their own culture?” He argues that it is clear that the differences between Western and Eastern cultures present two distinct worldviews, or differential theoretical perspectives and that these differences also reflect differences in their epistemologies.

Pettifor (2001) argues that there are already signs of change within the professions for example, psychologists, feminist counsellors, and multicultural counsellors are recognising the needs of diverse populations and are shifting the practice emphasis from individual pathology to social and community issues. Increasingly an ethic of responsibility to society is being articulated. Governments under the requirements of the European Union, the North American Free Trade Agreement, and the Canadian Agreement on Internal Trade are forcing the professions to develop competency-based criteria whereby each jurisdiction is able to accept the credentials of professionals from other jurisdictions. The opportunity is here to question traditional training programmes and to review and revise current regulatory requirements. The need to justify these on the basis of competency to practice is consistent with both ethical principles and concerns for multicultural practice.

Whatever the psychologist feels about professional standards, they are in place to help maintain the credibility of the professions and ethically these standards must serve the purposes for which they were intended in serving the public interest. Ethically, professionals are required to respect diversity and increase their understanding of individuals, groups, and communities. On a personal level there are possibly many psychologists doing this but it appears that at the professional level there is a lack of emphasis on the need for specialist training in cultural diversity.
Woolfe, Dryden & Strawbridge (2003) argue that frequent questioning and reflection on ethical implications of ideas and actions, both conscious and unconscious, are crucial to the professional development of the counselling psychologist. This essay has been an attempt at exactly this and has raised many of questions which are more rhetorical in nature. Nevertheless, for a practitioner, making such questions explicit aids in the reflection process.

As West (2002) suggests that there is sometimes too great a temptation to have an answer to ethical dilemmas in seeking an ethical code that answers all the issues raised. However, it appears that a better position is to face the doubt and uncertainty involved. West argues that such an approach is perhaps only tenable if one uses ‘ethical mindfulness’. Bond (2000) invites us not to rely uncritically on any ethical code or august body. He advocates cultivating an attitude of ‘ethical mindfulness’ instead he explains:

‘When training counsellors, I have definitely become more committed to encouraging ethical mindfulness rather than an unquestioning adherence to a set of ethical prescriptions, no matter how eminent the source. Being ethical not only involves wrestling with the issues in a systematic and considered way but also taking personal ownership of the responsibility for acting ethically. These are the major components of ethical mindfulness’.

Bond suggests that relying too much or too uncritically on codes and professional bodies might in itself be unethical whilst recognising the burden this then places on the counsellor or researcher:
‘To devolve this responsibility to a professional body or a text is arguably unethical in a profession that is fundamentally about relationships between people in all their diversity. This places a heavy burden on the counsellor. This burden is at its greatest when it is not clear how to resolve an ethical dilemma or in the face of uncertainties caused by the changing circumstances in which counselling is provided. Uncertainty is usually uncomfortable but, in my view, a degree of uncertainty is an inescapable component of counselling for counsellor and client alike’.

Research indicates that the mental health system is not offering an adequate service to the ethnic minority population. Many of the reasons for this appear to be issues at policy level. However, this impacts ethically on the individual professional. The major question raised by this essay is that of whether it is ethical for a counselling psychologist to work with someone of another culture. Reflection on this brings up a number of issues for the practicing professional some of which have been explored in this essay. From a practical perspective, however, a professional’s ethical decision making process may actually not be as free as is suggested by the guidelines to which they work. For a start the professional may have little choice other than to work with the person as a result of equal opportunities legislation. However, from a personal perspective what appears to be important is that at the individual level, the professional is aware of his or her values, biases, and assumptions about human behaviour which as Lakin (1991) argues is about self awareness. It appears that this is the very best that the individual can do? As the debate on the ethics of working with people of diverse cultures becomes more heated there is the opportunity for counselling psychologists to
ensure their diverse skills put them in a better position to meet the demands of the ever changing world in which we live?

4332 words
REFERENCES


Therapeutic

Dossier
Supervised Practice III

Supervised practice has been the most important aspect of my doctoral training. It has enabled me to work with clients in a safe way enabling me to develop and expand my therapeutic skills. I have been lucky that in both my placements I have been able to work using any therapeutic model that I felt appropriate. This has enabled me to include new concepts and techniques to my therapeutic approach as I have been introduced to them, assisting me in the development of my identity as a counselling psychologist. I decided early on that I did not want to work with children and as my research interests are in the area of psychosis I felt that it would be advantageous to work in this area as this would give me a clinical awareness of the issues pertaining to working with this client group. However, I felt that as a first year trainee this may be too big a jump and I therefore decided that I would first of all work in adult mental health where I could work with a client population with a variety of mental health issues in order to get a basic understanding of mental health issues.

Placement 1 – Community Mental Health Team, St George’s Hospital, Stafford

October 2008 – July 2010

My first placement was in a psychology department within an NHS Trust Hospital. The psychology department serves an adult population, with clients aged between 16 – 65 years with a variety of mental health issues ranging from anxiety through to psychoses. The mental health team is multidisciplinary, consisting of psychiatrists, clinical psychologists, a counselling psychologist; community psychiatric nurses, occupational therapists, and has close links with community and GP practices. My
supervisor at this placement was a chartered counselling psychologist who had undertaken her training at Wolverhampton University. I found it especially useful having a supervisor that understood the course as she could supervise in the context of my training.

I used to attend the team meetings every Thursday morning and I got to know the team really well. I sat in on some of my supervisor’s assessment sessions that taught me the basics of assessment and I still use the same assessment sheet that my supervisor devised herself now (see Appendix 1). I remember the first client I saw alone suffered from anxiety and I started off doing some psycho-education work teaching him the basics of anxiety and breathing exercises. I used the modules produced by the centre for clinical interventions as they have some useful resources on their website (See Appendix 2 for one of the modules I used). My supervisor asked the team to identify some clients that were not too severely ill. One of the nurses identified two clients for me to work with. Both of which became regular clients over the next year. Both clients suffered with anxiety and I soon learnt that the causes of anxiety can be so deep seated and different from one client to the next even though the basic symptoms appear the same. One of the clients I worked using mainly CBT with and she really began to become very proficient at keeping her thought diaries. I worked using the Padesky and Greenberger approach as we had covered this quite extensively on our CBT module and I liked the feeling of optimism it held. This client used to carry her thought diaries (Appendix 3) with her in her handbag when she was undertaking a journey that she felt nervous about. She reported that she would get them out and look at them to give her confidence that she had many examples of successful previous journeys. My sessions with her were very
structured and they felt relatively straightforward. Through the thought records we identified some of her negative core beliefs and she could see the links between these and her anxiety which gave her a great amount of insight and a level of power over her anxiety. I always remember the feeling of satisfaction when she came into the last session with a great big smile and a card and chocolates. She had managed to gain a job and was contemplating moving away from home, and she had distanced herself from her domineering mother which had been one of her major anxieties.

My other client's anxiety was two fold it was partly due to a traumatic hospital experience as a child and partly due to her lack of self esteem and assertiveness. My sessions with her felt less structured. I remember at one point really feeling that I did not have a handle on where we going with the sessions. It was around this time I realised that her life was so chaotic that the confusion I was feeling was due to this chaos. I worked using a person centred approach in the beginning with this client as this was the only approach I was really comfortable with at the time. As we were introduced to CBT on the course I gradually starting using some of the techniques which was useful with this client in helping her gain insight into her negative automatic thoughts and to her negative core beliefs. I remember one particular session where she unearthed a negative core belief of her being a “bad person” and she suddenly had a memory of her dead father telling her that she was a bad person and that she was the reason her mother was ill. It was a very emotional session but there was a massive shift in therapy from that day in almost like a great block had been removed (See Appendix 4 for extract from a transcription of the session). We worked on her feelings about herself very successfully after this using person centred therapy. We could not shift the fear, however, that she about the dangers in the world.
around her and her fear of choking. In talking it through at length with my supervisor we realised that what this client was experiencing was flash backs to her traumatic hospital experience. As my supervisor is a qualified EMDR therapist she agreed that the best and quickest way of dealing with this problem would be for her to see the client for 6 sessions of EMDR. This client is now also discharged after achieving her therapy goals.

My supervisor also asked me to see a client who had been seen by another trainee previously and had been discharged but had been re-referred for therapy within 6 months which meant that they do not have to be put on the waiting list, which was at this point over 2 years long. The client was referred, again for anxiety, and I began working with him in a similar way to how I had worked with the other clients I had seen to date, using person centred therapy to begin with and then using CBT techniques. CBT just did not seem to work at all with this client. In fact when I looked back through his notes it was quite clear that he had received a great deal of CBT. The problem appeared to be that he was not at all in touch with his emotions all of his experiencing was happening in his head. He did not even appear to have words to put to his emotions. This was to be my first real struggle with a client. This client has probably had the biggest impact on me for a number of reasons. I think because he was the first client I got to feel totally stuck with and, at times, really irritated by yet I also felt very protective towards him. I went through phases of real hope and phases of real despair in my 18 months of working with him. He brought out both the best and the worst in me as a therapist. At times I felt such strong emotion with him I could not work out where it was coming from. It was only when I was introduced to the psychodynamic approach part way through my work with him that I really began
to understand the dynamics between us. By this stage I had a very good understanding of his problems as what had first appeared to be straightforward anxiety, as it never is, turned out to be a very traumatic childhood, one where the young man had buried memories away so deep that it was almost impossible to work with them. I was now able to use transference and countertransference as part of my therapeutic work with him which worked well (See appendix 5 for extract from my psychodynamic essay). The main reason for his continuing anxiety was the fact that he was still living with the cause of his traumatic childhood, his mother, who was still behaving in the same erratically emotional way that she had all of his life. Although he knew this reality there was something that was preventing him from rescuing himself from this environment. I suppose it’s the old saying “better the devil you know”. I was coming to the end of my placement with the adult team and I decided that I would use our ending as a way of encouraging him to make some change. He had all of the insight, yet on a practical level nothing was changing. Four weeks before our final session he moved out from home and moved into a bed and breakfast as a temporary measure until he could get accommodation.

Our last few sessions were more practical in basis and were more about working out what his next strategy would be and gaining him the practical and emotional support he needed from the rest of team. I had to end therapy with this client, when I felt he still needed support and I found this particularly difficult. I took this to supervision many times and my supervisor and I came to the conclusion that this was the rescuer in me, which I fear is one of my weaknesses or maybe, even worse, the mother in me. We decided that the support that this client now needed was more practical in nature and this was not a role for a psychologist. He had, after all, received a great deal of
my time and my predecessor’s time. However, still today, I feel that twinge when I hear his name mentioned in the office.

A year into my placement with the adult team I decided to take on a client who had a diagnosis of borderline personality disorder and who was a self harmer. I remember her care coordinator coming to see me to warn me of this client’s manipulative behaviour. I can also remember feeling extremely angry that this client was being labelled in such a way. My main reason for undertaking the course was the fact that it was not advocating the medical model and I feel strongly about this. My work with this client was extremely difficult for many reasons. However, the main difficulties I experienced with this client were due in nature to the team. Once I had taken her on as a client, her care coordinator appeared to take on a lesser role with her. This client’s work brought up traumas from her past. We talked about how difficult it would be at first and how sometimes therapy can cause more problems in the initial period. She needed more, not less, support from the rest of the team in this time but the team did not seem to want to work with her at all. I understood that she had annoyed many of them over the years but in my mind their job is to support people regardless of their annoyances. I attended numerous care review meetings with her and we eventually got her the support she needed but the real problems appeared to lie with her care coordinator, who in the end she asked to have changed. I realised quite early on with this client that the work I needed to do with her was two fold. It was about working with the traumatic events from her past and it was also about working with her in alleviating the stress in her life, as this was impinging on therapy. Every session she would come in and offload about all of the stress she had experienced that week. I worked out that the stress was being caused mainly in her communication
with other people, for example, she would be complaining about her CPN or her boyfriend. I decided that it might be worth working from a more psychodynamic perspective in an attempt to use our relationship as a way of teaching her a model of a good, stable relationship as this is something she had never had (See Appendix 6 for extract from my psychodynamic essay). My placement finished and I am aware that she has now got a good level of support and has moved home which was one of her major aims. This was due to the hard work we put into the planning for her care reviews in order that she was very clear and precise about what she wanted so that the team could not say that she was just being manipulative again.

My supervision in my first placement was exactly what I needed as a first year trainee. I felt really supported and nurtured. My supervisor was very protective to begin with and ensured that I did not have clients that would cause me too much anguish. Hess (1987) identifies 3 stages of supervision from the perspective of the supervisee and the first stage is the inception stage involves a role induction for the therapist and demystification of therapy. In this stage various fears and fantasies are activated as a sudden change occurs; for example, the realisation that one is now really responsible for a live client who has real problems. This makes a great deal of sense to me and I gained the exact supervision I needed to manoeuvre me through this stage. However, as I proved to her that I was resilient enough to cope with a greater severity, she allowed me to choose my own clients from the waiting list. This is what Hess describes as the skill development stage which involves an increasingly better fit between one's clients and the didactic and experiential materials being mastered. Differentiation occurs in being able to view clients' particular needs and one's particular skills and modifying the latter. This is when I began to develop a sense of
autonomy. I began to find in supervision sessions that my supervisor would bring up issues she was experiencing with clients of her own and I would offer my perspectives and she would take them on board. Towards the end of my first placement supervision became more of a sharing experience than one where I felt that I needed to gain advice. I was able to almost sift through what my supervisor was offering me and accept what I felt was valid and graciously decline what I felt was not. Towards the end of this placement I began a dual placement working with an early intervention team for which I was provided with a second supervisor who was a clinical psychologist who had worked for many years with clients suffering psychosis. I remember around this time feeling that my original supervisor was becoming increasingly doubting of me. On one particular occasion after I had seen a client whom I had been seeing for quite a while, I felt the need to just flag up that this client may need a little extra support because she had suffered a bereavement of an especially close family member. As I was due to go on holiday the following week I felt that it would be worthwhile for one of the CPN’s to give her a call to check that she was okay. My supervisor was in with a client and there were no CPN’s around so I left a note asking her to just mention it at the team meeting so that someone would just check that the client was coping until I saw her the week after. On the way back from work I had repeated telephone calls from my supervisor and in the end I pulled over to ring her to see what the matter was. She sounded really anxious and asked me if I felt that this client was at risk. I told her that there was no way I would have just left a note if I thought she was at risk. I felt annoyed by this because on previous two occasions I had stayed behind with clients that I had felt at risk until I could manage to get them a bed on the wards. In fact the first time I had done this my supervisor was amazed that I had managed to get one particular client on the wards in such a
short space of time as she said that this was no easy feat. I remember thinking at the
time that it was probably my naivety that had been the main factor as I just assumed
that is someone was at risk of suicide then there was no way I was sending them home! So, with all this in mind, I was perplexed that she could think so badly of me.
I was really upset about it. In the next supervision session I suddenly realised that she
felt she had lost control of what I was doing as I was seeing clients from another team
that she was not responsible for but at the same time I was seeing clients that she was
ultimately responsible for and I realised that it was time to move on. I remember
speaking to my work place tutor at university and she talked to me about models and
stages of supervision. I realised that there was nothing wrong with what I had done
and that my supervisor was not really questioning me she was just feeling
uncomfortable with the lack of control and this is why she is such a good supervisor
for an inexperienced trainee as she has a hold over everything they do which makes
them feel safe and nurtured.

Placement 2 – South Staffordshire early intervention team – October 2009 – present

My second placement is with the early intervention team who work with young
people between the ages of 16 years to 35 years who are experiencing their first
episode of psychosis. Their aim is to catch people developing psychosis early and
work with them in a variety of ways to enable them to cope with the experiences they
are having. The team is made up of a psychiatrist, community psychiatric nurses,
occupational therapists, social workers, support to recovery workers and a youth
worker. The team have never had a psychologist working with them therefore this
placement has been a big challenge for me. I have not only worked with clients I have had input into the team becoming more psychologically minded when thinking about clients. The team were already open to this as many of them feel uncomfortable with the medical model and do sometimes question the diagnosis that the psychiatrist gives clients. What I have found interesting over the time I have been working with them is how they have come to question more and more diagnosis in relation to psychosis. I have talked to them a great deal about how trauma and dissociative symptoms can easily be misdiagnosed as psychosis and what is refreshing is now I hear them talking and questioning whether a client’s background issues such as abuse are more likely to be linked to a trauma model of mental illness than a psychotic illness such as schizophrenia. They have moved from just asking me to see clients because they feel confused with them and are not getting any where to asking my opinion on whether I feel there is any psychosis. What is amazing is that their caseload of clients who are psychotic has diminished as they were holding on to clients because they were too worried to refer them to the community mental health teams where the client could get psychological therapy. They appear now to have much more of a fluid system of dealing with clients providing them with more time to concentrate on the clients that really do need the intense support that the team are so excellent at providing. I have managed to assist with some of the clients in the transition of them moving from the team to the CMHTs by providing therapy for some clients. Some clients I have worked with have been discharged with no further need for support, which has been a fantastic feeling. I have worked with clients on this placement mainly using an integrative style. The integrative approach has the advantage of covering a range of methods from which it is possible to select the therapy which best fits the client's particular needs. I have used person centred skills
to build an empathic relationship with the client. I find this model of working is particularly useful in the explorative stage of therapy and essential in assessment. I have used a CBT model more in terms of the techniques it can allow me to employ to gain insight, and to help the client gain insight, into their negative thinking patterns which can provide clues to their negative core beliefs and I have used the psychodynamic model in analysing the communication between the client and I. In working this way I have found that formulation has been much more complicated.

There have been clients where they have been too highly medicated to work with and what this has taught me is the ability to be assertive and say I can’t work with this client until he or she is on a lower dosage of medication. I have, at times, disagreed with the psychiatrist and this has not been a very nice experience but it has taught me that I know just as much as they do in my own field. I am psychologically trained, they are medically trained, I can learn from them and they can learn from me. This in particular has been a steep learning curve as I have, in the past, felt inferior to psychiatrists.

My supervisor for this placement is a consultant clinical psychologist. She has never supervised a counselling psychology trainee before and was unaware of the requirements of the course. I have had to explain a lot about how the course runs and how we are trained. I feel this is a positive thing because the more that clinical psychologists learn about counselling psychology the easier it will be for us to gain more recognition for the skills we have and the work that we can do. For a start it helps us in to eradicate the notion that counselling psychologist’s only work with clients at the less severe end of the spectrum. She is used to supervising clinical
psychology trainees who appear to be monitored very closely. I notice that when she is completing the progress reports she is very careful about how we can prove what it is that she is stating. She has asked me to video certain sessions such as one where I was undertaking a WAIS with a client. She has asked to sit in on a session with me. I have found her feedback to be very useful. I thoroughly enjoy our supervision sessions as we reflect a great deal and I have learnt such a lot from her. The problems I have encountered with my placement with the early intervention team have been mostly due to the fact that there is no qualified psychologist working on the team. My supervisor works as part of an assertive outreach team and knows very little about the way in which the early intervention team works.

I have attempted to attend as many of the team meetings as possible but as the team covers a very large catchment area some of the meetings are held miles away. As I have to build up my client hours I feel that sometimes I am prioritising clients at the expense of working as closely as I would like to with the team. My supervisor has emphasised the importance of being part of the team as a way of helping them become more psychologically minded in their work. I have now begun to place much more emphasis on my communication with clients and have set up a supervision group with the team once a month where they can come and discuss various clients and we can look at their issues in relation to psychological theory. I have begun to teach them the basics of psychological formulation and they report that they find this helpful. This is in its early days but I plan to carry on with this up until I gain a job.

My supervisor has asked me if I will stay longer with the trust on a voluntary basis until a job comes up as she has not been given responsibility for providing
psychological services to the wards where there has been no psychological input before. She has asked if I would work with her to help in assessing all patients that come on to the wards. This will provide the basis for a treatment plan for them whilst they are on the wards and effective referral information for the patients that are discharged to their community mental health teams. I am also involved in helping in delivering a presentation to doctors who are just about to begin their psychiatric training on therapy for people with psychosis. This fits quite neatly with my research project as this is in relation to how clients and professionals feel about diagnosis and treatment of psychotic symptoms therefore I feel that I am quite knowledgeable in this area. The fact that she feels that I am knowledgeable enough in this area has given me a great deal of confidence.

Supervised practice has been possibly the hardest yet the most rewarding experience I have ever had, with the exception of motherhood. I have learnt so many things as a result of this part of my training. I have learnt to make sure I listen to the clients and don’t get hung up on diagnosis and labels as I really do believe they block therapy. I have learnt to make sure my notes are clear and up to date. I have learnt that it is imperative to have a good relationship with the people I work with. I have learnt to never judge a book by its cover. Most of all I have learnt that I do not, and will not, ever know everything and that there is always room for improvement!

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REFERENCES

Professional Issues

I was introduced to the discipline of counselling psychology in the last year of my undergraduate degree in psychology. Previous to this I had never heard of this particular arm of psychology. My interest in psychology began way back when I was working as an administrator in an NHS speech and language therapy department. I remember being really interested in reading the reports that the educational and clinical psychologist’s wrote about the patients on our caseload. At this time I was undertaking a business studies degree part time at Wolverhampton University which I went on to complete and gain a job in a further education college. Whilst working in this job I met a great cross section of society and as the college’s ethos was one of inclusion many of the students that I met had come from very difficult backgrounds. I was inspired by their tenacious attitude towards life and the possibilities that lay in their educational activities and I was also angry at the injustices some of my students had faced.

After having my three children, I realised that I had lost something of myself and felt the need to reclaim something of me back. The reality of just how sad I had become came to me one day when I was mopping my floor and the doorbell rang. I remember being really angry at my friend for coming and walking across my newly mopped floor! It was then I realised that I needed to find something to stimulate me, a new challenge in my life as mopping floors would not keep me going for ever! I felt that maybe this was the opportunity to study psychology, something I had wanted to do for many years by this stage. I didn’t really know a great deal about psychology but I knew that I wanted to understand more about how people’s minds worked. I think, at
this time, I was not sure about what I would do once I had finished the degree it was more about me knowing that I needed to get out and do something stimulating and challenging, otherwise I might go mad being at home with three children. I found the degree both challenging and rewarding and I met people on the course that I will never forget. I was introduced to counselling psychology by a lecturer who had undertaken the course herself and it was at this point that I felt that someone had written the programme specifically for me. It was a bizarre experience as I knew little about humanistic psychology but could instantly relate to its values.

The journey leading up to the counselling psychology programme has taken me as long as the course itself and it has been equally has enlightening. I remember when I finished my counselling course at the local college and my colleagues on the course were all planning on carrying on to do the counselling diploma and I felt a little confused about what I should do. Did I want to become a counsellor or did I want to become a counselling psychologist? This was a real crossroads for me as the diploma course was more affordable and more comfortable for me to do, yet the counselling psychology doctorate was expensive, challenging, and a dissent into the unknown. The decision making process I went through at this stage taught me some major things about myself, some of which I felt uncomfortable about. I chose to undertake the doctorate, I feel, mainly because it was a challenge and also I felt that it gave me what I’d always felt I lacked, a real profession, a feeling of belonging and I think proof that I was capable and deserving of such a title.

At this time I had no idea about just how challenging the course would be on a more personal level. I have found the personal therapy particularly difficult. I put it off for
as long as I could and I really struggled with my client work for a while whilst receiving therapy. In hindsight, I wonder if it would have been more advisable to have the therapy before I started the course but then I am not sure the same issues would have been brought up in therapy if that had been the case. However, through my struggles and times of bleakness, I have always managed to somehow remind myself of the reason for being on the course. Sometimes something a lecturer has said has just blown away the confusion and given me a sense of clarity again and sometimes it has just been something a colleague or my supervisor has said that has made me realise that actually I am good at being a therapist even if I sometimes struggle putting this on to paper.

Counselling psychology reflects well my values. I really struggle with labels and how language constructs who we are and what we believe. I remember, a few years ago, reading “To Kill a Mocking Bird”, I’d never read this at school as many people have. This book had an amazing impact on me. Atticus was like a moral compass and I admired the character so much. Counselling psychology, in it’s values, is a little like Atticus Finch, whenever I forget why I came to be putting myself through such stress, I remember that I can be different to other psychologists as I have a humanistic value base that means that I can just be with the client, I don’t have to be “the professional” I can be an equal, working with the client to resolve their issues and if nothing else help the clients learn something new each session about themselves.

One of the major challenges on this course has been the work I have undertaken as part of my supervised practice. I decided early on that I was mainly interested in working with adults and that a placement with adult mental health. My first
placement was in a psychology department serving an adult population, with clients aged between 16 – 65 years with a variety of mental health issues ranging from anxiety through to psychoses. The mental health team was multidisciplinary, consisting of psychiatrists, clinical psychologists, a counselling psychologist; community psychiatric nurses, occupational therapists, and has close links with community and GP practices. My supervisor at this placement was a chartered counselling psychologist who had undertaken her training at Wolverhampton University. I found it especially useful having a supervisor that understood the course as she could supervise me in the context of my training. I remember the first client I saw alone suffered from anxiety and I started off doing some psycho-education work teaching him the basics of anxiety and breathing exercises. My supervisor asked the team to identify some clients that were not too severely ill. One of the nurses identified two clients for me to work with. Both of which became regular clients over the next year. Both clients suffered with anxiety and I soon learnt that the causes of anxiety can be so deep seated and different from one client to the next even though the basic symptoms appear the same. One of the clients I worked using mainly CBT with and she really began to become very proficient at keeping her thought diaries. I worked using the Padesky and Greenberger approach as we had covered this quite extensively on our CBT module and I liked the feeling of optimism it held. This client used to carry her thought diaries with her in her handbag when she was undertaking a journey that she felt nervous about. She reported that she would get them out and look at them to give her confidence that she had many examples of successful previous journeys. My sessions with her were very structured and they felt relatively straightforward. Through the thought records we identified some of her negative core beliefs and she could see the links between these and her anxiety which
gave her a great amount of insight and a level of power over her anxiety. I always remember the feeling of satisfaction when she came into the last session with a great big smile and a card and chocolates. She had managed to gain a job and was contemplating moving away from home, and she had distanced herself from her domineering mother, which had been one of her major anxieties.

A year into my placement with the adult team I decided to take on a client who had a diagnosis of borderline personality disorder and who was a self-harmer. My main reason for deciding to work with this client was because of the label she had been given. It was almost a way of me testing out how accurate labels could be and how they manifested themselves in terms of the client. I remember her care coordinator coming to see me to warn me of this client’s manipulative behaviour and I remember feeling extremely angry that this client was being described in such a way. My main reason for undertaking the course was the fact that it was not advocating the medical model and I still feel strongly about this to date. In my first assessment session with the client when I was asking her questions about her current difficulties, she said “well you know I have borderline personality disorder” and it was as if she believed that this would explain everything about her problems in a nutshell when really it told me very little about her experiences. I remember asking her if being told that she had this particular disorder helped her in any way. She replied that it did not and I asked her if it would be more helpful if we forgot the label and didn’t use the term again. She agreed and her whole attitude towards me changed. Sessions were still difficult and she did appear at times to be manipulative but only in the sense that when she was really struggling with painful emotions did she cry out for help and if no one listened to her, she would then self harm to gain herself an admission to hospital as she just
felt she could not cope on her own and she was scared. The main difficulties I experienced with working with this client were due in nature to the team. Once I had taken her on as a client, her care coordinator appeared to take on a lesser role with her. This client’s work brought up traumas from her past. We talked about how difficult it would be at first and how sometimes therapy can cause more problems in the initial period. She needed more, not less, support from the rest of the team in this time but the team did not seem to want to work with her at all. I understood that she had annoyed many of them over the years but in my mind their job is to support people regardless of their annoyances. I realised quite early on with this client that the work I needed to do with her was two fold. It was about working with the traumatic events from her past and it was also about working with her in alleviating the stress in her life, as this was impinging on therapy. I worked out that the stress was being caused mainly in her communication with other people, for example, she would be complaining about her CPN or her boyfriend. I decided that it might be worth working from a more psychodynamic perspective in an attempt to use our relationship as a way of teaching her a model of a good, stable relationship as this is something she had never had in her life. This worked well while she was stable and we even got to what appeared to be the underlying theme in her life, one of guilt. She began writing letters to her abuser and his children, without sending them, expressing her guilt at destroying his family when she reported him for abusing her. She felt that she had been old enough at fifteen to prevent the abuse and that because of this she had been a part of what seemed a conspiracy and then when she had told her parents about it and they had gone to the police she had felt like a liar and a betrayer. Working with this client taught me a great deal about multidisciplinary team working and how easy it can be at times to forget who the client is. It is so easy to go along with the team as
they are my colleagues but even the best of teams can get things wrong. In my work with my current team I ask not to be told too much about the clients before I see them for assessment and I prefer not to look at the notes until after I have undertaken my assessment as I feel that it is too easy to become biased by information from other professionals. If I do hear that they have been given a diagnosis, I feel sometimes that it is a challenge to prove this diagnosis wrong or to see the client’s perspective. Some clients find diagnosis helpful and I respect that but I feel that in most cases diagnostic labels get in the way of therapy.

Supervision has been of the utmost importance in both my professional and personal development. In reflecting on the work I have been doing with clients with another psychologist I have been able to gain great insights into myself, and how this impacts on the way I work. I have realised at times that I can be prone to becoming the rescuer, the parent and that this is not of benefit to the client in promoting their autonomy. I have also realised that some of the emotions I feel when I am with clients are not always mine and this came about mainly through what I learnt from the psychodynamic model. This model of working has had the greatest impact on me. I am now able to identify better what is going on in the room between the client and me and I am better able to reflect this back in supervision. I have been better able to share experiences with the client when I have felt, at times, an overwhelming sense of an emotion that I feel is not mine and this has created great insights in therapy for both the client and me. I am no longer worried by such feelings as I now see them as something concrete that the client and I can work on. In the past I have felt that the overwhelming feelings I sometimes have as a weakness in that I was not able to control my own emotions and I felt that I was letting them get in the way of therapy.
I would say that one of my major strengths is in building a strong therapeutic alliance with clients. I find it easy to understand people and see things from their perspective. I feel this is imperative in therapy as without this there is little trust and openess. I do not have a problem in challenging clients but I feel that I could not do this without first having got to know them and to feel comfortable in doing so. If I feel there is any incongruence in the room I will use this as a way of working out with the client what is going on. I feel that sometimes this can also bring up weaknesses in me too, however, where I have to ensure that I am not weakening the boundaries too much in terms of ensuring sessions do not run over and balancing my disclosing non-disclosing. It’s the old debate of only disclosing if it is useful to the client and I always try and keep this in mind as I do feel that sometimes it is such a useful strategy for normalising. Confidentiality has been a very difficult aspect of working with the team as they work very much with the client and their family. They also share everything that the client says with each other. I struggled with this to begin with as the team would be asking me what a client was saying specifically and on some occasions had passed this on to parents. I realised very early on that this was something I needed to discuss with the client. I now talk to the client about levels of confidentiality and inform them that I do not have to tell the team specific things about what we have discussed and if they are happy with me to do this then the team do not have to share this with parents. It has been somewhat of a learning curve for the team too, to realise just who the client is.

Part of my journey to becoming a professional psychologist has been that of understanding the issues faced by counselling psychologists in the world of work. In
my mind, as a trainee, it can be very easy to ignore many of the issues faced by organisations that we have worked in. Unlike clinical trainees we are not trained to work in a specific sector. This brings with it a great amount of flexibility and freedom but it can also bring with it a level of complacency. The professional issues module has aimed to bring forward some of the current issues facing counselling psychologists who may work in different sectors of the healthcare system. I feel, at times, as a group we have got bogged down by the idea that we have to work within the NHS and as a result we have defined ourselves as being less skilled and knowledgeable than our clinical psychology colleagues. However, as pointed out by one of our lecturers, we are in a much better position in many respects because of our training as we have not been in the position where we have had to worry too much about issues faced by new government initiatives and mainly be new arrangements for commissioning. I have heard clinical trainees discussing the demise of their position as a result of IAPT measures whereby they feel that their roles are threatened as, lesser qualified staff are seeing the clients that they would normally see. Initially I too felt panicked by what they were saying feeling that counselling psychologists must be in that very same position, however, on researching the issue further I realise that in some respects this has strengthened my role as a counselling psychologist. An article I found on the Division of Psychology website confirmed my thinking on this issue. Smith (2000) argues that presently IAPT leaves the question of what do with post Step 3 and Step 4 clients largely unaddressed and that maybe IAPT and NICE need our help, as highly trained, integrative multi modal self evaluating practitioners to propose alternative treatment to these Steps? Otherwise it appears that we are serving no one, especially our clients or ourselves, by passively predicting the demise of psychology in public health systems. This is exactly what we have been doing as a group of
trainee counselling psychologists. It is therefore important that we make every attempt to get our research published and not just for the professional but also for the client as in this knew era of commissioning it maybe that the client will have a greater influence over their mental health care with general practitioners being one of the new commissioners.

My research ties in well with my last placement even though it wasn’t planned this way. I have been interested in working with people that hear voices since being introduced to the area on my degree course. I have read a lot about the subject since then and attended conferences and seminars run by the Hearing Voices Network. I also did some training with Rethink to become an advocate and did some of that for a while. In my mind any research I would undertake as part of this course would be in relation to hearing voices. Hearing voices is considered to be a major symptom of psychosis and in my research and work I have come to find this area fascinating. The more I read and the more I experience, the more I question the validity of the construct of psychosis. Research and writings by authors such as Boyle (2002), Bentall (2003) & Ross (1992) amongst many have informed my questioning of the label of psychosis. It has been interesting working in an early intervention team with this kind of questioning. I have come across young people that have been automatically diagnosed as having schizophrenia and other types of schizoaffective illnesses that I have felt have been more likely to have been suffering from a trauma based illness. It has taken a lot of courage for me, at times, to speak out against psychiatrists who have not taken into consideration sometime horrific incidences of trauma. It appears that they have asked the questions but they have not considered the information they have gained in making an informed diagnosis. In two particular
cases, I have totally disagreed with the diagnoses that have been made. One was a young girl who had been sexually abused as a child who heard voices and appeared to be experiencing symptoms of dissociation. She had been diagnosed as being schizophrenic. I disagreed with the psychiatrist and he then decided that it was bipolar that she was suffering. I disagreed with both diagnoses but I let the second one go because it had less of a detrimental affect on her future as having a label of schizophrenia could have lost her a job and her livelihood. In my mind, as long as the therapy she was receiving dealt with her issues and she was still able to work and keep her life on track then this particular label was inconsequential and in exploring it with the client she too was able to see that really most of us are bipolar, it’s a human condition! The other client, however, was different. His symptoms were so dissociative in nature that I had to be assertive and express my concern about the fact that the psychiatrist was misdiagnosing this client as schizophrenic and his treatment options relied on it. The young man was experiencing such severe bouts of dissociation that were akin to multiple personality disorder, a diagnosis that is very controversial. His dissociative episodes were becoming more frequent and his mother was severely distressed by them. I used the dissociative experiences scale (DES II) as a way of determining his levels of dissociation and his score was high. The psychiatrist did take this on board, to a degree, and awarded him the diagnosis of an anxiety disorder and although this meant very little it allowed him to escape the debilitating label of schizophrenia. As this client was not psychotic it meant that he was not a client for the early intervention team that meant that this young man was to be referred to his community mental health team. What I feel is unjust is that this man is as equally at risk as is someone with psychosis but that this is not considered at present. I have felt this way with other clients too and the team have taken this on
board and have asked me whether I feel it appropriate to work with clients who I feel strongly need help now rather than have to wait 7 months, which is the waiting time at the moment to see a psychologist. With some clients I have felt that I could do the work they needed before they would be offered an appointment and this has been the case, where clients have not needed to be referred to their CMHT because they have resolve their issues. On other occasions, like with this particular client, I have felt that I could work with them to help them to cope whilst they are waiting and prepare them for their forthcoming therapy. In the case of this particular client I knew he needed in-depth therapy to deal with his traumatic life but I also knew he would not cope waiting for 7 months. I decided, as I had the flexibility as a trainee, to work with him using grounding techniques to help him try to control his dissociative episodes. We worked out his triggers and we worked together to find effective ways of helping to ground him, to bring him back to reality. It was an enlightening and rewarding journey that we made together. I take a great deal of satisfaction from the experience of us both realising that we had been successful detectives in his experiences and in the knowledge that he will possibly never forget me and I him. I remember his mother thanking me for helping them as she had been part of the detective work too and I remember at that precise moment in time how I really had developed a great deal of knowledge and was able to communicate this in a straightforward way which I believe is the key to being a good professional.

As my placement nears its end I realise that until I gain a job I need to ensure that I continue with my professional development. It is now that I am starting to really take on board the various requirements of me as a professional from the two main professional bodies that ensure we are operating at the very minimum standard as
professionals. The BPS has always been at the forefront of my mind as it has played a prominent role in guiding its professionals. The HPC is a body I have been aware of, in the sense that I know I have to meet certain standards but it has not played a role in my personal journey. I just knew that at some stage I would have to register with them and make sure I had the paper trails in place to prove that I am meeting their standards. I have never worried that I would not because the BPS has always communicated its high standards to trainees through various means. I believe as a profession we must ensure that we support the BPS in supporting us as the HPC is merely the means by which the government is ensuring that we have minimum standards of competence. CPD is something that is being taken very seriously and since I have made myself aware of exactly what is needed I have realised that actually as an individual I am undertaking CPD a lot but I have not been recognising it as CPD, just having a discussion with my peer group provides me with some CPD activity as I am learning new things all of the time.

I feel that in order for me to have some formal CPD activity going on between finishing my course and gaining a job I will carry on with my placement. My supervisor has offered me with more varied activities, other than client work now that I do not need to worry about gaining client hours. She has asked me to work more functionally with the team in order that I can assist them in becoming more psychologically minded in their work with clients through offering supervision and training to the team members. I have already set up a supervision group for the team and we meet on a fortnightly basis, taking it in turns to bring a client or a problem to the group. My supervisor has also asked if I would assist her in providing some training on psychosis to junior doctors undertaking their psychiatry training and
alongside this I will be seeing my own caseload of clients, individuals that maybe the team are struggling to work with. One thing is certain my continuing professional development will certainly be in the area of psychosis as I believe there is still a great deal of work to be done both to change attitudes in this area.

Other areas I would like to develop are a spin off from this work really. I am very interested in training as an EMDR practitioner. I feel that if I could offer EMDR at the moment there are many clients on the early intervention caseload that would benefit and has it is a time limited therapy I could potentially prevent these clients from getting worse as waiting seven months to be seen for their trauma just seems unfair as these clients are also at risk as many of them can also be using self harming as a way of coping. I am sure that the waiting list for the CMHT’s would reduce as a result of me, and other members of the team, being trained in this area. The university is attempting to facilitate this course along with others, which is positive. I also feel that the university is attempting to still support us when we finish the course by offering us such opportunities and this is a good feeling as I feel that we will all feel a little vulnerable when we are cut loose from the university.

In writing this essay I have had to look back at my journey, both personal and professional and this has been a really useful reflective task. I realise that my identity now is very different from when I started the course. In a sense this sounds like a silly statement as we identity is transient and changes over time but I do believe that counselling psychology course has a bigger impact on a person’s identity than any other psychology course could. The main reason for this is that we are taught to be reflective practitioners and to not see ourselves as separate from the therapeutic
encounter but very much a part of it. I also realise that even though I am now near to finishing the course and gaining my professional qualification I am still a long way away from being the professional I want to be. It seems to me that the road I am on is a never-ending journey of gaining knowledge and insight and reflecting upon this. In a way this frightens me as I wonder if I will ever feel and look like some of the other professionals I see around me who have an air of confidence that I am not sure I exude. Then again, maybe the day that I feel like that is the day to retire, as at least my uncertainty keeps me on my toes!
REFERENCES


Research

Dossier
Diagnosing and Treating the Voices: The Clients’ and Professionals’ perspectives

By

Dawn Gearing
SEARCH STRATEGY

Electronic journal databases such as Medline, Psychinfo, PsycARTICLES, PsycBOOKS and Psychology and Behavioral Sciences Collection were searched. The following key words were used in searches: auditory verbal hallucinations; schizophrenia; psychosis; psychiatric diagnosis; treatment and interventions; trauma; childhood abuse; dissociative symptoms; psychiatric training; psychological training; side effects of antipsychotics; therapeutic techniques; Romme & Escher; qualitative research; Interpretative Phenomenological Analysis (IPA). The OPAC catalogue at the university was also searched and the NHS Trust library where the researcher is currently on placement. Articles and information were obtained from electronic databases, from journals and books held at the university, the NHS Trust library and some articles were ordered from the British Library. The search engines Google and Google Scholar were also used to search for articles. The most up to date and current literature was searched for and, therefore, the most recent studies were included. Where current literature was not found, older studies had to be used. A literature plan was produced, which asked questions about what the current study wanted to explore. All studies were read and evaluated to assess whether they met these questions. Other criteria that was used when appraising the literature was how relevant the literature was to the current study, what methodology was used and how the literature contributed to the psychology field and current literature on auditory verbal hallucinations.
Literature Review
Aetiology, diagnosis and treatment of auditory verbal hallucinations: A literature review.

Introduction

Auditory hallucinations are defined as a false perception of sound. They are described as the experience of internal sounds that have no real origin in the outside world and which are perceived to be separate from the person’s mental processes (Wing, Babor & Brugha, 1990). A common type of auditory hallucination involves hearing voices. The voice can be male or female, and with intonations and accents that differ from those of the client (Waters, 2010). Research suggests that auditory verbal hallucinations are experienced by clinical and non-clinical populations and that it is the distress that a person feels about their voices, that determines whether or not they need professional help. There has been a vast amount of research attempting to gain an understanding of the causes of auditory verbal hallucinations, yet there is still little agreement over the exact mechanism for their occurrence (Alarcon, 2009). As a result of this there is criticism about the scientific validity of psychiatric diagnosis and its ability to inform effective treatment for people who hear voices (Bentall, 2006; Boyle, 2007; Cuesta, Basterra, Sanchez-Torres & Peralta, 2009). In the present time diagnosis is possibly the principal subject of debate in the mental health field because of the imminent publication of the new editions of the DSM-V and the ICD-11. This has rejuvenated the debate about the efficacy and consistency of psychiatric diagnosis.
The treatment of auditory verbal hallucinations has traditionally been informed by the biomedical model and has focused primarily on suppression via medication (Asaad & Shapiro, 1986). Research suggests that medication works to suppress the voices in only 50% of cases and that medication can have serious, sometimes irreversible, side effects (Breggin, 1990; Turkington, Dudley, Warman & Beck, 2006). Criticism of psychiatry’s reliance on medication as the main treatment for a person hearing voices has come from groups such as the Hearing Voices Network (HVN). The HVN is a post-psychiatric organisation positioning itself outside of the mental health world in recognition that voices are an aspect of human differentness (Romme & Escher, 1989). This thinking has challenged conventional approaches to auditory verbal hallucinations by reframing them as voice-hearing experiences (Bracken & Thomas, 2005; Stastny & Lehmann, 2007).

The present paper aims to review the literature examining issues in relation to the aetiology, diagnosis and treatment of auditory verbal hallucinations in an attempt to explore the current approaches to working with people who hear voices. The terms auditory verbal hallucinations and hearing voices will be used interchangeably in line with the different perspectives mentioned above.

**The prevalence of auditory verbal hallucinations**

A hallucination is defined in the DSM-IV-TR as "a sensory perception that has a compelling sense of reality of a true perception, but occurs without external stimulation of the relevant sensory organ" (American Psychiatric Association, 2000). An auditory hallucination is the most common form of hallucinations and is defined
as a false perception of sound (Andreasen, 1997). Jones (2010) describes auditory verbal hallucinations as:

“a diverse phenomenological experience, which may involve single and/or multiple voices, who may be known and/or unknown, speaking sequentially and/or simultaneously, in the first, second, and/or third person and which may give commands, comments, insults, or encouragement” (pp.566).

Auditory verbal hallucinations are described as evolving over time with voices developing increasingly detailed dialogue with or about the patient (Nayani & David, 1996). This experience can have a devastating affect on a person’s life because the voices can be experienced as frightening, intrusive and disturbing (Watkins, 2008). However, the literature suggests that not everyone that hears voices experiences such circumstances. The research on auditory verbal hallucinations has been undertaken on both clinical and non-clinical populations. Research on clinical populations has been primarily devoted to clients with a diagnosis of a psychiatric disorder, where hallucinations are usually seen as a psychotic phenomena and a first rank symptom of schizophrenia (APA, 2000). Research suggests that there is a prevalence of 75% of people with schizophrenia that report hearing voices (Nayani & David, 1996). Six large scale studies on non-clinical populations found rates of between 0.6% to 8.2% annual or life-time prevalence of hallucinations in the general population (Tien, 1991; Van Os, Hanssen, Bijl & Ravelli, 2000; Ohayon, 2000; Johns, Nazroo, Bebbington, Kuipers, 2002; Dhosce, Ferdinand, Van der Ende, Hofstra & Verhulst, 2002). Three further studies of selected non-patient populations, primarily university students and medical patients, have reported higher rates of prevalence ranging from 2% to 13%
(Posey & Loche, 1983; Barrett & Etheridge, 1992; Glicksohn & Barrett, 2003). These studies conclude that the main difference between clinical and non-clinical populations is that the non-patients do not perceive their voices as negative or frightening and they therefore have little affect on their levels of functioning. Further studies have supported this and have shown that many people have, what would be described as psychotic experience and delusion-like ideas, without becoming distressed or disabled by them (van Os, 2003; van Os, Linscott, Myin-Germeyts, Delespaul & Krabbendam, 2009). Research indicates that psychosis exists as a continuum of experiences within a distribution in the general public (Johns & van Os, 2001; Verdoux & van Os, 2002). It is suggested that delusional or hallucinatory experiences are much more frequent in subjects from the general population than the prevalence of cases of psychotic disorders, thereby identifying the existence of a symptomatic continuum between subjects from the general population and clinical cases of psychosis (Bentall, Claridge & Slade, 1989). These people do not access the mental health system because they interpret their experiences in more positive ways, or hold more pragmatic and commonly accepted beliefs about their voices (Miller, O’Connor & DePasquale, 1993; Romme & Escher, 1994; Johns et al, 2001, Verdoux et al, 2002). Research suggests that some people find the experience of hearing voices to be a positive one that they would like to preserve. For example, a study undertaken by Jenner, Rutten, Beuckens, Boonstra & Sytema (2008) found a lifetime prevalence of positive voices of 40-60%. They stress the importance of considering this when working clinically, regardless of psychiatric diagnosis, as some patients may stop treatment because of fear of losing the voices protective powers. This research indicates the importance of studies involving non-clinical populations in attempting to gain a better understanding of the aetiology of psychosis.
Causes of auditory verbal hallucinations

There is an ongoing debate over the scientific validity of psychiatric diagnosis and its reliance upon the Diagnostic and Statistical Manual (DSM-IV-TR) (Pincus, Zarin & First, 1998; http://en.wikipedia.org/wiki/Digital_object_identifier Kendell & Jablensky, 2003; Boyle, 2007; Baca-Garcia, Perez-Rodriguez, Basurte-Villamor, Del Moral & Jimenez-Arriero, 2007). This disagreement has resulted in researchers attempting to search for scientifically rigid explanatory models in an attempt to develop a coherent theory of the causes of auditory verbal hallucinations (Kendler, 2008). For example, research into biological factors has attempted to determine the role of specific variables, such as genetic and biochemical factors and subtle changes in brain morphology (Craddock & Owen, 2010). Van Os & Kapur (2009) argue that genetic vulnerability in schizophrenia is shared with other disorders such as bipolar disorder and molecular genetic studies have found an overlap with developmental disorders such as autism. According to twin and family studies, more than half of the vulnerability for schizophrenia is of genetic origin. For example, monozygotic twin studies have shown that the greatest risk for developing schizophrenia is having a first-degree relative with the disease (risk is 6.5%) and that more than 40% of twins with schizophrenia are also affected (Picchioni & Murray, 2007). Attempts to discover the genes that relate directly to genetic linkage to a psychotic disorder have been disappointing and no consistent positive evidence has actually been found (Kendler & Diehl, 1993). Tandon, Keshavan & Nasrallah (2008) explain that “etiological heterogeneity, complex patterns of gene-gene and gene-environment interaction, and inadequately elucidated schizophrenia pathophysiology are among the explanations
invoked to explain our inadequate understanding of the etio-pathogenesis of schizophrenia” (pp. 1). They conclude that future research must question some of the basic assumptions that have been made about the causes and nature of schizophrenia and that there is the need for greater rigour in research in this area in an attempt to improve our understanding of causation. This indicates that the research into biological factors, albeit compelling, has not yet produced any definitive theory on the cause of auditory verbal hallucinations. As a result of this researchers have attempted to identify other ways in which genetic factors may be the cause. Research suggests that there may be a gene-environment interaction which produces psychosis (Henquet, Di Forti, Morrison, Kuepper & Murray, 2008; van Os, Rutten & Poulton, 2008; Van Winkel, Stefanis & Myin-Germeys, 2008). Leboyer & Henry (2005) believe that the fact that psychosis shares similar genetic origins to bipolar disorder supports the idea that there is a gene-environment interaction in the aetiology and course of the disorder (Leboyer & Henry, 2005). They argue that factors related to biological vulnerability with a genetic background interact with physical, psychological and environmental vulnerability factors such as trauma which can create psychosis. Broome, Woolley, Tabraham, Johns, Bramon et al (2005) have conceptualised this in a model, where they propose that the genes influencing risk for schizophrenia may do so indirectly by making individuals more sensitive to the effects of factors such as trauma. This research is encapsulated by the stress vulnerability model of psychosis which advocates that a person has a pre-dispositional factor, or set of factors, that cause them to become ill (Ingram & Luxton, 2005).

Research in relation to the stress vulnerability model has highlighted the similarities between the biological abnormalities associated with schizophrenia and the effects of
traumatic events on the developing brain (Perry, 1994; Read, Perry, Moskowitz, & Connolly, 2001). Research also indicates that psychotic experiences are more common in people who have experienced trauma or abuse (Kinderman, Cooke & Bentall 2000; Ross, 2007; Moscovitz & Corstens, 2007). Morrison, Frame & Larkin (2003) undertook a review that critically evaluated the research and theoretical literature on the potential links between trauma and psychosis. They found evidence of three specific relationships between trauma and psychosis, which were: psychosis as a cause of PTSD; trauma as a cause of psychosis; and, the possibility of psychosis and PTSD both being part of a spectrum of responses to a traumatic event. There is further evidence to support this relationship where research has suggested that clients diagnosed with psychosis are the most likely to have experienced severe trauma in childhood (Kilcommons & Morrison, 2005; Hammersley, Read, Woodall & Dillon, 2007).

Some studies have shown that the most common symptoms experienced by clients who have experienced childhood abuse are auditory verbal hallucinations (Ross, Anderson, & Clark, 1994; Schenkel, Spaulding, DiLillo & Silverstein, 2005; Borger, Cox, and Asmundson, 2005). In a review of 46 studies involving 2604 female patients, most of whom had diagnoses of psychoses, it was found that 48% reported having been sexually abused and 48% physically abused, with 69% having been subjected to one or the other or both (Read, van Os, Morrison & Ross, 2005). A study involving 8580 adults found evidence to suggest that trauma and auditory verbal hallucinations were strongly related. Participants that had been diagnosed with psychosis were fifteen times more likely to have experienced sexual abuse than those without psychiatric problems (Bebbington, Bhugra, Brugha, Singleton, Farrell et al,
Further research found that almost 76% of adults reporting child physical abuse and neglect had at least one psychiatric disorder in their lifetime and nearly 50% had three or more psychiatric disorders (Borger et al., 2005). Findings from these studies are supported by a systematic review of the literature (Janssen, Krabbendam, Bak, Hanssen & Vollebergh et al., 2004). It is argued that there is a plethora of research citing sexual abuse as the trauma that is most related to auditory verbal hallucinations. It has been hypothesised that this is because auditory verbal hallucinations are a meaningful response, metaphorically expressing emotionally undigested events related to abuse (Ensink, 1993; Haddock, Bentall & Slade, 1993; Honig, Romme, Ensink, Escher & Pennings 1998; Fowler, Garrety & Kuipers, 2001). Research suggests that the re-experiencing, avoidance and hyperarousal associated with trauma is a predictor of distressing beliefs about voices which may account for a significant proportion of the increased anxiety and depression in the psychiatric hearing voices population (Andrew, Gray & Snowden, 2008).

**Diagnosis of auditory verbal hallucinations**

As already discussed the DSM-IV-TR is used as the main resource of clinicians and psychiatrists to diagnose psychiatric illnesses. Within the DSM, diagnoses are described strictly in terms of patterns of symptoms that tend to cluster together. These symptoms can be observed by the clinician or reported by the client or family members. The most fundamental scientific criticism of the DSM concerns the validity and reliability of its diagnoses. Only one positive symptom is required for a diagnosis of schizophrenia to be made such as the person experiencing voices talking to each other or commenting on their behaviour which has raised concerns (APA,
McLaren (2007) argues that the DSM lacks validity because it has no relation to an agreed scientific model of mental disorder and therefore the decisions taken about its categories were not scientific in nature; and that it lacks reliability because different diagnoses share many criteria, and different criteria are often merely rewordings of the same idea, meaning that the decision to allocate one diagnosis or another to a patient is to some extent a matter of personal prejudice. A further dimension of psychiatric diagnosis that has received criticism is that of the importance of spatial location of voices in relation to decisions about diagnosis (Copolov, Trauer & Mackinnon, 2004). Plaze, Paillère-Martinot, Penttilä & Januel et al (2011) explain that spatial location has been considered a main clinical feature in classical psychiatry that distinguished between two types of auditory hallucinations, ‘true’ and ‘pseudo’ hallucinations. Voices that are heard externally are defined as ‘true’ hallucinations whereas voices located within the head are considered ‘pseudo’ hallucinations. In general terms, ‘true’ hallucinations are considered as being experienced by a person who has schizophrenia. Research suggests that the clinical relevance of location is not a scientifically valid criteria for determining whether a person is psychotic or not (van der Zwaard & Polak, 2001; Baethge, 2002; Copolov et al, 2004).

The uncertainty about aetiology and inconsistency in diagnosis of auditory verbal hallucinations has led to the suggestion that there needs to be a re-evaluation of diagnostic practice (Moscowitz & Corstens, 2007). Tucker (1998) argues that in psychiatric diagnosis, no matter how scientifically and rigidly psychiatrists use scales to estimate the client's pathological symptoms, they are still only recognising patterns in order to make an empirical diagnosis rather than a deductive based diagnosis. He
identifies other problems with the use of the DSM for diagnosis as: the loss of the patient's story; how the diagnosis rather than the patient gets treated; and, the fact that there is a lack of research into the various psychopathologies experienced by patients. The contention that diagnosis is reductionist is supported by research that has found that auditory verbal hallucinations have many more potential causes that are not always considered. They have been linked to many life circumstances, including religious phenomena, bereavement, trauma, drug use, sensory deprivation, and near-death experiences (Nicolson, Mayberg, Pennell & Nemeroff, 2006). The clinical implications of this are that it is important that professionals who are undertaking diagnosis undertake a holistic assessment ensuring that any of these issues are considered before diagnosis is made to avoid misdiagnosis, especially in light of the burgeoning literature on the link between trauma and auditory verbal hallucinations.

**Lack of consideration of trauma in diagnosis**

Research indicates that mental health professionals have traditionally not asked for information about traumatic events (Read & Fraser, 1998; Briere, 1999; Lothian & Read, 2002). Read, Hammersley & Rudgeir (2007) found that the reasons cited for this were: that there were too many more immediate needs; that the patient would find the issue too disturbing; that it may cause deterioration in their psychological state; fear of inducing false memories; the client being male and/or being over 60 years of age; and, the clinician having strong biogenetic causal beliefs. In some studies professionals have admitted that they do not ask enough about traumatic events such as childhood abuse because they believe that there is not enough evidence to indicate that such circumstances could lead a client to develop symptoms of psychosis.
(Morgan, Fisher & Fearon, 2006; Read, van Os & Morrison, 2006; Spataro, Mullen, Burgess, Wells & Moss, 2004). Read et al (2007) suggests that another reason for not asking about such experiences is due to lack of training, for example, they found that only 30% of mental health staff had received training in the assessment and/or treatment of sexual abuse (13% of nurses, 33% of psychiatrists and 46% of psychologists) which concluded that mental health professionals do not feel equipped to deal with issues pertaining to sexual abuse (Read, McGregor, Coggan & Thomas, 2006). This study also researched clients’ perspectives of being asked about abuse and found although 64% had experienced abuse in some form, 78% had not been asked about this at initial assessment. Lothian & Read (2002) found that clients who had reported abuse were more likely than other participants to believe that their diagnosis was not an accurate description of their difficulties and to be dissatisfied with their treatment. Psychiatrists use the DSM to determine and help communicate a client's diagnosis after an assessment. It is also used as a way of categorising clients using diagnostic criteria for research purposes. As diagnosis is the mechanism that informs the best treatment options for someone hearing voices, there is an argument that its consistency and reliability are crucial in ensuring that the client is offered the most appropriate and effective treatment for their individual needs.

**Treatment of auditory verbal hallucinations**

The treatment of auditory verbal hallucinations has traditionally been informed by the biomedical model and has focused primarily on suppression of voices using medication (Barker, 2009). Research indicates that medication works to suppress the voices in 50% of cases and can at the same time have serious, sometimes irreversible side effects such as weight gain, type II diabetes mellitus, hyperlipidemia, QTC
interval prolongation, myocarditis, sexual side effects, extrapyramidal side effects and cataract problems (Lewis, Bagnall, Leitner, 2005; Breggin, 2007; Ücok & Gaebel, 2008; Gray, 2009).

Whitaker (2001) argues that, despite treatment by neuroleptics, over the past twenty-five years, outcomes for people suffering with schizophrenia in developed countries have worsened. His argument is based upon research undertaken by the World Health Organization (WHO) who have found that at both two-year and five-year follow-ups, patients in poor countries such as India, Nigeria, and Colombia, were doing dramatically better than clients in developed countries. They found that at five years, 64% of the clients in the poor countries were asymptomatic and functioning well and that 12% were no longer chronically ill. This contrasted with only 18% of the clients in the developed countries who were asymptomatic and 65% who had poor outcomes (WHO, 1973; 1979). Research has shown that richer countries use newer drugs that have not been well tested on their populations, as they are more readily available than they are to poorer countries (Adams, Tharyan, Coutinho & Stroup, 2006). There is growing controversy over the problems with the methodological approaches to the development of drug-based therapies. Thornley & Adams (1998) found that over the past fifty years drug trials were of limited quality, duration, and clinical utility. Other studies in this area have concluded that the way in which such drugs are trialled is not effective enough to identify the risk factors associated with them as the methods used were not systematic and consideration has not been given to all potential side effects (Pope, Adams, Paton, Weaver & Barnes, 2010). This is supported by a number of systematic reviews which have also concluded that there is not enough evidence that some of the major drugs used for psychosis actually work (Leucht & Hartung, 2006;
Leucht, Kissling & McGrath, 2007; Schwarz, Volz, Li & Leucht, 2008; Volz, Khorsand, Gillies, Leucht, 2007; Duggan, Fenton, Rathbone, Dardennes, El-Dosoky & Indran, 2005). The research in this area supports the idea that there is little scientific validity in the pharmacological treatment of clients who hear voices and as these drugs cause serious side effects it is argued that there needs to be further research to improve the way in which drugs are trialled and to look at alternative ways of treating the phenomenon.

Research supports the efficacy of working therapeutically with clients who hear voices. Two psychological treatment approaches that have gained prominence as effective therapies for the treatment of schizophrenia in the United Kingdom are family interventions and cognitive behavioural therapy (CBT) (Birchwood & Spencer, 1999). Randomised controlled trials have produced evidence for the effectiveness of these approaches that have been systematically reviewed, using meta-analytic techniques (Pilling, Bebbington, Kuipers, Garety & Geddes et al., 2002a, 2002b). The National Institute for Clinical Excellence (NICE) guidelines now recommend that Cognitive Behavioural Therapy (CBT) and family interventions should be available to clients with a diagnosis of schizophrenia and their carers (NICE, 2009). CBT is a therapeutic model that takes as its central focus the symptoms of psychosis and the individual's attempts to understand them. The main goal being to help the individual to develop an understanding of psychosis which is less distressing, and assist the individual in preventing reoccurrence or in managing any unwanted experiences. It is used to change the client’s perception of their voices in order to minimise or alleviate the distress associated with them (Garety, 2003). This research amongst others has found that CBT has a proven role as an adjunct to antipsychotic medication (Tarrier,
There are however also questions over the scientific rigour of the research supporting the efficacy of CBT for psychosis (Barrowclough, Haddock, Lobban, Jones & Siddle; Wykes, Reeder, Landau & Everitt, 2005). A number of empirical inconsistencies have been highlighted, these being: the little evidence that cognitive interventions provide added value to the therapy; the fact that CBT is often associated with a rapid, early improvement in symptoms that most likely occurs before the implementation of any distinctive cognitive techniques; and, that the measured changes in cognitive mediators does not seem to precede changes in symptoms (Hayes, 2004a). Such inconsistencies have given rise to research attempting to define what the active ingredients in CBT are. For example, in a review of the current status of CBT for schizophrenia, it was found that there was still little knowledge about the possible active, change-producing elements of CBT or the longer-term predictors of outcome (Rathod, Phiri & Kingdon, 2010). Orsillo, Roemer, Lerner, and Tull (2004) argue that there is a problem in evaluating the mechanisms of change in cognitive behaviour therapy as research has not managed to identify which techniques employed in CBT actually produce the results that have been so widely publicised. A comprehensive review of research into the active elements of CBT in relation to depression and the anxiety disorders found that there was no difference in effectiveness between the cognitive and behavioural elements of CBT. This review also indicates that there was no evidence that cognitive interventions provide added value to behavioural interventions (Longmore & Worrell, 2007). Lynch, Laws & McKenna (2010), in a meta-analytical review of studies and meta-analyses, found that
although CBT is claimed to be effective in schizophrenia studies researchers have not fully considered the potential methodological problems in relation to influence of blindness or the use of control interventions. They conclude that CBT is no better than non-specific control interventions in the treatment of schizophrenia and that it does not reduce relapse rates. Taken together, these studies provide a substantial body of research that suggests that there are methodological problems with the research suggesting that CBT is the most effective therapy for psychosis.

There has been an increasing interest in the potential benefits of third wave cognitive therapies for psychosis. For example, Chadwick, Hughes, Russell, Russell & Dagnanin (2009) has integrated traditional cognitive therapy with a third wave acceptance based approach, including use of formal mindfulness meditation to specifically work with voice hearers. They found that following therapy there were significant improvements in psychosocial well-being as well as on measures of voice distress and voice control and these improvements were maintained at a one month follow up. Mindfulness and acceptance approaches, often described as the ‘third wave’ of behaviour therapy, are drawn from a combination of Eastern meditation and Western psychology, they are used to help patients learn to tolerate difficult emotions and overcome depressing thoughts and have been found to be as efficacious as CBT (García & Pérez, 2001; Hayes, 2004a). Bach & Hayes (2002) undertook a study that examined the impact of a brief version of Acceptance and Commitment Therapy (ACT) in order to teach patients to accept unavoidable private events; to identify and focus on actions directed toward valued goals; and to defuse from odd cognition, just noticing thoughts rather than treating them as either true or false. Eighty inpatient participants with positive psychotic symptoms were randomly assigned to treatment
as usual or to 4 sessions of ACT plus treatment as usual. ACT participants showed significantly higher symptom reporting and lower symptom believability and a rate of re-hospitalisation half that of treatment as usual participants over a 4-month follow-up period.

A growing body of research demonstrates that other therapies are as equally proven as CBT. Shedler (2010), for example, found that psychodynamic therapies were as efficacious as therapies such as CBT that have been actively promoted as ‘empirically supported’ and ‘evidence based’. He also argues that it is difficult to compare the efficacy of different therapies as there are inconsistencies in the way in which therapy is conducted. Elkin, Shea, Watkins, Imber, & Parloff et al (1989) found that even in controlled studies designed to compare manualised treatments, therapists interact with patients in different ways, implement interventions differently, and introduce processes not specified by the treatment manuals. This has created problems for researchers as they have had difficulty determining from session transcripts which treatment was being provided. Luborsky, Diguer, Seligman, Rosenthal & Schweizer (1999) argue that there is little difference between outcomes for different therapies, and there is no form of psychotherapy that can be proved superior to any other. They found that in the rare instances when studies found differences between active treatments, the findings nearly always favoured the preferred treatment of the investigators, something known as the ‘investigator allegiance effect’. It is argued that even though NICE guidelines suggest CBT as one of the most efficacious treatments for the symptoms of psychosis that there may be other therapies that would work as effectively and that client choice should be widened.
It appears that there is still uncertainty about the efficacy of both pharmacological and therapeutic treatment of auditory verbal hallucinations. There is also a paucity of research into clients’ subjective experiences of the treatment of auditory verbal hallucinations. There is little known about how they feel about taking medication and/or undertaking therapy and it is suggested that the clients’ opinions may be a good predictor of what works best for them. As a result of this some researchers are suggesting that more research should be undertaken in this area in order that an assessment can be made of the efficacy of current clinical practices (El-Sayeh, Morganti & Adams, 2006; Hamer & Hadad, 2007).

Clients’ perspectives on care

There is little research into clients’ perspectives of their mental health care. Wallace (2001) explains that results of a survey carried out by a UK national telephone helpline (Saneline), showed that availability and access to better medications and services are among the most important issues for patients with mental illness. The study involved 202 completed questionnaires and 99% of clients reported side effects from their medication of which 31% were perceived as severe. Wallace (2001) concludes that there is a high level of patient dissatisfaction and distress related to the currently available medications, which may have unfavourable effects on compliance and treatment outcome. Gray, Rofail, Allen & Newey (2005) found that clients did not feel involved in treatment decisions and that they took medication only because they were told to. This study found that clients were not given written information about their treatment or warned about side effects, and were not offered alternative non-pharmacological interventions. This is supported by a literature review by Chue
(2006) where the most frequently reported reasons for client dissatisfaction included drug side effects, lack of involvement in decisions about treatment and lack of involvement of family members in the care plan. Patient involvement in health care has become an increasingly important issue in many countries. In the UK, a number of different initiatives have given it more prominence such as: the democratic rights of tax-paying citizens; the desire to increase accountability throughout the health service; and, the move towards patients being considered as consumers. Initiatives such as “Building on the Best” sets out a series of measures to extend patient choice across primary, secondary, and community care (Department of Health, 2003). In spite of the priority given to this policy making, there has been relatively little work exploring aspects of patient involvement for people with serious mental illness. (Lester, Tait, England & Tritter, 2006).

Conclusions

Despite the abundance of literature attempting to understand the aetiology of auditory verbal hallucinations there is still a lack of a scientifically consistent theory on their causes. This has subsequent effects on the diagnosis and treatment of the phenomenon, as if professionals do not have a full understanding of the causes it follows that there will be problems with the effectiveness of diagnosis and treatment. The research examined in this paper supports this idea. Auditory verbal hallucinations are frequently present in the general population providing doubt about whether their mere existence constitutes a mental illness. Diagnostically there are problems with: consistency in gaining pertinent information; informed decisions about diagnostic categories; and, the lack of consideration of trauma. The literature
examining the efficacy of treatment is also problematic as a number of systematic reviews have indicated that drug therapy may not be as effective as early research has suggested. Research also documents the problematic side effects of drug treatments. Literature suggests that there are problems associated with clients not being given choice in treatment options. Although research indicates that psychological therapies are efficacious in the treatment of auditory verbal hallucinations there is disagreement about which therapies work best, with comparative research suggesting that no one therapy is any more effective than any other. The majority of the research in this area is quantitative in nature with a paucity of qualitative research gaining the views of the clients’ and the professionals’ perspectives. Research to date has not elucidated any concrete findings in relation to aetiology, diagnosis and treatment and due to the gaps in phenomenological research, in this area, it is argued that there is a need to gain the perspectives of both the professionals and clients as these populations are most knowledgeable about the diagnosis and treatment of voices.
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Research Report
Abstract

The aims of this study were to explore professionals’ and clients’ experiences of diagnosis and treatment of auditory verbal hallucinations with a view to identifying important clinical issues for counselling psychologists. Six professionals, three psychologists and three psychiatrists, who had worked with people who hear voices, alongside four clients who hear voices, volunteered and participated in a semi-structured interview. These interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) as described by Smith, Flowers and Larkin (2009). A table of super-ordinate and sub-ordinate themes was created as a result of this analysis.

A number of themes arose from both groups of participants’ experiences. The main themes that arose for the professionals was: professional ambivalence; varying theories on causes of voices; perspectives on diagnosis and formulation; perspectives on medication; thoughts on working therapeutically; and, thinking on recovery. The themes that arose from the clients’ experiences were feelings about diagnosis and experiences of treatment.

This research concludes that there is professional ambivalence in working with people who hear voices that is caused by a lack of certainty about the causes of the phenomenon alongside a lack of training in working with clients who have symptoms of psychosis. This impacts clients in several ways. The clients in this study were not offered the option to have any involvement in their own care and none of them were offered therapy as a treatment option. The study also concludes that psychiatric diagnosis does not consider all pertinent information related to clients’ issues which can lead to inconsistency in the diagnosis of clients who hear voices.
Hallucinations are “sensory perceptions in the absence of sensory stimulation” (Sims, 2002). An auditory hallucination (AH) is defined as a false perception of sound (Badcock, 2010) and is the most common form of hallucinations (Andreasen, 1997). Auditory hallucinations are believed to fall into two categories, elementary and complex. Elementary hallucinations involve the perception of sounds such as hissing, whistling and an extended tone, for example, in some cases tinnitus is referred to as an elementary auditory hallucination. Complex hallucinations are those of voices, music, or other sounds and are normally associated with psychosis. A common manifestation of complex hallucinations is where a person hears two or more voices talking about them in the third person either coming from inside or outside of their head. According to the Diagnostic and Statistical Manual (DSM-IV-TR), if someone is hearing voices it is sufficient enough to diagnose schizophrenia when the hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or there are two or more voices conversing with each other (APA, 2000). Auditory verbal hallucinations feature prominently in severe psychiatric disorders such as schizophrenia and are considered a first class symptom of psychosis.

Auditory verbal hallucinations have perceptual qualities that are veridical in nature and as a result individuals may or may not have insight into their reality. This is an important aspect in the experience of hallucinations as the extent to which the individual considers them to be true can impact on their distress. Individuals with insight will acknowledge that the experience is abnormal and will report less interference with everyday activities and will be less likely to require professional help than the
individual with no insight (Waters, 2010). The incidence of auditory hallucinations in the population is a subject of debate. It is estimated that approximately 75% of people with schizophrenia experience hearing voices. However, research suggests that there is a large proportion of the population that never access the mental health system (Posey & Losch, 1983; Bentall & Slade, 1985; Green & McCreery, 1994) which makes it difficult to fully estimate the number of people who experience auditory hallucinations. In the general population auditory verbal hallucinations are not always associated with mental illness, and studies show that 10% to 40% of people without a psychiatric illness report auditory hallucinations (Tien, 1991; Ohayon, 2000).

Although there has been a vast amount of research into the phenomenon there is still little agreement about their causes. Biological research suggests that they may be associated with structural or functional abnormalities of the nervous system, or both and this has become the main focus of the studies in this area (Meltzer, 1987). However, the non-specificity of neuroanatomical abnormalities, the failure to find genetic markers for psychiatric conditions and the inconsistency of biochemical research have lead some researchers to conclude that psychiatric diagnoses are nothing more than pragmatic constructs which can not be viewed as real entities (Moncrieff, 2008). Research suggests that although auditory verbal hallucinations are recognised as a first rank symptom of psychosis they can also be assigned to other illnesses such as bipolar disorder, psychotic depression (Schatzberg, 2003) and Post Traumatic Stress Disorder (Hammersely, Dias, Todd, Bowen-Jones & Reilly & Bentall, 2003). An association between childhood trauma and hearing voices has consistently been reported, both in individuals who appear otherwise healthy (Andrew, Gray & Snowden, 2008) and in clinical subjects (Shevlin, Dorahy & Adamson, 2007). The literature linking
childhood trauma to hearing voices is growing and there is a strong argument that there may be cases of misdiagnosis, where clients who hear voices and who have experienced such trauma, may actually be experiencing symptoms of post traumatic stress disorder (PTSD) rather than symptoms of psychosis.

Treatment of auditory verbal hallucinations is mainly drug based even though research indicates that therapy is efficacious in dealing with them. The research in relation to the effectiveness of drugs has been subject to methodological flaws (Thornley & Adams, 1998) and research indicates that the side effects of such drugs can be destructive both physically and psychologically (Pope, Adams, Paton, Weaver & Barnes, 2010). Government guidelines state that cognitive behavioural therapy (CBT) and family therapy should be offered to everyone that has a diagnosis of schizophrenia (National Institute for Clinical Excellence, 2009). Despite this a survey undertaken by Rethink, the mental health charity, involving 959 mental health users, found that only 14% of people interviewed had received CBT (Rethink, 2008). The research on the most effective therapies for working with voice hearers also suffers from methodological problems with some professionals in the field arguing that there is no one therapy that is better than any other in the treatment of the phenomenon (Rathod, Phiri & Kingdon, 2010; Barrowclough et al, 2006; Wykes, Hayward, Thomas, Green & Surguladze et al, 2005). As a major factor in the success of any treatment relies heavily upon the motivation and engagement of the client, it poses the argument that clients should be provided with the choice over which therapy may work best for them. There is a gap in the research in relation to the subjective experiences of clients in relation to diagnosis and treatment. Research that has been conducted in this area has been mainly quantitative in nature and has failed to capture the real experiences that individuals have of the affects of diagnosis and treatment. This research has, however, unearthed a sense
of dissatisfaction amongst clients who feel that they are not provided with enough information and involvement in their diagnosis and treatment (Rogers, Pilgrim & Lacey 1993; Mental Health Foundation, 2000). Conversely there has been a lack of research into the subjective experiences of mental health professionals in relation to how they feel about the efficacy of diagnosis and treatment of clients who hear voices.

There are significant clinical implications in ensuring consistency of diagnosis in relation to auditory verbal hallucinations. It is argued that if diagnosis is incorrect then the most appropriate treatment options for the client will not be offered or administered. The fact that clients are not being offered therapy and are not receiving more choices in their care suggests that there is the need for a re-evaluation of clinical practices. The intention of the current research study is to explore the participants’ experience of diagnosis and treatment of auditory verbal hallucinations. There has been a vast amount of quantitative research in this area into many aspects of auditory hallucinations creating much debate over their aetiology, diagnosis and treatment.

There has been a distinct paucity of qualitative research in this area and moreover very little research into the exploration of clients’ and professionals’ views of the diagnosis and treatment of hearing voices. There is a gap in research in terms of gaining specific information on the implied inconsistencies in the way diagnosis is carried out both within and between professions leaving the field open to criticisms of misdiagnosis. There is also a lack of information in relation to how clients and professionals feel about diagnosis and its usefulness in understanding the issues faced by the client and the way in which diagnosis informs treatment options for clients. This research will add to the literature about diagnosis and treatment of auditory verbal hallucinations. Exploring clients’ experiences of diagnosis and treatment of auditory verbal hallucinations is
important because there is little known about how they impact upon the client’s internal world. The current study also aims to elucidate the subjective experiences of both psychiatrists and psychologists as it is argued that these two professional groups spend much of their time attempting to understand the internal world of clients through their assessment and diagnosis. The main reason for focusing on diagnosis and treatment is because this is where research can have most impact in terms of informing clinical practice.

**Method**

**Methodological Approach and Rationale**

Existing research into clients’ experiences of the care they have received in relation to hearing voices has mostly used quantitative methods to test researchers’ hypotheses. For example, they have assessed levels of patient satisfaction with their pharmacological treatment (Chue, 2006; Rethink, 2008). This research suggests that there are high levels of dissatisfaction amongst the hearing voices population in relation to their drugs and to the care they receive. It does not, however, give clients the opportunity to explain how diagnosis and treatment decisions affect them in their everyday life or provide any perspective on how they feel their care can be improved. There is a distinct paucity of literature gaining professionals’ views on the diagnosis and treatment of auditory verbal hallucinations. Research has been conducted on professionals’ attitudes towards mental health patients but this has been mainly quantitative in nature. For example, a review undertaken by Wahl & Aroesty-Cohen (2010) found 19 empirical studies of the attitudes of mental health professionals. Although most of these studies revealed overall positive attitudes there was evidence of negative attitudes and expectations too. This research
has not provided us with information on the reasons behind such attitudes towards clients. The current study employs qualitative research in the form of Interpretative Phenomenological Analysis (IPA) to enable a fuller exploration of clients and professionals experiences of diagnosis and treatment.

**Qualitative Research**

McLeod (1998) postulates that the aim of qualitative research is to highlight and elucidate the meaning of social interactions and situations with the intention of understanding phenomenon rather than explaining it. The aim of qualitative research is not to predict outcomes; rather it is about asking questions about processes. Researchers utilising qualitative methods tend to be interested in the meanings attributed to events by the research participants themselves. The objective of data collection is to create a comprehensive record of participants’ words and actions (Willig, 2001). Researchers need to engage in how the world is perceived through the eyes of the participant if a phenomenon is to be understood (Denzin & Lincoln, 2000). It is the investigation of the individual’s *perception* of the world that sets qualitative research apart from quantitative methods.

Qualitative methods can be used to obtain the intricate details of phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through quantitative research methods. The experience of auditory verbal hallucinations can be traumatic in itself but evidence suggests that patient experiences of diagnosis and treatment can also cause a person a great deal of stress (Morrison, 1998). From the professional’s perspective, working with people who are experiencing
serious mental illness can be extremely stressful (Fothergill, Edwards & Burnard, 2004). The Literature Review for the present study has identified gaps in the existing knowledge base about clients’ and professionals’ perspectives on diagnosis and treatment. Research also suggests that there is disagreement in the mental health field amongst professionals in relation to the causes of auditory verbal hallucinations. This study aims to explore the impact that diagnosis and treatment have on clients’ lives. The study also aims to explore, with professionals, their perspectives on diagnosis and treatment of auditory hallucinations.

**Introduction to Interpretative Phenomenological Analysis**

This study will use Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). This approach explores how people make sense of the world and how they experience events. It aims to understand and represent the experiences and actions of people as they encounter, engage and live through situations. This is particularly suited to this study as it aims to explore how patients and professionals encounter and engage with issues around auditory verbal hallucinations. In deciding on the best method of analysis, other qualitative approaches have been considered. In conclusion the researcher decided that grounded theory was more related to social processes whereas IPA is more concerned with a person’s way of making sense of the world (Willig, 2001). IPA shares the same aims to data analysis as other phenomenological approaches, such as idiographic, eidetic and transcendental, in that it wishes to capture the quality and texture of individual experience and because it focuses on the world as it is subjectively experienced by individuals within their particular social, cultural and historical contexts and so it enables the researcher to investigate the diversity and
variability of human experience. Discourse analysis and IPA as qualitative analysis methods share some similarities, but discourse analysis aims more at elucidating the interactions of verbal statements, how those are accomplished and the linguistic resources they draw on (Smith & Osborne, 2008).

Requiring smaller sample sizes than other qualitative methods, IPA is used for in-depth understanding of a particular sub sample which fits well with this study as the participants are patients with auditory verbal hallucinations, a sub sample of a client population of people with symptoms of psychosis and, psychiatrists and psychologists, a sub sample of mental health professionals. IPA studies typically recruit between 6 and 12 participants, depending on the breadth of data obtained in each interview (Smith & Osborne, 2008).

IPA is informed by some of the principles associated with phenomenology, a philosophical concept concerned with the ways that human beings gain knowledge of the world around them (Willig, 2001). By analysing accounts of experiences presented by research participants, the researcher is attempting to gain understanding of someone else’s experience based on their description of it. In phenomenological psychological research, the research participant’s account becomes the phenomenon with which the researcher engages.

IPA offers a person-centred approach for understanding the experiences of participants in exploring their own narrative, conveying an experience that is impossible to achieve by the use of other methods such as questionnaires. The open-ended style of questioning allows for full exploration, and this is a particular strength of this methodology. It is an effective methodology for focusing on perceptions through the exploration of
professional’s and patient’s experiences of diagnosis and treatment. Regardless of the research that has been undertaken to date it is the perceptions of the people that are most affected by them that matter most. As Kvale (1996, p.52) argues “the important reality is what people perceive it to be”. In working with clients it is crucial that the counselling psychologist understands how the individual perceives and interprets events if effective formulation and interventions are to be suggested in cases of emotional distress.

Smith (2004) explains that IPA is characterised as having three defining features: it is idiographic, inductive and interrogative. Willig describes an idiographic approach as a process whereby insights produced as a result of intensive and detailed engagement with individual cases are integrated only in the later stages of the research. Individual tables of themes elicited from interviews in the current study were integrated at the end of the process to produce a master table of themes. Unlike quantitative research, IPA makes no attempt to limit itself by establishing hypotheses at the outset. This inductive approach was taken with the current study. This rationale gave flexibility and allowed for unpredicted themes to emerge. The approach provided the opportunity for creativity and production of new knowledge. The themes elicited from the analysis did not exist in isolation; they were related to existing theoretical knowledge within the discussion, thus allowing the process to be interrogative. To enable the phenomenon in question to be explored it was important to achieve homogeneity. This was achieved by use of the inclusion and exclusion criteria that ensured that the participants shared particular features; in the current study all professionals shared an experience of working with people that hear voices and all patients shared an experience of hearing voices and being diagnosed and treated by professionals within the mental health field.
While IPA aims to explore the research participant’s experience from the individual’s perspective, it recognises the impossibility of impartiality and that the analysis will always be touched by the researcher’s own view of the world as well as by the interaction between the researcher and participant. As such, the analysis is always an interpretation of the participant’s experience (Smith, 1995). As analysis is both phenomenological and interpretative the researcher is “necessarily implicated in the analysis” (Willig, 2001, p. 67). Because of this IPA requires reflexivity from the researcher, which will be discussed in the Critical Appraisal of the Research Process section.

**Ethical approval**

This study was approved by, the Ethics Committees of the University of Wolverhampton, School of Applied Science and West Midlands Local Research Ethics Committee (Appendix 3). Approval was gained from the Research and Development Department of South Staffordshire and Shropshire Foundation Trust (Appendix 4).

**Researcher**

At the point of beginning the research process the researcher was a trainee on a Counselling Psychology Doctoral programme at the University of Wolverhampton. Whilst undertaking this programme and research, work placements have been completed at a NHS foundation trust working with an early intervention team and an adult community mental health team.
Participants

Information regarding the participants is included in Table 1 for the professional participants and Table 2 for the client participants. Both tables are at the end of this section. Six participants were recruited from the professionals’ population and four participants were recruited from the clients’ population.

The inclusion criteria were that clients must have had a diagnosis of psychosis for more than 1 year and must be deemed as stable by their care coordinator. The exclusion criteria were that the study would not recruit clients that had received support from the Early Intervention Team, at any point in their care, due to the specialist nature of the services they would have received. The inclusion criteria for the professionals were that they all must have had experience of working with someone that heard voices.

As the purpose of the study was to explore the professionals’ and clients’ experiences of diagnosis and treatment in relation to hearing voices, an important consideration was the having a homogenous group of participants who had first hand experience of diagnosis and treatment. Smith, Flowers & Larkin (2009) suggest that IPA sampling tends to be purposive and broadly homogenous as a small sample size can provide a sufficient perspective given adequate contextualisation. They also suggest, as is the case in this study, that it may sometimes be useful to divide the sample so that the phenomenon can be understood from more that one perspective. In this case the study is analysing the experience of diagnosis and treatment of auditory verbal hallucinations both from the
client’s perspective and from the professional’s perspective. The samples of professionals and clients were therefore not linked in any way as the objective of the study was to explore professionals’ experiences separately to the experiences of clients.

Table 1: Participant Information – Professionals

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Years qualified</th>
<th>Ethnicity</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>“John”</td>
<td>Male</td>
<td>4 years</td>
<td>White British</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>“June”</td>
<td>Female</td>
<td>10 years</td>
<td>White British</td>
<td>Counselling psychologist</td>
</tr>
<tr>
<td>“Janet”</td>
<td>Female</td>
<td>22 years</td>
<td>White British</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>“Matthew”</td>
<td>Male</td>
<td>30 years</td>
<td>Asian British</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>“James”</td>
<td>Male</td>
<td>13 years</td>
<td>White British</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>“Harry”</td>
<td>Male</td>
<td>10 years</td>
<td>Asian British</td>
<td>Psychiatrist</td>
</tr>
</tbody>
</table>

Table 2: Participant Information- Clients

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Length of time hearing voices</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Sara”</td>
<td>Female</td>
<td>19 years</td>
<td>White British</td>
<td>2 years</td>
</tr>
<tr>
<td>“Paul”</td>
<td>Male</td>
<td>45 years</td>
<td>White British</td>
<td>22 years</td>
</tr>
<tr>
<td>“Mark”</td>
<td>Male</td>
<td>42 years</td>
<td>White British</td>
<td>20 years</td>
</tr>
<tr>
<td>“Jo”</td>
<td>Female</td>
<td>40 years</td>
<td>White British</td>
<td>30 years</td>
</tr>
</tbody>
</table>

Interview Schedule

A semi-structured, open-ended style interview schedule was devised for each set of participants as recommended by Smith (1996) as it is argued that this allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of participants’ responses and the investigator is able to probe interesting and important areas that arise (Smith, 1996). The questions for the original schedule were developed after reflecting upon the existing literature and following discussions within supervision. The objective was to gain a rich account of professionals’ and clients’ experiences of diagnosis and treatment. After the first interview the schedule was amended to make the questions more open ended in nature as the researcher felt that the questions in the initial schedule were too closed and
leading. All of the participants were asked the questions that were on the schedule. In addition individual participants were asked questions where clarity or elaboration was needed. Copies of individual interview questions are included in Appendix 10 and 11.

The interviews varied in length depending upon how much the participant had to say. The taped interviews lasted between 25-60 minutes. Interviews were analysed using IPA.

**Procedure**

Emails were sent out to psychiatrists and psychologists within South Staffordshire and Shropshire Foundation Trust. Once the professionals had contacted the researcher a letter and information sheet was sent to them (Appendix 7 and 9). The researcher telephoned each professional and arranged to conduct the interview at a mutually convenient time at the professional’s work base. At the point of meeting time was allowed for introductions and to outline the rationale and procedure for the interview. Semi-structured interviews were conducted with each of the participants and lasted approximately one hour. A consent form (Appendix 8) was given to the participant to sign which outlined issues of confidentiality and advised of their right to withdraw from the study. Participants were advised, in accordance with British Psychological Society’s (2008) guidelines, that transcripts would be anonymised and pseudonyms would be used and that tapes and transcripts would be stored securely. The interview was audio taped using a digital recorder.

Clients were selected by, their care coordinator, or ward manager, in accordance with the inclusion and exclusion criteria discussed in the section above. The care
coordinators were provided with the invitation letters and information sheets (Appendix 4 and 6). They were asked to talk to the client about the research and to gain initial verbal consent that they were interested in participating in the research and that they were happy for their personal details to be passed on to the researcher. The researcher then made contact with the patient to arrange a mutually convenient time and venue for the meeting. At the point of meeting time was given for introductions in order to ensure that the patient felt as comfortable as possible in undertaking the interview. This is especially important when working with this client group as trust is an important component of the patient engaging in the process. At this stage the rationale and procedure for the interview was outlined. A consent form (Appendix 5) was given to the participant to sign that outlined issues of confidentiality and advised of their right to withdraw from the study. Participants were advised, in accordance with British Psychological Society’s (2008) guidelines, that transcripts would be anonymised and pseudonyms would be used and that tapes and transcripts would be destroyed after analysis. Participants were informed that if they felt that they wanted to end the interview, they could do so at any time. They were also informed that if they did feel at all upset at any time that the researcher would telephone a friend or a relative and would wait with them until they arrived. The interview was audio taped using a digital recorder.

**Analytic Strategy**

Each taped interview was transcribed and given line numbers (see Confidential Attachment for copies of transcripts and Appendix 13 for transcription protocol). The transcripts were analysed using IPA, following the guidelines suggested by Smith
Each script was read and re-read allowing the researcher to immerse herself in the narrative. Any issues, thoughts or questions that arose out of engaging with the text were noted. The transcript from Participant 1 was then used to produce a list of themes on a separate sheet and the other transcripts were studied to identify further instances of these themes, contradict or related themes and any additional themes. A separate sheet was used for each theme and participant and line number identifiers and verbatim quotes were recorded on each sheet. The themes were then analysed with frequent reference to the original text to check the validity of the interpretations and where they appeared to be linked and related, were clustered together to produce a list of superordinate themes. Some of the initial superordinate themes were amalgamated together to form one theme as links were found between themes. It is to be noted that a theme entitled “thinking on recovery” arose from the analysis that will not be discussed in this report because of the word limits and the lack of relevance to the research aims. A table of all super-ordinate themes together with their related sub-ordinate themes was then drawn up (Appendix 14, 15 and 16). This is summarised and reported in the results section and forms the basis for the discussion and conclusion of this study.

**Analysis**

This study aimed to investigate the experiences of professionals and clients in relation to diagnosis and treatment of auditory verbal hallucinations. The first section will analyse the professional themes and the second section will analyse the client themes. Master tables of all super-ordinate and subordinate themes were developed (see Table 3...
for the professional themes and Table 4 for the client themes).

The professionals’ and the clients’ transcripts were analysed separately for two main reasons: one, because there was no linkage between the two sets of participants in that they had not worked together and did not therefore share any experiences on either a personal or professional level; secondly, the researcher aimed to elucidate two different sets of perspectives, that of understanding professionals’ experiences of diagnosing and treating clients at the same time as also attempting to understand how professionals’ decisions about diagnosis and treatment impacted on clients’ lives. This was an important decision that was made early on as past research had not successfully provided in-depth information on the subjective experiences of diagnosis and treatment for both groups and it was felt that the most effective way of gaining this knowledge would be to analyse both sets of data separately in order to allow themes to arise that were pertinent to the two different participant groups.

Professionals’ themes

Seven super-ordinate themes were identified, however, because of the word limits of this thesis and the fact that it was less relevant to the thesis aims, the super-ordinate theme of “thinking on recovery” will not be discussed.

- Professional ambivalence
- Problems in team-working
- Varying theories on causes of voices
• Perspectives on diagnosis and formulation
• Perspectives on medication
• The utility of therapy
Table 3: Master Table of Professionals’ Super-ordinate and Sub-ordinate Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Quotes from Interviews</th>
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<tbody>
<tr>
<td><strong>Professional Ambivalence</strong></td>
<td></td>
</tr>
<tr>
<td>1. Challenging yet satisfying</td>
<td>“…it’s challenging because of the distress that people are experiencing and it’s rewarding…” (June, lines 9-10)</td>
</tr>
<tr>
<td>2. Difficulties in engaging</td>
<td>“…a voice has said something that is very difficult to ignore so that can take the emphasis away from the session” (John, line 127)</td>
</tr>
<tr>
<td>3. Lack of training and experience</td>
<td>“Clinical psychology training you tend to start off quite gently and its only if you have a particular interest that you would then perhaps work with people that hear voices” (John, lines 86-90)</td>
</tr>
<tr>
<td><strong>Problems in team working</strong></td>
<td></td>
</tr>
<tr>
<td>1. Professional tensions</td>
<td>“I think there is a resistance from psychologists to see such patients and it is extremely difficult for erm for us to get patients seen anyway by a psychologist…” (Harry, lines 181-183)</td>
</tr>
<tr>
<td>2. The power of psychiatry</td>
<td>“We do usually erm ask for psychological assessments but not as a clarification for diagnosis I don’t think I would do that I don’t think we would do that…” (Harry, lines 164-165)</td>
</tr>
<tr>
<td><strong>Varying theories on causes of voices</strong></td>
<td></td>
</tr>
<tr>
<td>1. Stress vulnerability and trauma</td>
<td>“…voices might have meaning and might be symptomatic of underlying issues whether that’s kind of trauma sexual abuse or physical abuse or bullying” (June, lines 41-42)</td>
</tr>
<tr>
<td>2. Biological/organic</td>
<td>“…sometimes they can have organic causes as well, say for instance delirium and dementia which are also responsible for auditory hallucinations or yes substance misuse or withdrawal from drugs or withdrawal from alcohol…” (Harry, lines 33-35)</td>
</tr>
<tr>
<td>3. Psychotic Illness</td>
<td>“Often auditory hallucinations will be a symptom of psychotic illnesses, say schizophrenia or other psychotic illnesses” (Harry, lines 16-19)</td>
</tr>
<tr>
<td><strong>Perspectives on diagnosis and formulation</strong></td>
<td></td>
</tr>
<tr>
<td>1. The reductionist nature of diagnosis</td>
<td>“…it has the effect sometimes of stopping people thinking more widely, thinking out of the box and thinking in a free way that might be actually more helpful to the client…”(June, lines 124-126)</td>
</tr>
<tr>
<td>2. The utility of psychological formulation</td>
<td>“the psychiatrist is looking for information, will look for information to categorise and I will be looking for information that will shed light on how they got here in the first place” (John, lines 177-180)</td>
</tr>
<tr>
<td>3. The inconsistency of diagnosis</td>
<td>“… it could be schizophrenia, it could just be a psychotic episode, it could be psychotic depression, it could be bipolar and it could be related to a manic episode and it just seems so variable” (Lines 200-202)</td>
</tr>
<tr>
<td>4. The acknowledgement of misdiagnosis</td>
<td>“I have certainly come across a number of people who have been misdiagnosed so they’ve been treated as if they are psychotic but actually they’ve got post traumatic stress disorder….” (Janet, lines 130-133)</td>
</tr>
<tr>
<td>5. Utility of diagnosis</td>
<td>“…diagnostic categories make people feel much more secure whether the clients erm a lot of them find it particularly helpful I don’t know I know” (June, Lines 166-168)</td>
</tr>
<tr>
<td><strong>Perspectives on medication</strong></td>
<td></td>
</tr>
<tr>
<td>1. Medication is essential</td>
<td>“… because their mental health deteriorates without it and they can be a danger either to themselves and others so in order to do the trauma work they need medication” (June, lines 144-146)</td>
</tr>
<tr>
<td>2. Medication and therapy essential</td>
<td>“…but I think for the voices to go away you are looking at a combination of therapy and medication…” (June, lines 322-323)</td>
</tr>
<tr>
<td>3. Problems with medication</td>
<td>“…she lost her job, she lost her friends, she lost her self esteem really because she just became erm a very different person.” (Janet, lines 23-30)</td>
</tr>
</tbody>
</table>
### 4. The trauma of medication

“…they can be sectioned and medicated against their will and I have treated people for the trauma of that because it totally traumatises them…” (Janet, lines 115-118)

### The utility of therapy

<table>
<thead>
<tr>
<th>1. Uncertainty about the role of therapy</th>
<th>“… But I don’t think most psychiatrists are actually aware of how it works they will tell you but I don’t think we really know…” (Harry, lines 137-141)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Different therapeutic approaches</td>
<td>“…I think there’s a whole load of psychological work that is generally done by the psychologist that** is better done by other people about sort of coping strategies and learning to deal with voices for example in a more effective way” (June, lines 230-234)</td>
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</table>
Professional ambivalence

This super-ordinate theme arose when participants reflected on their experiences of working with clients who experienced auditory verbal hallucinations. Nearly all participants expressed feelings of ambivalence about working with this client group. The causes of this ambivalence were related to the fact that all of the professionals found value in working with clients who hear voices yet at the same time felt that the work was very challenging. This appeared to be due to the fact that the clients could be difficult to engage because of their levels of distress and that there was a lack of specialist training in the area. Some of the other super-ordinate themes also feed into this ambivalence such as problems in team working.

1. Challenging yet satisfying

Although the professionals find the work extremely challenging and difficult they also find it rewarding and interesting. Two of the psychiatrists, Harry and James, express similar feelings to one of the psychologists, June in terms of ambivalence. However, June’s positivity is related to feeling that she has helped the client even though the work has been tough:

“...it’s challenging because of the distress that people are experiencing and it’s rewarding when you sort of feel perhaps you’ve made a bit of a difference...”

(June, lines, 9-10)

Harry and James’ positivity on the other hand appears more related to the fact that they
find the work stimulating.

“I mean it is challenging, it is difficult and er and at the same time it is also interesting...” (Harry, lines 4-5)

June reflects on how, even though the work is difficult she feels that she has something concrete that she can work with and that this makes the work feel more straightforward than working with other client groups. Yet she feels that this may be deceptive:

“I think it’s actually quite erm deceptive because I think it is harder actually to work with people who hear voices...” (June, lines 15-16)

2. Difficulties in engaging

Some of the participants talked about how engaging with clients can be particularly difficult when they are distracted by their voices as this can impede therapeutic work:

“...she was arguing with them and so I found it was really difficult to actually work psychologically with her...” (Janet, lines 13-15)

John, a psychologist, also reflects on the struggles of working with clients who hear voices:

“...a voice has said something that is very difficult to ignore so that can take the emphasis away from the session” (John, line 127)
3. Lack of training and knowledge

Participants talked about how they lacked confidence in working with clients who hear voices. They explained how they lacked knowledge in certain elements of this work which subsequently led to this lack of confidence. Lack of adequate training on psychosis was the reason John felt nervous about working with voice hearers. He feels that this along with the lack of experience from his placements made it difficult for him to work with the client group. It is possible to gain a sense of why John feels there is ambivalence in working with clients who hear voices because of this:

“...Clinical psychology training you tend to start off quite gently and its only if you have a particular interest that you would then perhaps work with people that hear voices... and so what I’ve found in sort of my career I know didn’t do very much of that at all...” (John, lines 86-90)

The psychiatrists in the study all expressed the fact that they lacked knowledge in how therapy actually works with clients who hear voices. Even though psychiatric training is now placing more emphasis on therapy, Matthew, along with the other psychiatrists, feel that there is still limited understanding of how it actually works. For example, Harry and James had reservations about how successful it could be. James felt that the CBT work he did with clients to help them cope better was basic and that there was potentially the need for something that worked at a deeper level. There is a sense that he is not convinced that CBT works with voice hearers:

“I mean the literature is suggesting that CBT works with people with psychosis and
obviously as psychiatrists our therapeutic training is limited so we can only do the basic coping work but I’m not sure how much deeper that can go?” (James, lines 47 -50)

This super-ordinate theme contributes to the understanding of the reasons why working with clients who experience auditory verbal hallucinations is so challenging. Most of the participants in this study express their ambivalence about working with this client group and they hypothesise about why this is. It is apparent that it is more difficult to work clinically with clients’ that are distracted and highly distressed by their voices and that this will make clinical work more difficult. Feelings of lack of preparedness add to this, because of lack of training and experience, which have a major impact on the confidence of professionals in their own, and other professionals, ability to work with this client group which could potentially have an impact on working relationships within the community mental health teams.

**Problems in team working**

1. Professional tensions

As the participants talked about the ways in which other professionals worked with clients it became apparent that there was a level of friction between the psychologists and the psychiatrists. The psychologists appeared bemused as to why clients were not being provided with a psychological formulation and the psychiatrists all expressed their frustration at the difficulties they had in referring to psychologists. The psychiatrists were more vocal about the tensions between the two professional groups.
For example, Harry feels that psychologists don’t want to work with clients who hear voices. He infers that there is little point in trying to get psychologists to see clients with psychotic symptoms and that this is the reason why psychiatrists don’t bother referring:

“I think er there is a resistance from psychologists to see such patients and it is extremely difficult for erm for us to get patients seen anyway by a psychologist so I don’t think, I think it’s easier to see a psychiatrist” (Harry, lines 180-184)

He feels that psychologists are not trained to deal with the severity of auditory verbal hallucinations and that most of them would prefer something simpler. He appears to believe that psychologists lack appropriate skills in working at this level, unless they are specifically trained for it:

“there are some psychologists who perhaps are not so er so well trained to deal with these issues I think mostly psychologists would prefer the normal case which I would call the normal case which would be a straightforward CBT case or something with depression” (Harry, lines 190-195)

James also feels that referring to a psychologist is futile as there is resistance from them in working with clients diagnosed with psychosis. It is obvious from his reflection that he is uncertain about why there is a resistance indicating that there is a lack of dialogue between the two professional groups:

“… some psychologists won’t work with people with psychosis, I’m not sure if this is to
do with their training or what it is…” (James, lines 43-44)

Harry reports that psychologists usually say they can’t see clients because of long waiting lists. He feels that psychologists may be reticent about seeing clients who hear voices because of the length of time needed to deal with their issues. There is a suggestion that he feels it would take a lot of therapy to work with voice hearers:

“I think that we must look at the er at the causes or the causes that they give the explanations that they give say it’s because of caseload or if it’s because of lack of time…” (Harry, lines 186-188)

Even though Matthew places importance on gaining a psychological perspective for his clients he explains that the psychologists in his team refuse to see clients with symptoms of psychosis. His frustration with the situation is apparent as he describes a conversation with a psychologist from his team:

“...I confronted him and said that means you are doing a paper saying there shouldn’t be diagnosis and at the same time in your practice you refuse to see schizophrenia patients?…” (Matthew, lines 131-133)

2. The power of psychiatry

The frustration that Matthew feels is not limited to psychologists. He is also critical of his own profession as he believes that his peers do not believe therapy can help. He feels that his clients would benefit from therapy, yet he has little support in his
endeavour to make this possible as the psychologists refuse to see his clients and his own profession are not of the belief that therapy works:

“... they don’t have interests in psychotherapy and they don’t have that sort belief that psychotherapy works and I do not think that most of them are as keen as I am.”
(Matthew, lines 59-61)

The fact that psychiatrists are not certain about the benefits of therapy is an important issue as they are the professionals that hold the most power over whether clients are referred to a psychologist. This sense of power is evident in the psychiatrists’ reflections. For example, Harry appears to believe that a psychological perspective would make little difference in his decision about diagnosis:

“We do usually erm ask for psychological assessments but not as a clarification for diagnosis I don’t think I would do that I don’t think we would do that...”  (Harry, lines 164-165)

James expresses a clear division between his aims and the psychologists and that he seems to feel that diagnosis is more important than a psychological formulation. For example, he views a client’s depression as underlying and something that can be resolved by a psychologist and implies that is somehow separate to their main diagnosis:

“Er yes if I thought that the client had say depression or some underlying personality issue that I felt appropriate for a psychologist I would refer...”  (James, lines 39-40)
John suggests that psychiatrists decide on which clients psychologists should work with. John is pleased with his team but he implies that effective team working is not always the case:

“because I have had quite a few referrals for people that hear voices because of the distress of the voices and rather than trying to manage them psychiatrically only there is a bit more of a multidisciplinary approach here so it is quite good and I think that is probably driven by the psychiatrists” (John, lines 102-106)

Team working is an important aspect of effective client care. This super-ordinate theme provides insight into the problems that the professionals are encountering in this area. Psychiatrists feel that there is resistance by psychologists in working with people who hear voices. There appears to be a lack of communication between the two professional groups about ways of working. The psychiatrists appear to feel in control of which clients are most appropriate for referring to a psychologist.

**Varying theories on causes of voices**

Four subordinate themes arose which included stress vulnerability and trauma; biological and organic; psychotic illness and uncertainty about causes.

1. **Stress vulnerability and trauma**

Some of the participants believe that the stress vulnerability model originally proposed
by Zubin and Spring (1977) holds most credence in the causes of auditory hallucinations. This model proposes that a person may have a vulnerability to an experience such as hearing voices but that it is stress such as trauma that triggers the vulnerability. All of the participants believe that trauma has some role to play in a person hearing voices.

The fact that there is no definitive theory on the aetiology of auditory hallucinations is endorsed by June, a psychologist. She has adopted the stress vulnerability model as being the most credible theory. She believes that it is trauma that causes the triggering of stress. She recalls that all of her clients have experienced some trauma:

“I’m trying to think of people I’ve worked with in recent years...all of them have some kind of trauma” (June, lines 59-61)

She talks in more detail about the types of trauma that her clients have experienced and cites sexual abuse as a major contributory factor to auditory verbal hallucinations:

“...I know people who’ve had erm been sexually abused perhaps you know a male on male abuse will often their voices will tell them for example that they’re gay...”

(June, lines 29-31)

The link between the content of the voices and the experiences of the client’s abuse, in June’s experience are important clues to the fact that it is the abuse that is creating the messages from the voices. She believes that it is the emotion associated with the trauma that is expressed by the voices:
“...often what you get I think you get that projected out in the voices that stress the unbearable feelings are projected out and heard as voices similarly you know you get with girls who are sexually abused by a male it's often that they're a slut they're a tart they're a whore” (June, lines 39-42)

June believes that it is the trauma that has triggered the vulnerability and she suggests that the voices may hold the clue to what the core issue is that needs dealing with:

“...voices might have meaning and might be symptomatic of underlying issues whether that's kind of trauma sexual abuse or physical abuse or bullying”

(June, lines 41-42)

The theory that there is a direct correlation between childhood abuse and hearing voices is not something that James, a psychiatrist, advocates. He feels that hearing voices are more likely to be related to a psychotic illness than PTSD:

“...I personally would look for signs of reliving the trauma, such as nightmares, flashbacks etc but auditory hallucinations are usually associated with psychosis...”

(James, Lines 25-28)

On reflection, James recalls the number of clients he has seen that have experienced abuse. He seems to develop a degree of uncertainty about whether or not there is a direct link between abuse and people hearing voices as he talks:
“there does seem to be a great deal of these patients that have experienced abuse, be it sexual, emotional or sometimes neglect so I would say that there may certainly be a link but I’m not sure whether that in itself would cause the hallucinations…” (James, Lines 22-25)

2. Biological/Organic causes.

Some of the participants talked about the impact that smoking cannabis can have. All of the psychologists talked of clients that they had worked with that heard voices, as a result of cannabis use and how difficult it can be for clients to resolve their problems as a result of this. For example, John, a psychologist, describes his experience of working in Australia:

“oh god in Australia there are masses of people who are cannabis induced....” (John, lines: 160-161)

Janet, also a psychologist, believes that although there may be some genetic predisposition to hearing voices that drugs such as cannabis can be the trigger and that it can be a real struggle for clients:

“...she’d taken drugs or think smoked cannabis and actually erm she’d had a psychotic episode following smoking cannabis and actually never really escaped from it from that point.” (Janet, lines 20-23)

Other organic causes of auditory hallucinations, are suggested by Harry, a psychiatrist,
as being withdrawal from alcohol and other substance abuse:

“...sometimes they can have organic causes as well, say for instance delirium and dementia which are also responsible for auditory hallucinations or yes substance misuse or withdrawal from drugs or withdrawal from alcohol...” (Harry, lines 33-35)

3. Psychotic Illness

Both James and Harry appear to be believe that auditory verbal hallucinations are a symptom of a psychotic illness, however, Harry is more explicit in his views on this. He cites three main causes of auditory verbal hallucinations:

“Often auditory hallucinations will be a symptom of psychotic illnesses, say schizophrenia or other psychotic illnesses, sometimes we have hallucination in those who have depression and those who have mood disorders so those three would be the commonest causes of hallucinations” (Harry, lines 16-19)

All of the other participants were tentative in their views on the causes of auditory verbal hallucinations. They all recalled clients that had experienced some form of trauma. Some of the participants placed more emphasis on organic causes. The psychologists tended to place more emphasis on trauma than the psychiatrists, whereas the psychiatrists believed that psychosis was the most likely reason for hearing voices.

Perspectives on diagnosis and formulation
Four subordinate themes were identified, these were: the reductionist nature of diagnosis; the utility of psychological formulation; the inconsistency of diagnosis; the acknowledgement of misdiagnosis and impact of diagnosis on clients.

1. The reductionist nature of diagnosis

Most of the participants in the study believe that crucial information pertaining to a client’s issues is not considered in diagnosis. For example, Matthew, a psychiatrist, is concerned about the fact that a diagnosis can be made on the strength of just one symptom of psychosis:

“... it's not a good thing anyway to diagnose people on one or two symptoms without putting into context with other symptoms, patient history or current mental state...”

(Matthew, lines 14-16)

June, a psychologist, explains that she feels that psychiatrists ask for lots of information that they don’t actually use in their decision-making. She believes that diagnosis can be reductionist and can prevent professionals from thinking more widely about the client’s issues:

“...it has the effect sometimes of stopping people thinking more widely, thinking out of the box and thinking in a free way that might be actually more helpful to the client...”

(June, lines 124-126)

John, a psychologist, feels that diagnostic categorisation has become more important
than understanding the whole spectrum of a person’s problems. He believes that issues such as trauma are not considered when making a diagnosis:

“…diagnosis doesn’t take that into consideration factors such as sexual abuse, having trauma like symptoms, it’s only a diagnostic category for symptoms background factors are rarely in there” (John, lines 210-212)

2. The utility of psychological formulation

John highlights what he considers to be the differentiation between psychiatrists’ aims and psychologists’ aims in the assessment of clients. He believes the psychiatrist’s main aim is to find the correct diagnosis whilst the psychologist is looking for the issues that made the client ill:

“Well that’s because we have different aims don’t we? the psychiatrist is looking for information, will look for information to categorise and I will be looking for information that will shed light on how they got here in the first place” (John, lines 177-180)

June thinks about what she, as a psychologist, would want to gain from her assessment. She wants to know about the client’s experiences as a whole. She implies that clients who hear voices are treated differently than other clients:

“…you would be asking people all the things you would be asking any other person who comes through the door the same way you would ask people with anxiety and depression about childhood experiences” (June, lines 78-81)
Janet believes that there is an absolute necessity for a psychological formulation as she feels that this way important information will not be missed, suggesting that psychiatric diagnosis on its own is not enough:

“I would say there is an absolute necessity to not just have a psychiatric assessment to have a psychological assessment as well so that you don’t miss things” (Janet, lines 162-164)

She provides an example, with a client she has worked with whose voices were directly related to childhood sexual abuse. The voices were her perpetrators and she explains that even though the psychiatrist was aware of the abuse no connection was made between the two:

“… it was directly connected to the abuse erm but it was treated as an hallucination as if it didn’t connect… it was bizarre…” (Janet, lines 200-201)

Janet explains how a psychological formulation is not routinely asked for but how she believes a holistic assessment is essential:

“…So it might be a number of factors why they don’t but erm in an ideal world they should have both in my view.” (Janet, lines 174-175)

The importance of a formulation, in providing the client with an explanation, is illustrated by Janet, as she feels it aids understanding of how they have come to be ill and an explanation of how they can get better:
“...This is the thing that has triggered you becoming ill and this is the sort of thing that might help you...” (Janet, lines 74-75)

John, a psychologist, feels that there needs to be a multidisciplinary approach to assessment and formulation. He feels that this should take into account other professionals’ assessments even though, presently, this doesn’t happen routinely:

“...I think the idea should be get together to share the information and come up with a joint plan drawing on the strengths of each of the disciplines but I’m not sure that happens often” (John, lines 228-233)

3. The inconsistency of diagnosis

James, a psychiatrist, explains how it is possible that a diagnosis may change over time indicating how variable it can be:

“...And of course sometimes we change our mind about diagnosis, which can be helpful and unhelpful, because as we monitor the client and the client gets maybe more stable it may become apparent that they aren’t suffering from what we initially diagnosed or you get dual diagnosis...” (James, lines 89-92)

Janet and John, both psychologists, suggest that there is a problem with diagnosis because of this variability. John appears confused by the number of diagnoses a person
can be given and has concerns about the accuracy of diagnosis because of this:

“... it could be schizophrenia, it could just be a psychotic episode, it could be psychotic depression, it could be bipolar and it could be related to a manic episode and it just seems so variable” (John, lines 200-202)

Harry and James, both psychiatrists, express the importance of location of voices for diagnosis. Harry attempts to explain the difference between pseudo and true hallucinations. However both also express how it can be difficult to make a decision based on location. He believes that consideration of other factors such as childhood sexual abuse, client history and personality traits is important. There is a sense in his reflections that there are many factors that can affect whether a person hears voices inside or outside of their head that can make it difficult to make a decision based on this:

“...it is not uncommon that people will have both hallucinations. Sometimes people will start with true hallucinations and then the gravity will change and then it will become a pseudo hallucination.” (Harry, Lines 65-67)

Harry reflects on how it can be difficult to know how to treat a client who hears voices. He appears to believe that voices are not treatable in their own right because they are a symptom of psychosis:

“...So an hallucination in itself is just a symptom of something and we need to know what that something is and er depending on the situation, depending on the severity,
depending on the er... acuteness of the situation then the treatment will be different.”
(Harry, lines 124-128)

4. The acknowledgement of misdiagnosis

Janet, a psychologist, recalls how she has experienced misdiagnosis, specifically in relation to PTSD. She explains that the symptoms of psychosis and PTSD are very similar and that clients can hear voices as a result of experiencing trauma which sometimes means they can be misdiagnosed and treated for the wrong illness:

“I have certainly come across a number of people who have been misdiagnosed so they’ve been treated as if they are psychotic but actually they’ve got post traumatic stress disorder....” (Janet, lines 130-133)

Misdiagnosis is also something that June, a psychologist, has come across and she believes that this is because auditory hallucinations are not seen as a symptom of PTSD. She believes that although diagnosis is now seen by many professionals as being only part of the assessment process, it remains dominant because psychiatrists still hold great power:

“...diagnosis now has a small... smaller role but what’s interesting is its power is just as great as it always was because the group that espouse those models are actually a very powerful group and that’s the problem as our understanding has increased...” (June, lines 152-155)
One of Janet’s clients had been misdiagnosed and treated as psychotic for ten years even though the psychiatrist knew that she had been sexually abused. She explains how when she assessed her it was clear she had PTSD and that when she treated her accordingly, she recovered:

“...So when eventually she came through to me, very clearly she had PTSD and we worked on that and her medication was gradually reduced and she is functioning very well working etc...” (Janet, lines 186-188)

Janet recalls another client who was misdiagnosed and explains how when she assessed her has having PTSD and worked with her using Eye Movement Desensitization and Reprocessing (EMDR) she also recovered. She indicates here that if she had not assessed and treated her for her PTSD then she too could have been in the mental health system for a long time:

“...She literally had 4 sessions of EMDR and was back to normal, so she could have been in the system and still being treated...” (Janet, lines 222-223)

She expresses her concern that psychiatrists are not trained effectively in identifying PTSD and that as a result there may be many misdiagnosed people in the mental health system that would be able to recover with appropriate treatment. She explains that PTSD will not get better with just medication. She feels it is essential that the client receives the appropriate therapy. She believes that psychiatrists need to be trained to be aware of this:
“...With trauma focused CBT and EMDR which are now NICE guideline recommended those treatments are seen as things that do actually shift PTSD and PTSD is now very treatable so maybe it could be more on the radar now of psychiatrists. So that’s what I would perhaps think needs to happen...” (Janet, lines 236-239)

5. Utility of diagnosis

John, a psychologist, reflects on how he feels diagnosis can be helpful for some clients in reducing the distress associated with their voices because a label helps them understand why they are hearing voices:

“...I think categorisation has its place, yeah I think it has a use from time to time because I think if you’re hearing voices it can be quite terrifying and for someone to be able to give you a label of why that is... I think it can reduce the distress...”

James, a psychiatrist, feels that diagnosis provides clients with relief in the knowledge that they are not on their own and that there are other people that are experiencing the same things...” (John, lines 175-179)

James also feels that diagnosis can be useful for some clients as it can provide them with the opportunity to find out more about their illness that enables them to feel more in control of their situation:

“...For some it gives them the opportunity to do research and find out more about their illness so that they feel empowered in a way...” (James. lines 82-85)
June, a psychologist, feels that, in her experience, diagnosis helped one particular client but she questions whether this was due to the fact that she was the care coordinator and spent time helping him understand his experiences in the context of his diagnosis, implying that maybe diagnosis alone would not have been so helpful:

“…I’m not sure how much of that is down to me helping him understand his experiences which is a much broader conversations than just the diagnostic and the medical thingy about that so whether that’s helped…” (June, lines 172-174)

Janet, also a psychologist, recalls clients that she has seen that have been extremely distressed by their diagnosis because they feel that they’ve got an illness that is totally shocking. In her reflection it is apparent that she feels that this is due to the fact that the diagnosis has not been explained to them in a way that they can make sense of. She appears to believe that the problem is in the clients’ lack of understanding, again linking back to the fact that a diagnosis without a formulation can be unhelpful:

“…they have been told that they’ve got this heinous thing going on and actually they don’t know why, they don’t understand” (Janet, lines 99-101)

Although James, a psychiatrist, feels that some clients find diagnosis empowering, he has also come across clients that have found it unhelpful. He explains about the emotional distress expressed by some clients when faced with being told they are psychotic:
“...they start crying and it can sometimes make their symptoms worse, just the diagnosis in itself can be a cause of stress for them...erm...I’ve had clients get really angry with me...” (James, lines 60-63)

John, a psychologist, believes that one of the pitfalls of diagnosis is that it can create obstacles for clients as it can disempower them and make them feel that there is nothing they can do about their situation. John appears to feel that there is a hopelessness about a diagnosis such as schizophrenia, that is felt by both the client and the psychiatrist:

“...then you can see people sitting back and thinking okay well that’s that then. I think what is wrong with that label is the psychiatric ideas around it that that’s it, now you’ll be on these drugs for life” (John, lines 180-185)

June believes that the stigma attached to diagnosis can affect a person’s sense of self:

“..., you know erm there are a lot of conceptions about it you know and there’s this whole thing about redefining who you are as a person...” (June, lines 198-199)

James feels that this stigma is related to the public being afraid of the diagnosis because they feel that someone with schizophrenia is dangerous and therefore should be confined. He believes that this stigma directly impacts on the client:

“...I had one patient that thought that she may have to be locked up forever, you know, didn’t think that she would be able to go home to her family.” (James, lines 66-68)
He explains the enormity of the responsibility associated with giving someone a
diagnosis and stresses the importance of professionals understanding the impact that
diagnosis can have on client’s lives:

“…How in a few words we change someone’s life, it’s a big responsibility really…not to
be minimised really when you think about it?” (James, lines 85-90)

The belief that diagnosis is more helpful to professionals is held by Janet and June,
psychologists, as they feel it helps the professional feel reassured that they are making
the correct decisions about treatment. June is uncertain about the helpfulness of
diagnosis to the client:

“…diagnostic categories make people feel much more secure whether the clients erm a
lot of them find it particularly helpful I don’t know, I don’t know” (June, Lines 166-168)

Janet reflects on how a client can be empowered by a psychological formulation as it
aids understanding and provides the basis for a treatment plan:

“… it gives them a sense of control rather than oh goodness I’ve just gone mad and…”
(Janet, lines 86-87)

Most of the participants in this study believe that diagnosis can be useful for
professionals in planning their care. Some of the participants, however, highlighted
how diagnosis can also be restrictive for professionals as it prevents them from thinking
more widely about a client’s problems. One of the major issues that arose from this
theme was that most participants believe that diagnosis alone is not helpful to clients as it does not provide them with the explanation they need to feel empowered and in control of their situation. Some of the participants advocate that a psychological formulation alongside a diagnosis would provide the information that would make the process more meaningful and helpful to clients, reducing feelings of stigma. Some of the participants also expressed how they felt that misdiagnosis does happen and the impact that this can have on a person’s recovery. All of the participants talked about the difficulties with diagnosis in relation to inconsistency.

**Perspectives on medication**

1. **Medication is essential**

The participants highlighted the importance of accurate diagnosis in order that the correct treatment was administered. For example, James reflects on how he would make a decision on which drug was best for symptoms of psychosis:

“If we thought the patient had a psychotic illness then we would normally prescribe an antipsychotic...” (James, lines 30-33)

The belief that medication is useful for auditory verbal hallucinations is shared by Janet, a psychologist, as she feels that it quietens the voices and makes it easier to work with clients, as was discussed as part of an earlier theme:

“...I think obviously as I mentioned medication can be useful as it can bring the symptoms down...” (Janet, lines 108-109)
For some clients June, also a psychologist, believes that medication is essential as they would not be able to undertake the therapeutic work needed without it. She also feels that medication is important in terms of risk reduction:

“… because their mental health deteriorates without it and they can be a danger either to themselves and others so in order to do the trauma work they need medication”

(June, lines 144-146)

2. Medication and therapy essential

All of the psychologists and one of the psychiatrists believed that medication alone would not resolve a client’s problems. These professionals believe that medication can be used in an attempt to help a client become more stable but that the real work that needs to be done is therapeutic in nature. Matthew, a psychiatrist, expresses how he feels that medication alone will not get to the core of client’s problems:

“It’s a bit like a patient coming to me with depression, I give antidepressants without treating or looking at the marital conflict that is going on, the financial stress, the children’s stress and the patients own abusive childhood. So it’s just treating the superficial…” (Matthew, lines 94-97)

The need for a two-pronged approach to treatment is also expressed by June, a psychologist, as she believes that medication alongside therapy is the only way in which
a person will eradicate their voices:

“...but I think for the voices to go away you are looking at a combination of therapy and medication...” (June, lines 322-323)

Research suggests that medication does not work for all clients and John, also a psychologist, supports this. He reports that he has not seen real evidence of drugs working while he has seen evidence that therapy does:

“...I’ve not really seen a lot of evidence that erm psychiatric medication is particularly helpful and I have seen evidence that psychological therapy is...” (John, lines 228-230)

3. Problems with medication

Although most of the participants agree that medication can be useful in stabilising clients in order that more in-depth work can be done, John recalls the difficulties of working with clients who were on high doses of medication. He reflects on how it is sometimes not possible for clients to engage in therapy:

“...I have had the odd occasion when the people have been so highly medicated that they are not able to engage in anything...” (John, lines 120-121)

Matthew is concerned about increasing medication because of increased side effects. He gives the impression that as a psychiatrist if client’s symptoms are not getting better he has little else he can offer other than medication:
“... the next step would be to increase the dose and the side effects the more dose you give the more side effects” (Matthew, lines 51-52)

Janet, a psychologist, recalls the impact that the side effects had on one of her clients and how this affected her life and her sense of self:

“...she lost her job, she lost her friends, she lost her self esteem really because she just became erm a very different person.” (Janet, lines 23-30)

Janet talks of the devastation that the side effects can have on a person’s life. There is an implication here that the medication hasn’t helped the client very much:

“I mean it’s brilliant but what a loss you know those 10 years, 10 years. Yeah so not functioning particularly, highly medicated, side effects of the medication cos quite hefty medication yeah ten years...” (Janet, lines 190-192)

The emotional and psychological factors involved in taking medication are something that James considers as being negative. He believes that it doesn’t just affect clients’ physically but it also affects their sense of who they are:

“...from their inside view being on medication, for example, may be detrimental to their feelings, you know their identity...” (James, lines 112-113)

4. The trauma of medication
The trauma involved in being forced to take medication is something that Janet has had to treat clients for. She explains how she has also had to work with clients on the trauma of the diagnosis itself:

“...they can be sectioned and medicated against their will and I have treated people for the trauma of that because it totally traumatises them...” (Janet, lines 115-118)

The utility of therapy

This super-ordinate theme arose when participants reflected on their thoughts about how professionals can work therapeutically with voice hearers. Three subordinate themes were identified that contributed to this understanding and two of these themes will be analysed in this section which are uncertainty about the role of therapy and different therapeutic approaches.

1. Uncertainty about the role of therapy

All of the psychiatrists in this study were uncertain about how therapy works. Harry illustrates this uncertainty when he describes how other professionals deal with clients. He believes that therapy will not work when the client is acutely unwell, however, he suggests that this is sometimes undertaken informally by the client’s family and the nurses and doctors:

“Or when the medics or the nurses sit with the patient and they say don’t worry and you know it starts from that reassurance...” (Harry, lines 136-137)
In Harry’s opinion once a client is more stabilised and less distressed he feels that more formal psychological techniques may be useful. He admits that he, and other psychiatrists, are not knowledgeable in how therapy works. He also feels that some psychiatrist’s may not be willing to admit this:

“... But I don’t think most psychiatrists are actually aware of how it works they will tell you but I don’t think we really know...” (Harry, lines 137-141)

Matthew believes that therapy is an important factor in the recovery of clients. He expresses his disappointment that most of his psychiatry colleagues do not agree with him on the importance of therapy for auditory hallucinations:

“... most of the psychiatrists they don’t have interests in psychotherapy and they don’t have that sort belief that psychotherapy works” (Matthew, lines 58-60)

2. Differing therapeutic approaches

The participants had different opinions on ways of working therapeutically with clients. Some participants advocate working with the content of the voices and others believe in working only with the distress that the voices cause.

Janet, a psychologist, believes that working with the experience of hearing the voices and their content is the only way forward as otherwise clients will not engage. She feels that encouraging the client to talk in detail about their voices helps her build an effective therapeutic relationship:
“...in order to engage and to actually work with what she was experiencing, whether it was real or hallucinatory erm it was about asking her to describe what is it that you're hearing, where are you hearing it...” (Janet, lines 33-39)

John, also a psychologist, has a more pragmatic approach to working with clients, depending on the psychological formulation. He works with clients on the issues that trouble them most. If their distress is directly related to the voices he will work with them on controlling their voices using techniques such as distraction:

“...I would more work on a practical level erm you know very pragmatic suggestions of distraction of listening to music of you know talking on the phone” (John, lines 60-65)

June, a psychologist, explains how she feels that although there are different models that psychologists use to work with voice hearers, she also believes that there is psychological work that other professionals can do in helping clients have more control over their voices. She suggests that there are different levels of working with clients and that at the coping level other professionals are better placed to undertake the work:

“...I think there’s a whole load of psychological work that is generally done by the psychologist that is better done by other people about sort of coping strategies and learning to deal with voices for example in a more effective way” (June, lines 230-234)

Matthew, a psychiatrist, also implies that there are different levels of work that professionals can do. He believes that working at the level of distraction is not the answer and that unless the core work is done clients’ issues will not be resolved:
“...So I think we should be doing more than distracting techniques you need to strike at the root...” (Matthew, lines 97-98)

He believes that the CBT approach is superficial and that he would take a more psychodynamic approach because he believes that this model enables the professionals to understand the root causes of a client’s problems:

“...the aim of the psychodynamic psychotherapist to develop this insight into the patient to realise their problems and obviously help them to deal with them...”

(Matthew, lines 100-105)

Janet reflects on the importance of talking about the content of the voices, both because it is important for the therapeutic relationship and for potentially uncovering the significant issues that need dealing with:

“I mean your job is to hear what someone says not to tell them its rubbish but to uncover what it is those voices might be talking about what it is that is significant”

(Janet, lines 268-270)

Harry, a psychiatrist, also takes into consideration the content of the voices, however, he finds the client’s subjective understanding of the voices more insightful:

“...you need to what is the person’s actually own perception of the voices as well.”

(Harry, lines 119-122)
John, a psychologist, avoids making any meaning from the voices and believes that a better approach is to help clients accept the voices rather than make any judgements about them as he feels that this is more effective in reducing their distress. In order to work in this way John uses Acceptance and Commitment Therapy (ACT) as his main therapeutic model:

“...you know but actually the way I tend to work more with voices rather than CBT or anything else is from an ACT approach so we look at what the voices are and learn to accept those voices...” (John, lines 67-71)

Summary of professionals’ themes

There are a number of pertinent points raised in the analysis of the professional themes that may have an impact upon the way in which professionals work with clients. Professionals within the study all reflected ambivalence about working with the client group. They talked about the reasons for this as challenges such as difficulties engaging clients in therapeutic work; lack of confidence because of deficits in training and the difficulties associated with working with other professionals whereby the psychologists felt that the psychiatrists were not referring to them and the psychiatrists felt that the psychologists were resistant to working with clients who hear voices. Other important points that came out of the analysis were the fact that there was disagreement between professionals on the causes of auditory verbal hallucinations highlighting potential inconsistencies in diagnosis. The main points that arose from the reflections on diagnosis were that it can be reductionist; that on the whole it has a negative impact;
that it is of little use without a psychological formulation and that there is a great potential for misdiagnosis. In terms of medication, professionals feel that it can help in stabilising clients but therapeutic work is the key to success and some professionals feel that the side effects can have a very negative impact on a person. There was a degree of uncertainty with some psychiatrists about how therapy worked. There also appeared to be disagreement between how to work with voices and which therapeutic models to use. There was uncertainty about recovery, both in terms of what it meant and whether it was possible for clients. The general consensus was that clients may need to take medication for life and there appeared to be a sense of hopelessness in most of the professionals’ reflections on recovery.

Clients’ themes

This section will analyse the client’s perspectives on diagnosis and treatment. From their reflections two important super-ordinate themes arose (see Table 3 for master table of themes). These themes are:

- Feelings about diagnosis
- Experiences of treatment
### Table 4: Master Table of Clients’ Super-ordinate and Sub-ordinate Themes

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<td>“…erm my CPN was okay, she would try to talk to me but I suppose, she probably did her best…” (Jo, Lines 11-12)</td>
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<td>“…I wasn’t completely happy with the medication because I thinkas kept on it for too long…erm…” (Sara, lines 70-72)</td>
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<tr>
<td>4. Lack of options</td>
<td>“… I don’t know anything about that… no one has mentioned having therapy or anything other than medication no one has mentioned anything like it to me…” (Mark, lines 78-80)</td>
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### Feelings about diagnosis

Four subordinate themes were identified, these were: problems with diagnosis; my perspective was disregarded; lack of explanation and, disagreement about diagnosis.

#### 1. Problems with diagnosis

All of the participants in the study were unhappy with having a diagnosis of schizophrenia because of how it made them feel about themselves. For example, Sara explains how shocked she felt at being diagnosed schizophrenic, because she hadn’t thought herself so unwell. She feels that this may have been because her view of schizophrenia had come from the negative stereotype that many people have about the
illness:

“...I hadn’t really considered myself as that ill at all and also because of the negative social views of schizophrenia, I didn’t really want that...” (Sara, lines 25-26)

She feels that she has let herself down by becoming so ill and that she somehow was to blame for her illness:

“...I felt sort of disappointment with myself erm and just really shock more than anything...” (Sara, lines 27-28)

Mark explains how being told he was schizophrenic has made him feel negative about himself and there is a suggestion that he also blames himself for becoming ill. There is a feeling that being given a diagnosis of schizophrenia has brought with it a sense of hopelessness about any chance of recovery:

“Dan says I am a schizophrenic and that makes me feel bad...makes me feel hopeless...like I’ll never get better ever...” (Mark, lines 36-37)

Jo also recalls how being diagnosed with schizophrenia affected her sense of self as she felt that she must be mad if she had schizophrenia:

“...I mean you’re going to feel like a loony if you’re told you’ve got schizophrenia aren’t you?...” (Jo, lines 143-145)

She goes on to explain that although the stress associated with being diagnosed is bad
enough, it is the life changing events that occurred for her that also have had a major impact. The guilt that she feels is apparent when she explains how if has affected her children:

“...Well, first of all, I was in hospital for years off and on, my children had to go and live with their dad, can you imagine the guilt that goes with that? I'll never be able to make those years up for them...” (Jo, lines 35-41)

Paul also talks about the problems that being diagnosed has caused. He believes that it is because of his diagnosis that he is not allowed to see his son. There is a sense of hurt and anger in Paul’s reflection:

“...He was 5 when I last seen him... that's the biggest problem. If that wasn't there I wouldn't give a shit but it is there and he's mine and I need him, but because I've been told I'm schizophrenic I can't see him.” (Paul, lines 8-12)

As Mark considers the impact of his diagnosis, he explains how he can understand why there are people who hear voices that would not access help from professionals. He feels that the process of being given a diagnosis of schizophrenia and being given medication has been problematic for him:

“...people won't tell if they can cope, because they will be told they've got schizophrenia and be given medication...being called schizophrenic hasn't done me any good...” (Mark, lines 58-60)
2. My perspective was disregarded

All of the participants in the study had their own perspective on why they heard voices. All of them felt that their perspective had not been considered by the professionals. For example, Mark explains that he has not been asked for his opinion on the cause of his voices even though he feels he knows what it is:

“No…no one has asked what I think caused them... it was a bad trip in Great Yarmouth, that’s what I think triggered it off ...” (Mark, lines 27-28)

Sara also recalls that she was not asked about her views about the build up to her illness either and believes that this may have been due to her being too ill at the time. She appears uncertain about what information they gained to make a diagnosis and how they came about gaining it:

“Erm I don’t recall them asking me very much really, they sort of asked how things were and how things had been going erm …” (Sara, line 36-42)

Jo, on the other hand, remembers telling the professionals about her abuse as she believes it is related to her voices but she feels that this did not make any difference to her diagnosis as they changed their mind several times about this:

“…I told them everything because I really believed that I was going to die and I wanted them to help me so I was completely honest... erm but it still didn’t seem to provide them with enough information to help them make a certain diagnosis...” (Jo, lines 53-57)
Paul explains that he was abused as a child and that this has affected him negatively. He recalls that the professionals did ask about his abuse but, like Jo, he also feels that it made little difference to his diagnosis:

“Yes they did ask about my abuse and they didn’t take any notice even though it has affected me” (Paul, lines 37-38)

3. Lack of explanation

None of the participants in the study report having had an explanation about their illness, other than being told what their diagnosis was. Two of the participants did not appear concerned about this, Mark because he felt that there was little else the professionals could do and Paul because he disagreed with his diagnosis and believed it was a spiritual phenomenon that he was experiencing. Sara and Jo, however, both felt that a discussion about the possible causes of their illness would have been helpful. Sara appeared confused and lacked certainty as she attempted to make sense of issues that she felt may have contributed to her illness. She feels that maybe the professionals aren’t sure what triggered it:

“...but I don’t really know what triggered it, I’m not sure anyone knows what triggered it?... ”(Sara, lines 42-46)

Her confusion about her illness becomes more apparent as she reflects further. She appears to realise that it may be useful to know the causes of schizophrenia as it could
help her understand the triggers for her illness. There is a feeling of in her reflections:

“...I just presumed that it just happened and that's just how it is?...” (Sara, lines 49-53)

She feels that although she would like to know more she is not sure how the professionals can help with this. As a result of this she appears to have tentatively developed her own theory on why she was ill without any help from professionals:

“...I would like to know more about it but I didn’t really think it was something they could necessarily explain because it could just be a random thing like say I had a relative that had had it that I wasn’t aware of?” (Sara, Lines 57-59)

Sara feels that an explanation may help her feel more in control of her own recovery. She explains how such a conversation would help her feel better about her situation and how it could help her by providing her with closure:

“...I’d feel sort of more secure to stop it happening again and I’d feel more resolved, so I would sort of have closure...” (Sara, lines 94-100)

Mark also explains how the lack of understanding is not just difficult for him but also for his mother who, if she understood more, may not get so stressed by his symptoms.

“I think my mom gets stressed by it all...but I can’t help it...she doesn’t understand much about it...” (Mark, Lines 70-71)
4. Disagreement about diagnosis

Jo explains how she has been given so many diagnoses that she finds it difficult to have respect for the professionals’ opinions. She explains that she no longer takes diagnosis seriously because of the way her diagnosis has changed over time. She questions whether the professionals know what they are doing:

“…initially I think it was paranoid schizophrenia but then that got changed, I mean they were even thinking of bipolar at one stage, oh and then I had a personality disorder, I think I may still have that one, but now it’s been called schizoaffective disorder?...” (Jo, lines 27-35)

Paul also disagrees with his diagnosis as he doesn’t believe he is psychotic. He feels that it is his spiritual beliefs have led professionals to think that he is delusional and hallucinatory. He feels that he should not be judged on this when it is something that makes him happy:

“…but I am not psychotic because if I was would I be talking like this, would I be able to look at you and have a conversation with you. They know who I am they are just disbelievers…I’m not a paranoid schizophrenic they don’t believe me…I’ve been diagnosed because of my beliefs…” (Pauls, lines 27-30)

Experiences of treatment

Four subordinate themes arose when clients talked about their experiences of treatment. These are: perspectives on how professionals have helped; the limited efficacy of
medication; problems with medication; and, lack of options.

1. Perspectives on how professionals have helped

All of the participants in the study had received support from a psychiatrist and a community psychiatric nurse (CPN). Sara had also received support from a support time recovery worker (STR). All of the participants had been admitted to hospital at some stage in their illness and therefore would have received care from ward staff. None of the participants had seen a psychologist.

Mark and Sara both appeared quite satisfied with the care they had received from their CPN although neither of them elaborated on what it was that they found helpful in their interactions:

“…Quite good, ah he helps me with my voices…” (Mark, line 17)

Sara also felt quite satisfied with the professionals involved in her care but again she did not elaborate on how or why. There is a sense that she is not sure what she should expect from the professionals. Both Mark and Sara appear lacking in knowledge about what the role of the professionals is and it is therefore appears difficult for them to make a decision about how satisfied they are with their care:

“…erm…I’m pretty happy with my CPN and my recovery worker…” (Sara, line 70)

Jo reflects on how, when she was very ill, she felt that she wasn’t getting the support she
needed and that she felt alone. She feels that she has had to cope with her voices without professional help and has had to rely on personal resources:

“...I’ve just sort of got used to having the voices and I’ve managed to cope with them myself, with the help of friends really...” (Jo, lines 6-11)

She recalls that her CPN was quite supportive, however, there is a reticence in this statement which implies that Jo maybe disappointed in the care she has received. She also appears uncertain about what she should have expected from her CPN:

“...erm my CPN was okay, she would try to talk to me but I suppose, she probably did her best...” (Jo, Lines 11-12)

She expresses her disappointment with her psychiatrist as she feels that he was more focused on getting the dosage of her medication right, than finding out about her. She explains how she felt she had to be dishonest in order to have some control over the level of her medication. It appears that Jo had little trust in her psychiatrist and had to become the professional in her own care:

“...I used to lie and say that the voices were distant, when really they were quite bad, because if I told him that they were bad, he would increase my medication and then I wouldn’t be able to operate very well.” (Jo, lines 12-17)

She expresses her disappointment with professionals for not understanding how her self-harming is a coping strategy. She indicates that she felt alone with her self as no one
understood her motives. She felt that professionals judged her negatively because of it:

“...I used to cut myself to cope with them, it helped me at the time, even though my nurse would advise me against it. I mean it’s not something you do by choice is it?...” (Jo, lines 17-21)

Paul was also disappointed in the way professionals related to him. He recalls a conversation that he had with a psychiatrist that had offended him. The psychiatrist had told him to not talk to children and not be around them in case their parents thought he was a paedophile. He expresses how the conversation made him feel:

“It made me f***ing angry because I love kids, I couldn’t have been insulted any more, I just looked at him and thought you are sicker than me...someone called me a paedophile...” (Paul, lines 56-59)

He also explains about his disappointment with other professionals at the level of care inpatients receive. He recalls a young woman who he claims had managed to escape the hospital ward and had committed suicide. He blames the fact that the professionals don’t pay enough attention on patients for this:

“...How’s that care...she’s in hospital and supposed to be getting better...ends up killing herself...how’s that helping anybody...they just sit in that office...” (Paul, lines 68-71)

He feels that professionals don’t treat the patients well as they do not interact enough with them and do not treat them with respect:
“...What you want to do is go outside and watch people just sit there. Go in the office and pretend to write and watch you’ll be thinking what’s he doing? That’s not right...”

(Paul, lines 75-79)

2. The limited efficacy of medication

All of the clients in the study were taking medication. All, except Paul, were taking this voluntarily. Paul is the only participant who reported that medication did not dull his voices. None of the participants’ voices had disappeared completely as a result of being on medication. For example, Mark expresses how his medication doesn’t alleviate his voices completely but that it does calm them down:

“...It tries to calm the voices, so you don’t hear them... but it doesn’t make them go away...” (Mark, lines 23-24)

He explains how he has realised how important his medication is in keeping him stable as he has tried to stop taking his medication in the hope that he will recover, suggesting that while he is on medication he will not recover. However, when he has done this he has become very unwell:

“...I won’t let anyone come near me I wouldn’t let Dan come near me to give me my medication and the voices get bad and tell me to do all sorts of things” (Mark, lines 45-49)

Jo does not feel that the medication has helped in her recovery. However, like Mark, she explains that the medication can help calm the voices but she explains that with any
added stress their ferocity returns:

“...You know like, cos the medication hasn’t really made a great deal of...er...change really, although it has helped dull them out at times but as soon as I get stressed then they come back really...” (Jo, lines 85-87)

3. Problems with medication

All of the participants in the study had experienced side effects from their medication. Mark explains his unhappiness with the side effects:

“...they’ve increased my medication now which has helped a bit but the side effects are pretty bad look” (shows how hands are shaking) (Mark, lines 71-73)

Sara also explains how she didn’t like being on her medication because of the side effects. She recalls how it has caused problems for her such as panic attacks, weight gain and sleeping problems. She appears confused as to what issues are related to her illness and what are related to the side effects of her drugs:

“...I’m not sure if the panic attacks were side effects as the tablets are supposed to calm you down so I think it was psychosomatic...” (Sara, lines 72-76)

She also has issues with the length of time she was left on a high dose of the medication as she feels she was on it for longer than she needed to be:
“...I wasn’t completely happy with the medication because I think I was kept on it for too long...erm...” (Sara, lines 70-72)

She explains her relief at having a new doctor that is as keen as she is to reduce her medication as she will be much happier when she is drug free. Again she stresses how important it is for her not to be on medication:

“...I got a new doctor that is keener on reducing more quickly so that’s changed...I was relieved erm I’m on 400mg now. I’ll be happier when I’m not on it.” (Sara, lines 80-84)

Sara explains about the difference it will make, not being on the tablets, in terms of her weight and panic attacks. There is a real sense of how important this issue is to her in regaining her life and the relief in having a new doctor is apparent when she explains how long it could have taken for her to come off the tablets:

“...I’ll be able to lose weight and I haven’t really tried while I’m on the tablets and if I can’t cope without the tablets I’ll end up yo-yoing...but the biggest side effects are the panic attacks, it hasn’t been very pleasant. I would have been 23 by the time I’d been off the tablets completely with the other doctors so that would have been six years of being on the tablets...” (Sara, lines 86-92)

Paul explains how he feels that he is not ill and therefore does not need medication. He is given medication against his will with depot injections. He reflects on the distress he feels about being forced to take medication and the language that he uses provides an insight into how much he detests taking the medication:
“...I’m on an injection medication which I hate very much it’s devil dust...” (Paul, lines 26-27)

He recalls the first time he was made to take the medication and the pain involved in this. He implores professionals to investigate the problems it causes for people through expressing how destructive it is:

“I wish, I really wish that, please look at it, some big time people please look at it, it’s knackering people up this medication is...” (Paul, lines 62-66)

4. Lack of options

All of the participants appeared to lack knowledge about alternative treatment options available. When they were asked if any other treatment options such as therapy had been offered, it became apparent that they weren’t aware that there were any other options. None of the participants were offered psychological therapy even though medication was not dealing with all of their issues:

“...I was treatment resistant erm they just stuck with increasing the quetiapine... but they didn’t offer anything else, oh I saw my CPN and a recovery worker?...” (Sara, lines 30-34)

Sara reflects on some of the other attempts that have been made to support her, for example, she was referred to a centre where she could undertake activities and she also
had some support from her psychiatrist on her intrusive thoughts. She concludes that
this support was more practical in nature and expresses her confusion about the different
roles of professionals:

“...I’m not sure what the difference is between a psychiatrist and a psychologist...erm I
did lots of practical things but we did discuss the bullying but it was more about going
out and going around town erm we tend to have focused more on the practical
things...” (Sara, lines 61-68)

Mark is of the belief that nothing will help him eradicate his voices, there is a sense of
hopelessness in Mark’s reflection:

“...nothing will stop the voices medication does the trick a bit, but it doesn’t do it
completely...” (Mark, lines 50-51)

Although he initially indicated that he probably wouldn’t take up the offer of therapy
because of his shyness an inquisitiveness appears to develop. He explains that he
doesn’t really know anything about therapy to make a decision:

“... I don’t know anything about that... no one has mentioned having therapy or
anything other than medication no one has mentioned anything like it to me...” (Mark,
lines 78-80)

Paul, conversely, is confident that having someone to talk to him on a one to one basis,
about his feelings would have helped him. There is a sense that he feels that there is a
lack of empathy in his encounters with professionals:

“...I would like someone to sit down and talk to me the way you are talking to me now...” (Paul, lines 44-46)

He uses the analogy of how a parent can discipline their children, yet still love and respect them as a way of communicating how he feels professionals should interact with clients rather than focusing too much on their administrative work:

“...there's no feeling like that here...other than with the other patients...they just watch people and write stuff down...they don't sit down eye to eye like us...” (Paul, lines 48-52)

His hopelessness and aloneness about this situation is apparent. He feels that there are issues that professionals could help him with but all he has is the medication which he detests:

“...never seen a psychologist and I have lots of issues but I suppose I can only fix this myself, but I know I'm good person...all I have is medication...” (Paul, lines 60-61)

**Summary of clients’ themes**

A number of important points emerged from the participants’ reflections on their experiences of diagnosis and treatment. All of the participants expressed how diagnosis
had been problematic for them. These problems were related to: the person’s sense of self; feeling disappointed and to blame for their illness; and, feeling hopeless about their future. Two of the participants discussed the implications being diagnosed with schizophrenia had on their ability to have contact with their children. Participants also felt that professionals had not listened to their life story or their perspective on their illness in making a decision about diagnosis. All of them reported not having had an explanation about how they had become ill and how the decision about diagnosis had been reached, which had affected their sense of control over their situation. In terms of the participants’ experiences of treatment, although some of the participants were satisfied with the care they had received from professionals, they all appeared reticent in talking about what they were satisfied with. None of the participants appeared sure about what the role of the professionals was in their care. Two of the participants expressed their lack of respect for professionals because of bad experiences. All of the participants related problems with side effects from their medication even though two of them believed that medication had helped stabilise them. None of the participants had been offered therapy and had any knowledge of it even though all of them still experienced their voices whilst taking medication. This situation has led to most of the participants feeling hopeless about recovering from their illness.

**Discussion**

Despite the vast amount of research devoted to understanding the phenomenon of auditory verbal hallucinations there are still problems in relation to the consistency and effectiveness of its diagnosis and treatment. There is a paucity of studies attempting to gain the perspectives of the people most affected by the decision making that informs
diagnosis and treatment, namely the clients who are affected by voices and the professionals who have to undertake the decision making. This study explored the perspectives of both professionals’ and clients’ experiences of diagnosis and treatment of auditory verbal hallucinations with a view to gaining insight into the real impact that they have on the client’s life and on the professional’s working practices. The themes elicited support the existing literature, however, there are important novel points raised too. Discussion of the pertinent points of the themes will follow.

Professional Issues

1. Professional ambivalence

This theme is specifically connected to the professionals’ experiences in working with clients with auditory verbal hallucinations. The professionals talked of the various ways in which they found working with this client group to be both challenging and stimulating. A challenge that was highlighted by the study was related to the difficulties in engaging with clients because of the impact that voices can have on the ability for clients to concentrate. There is little research exploring the difficulties in engaging clients who hear voices in therapy. It is therefore understandable that professionals may feel bewildered by how to overcome the obstacle of distraction in therapy. Managing sessions with clients who struggle to concentrate whilst hearing voices involves a great deal of skill which not all professionals are trained in (Kingdon & Turkington, 2002). Other therapeutic obstacles that were raised by the professionals were difficulties associated with therapeutic engagement. A further challenge raised was that of difficulties in establishing the therapeutic relationship. The therapeutic alliance is an essential pre-requisite of effective engagement in psychological therapy (Roth, Fonagy,
Parry, Target & Woods, 2006). However, engaging people during an acute schizophrenic illness can be difficult and demands great flexibility and skill in therapeutic working. Furthermore, once engaged in a constructive therapeutic relationship, it is equally necessary to maintain this, often over long periods and this can be especially difficult with clients who are on high doses of medication, who may be experiencing a wide range of side effects that make it more difficult to concentrate (NICE, 2009).

A challenge raised by a psychologist in the current study related to lack of training and experience in dealing with clients who hear voices. There is a paucity of research into the effectiveness of psychology training programmes in working with people with severe mental illness. There is, however, an ongoing debate about the scientific validity of the working practises of psychologists, which may impact on their confidence in undertaking this work. For example, Baker, McFall & Shoham (2008) found that even though there is evidence that many psychological interventions are evidence based and value for money they are used infrequently with clients who would benefit from them. They believe that this is due to the fact that psychologists have not made a strong enough case for the use of such interventions, for example, by measuring efficacy rates within their own clinical practice and providing this data to NHS decision makers. They also argue that psychologists do not themselves always use interventions that are evidence based even when given the opportunity to do so. The authors believe this is due to:

“...their perceived lack of adequate science training, which leads them to value personal clinical experience over research evidence; use assessment practices that have
dubious psychometric support and not use the interventions for which there is the strongest evidence of efficacy.” (Baker et al, 2008, pp. 67)

The psychologists in this study work with clients in clinical settings which are increasingly defined in medical terms where the powerful, biomedical model has dominated since the nineteenth century. Strawbridge & Woolfe (2003) argue that within this context, the effectiveness of the struggle to establish and maintain a distinctly psychological approach can only be maintained with a strong bias on experimental behavioural science in psychology. It is possible to understand that for some psychologists this creates an ethical struggle between abiding by supposedly scientific medical categories, when a client’s problems may not fit so neatly into such categories. It is here that psychologists may feel the need to use their experience in using interventions that from their perspective work best with clients even if they are not the most evidence based. It is also possible to see that within this environment, psychologists may lack confidence in their own training. Research indicates that a major causes of stress for psychologists is in their confidence in their own professional ability, especially in an environment where there is so much emphasis placed on the use of drugs for the treatment of psychotic symptoms, an area that psychologists have little training in (Cushway, Tyler & Nolan, 1996).

The psychiatrists in this study also expressed their ambivalence about working with clients who hear voices. All of the psychiatrists admitted that although they were aware that therapy was reported to be effective, they weren’t actually aware of how therapy worked. It is only since 2004 that training in psychotherapy has been a compulsory part of eligibility criteria for the MRCPsych part II examination. Despite this there is debate
over the successfulness of psychiatry therapy training programmes. For example, Pretorius & Goldbeck (2006) found that even the trainees that were interested in psychotherapy and were motivated to undertake the training, frequently fail to meet the basic requirements, suggesting that there are practical and organisational problems limiting access to a wider range of psychotherapies. This lack of training may be a factor in psychiatrists’ ambivalence.

Research into psychiatrists’ ambivalence suggests that there is also ambivalence in relation to diagnosis. Whooley (2010) believes that this results from the tension between using the DSM and maintaining professional autonomy. He argues that although the DSM has solidified the position of psychiatry in mental health it has also reduced individual professional autonomy in practice. In an attempt to remain autonomous and avoid the reductionist nature of the DSM, psychiatrists adopt informal strategies, such as: employing alternative typologies; manipulating the diagnostic codes on documentation; and, negotiating diagnoses with patients (Whooley, 2010). It appears that both psychiatrists and psychologists use informal practices to avoid the restrictions of scientific boundaries that affect their working practices; however, it appears that this is not communicated. It is therefore possible that both professions adopt working practices with the aim of the same goal, that of seeing the individual in a more holistic way.

2. Problems in team working

An important issue highlighted by this study is that of problems in communication between psychiatrists and psychologists which impacts negatively on team work
between the two professional groups. The psychiatrists in the study felt that there was a resistance from psychologists in working with clients with symptoms such as auditory verbal hallucinations. They were uncertain as to what caused this resistance and hypothesised that it was either due to lack of training and/or long waiting lists. However, all of the psychologists in this study felt that they did not get enough opportunity to undertake a psychological formulation with clients with symptoms of psychosis and were uncertain why this was. The literature on the working alliance between psychologists and psychiatrists is outdated. However, it is suggested that historically, the diagnostic relationship between psychiatrists and psychologists has been difficult. Berg (1986) believes that this tension is caused by: differing professional identities; a history of political conflict, and economic rivalry and identity conflicts within the professions. Empirical surveys have revealed that psychiatrists criticise psychological reports for being too specialist and ambiguous in their content and therefore value only a small percentage of the information contained in them (Berg, 1986). Furthermore, psychiatrists complain that the working relationship with psychologists is unproductive and is subject to failures in communication (Gabbard & Smith, 1982). Since the publication of this literature there has been the introduction of community mental health teams and an even greater need for teamwork between professional groups. Teamwork and collaboration are central to good working relationships and service delivery, yet research indicates that there is a problem with this within CMHT’s (Norman & Peck, 1999). There is much debate in the literature over the effectiveness of teams in caring for people with challenging needs (Patmore & Weaver, 1991; Sayce, Craig & Boardman, 1991). Belbin (1993) found that good teams were composed of individuals who were more flexible in their roles, timed their interventions appropriately, respected other professionals’ roles and did jobs that other
members attempted to evade. In this study, there appears to be a lack of this style of team work, especially in relation to an understanding and respect of the training and roles of other professionals. In the analysis of the professionals’ reflections it became apparent that the psychiatrists have greater influence over a client’s diagnosis and treatment than the psychologists have. This was highlighted by both professionals’ perspectives. It is argued that this situation prevents effective fostering of positive team working which impacts on the clients. As will be discussed later, none of the clients within this study met with a psychologist or were offered therapy.

3. Theories on causes of voices

The findings of this study support the literature indicating that there is disagreement between professionals on the causes of auditory verbal hallucinations. It is argued that the inconsistency in the perspectives of professionals impacts decisions about diagnosis and treatment because if a professional favours a particular model this will bias their decision about which diagnosis fits best and which treatment options are most effective.

The study supported the literature suggesting that trauma was one of the major factors that can be linked with auditory verbal hallucinations (Read, van Os, Read, Morrison & Ross, 2005). Most of the professionals advocated a stress vulnerability model and viewed trauma as the ‘stress’ that triggered the voices. The stress vulnerability model assumes that biologically vulnerable people become psychotic when exposed to stressful life events (Ingram & Luxton, 2005). The professionals in this study explained that all of the clients that they had worked with that had been diagnosed as having psychosis had all experienced some form of trauma. In particular they mention that
many of the clients that they have worked with have experienced childhood sexual abuse.

This is consistent with the burgeoning literature suggesting that trauma, and in particular childhood sexual abuse, is one of the main factors associated with people hearing voices (Ross, Anderson, & Clark, 1994; Kinderman, Cooke, Bentall, 2000; Schenkel, Spaulding, DiLillo & Silverstein, 2005; Read et al, 2005). Mueser, Bolton & Rosenberg (2007) argue that clients with severe mental illness, such as schizophrenia are more likely to have experienced trauma in childhood, adolescence, and throughout their adult lives than the general population. One of the psychologists in the study explained that auditory verbal hallucinations can be a symptom of PTSD as part of flashbacks and re-experiencing the trauma. A survey undertaken by Shevlin, Houston, Dorahy & Adamson (2008) found that multiple traumatic experiences were associated with an increased likelihood of psychotic symptoms such as hearing voices. The authors argue that experiencing two or more types of trauma significantly increased the likelihood of symptoms of psychosis, with dramatic increases associated with experiencing all trauma types. Even though trauma was something that all professionals within the study mentioned, only one of them talked about the possibility that clients could be experiencing PTSD.

PTSD is a severe anxiety disorder that emerges following a psychologically distressing traumatic event such as a natural disaster, a bad accident, war or rape (Reber & Reber, 2001). Morrison, Frame & Larkin (2003) argue that there is an important relationship between psychosis and PTSD and that this is what professionals should be focusing on. In their review, they found evidence of three relationships between psychosis and
PTSD. These were: the experience of acute psychosis and psychiatric hospitalisation traumatises the individual; that psychosis may emerge as a reaction to trauma; and, that psychosis and PTSD were both part of a spectrum of responses to a traumatic event.

A model that is often not considered by mental health professionals is the diathesis-stress models of Posttraumatic Stress Disorder (PTSD) which asserts that traumatic events function as stressors that interact with pre-trauma individual differences to lead to the development of PTSD (Bowman & Yehuda, 2004; McKeever & Huff, 2003). During the past decade, research has shown that one of the most common consequences of trauma in patients with serious mental illness is their high vulnerability to PTSD. It is estimated that the lifetime prevalence of PTSD in the general population is 8% to 12% (Breslau, Peterson, Poisson, Schultz & Lucia, 2004; Kessler, Chiu, Demler & Walters, 2005). In comparison, patients with an illness such as schizophrenia have much higher rates of PTSD, with most reported estimates ranging from 29% to 47% (Calhoun, Stechuchak, Strauss, Bosworth, Marx & Butterfield, 2007; McFarlane, Bookless & Air, 2001). A major problem for diagnosis occurs when clients are experiencing symptoms that can be associated with multiple illnesses making it difficult to assign a definite diagnosis, an issue raised by one of the clients in the current study. In medicine, comorbidity describes the effect of multiple diseases an individual patient might have other than their primary disease, however, in psychiatric classification comorbidity does not necessarily imply the presence of multiple diseases, but instead can reflect the inability to decide on a single diagnosis that accounts for all symptoms. This is especially problematic when diagnosing a client who hears voices as these can be viewed as symptoms of a number of different diagnoses (First, 2009). Despite the high comorbidity of PTSD in serious mental illness, research has only recently paid
attention to the relationship between PTSD and symptoms of psychosis such as hearing voices. Mental health professionals are just coming to terms with the relationship and this has created problems in terms of the under-diagnosis of PTSD. There are two major clinical implications associated with this. First, inadequate diagnosis leads to inappropriate treatment of PTSD and continued distress for patients. Second, the inability to recognise PTSD may lead to misdiagnosis of PTSD as another disorder (Mueser, Rosenberg, Goodman & Trumbetta, 2007).

Ross (2007) argues that there is a need to consider a trauma model of mental disorders as a way of solving the problem of comorbidity. The trauma model offers an explanation for the spectrum of severity of the various mental disorders and for why some patients do not get better as quickly as others. According to this model, psychotic symptoms are more common in individuals who have experienced trauma and the symptoms are accompanied by more comorbidity the more trauma there has been. Ross (2007) believes that psychiatry’s reliance upon prescribing medication in order to help clients with voices is flawed. This is supported by literature indicating that medication does not work for all clients. The trauma model views clients’ voices as being potential clients too where the professional may work with the voices to negotiate a new relationship between them and the client. This is reflective of approaches undertaken with dissociative disorders. As auditory verbal hallucinations are more common in cases of dissociative disorders it is argued that this approach may, for clients who have experienced trauma, provide a better chance of recovery.

4. Perspectives on diagnosis and formulation

There has been much criticism in literature of the current diagnostic system because of
its reductionist nature and over reliance on medication. However, all of the professionals in the current study expressed the view that they felt that diagnosis could be helpful, albeit more for the professional than for the client. Despite this some of these professionals felt that not all pertinent information is considered by psychiatric diagnosis. All of the psychologists and one of the psychiatrists felt that a psychological formulation was essential in understanding a client’s problems. This raised other interesting points such as the inconsistency of diagnosis; potential for misdiagnosis; and, the negative impact that diagnosis had on the client.

Most of the professionals in the study expressed how they felt that diagnosis did not capture the full picture of a client’s issues. Double (1990) argues that medical diagnosis oversimplifies the nature of a patient's problems and that too much emphasis is placed on diagnosis in everyday psychiatric practice. This prevents psychiatrists from producing a commonsense understanding of why clients react in the way that they do to adverse situations. It is argued that there needs to be more of an understanding of a person’s problems by not moving on too soon to a single-word diagnosis and to gain more of a sense of a person’s life circumstances and their perspective on their own problems.

Mace and Binyon (2005) explain that diagnosis is generally just a summary label. They argue that it should be a multi-axial summary of psychiatric syndromes, personality, non-psychiatric illness, social and situational factors, should be considered, yet it rarely takes this form in practice. Furthermore, although multi-axial diagnosis potentially offers information about more aspects of a client’s current state, it is limited by the number of diagnoses psychiatrists have
available to them. The authors conclude that diagnosis remains fundamentally an exercise in naming what one client has in common with others, leaving it to a formulation to identify and explain what is unique about a client’s presentation.

It is possible to understand how a diagnosis of trauma can be missed in the psychiatric interview as symptoms of trauma are very similar to symptoms of psychosis, for example, the idea that hallucinations and delusions are relatively common in primary PTSD but can easily be mistaken for symptoms of schizophrenia (Butler et al, 1996; Hamner et al, 1999). Symptoms of trauma are sometimes dissociative in nature. Dissociation is an altered state of consciousness by partial or complete disturbance of the normal integration of a person’s conscious or psychological functioning (Dell & O'Neil, 2009). A person can experience dissociation as being detached from their emotions, body and immediate surroundings (Lynn & Rhue, 1994). Dissociation is regarded as a psychological coping mechanism to help with the overwhelming experience of trauma such as sexual abuse (Haines, 2007). Moscowitz & Evans (2009) argues that of all the psychotic symptoms, auditory verbal hallucinations can most strongly be related to dissociation, again supporting the argument that diagnosis should always consider issues of trauma as a way of discounting PTSD.

The psychologists within the study all stressed the need for a psychological formulation for all clients who hear voices. This is a theoretically-based explanation or conceptualisation of the information obtained from a psychological assessment. It offers both the client and the professional a hypothesis about the cause and nature of the presenting problems (Johnstone & Dallos, 2009). It has been considered an alternative approach to the more categorical approach of psychiatric diagnosis (Bond & Bruch, 1998). The structure and content of a formulation is determined by the psychological
model that the professional adheres to. Most systems of formulation contain the following broad categories of information: symptoms and problems; precipitating stressors or events; predisposing life events or stressors; and an explanatory mechanism that links the preceding categories together and offers a description of the precipitants and maintaining influences of the person's problems (Eells, Kendjelic & Lucas, 1998).

A formulation seeks to understand a person’s difficulties, in a more holistic way than the categorisation of diagnosis (Sim, Gwee & Bateman, 2005). It allows for an understanding of how an individual’s difficulties arise and are maintained in the system that surrounds them, as well as the wider environment, of cultural and societal norms. It attempts to identify and understand the thoughts, emotions and behaviours evoked in, and from, an individual, and those who interact with them (Summers, 2003). These can then be focused on in therapy, providing an individualised, integrative approach, which is grounded in theory and evidence. The professionals in this study believed that a psychological formulation considers more personal information than the psychiatric interview does. It is argued that if a more holistic picture of the client is built at an earlier stage then there may be less inconsistency, less opportunity to miss comorbidity and less misdiagnosis in relation to clients who hear voices.

Five of the professionals in the current study acknowledged the possibility of misdiagnosis in relation to clients who hear voices. Two of the psychiatrists explained how they used location of voices as the starting point for diagnosis even though research indicates that this is not a consistent method of diagnosis. One of the psychologists in the current study talked of two instances where she had assessed clients who had been misdiagnosed with schizophrenia when they were suffering from PTSD.
Interestingly, both of these were isolated cases as the psychologist was not routinely asked to assess clients who hear voices.

The psychiatrists within this study also reflected on how they can sometimes change their mind about diagnosis. This is supported by one of the clients in the study who explained how she knew that her voices were related to her childhood sexual abuse but that the professionals had not made the connection. Interestingly even though this client had experienced sexual abuse a diagnosis of PTSD had not been considered. This raises an important clinical issue as the major difference between a diagnosis of psychosis and PTSD is the fact that professionals believe that PTSD is a psychological problem that is treatable using therapy whilst psychosis is not. Even though the NICE guidelines recommend therapy for psychosis, in this study, it is apparent that not all clients who are diagnosed with a psychotic illness are given the opportunity to have therapy. This was reported both by the professionals and the clients in this study.

5. Perspectives on medication

The findings in the current study support the literature indicating that the side effects of medication can have a detrimental physical and psychological impact on a client’s life (Gosden, 2001; Lewis, Bagnall & Leitner, 2005; Breggin & Cohen, 2007). Research in this area has mainly focused on the physical side effects of medication on a person’s life. However, the professionals in the study explained how they felt taking medication can affect how clients feel about themselves. Eisenhauer & Murphy (1998) argue that drug therapy can result in a person changing their perception of themselves from being well to being ill. They also explain that physical changes to body appearance such as Parkinsonian side effects and extrapyramidal can affect a person's body image and sense
of self-worth.

6. Thoughts on working therapeutically

As already discussed, the psychiatrists in this study had mixed feelings about the usefulness of therapy. The psychologists all advocated the need for therapy in the resolution of a client’s issues. One of the psychiatrists believed that therapy was crucial and the other two were uncertain about how therapy actually worked. It is argued that uncertainty about therapy may be a factor in why clients are not offered therapy.

The professionals in the current study had different opinions on how they would work with clients with auditory verbal hallucinations. All of them advocated the need for a careful balance of medication in order that clients were stable. An interesting point that arose was the fact that the professionals advocated different ways in which to work therapeutically with clients. For example, three of the professionals, a psychologist and two psychiatrists, believed that the best approach was to work with a client’s distress about their voices. The other professionals felt there was a need to work with the underlying issues that were causing the voices. These professionals advocated using the content of the voices as a clue to underlying issues. The different therapeutic models that the professionals mentioned were CBT, ACT, EMDR and the psychodynamic approach as ways of working with voice hearers.

There has been a great deal of research in relation to how best to work with clients who hear voices. The work aimed at reducing the distress associated with voices has been developed as a result of research indicating that there are many people that hear voices
that are not distressed by them. Honig, Romme, Ensink, Escher, Pennings et al (1998) compared the hallucinations of patients with diagnoses of: schizophrenia; dissociative disorder and, non-patient voice-hearers. They found that the form of the hallucinatory experiences was not significantly different between the three groups. The main differences between the groups were related to the content, emotional quality, and how much the person felt they were in control of the voices. The findings of this study are important as they provide evidence that the form of the hallucinations experienced by both patient and non-patient groups is similar, regardless of diagnosis.

There have been a number of therapeutic models that are considered as working effectively in helping clients relieve distress and gain better control over their voices. Romme, Honig, Noorthoorn, & Escher (1992) found four strategies that were useful for coping, these were: distraction; ignoring the voices; selective listening to them; and, setting limits on their influence. This work has mainly been achieved using the CBT model. CBT aims to help people become aware of when they make negative interpretations, and of behavioural patterns which reinforce the distorted thinking. Its aim is to help people to develop alternative ways of thinking and behaving which reduce their psychological distress (Mansell, 2008). There are a number of direct therapies that have been used in relation to the CBT model for specific symptoms of psychosis (Fowler & Morley, 1989; Chadwick & Lowe, 1990; Haddock, Bentall & Slade, 1993; Bentall, Haddock & Slade, 1994; Chadwick & Birchwood, 1994; Garety, Kuipers, Fowler, Chamberlain & Dunn, 1994) to help clients normalise their experiences as a way of accepting what otherwise would be a disturbing situation (Kingdon & Turkington, 1994; Turkington, Kingdon & Chadwick, 2003) as a way of developing clients’ coping skills through various strategies such as avoidance and
distraction (Tarrier, Harwood, Yusopoff, Beckett & Baker, 1990; Tarrier, Beckett Harwood, Baker Yusopoff et al, 1993) or, to help clients normalise their experiences as a way of accepting what otherwise would be a disturbing situation (Kingdon & Turkington, 1994; Turkington et al, 2003).

Pankney & Hayes (2003) argue that there are several problems with this perspective. For example as mentioned earlier, for some individuals the mere presence of symptoms is not distressing and many patients are successful in staying out of the hospital. They also have practical concerns, especially in relation to clients who hear voices. As individuals who usually experience negative private events such as visual or auditory hallucinations, usually focus their attention on dealing with these intrusive private experiences that may result in an unusual internal focus. Their argument is that psychosocial interventions that are focused on the adaptation of private events might increase an already unwarranted internal focus. Wegner, Schneider, Carter & White (1987) argue that targeting private events, in an attempt to control them, can sometimes have the opposite effect. Research indicates that active attempts to eliminate such symptoms as auditory hallucinations may exacerbate clients’ problems (Morrison, Haddock & Tarrier, 1995). Research undertaken by Romme & Escher (1993) demonstrated that seriously mentally ill clients who attempted to distract themselves from auditory hallucinations had poorer outcomes. Birchwood & Trower (2006) believe that the way in which traditional CBT has followed the aims of neuroleptics in attempting to reduce psychotic symptoms, increase insight and promote medication adherence has detracted from the aims of the model. They argue that CBT for psychosis needs to move towards understanding the relationship between emotion and psychosis in order to develop interventions to deal with emotional/behavioural dysfunction alone.
or to prevent or mitigate psychosis and its positive symptoms. This thinking has manifested in CBTp which is a verbal therapy aimed at easing distress by reducing positive symptoms. Chadwick, Birchwood & Trower (1996) believe that the understanding of psychosis has undergone a positive paradigm shift away from a syndrome model to a symptom model. There is the argument that this change occurred mainly because of major scientific questions over the validity of the concept of schizophrenia (Bentall, 2007; Boyle, 2007). As a result of this thinking they have developed a model called person based cognitive therapy (PBCT) which they describe as an overarching structure for therapy that places the client, with all causes of distress, and positive strengths at the heart of the process.

Alongside such developments, a variety of newer behavioural and cognitive therapies have also emerged that are focused on acceptance, mindfulness, cognitive defusion, and similar methods (Hayes, Jacobson, Follette & Dougher, 1994; Hayes, Follette & Linehan, 2004). Segal, Williams & Teasdale (2002) explain that the difference in these methods is that there is little emphasis on changing the content of thoughts; rather, the emphasis is on changing awareness of, and relationship to, thoughts. This type of intervention would focus on altering the believability and behavioural impact of problematic cognitions without directly challenging them or targeting their content for change (Bach & Hayes, 2002).

One of the psychologists in the study explained that he used ACT in an attempt to reduce a client’s distress. Gaudiano (2009) describes ACT as a novel acceptance and mindfulness-based behavioural psychotherapy that has an increasing base of empirical support. ACT aims to teach people to clarify, accept and embrace their experiences,
especially previously unwanted ones rather than trying to teach them to gain control over such experiences (Pankey et al, 2003). The ACT approach has necessitated a review of the goals and purposes of traditional psychotherapy. Traditional therapy, undertaken with clients with psychosis has involved help with logical reasoning, building evidence for and against distressing beliefs, reality testing, and development of alternative explanations for psychotic symptoms (Kington, Turkington & John, 1994). From an ACT perspective it is the function of the undesirable thoughts that is important as trying to eliminate the thought doesn’t change the function but just makes the thought even more important (Pankey et al, 2003). Hayes (2005) describes six core processes of ACT: acceptance; cognitive defusion; being present; self as context; valuing; and, committed action. Dewane (2008) believes that ACT is a valuable tool for working with experiences of childhood abuse because, from this perspective, the cognitions and emotions that result from a history of abuse can be modified. A major difference between CBT and ACT is that CBT aims to alter the form of self-talk while ACT aims to change the function of the thoughts and feelings. Cognitive therapy views negative thoughts and feelings in terms of their logical reasonableness; ACT focuses on how reasonable these are psychologically (Wilson, Follette, Hayes & Batten, 1996). Dewane (2008) argues that “To tell an incest survivor that her disturbing thoughts in situations of sexual intimacy are irrational is not particularly helpful. It is more useful to point out the psychological function of these thoughts” (pp.36).

A psychologist in the current study reported that she had used EMDR with two clients who she felt had been misdiagnosed with schizophrenia when they had PTSD. In both scenarios she had helped resolve the clients’ issues using this technique. EMDR is a form of psychotherapy that was developed to resolve the development of trauma-related
disorders caused by exposure to distressing events (Shapiro, 2001). Shapiro (2001) argues that when a person experiences a traumatic or distressing event, it can overwhelm their normal cognitive and neurological coping mechanisms. She explains that it is a problem with processing that causes the memory and related stimuli to be dysfunctionally stored in an ‘isolated memory network’. The goal of EMDR is to process such distressing memories in order to alleviate their powerful influence, allowing clients to develop more adaptive coping mechanisms.

As already discussed, there is a burgeoning literature on the link between trauma and psychosis. It is therefore argued that clients who have experienced childhood trauma and/or abuse would benefit from working on these traumatic experiences using a therapy such as EMDR. There is limited research on the efficacy of using EMDR with clients with a diagnosis of a psychotic disorder. However, van den Berg & van der Gaag (2011) undertook a pilot study that supported the idea that short term EMDR therapy is effective and safe in the treatment of PTSD in subjects with a psychotic disorder. They conclude that treatment of PTSD has a positive effect on auditory verbal hallucinations, delusions, anxiety symptoms, depression symptoms, and self-esteem. They also state that EMDR can be applied to this group of patients without adapting the treatment protocol or delaying treatment by preceding it with stabilising interventions.

One of the psychiatrists in this study had been trained to use the psychodynamic model and believed it was an approach that could help the therapist search out the core of the clients’ problems. Shedler (2010) describes psychodynamic psychotherapy as a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than the original psychoanalysis model. The
aim of psychodynamic therapy is to explore the aspects of the self that are not fully known, especially as they are manifested and potentially influenced in the therapeutic relationship. Martindale (2007) believes that psychodynamic therapy can contribute to the work of professionals in improving their understanding of patients and families and informing them of interventions. McKinley (2011) argues that psychodynamic therapy has lost its popularity over the past mainly because of pressures within, and outside, the field which are demanding greater accountability and proven effectiveness for analytically informed psychotherapies. In countries such as Scandinavia psychodynamic and systemic understandings of psychosis are often routinely integrated into the approach to treatment, with good results (Alanen, 1997; Cullberg, Mattsson, Levander, Holmqvist, Tomsmark, et al, 2006; Seikkula, Aaltonen, Alakare, Haarakangas, Keränen et al, 2006). However, in the UK psychodynamics is rarely integrated into the psychiatry of psychosis because until fairly recently there has not been any specialist training in psychotherapy for psychiatric trainees. In the current study two of the psychiatrists had received some training in CBT but felt that this was only effective at working at the surface level of a person’s problems whereas another psychiatrist believed that the psychodynamic approach was the most effective way of working with clients who hear voices. Meaden and Van Marle (2008) explain that some people with psychosis continue to do badly even when therapies such as CBT and other psychosocial approaches such as behavioural family therapy are offered as early interventions and that as a result different therapies such as psychodynamic therapy need to be considered in this work. Shedler (2010) argues that the belief held among some professionals that psychodynamic concepts and treatments lack empirical support, and that scientific evidence shows that other forms of treatment
are more effective, is unfounded. In his review of five independent meta-analyses he found evidence that the benefits of psychodynamic therapy not only last but increase with time. In contrast, he argues that the benefits of other empirically supported therapies tend to reduce over time. In terms of recovery, the goals of psychodynamic therapy are at the level of alleviation of acute symptoms rather than at the level of coping. It is argued that this relates to what the professionals in this study refer to when they discuss working at the core of the person’s problems in an attempt to resolve issues rather than working at surface level. Psychodynamic therapy views psychological health as not merely being the absence of symptoms but also the positive presence of inner capacities and resources that allow people to live life with a greater sense of freedom and possibility and therefore achieve a complete recovery. There has been a renewed interest in using a psychodynamic approach in working with clients with voices. For example, attachment theory has been used as an approach to working with early trauma (Allen, 2001) and there have also been developments in the area of drama therapy (Casson, 2004).

Some of the professionals in the current study believed that professionals needed to pay attention to the content of the voices as these hold the clues to the issues that the client needs to address. The topic of listening to the content of voices of the ‘psychotic’ individual is controversial as traditional thinking in this area likens this to colluding with clients’ delusional thinking (Romme & Escher, 1993). Research into therapeutic techniques that advocate listening to the content of auditory verbal hallucinations is limited. Yet professionals in their clinical experiences talk of the relevance of the content of voices in helping to formulate the client’s problems. There have been attempts at developing an integrated model for working in this way. For example, as
already discussed, the trauma model has made attempts at developing ways of working with auditory verbal hallucinations based on some of the work already being undertaken with clients with dissociative disorders (Ross, 2007). The Maastricht approach has been developed over the past twenty years by Romme & Escher (1993). This method also aims to make sense of the client’s voices. The main belief of this approach is that clients can learn to cope with their voices and benefit from psychological interventions in making some sense of them and that voices are more likely to be dissociative in nature than a symptom of psychosis.

Other attempts have been made at working directly with voices. For example, voice dialogue (Corstens & Romme, 2004), a model supported by the Maastricht approach, is believed by some professionals to be an effective method of helping voice hearers. It involves conversing with a psychotic person’s voices to understand their life experiences and the voices’ ‘motives’. This technique has been developed by adapting the voice dialogue method of Stone & Stone (1989), a psycho-spiritual approach to consciousness, that provides a basic method for contacting, learning about, and working with the many selves that make up a person. The use of the technique with auditory verbal hallucinations has received criticism from some professionals in the field because they argue that it has not yet gained a sufficient evidence base. However, proponents of the method believe that it shares similarities with both traditional CBT and a new wave of CBT techniques, such as ACT and mindfulness. A further development in this area is that of relational therapy which offers clients the opportunity to explore the power and intimacy within their relationships with their voices in an attempt to explore and seek to change the relationship with their predominant voice (Hayward, Overton, Dorey & Denney, 2009). Hayward & Fuller (2009) found evidence that indicated that this model
of working provides therapists with a therapeutic framework with which to work with clients in order to change distressing relationships with voices in order to aid recovery.

These techniques offer alternative ways of understanding and working with the voice hearing phenomenon, however, because the literature base for such interventions is still building these approaches have not been considered by NICE. What is suggested by the psychiatrists in the current study is that they have little to offer in terms of therapeutic intervention. The psychologists, however, believe that therapy is crucial in working with voice hearers and have the training to enable them to work in a flexible way with clients. As the experience of hearing voices can develop and change over time and the phenomenology of the experience varies from person to person it is argued that there is a need to have a flexible approach to working with people who hear voices (Nayani & David, 1996; Jones, 2010). This suggests that a formulation based approach to working with a client with auditory verbal hallucinations is essential as this involves the client having a role in their own recovery with the opportunity to set their own therapeutic goals.

Clients’ Issues

This study identifies some of the ways in which diagnosis and treatment impacts upon clients. There is a paucity of research into clients’ experiences of diagnosis and treatment, however, findings from this study indicate that there can be both negative and positive implications of both. Many of the issues that affect clients care have been explored through the professional’s issues. However, the following section will explore some of the issues raised directly by the clients.
1. Feelings about diagnosis

All of the participants in the current study found their diagnosis to be unhelpful, especially in relation to how it affected their sense of themselves. It is argued that the negative connotations that they have about a diagnosis such as schizophrenia are due to the stigma that is attached to mental illness. Patients with mental illness are stigmatized and suffer negative issues such as social isolation, lack of opportunities in life, and poor access to treatment (Link, 1982; Fink & Tasman, 1992; Rosenfield, 1997). This stigma may come from many directions such as the client’s community, their family, the client themselves and even the mental health professionals involved in the client’s care. Reviews of the literature on community attitudes suggest that individuals with a mental illness are viewed negatively by others (Penn, Kommana, Mansfield & Link, 1999). Results from an international survey of 732 schizophrenic subjects in 27 countries was conducted which indicated that up to 47 percent experienced discrimination in relationships with friends and family, 27 percent experienced discrimination with significant others and 29 percent experienced employment or workplace discrimination (Thornicroft, Brohan, Rose, Sartorius & Leese, 2009). Discrimination from families can be particularly distressing for clients. The majority of people reported that the main problem with families was that the mental illness was not understood properly and some mentally ill people are ostracised and distanced from their families (Mental Health Foundation). Penn, Guynan, Dally, Spauldlng, Garbin et al (1994) explain that the implications of such negative perceptions lead to lowering of the client's self-esteem and contributes to disrupted family relationships. This was reported by two of the clients in the current study who explained how their diagnosis had affected their ability
to look after their children. One of the clients within this study explained how his mother found living with him stressful, he felt that this stemmed from her lack of understanding of his illness. There is an argument that family members would feel less stressed and would be less prone to discriminatory behaviour if professionals provided them with information about the client’s illness. Drapalski, Leith & Dixon (2009) argue that there are a number of barriers that inhibit family involvement, and if a more individualised, tailored approach to working with families is used, many of these barriers can be overcome which would both reduce any distress and discrimination that the family may feel.

Research indicates that clients suffering from schizophrenia also experience social distancing, exclusion and stigma from mental health professionals (Nordt, Rössler & Lauber, 2006; Jackowska, 2009; Rao, Mahadevappa, Pillay, Sessay & Abraham et al, 2009). One of the participants in the study explained how his psychiatrist had made negative comments to him. He also reported how the professionals on the wards made little personal contact with the clients. One of the clients in the study felt that the professionals involved in her care discriminated against her because she self harmed. McHale & Felton (2010) found evidence to show that historically, people who self-harm, often have negative experiences because of the attitudes of the healthcare professionals employed to help them. They argue that this is due to the lack of professional education on self-harm. Horsfall, Cleary & Hunt (2010)
argue that stigmatising attitudes are not uncommon among mental health professionals who may be less than optimistic about outcomes for people with long-term mental health problems and that the way that these professionals work with patients can have an important effect on their recovery. This is supported by the current study where five of the six professionals held little hope for a complete recovery from an illness such as schizophrenia. It is argued that this lack of hopefulness by professionals has impacted on clients’ optimism about recovery.

Glover (2001) believes that professionals should be ‘holders of hope’ for service users whose ability to hope and dream for themselves has been eroded by their illness and by negative messages from others. Hope is an important concept in the pursuit of recovery for people with mental health problems. Researchers have attempted to define the characteristics of hope and to show its connection to recovery. Dufault & Martococchio (1985) view recovery as a ‘multidimensional dynamic life-force characterized by a confident yet uncertain expectation of achieving a personally significant goal’ (p.380). It is essential that professionals are supportive to clients, especially in the early stages of recovery when clients tend to feel more hopeless and discouraged. Russinova (1999) suggests that clients often gain the most despairing and discouraging messages from professionals when they are first diagnosed which creates a situation in which the client can stagnate and thus limits any activities that they may pursue on their road to recovery. Wallcraft (2002) believes that in order for clients to feel more hopeful and to be successful in their recovery there is the need for the professional to allow the client to define their own aims for recovery because, as has already been discussed, the concept of recovery is ambiguous. She also explains about the importance of gaining the client’s perspective on the causes of their illness. She argues that if there is a
disagreement between the practitioner and the client about the origin of the problems, this is bound to impact on the therapeutic alliance, and make it less likely that the patient will feel understood and motivated to accept their diagnosis and treatment.

In the current study none of the clients had been asked about what they felt had caused their problems or had been provided with an explanation about their diagnosis. Three of the four clients interviewed explained that they knew what had triggered their illness, yet none of them had been asked to share this insight with the professionals involved in their diagnosis. Wallcraft (2002) argues that listening to the client’s own views of what led up to the problems helps to develop recovery strategies which takes into consideration the person’s social situation and stress factors. Briere (1999) found that even though over eighty percent of patients admitted in a crisis have experienced childhood or violence in adulthood, staff in psychiatric emergency services, rarely ask questions pertaining to trauma. This is supported by the findings from the current study.

Good doctor-patient relationships, built on mutual trust and sharing of information enable doctors to make accurate diagnoses (Teutsch, 2003). Effective communication is essential in diagnosing mental illness as, unlike medical problems which can be diagnosed using specialized tests, psychiatric diagnoses should only be formed from a broader assessment of the client. Good communication between the doctor and patient also has a major influence on clients’ commitment to their treatment. It can help regulate clients' emotions, assist in their understanding of medical information, and allow for better identification of their needs, perceptions, and expectations (Arora, 2003; Platt & Keating, 2007). Clients reporting good communication with their doctor are more likely to be satisfied with their care, and especially to share personal and
important information for accurate diagnosis of their problems (Ha & Longnecker, 2010). The clients in the current study have not experienced effective communication and this is possibly a factor in their feelings of hopelessness about their situation.

Ha et al (2010) argues that when clients take an active role in the management of their illness, they tend to feel empowered and motivated to work with their doctor. They have found that an accurate diagnosis and a greater patient commitment have been shown to lead to better outcomes, including fewer and/or less severe symptoms, improved quality of life, and a greater chance of recovery. It is argued that a formulation or diagnosis that is undertaken in collaboration with the client would facilitate these positive opportunities for the client. The clients within the current study were not involved in the decision making about their diagnosis and treatment and this may be a factor in their hopelessness and continued experiencing of symptoms. Marvel, Epstein, Flowers & Beckman (1999) found evidence that suggests that patients asked to describe their concerns by a physician, were most often redirected after the first expressed concern and after a mean time of only 18–23 seconds. They also found that the frequency with which experienced physicians solicited the patient's complete agenda is quite low (28%). This resulted in missed opportunities to gather potentially important patient data which supports the findings in the current study. It is argued that a psychological formulation may have resolved the issues that the clients raised in this study. This could have impacted on the clients feeling more knowledgeable about their illness, more in control of their situation and more able to make informed decisions about their treatment.

2. Feelings about treatment
None of the clients in the study had been offered therapy even though NICE guidelines recommend it (NICE, 2009). They were not aware that there was such an option. All of the clients explained how medication was problematic in terms of its side effects. One of the clients in the study explained how she had been dishonest with the psychiatrist in order that her medication would not be increased as she didn’t want an increase in side effects. Despite the burgeoning literature documenting the negative side effects of medication, antipsychotic drugs are the primary treatment modality for the management of acute psychosis as well as for relapse prevention in the long term maintenance of psychosis (Lehman & Steinwachs, 1998). Birnbaum & Sharif (2008) argue that management of a psychotic illness such as schizophrenia cannot be done without psychotropic treatment both in hospitalised patients as well as in outpatients as it enables symptom attenuation or resolution so that other forms of therapies such as social skills training, cognitive behavioural therapy, and vocational rehabilitation can be undertaken. This is supported to some degree by the current study where the clients and professionals explain the benefits of symptom reduction and stabilisation as a result of medication. The issue is that there needs to be careful balancing of medication, in order that, the benefits of medication are not outweighed by the negatives of side effects. Clients, in this study, were not offered therapy alongside their medication. The potential reasons for this have been elucidated by the professionals within this study as being psychiatrists’ uncertainty about therapy alongside psychologists’ ambivalence in working with clients who hear voices.

**Implications for Counselling Psychologists and Service Development**
One of the clinical implications that arose from this study was that of psychologists’ ambivalence in working with clients who suffer from symptoms of psychosis such as auditory verbal hallucinations. Research suggests that this perspective is gradually changing over time as a result of an increasing belief that psychological therapies can be effective in working with symptoms of psychosis. This is supported by the British Psychological Society, who in their report ‘New Ways of Working’ (BPS, 2007) specify both the increasing demand by service users and carers for psychological interventions for psychosis, and recognise that such interventions are being proven to be increasingly efficacious in working with clients with psychotic illnesses. The report acknowledges the fact that currently the skill base for such work is limited and that there is a need for more training for psychologists in order for them to be competent in this work. The ambivalence felt by psychologists’ indicates that such training has not yet filtered through to all psychologists. There is also an historical tendency for psychologists to feel that they have little to offer individuals suffering from serious mental disorders, such as schizophrenia and have considered such cases to be more suitable for psychiatric treatment (Beddell, Hunter & Corrigan, 1997). In the current study it is apparent that this thinking is also still reflected in some psychiatrists’ thinking.

A finding of this study was the lack of communication between the two professional groups, creating a level of misunderstanding about the roles of each discipline. This begins at the level of training as there is little on training programmes to provide information on the training and roles of other mental health professionals and therefore could be resolved at this level. It could also be dealt with at service level with better communication between members of the CMHT. CMHT’s were set up in order to provide a comprehensive service to clients but if professionals within the team are not
communicating effectively then gaps may appear in service. Psychiatrists in this study were unsure why psychologists were not available to see clients with symptoms of psychosis, yet the psychologists were advocating that everyone should have a psychological formulation. This indicates that there is a lack of effective communication within CMHT’s and may be the reason why clients are not being offered the therapeutic options that should be available to them.

An important issue that arose from this study was the need for a comprehensive assessment of clients. The psychologists in this study believe that important information is not considered when the psychiatrists make decisions about diagnosis. The clients in this study supported this as all of them reported that they had not been asked about their perspective on their illness. This alongside the research suggesting that trauma is a potential factor linked to people hearing voices prioritises the importance of identifying this early on. It is recommended that psychologists assessing clients who hear voices should undertake a thorough assessment of trauma using the appropriate tests. This would ensure that there is accurate diagnosis and eliminate the possibility of misdiagnosis or any issues of comorbidity. It is recommended that all clients who hear voices should have a psychological assessment alongside a psychiatric interview. It is argued that if a psychological formulation were gained this would provide clients with the opportunity to share their perspective. This would provide clients with the opportunity to ask questions and to gain information pertaining to their diagnosis alongside having a discussion about their treatment options. Client involvement in their own care is a major factor in effective recovery therefore it is argued that through a psychological formulation clients can be provided with information about the options for the effective treatment of their issues.
Of central importance to counselling psychology is the therapeutic relationship which involves working towards a genuine equality between client and professional. Counselling psychology has carried with it a reputation of not working with serious mental illness, which is an informal opinion not based on research but a rumour that affects counselling psychologists on a daily basis. This may be as a result of the fact that the profession has distanced itself from the biomedical model and its practices (Strawbridge & Woolfe, 2002). This has changed more recently as counselling psychologists are now being increasingly recognised for the strengths they bring to working with clients with serious mental illnesses. Counselling psychologists are well placed to work with clients who hear voices because their training emphasises the importance of understanding the clients’ subjective experiences in seeking to work collaboratively with the client in order to fully understand their inner worlds and realities (Strawbridge & Woolfe, 2002). It is argued that counselling psychology practices could provide the basis for the future understanding of the assessment and treatment of clients who hear voices.

There is a shift in thinking that psychological therapy is ineffective in working with clients. The psychologists within this study had all worked with clients who hear voices in using a variety of therapeutic models. It is clear that counselling psychology training programmes, in the future, need to include relevant training in working with this client group to ensure that newly qualified trainees are prepared for the difficulties involved in engaging clients who hear voices. It is also important that currently trained counselling psychologists ensure that they gain the necessary skills through their continuing professional development in some of the newer models of working with psychosis,
...some of which have been mentioned in this report. A pertinent issue highlighted by this study was the fact that there are a number of therapeutic models that work well with clients who hear voices, however, not all of these models are indicated in the NICE guidelines. It is recommended that counselling psychologists keep abreast of developments in this area in order that client choice in therapy can be exercised.

Limitations and suggestions for future research

The participants selected for this study were a relatively homogenous sample (Willig, 2001). Purposive sampling was employed to select professionals who had worked with clients who hear voices and clients who were stable but had not received specialist services. All of the clients were recruited via their care coordinators and all of the professionals volunteered their time. It could be argued that this limits transferability as the clients that were recruited may have been ones that the care coordinators felt were less difficult and more articulate and that the professionals were interested in working with auditory verbal hallucinations and were more motivated to learn more. A limitation is that all of the clients were white which eliminates any potential cultural issues. Other limitations of the study are that only four clients were recruited as care coordinators were reluctant for their clients to be interviewed. However, IPA studies are conducted on small sample sizes as the detailed case-by-case analysis of individual transcripts takes a long time, and the aim of this study is to say something in detail about the perceptions and understandings of a particular group rather than prematurely make more general claims. This is described as an idiographic mode of inquiry as opposed to the nomothetic approach that predominates in psychology. Previous research has been dominated by nomothetic studies, analysing at the level of groups...
making only probabilistic claims about individuals (Smith & Osborn, 2007). The themes derived from the six interviews with professionals are best understood as applying to the recalled experiences of those six participants albeit that this group was separated into two groups of professionals and it could therefore be argued that there are two samples involved within the professional group. All of the clients had received care from only psychiatrists and no psychologists in this study. It is important, therefore, that generalisations are not made from the findings of this study as conclusions can only be related to the specific groups involved. If the study had involved other groups of professionals such as nurses or support workers then there could have been a very different set of themes emerging from the interviews. This is certainly an avenue for further research in order to explore the generalisability of the themes that emerged.

Shorter interview times were gained from the client participants, due to the fact that the clients were still experiencing symptoms and receiving NHS treatment. The interviewer was also careful to steer clients away from potentially distressing topics which limited the interview times.

Recruitment specifically avoided participants who had received support from specialist services, such as early intervention, or self help groups, such as the Hearing Voices network (HVN) due to the fact that this could involve a biased sample of individuals. The HVN is part of a larger movement called Intervoice which is critical of psychiatry and the way in which it diagnoses and treats voice hearers. In the current study, originality comes from recruiting participants from the NHS caseload to gain valuable insight into different perspectives on diagnosis and treatment. As a result, there were some methodological challenges including finding participants that were ill, but not too
ill that they could not articulate their perspectives. Thus, the interviews were shorter in length than those of the professionals representing a cautious balance between the awareness of the ethical issues of distressing participants by exploring too deeply and still acquiring useful, and IPA consistent, data. Regardless of these issues, the themes that emerged from the interviews were very interesting and it was possible to see a clear link between some of the perspectives and experiences of the professionals and the impact that these had on clients’ experiences.

The current study has raised a number of important issues that require further research. Firstly, the generalisability of the themes elicited in this study could be explored further by recruiting professionals from different disciplines within the CMHT. It may also be illuminating to recruit more clients from different ethnic backgrounds to explore any cultural issues that may affect the data. A major area of uncertainty raised by this study is the accuracy of diagnosis and potential misdiagnosis in the field. It would be useful to undertake research assessing clients that have a current diagnosis of a psychotic illness for any trauma related symptoms. This research could involve undertaking a psychological formulation alongside an assessment of trauma. Such research would provide some indication of the number of clients that are experiencing symptoms of trauma that are not being treated appropriately. This would also provide an indication of the actual number of clients who hear voices but who are not being offered therapy, as research in this area is limited. A further area that would benefit from research is in relation to the communication between professionals within the CMHT to gain some perspective on the attitudes and beliefs that different professional groups have about each other. This is important because the research that is available is outdated and because this directly affects the client who may not be gaining the support of all the
professionals they need within the team because of conflict within the team.

This study raised issues relating to the lack of choice for professionals and clients in terms of integrated therapeutic models for working with voice hearers. NICE guidelines currently recommend only two approaches to working with schizophrenia, CBT and family interventions. Some of the professionals in this study indicated their uncertainty about the merits of CBT and others mentioned other models of working that they would prefer to use. There are many exciting new developments in the field and researchers are attempting vigorously to gain evidence base for such therapies. It goes without saying that further research is needed in this area in order to ensure that influential policies such as NICE guidelines include such therapeutic models in their recommendations. This would provide both professionals and clients with the choice they need to find effective treatment for auditory verbal hallucinations.

Summary and Conclusions

The purpose of this study was to gain professionals’ and clients’ perspectives on diagnosis and treatment of auditory verbal hallucinations. There is a lack of research in this area and a lack of qualitative research generally on the hearing voices phenomenon. The researcher has achieved this objective through the analysis of the data and discussion of the themes that were derived. The current study adds to the literature on how diagnosis and treatment impact upon clients and how the clinical practices of professionals can be improved in their work with clients who hear voices. The themes that have been elicited from this study support the literature that indicates that there is disagreement in opinions about the causes of auditory verbal hallucinations which it is
argued creates inconsistency and disagreement in relation to diagnosis and treatment and has a negative impact on clients.

A pertinent issue raised by this study is that of professionals’ perceptions that diagnosis can be reductionist creating inconsistency and sometimes inaccuracy. The debate about the usefulness of the current system of psychiatric diagnosis has not been discussed within this thesis as it has there is a plethora of research in this area. Also all of the professionals felt that psychiatric classification had its uses. However, all of the psychologists within the study felt that the problems of inconsistency and inaccuracy could be overcome by undertaking a psychological formulation, including a trauma assessment, alongside a psychiatric interview with every client. This could potentially resolve the issues regarding misdiagnosis or the lack of consideration of comorbid symptoms of trauma. It would also ensure a holistic picture of the clients’ issues and provide opportunities for therapeutic interventions to deal with such issues. This clinical practice could deal with problems raised by the clients in this study such as: lack of an explanation about their diagnosis causing them to feel internal stigma; low self esteem; lack of opportunity in providing their own perspective on their illness; and, lack of choice of treatment.

An important finding of this study was that of professional ambivalence thereby causing a level of uncertainty about how best to work with clients who hear voices. Professionals related this ambivalence to lack of training as they explain that there is a lack of an explanation of how to work with severe mental illness on their training programmes. This led them to lack confidence in working with the challenges of engaging clients who can be distracted by their voices or who are on heavy doses of
medication.

The professionals in the study expressed problems with communication between the two professional groups. This situation is potentially causing problems for clients who may not be offered therapy as a result. None of the clients in the current study had been seen by a psychologist for a formulation or had been offered therapy for their problems.

The main clinical implications that arise from this study are that: there is the need for every client who hears voices to have a psychological formulation, including a trauma assessment, alongside their psychiatric interview; psychologist training must include modules that are dedicated to working with serious mental illness and specifically voice hearing; there is the need for interventions to encourage better multidisciplinary working; and, professionals must keep abreast of new therapeutic models that are being developed to specifically work with auditory verbal hallucinations.

Some ideas for future research are: a study that would test the generalisability of the themes elicited by recruiting professionals from different groups and clients from different ethnic backgrounds; further research identifying the numbers of clients diagnosed with a psychotic disorder that also meet the criteria for PTSD; further research about professionals attitudes and communication patterns within CMHT’s and, more random controlled trials on newer models for working with voice hearers such as ACT, EMDR, voice dialogue and relational therapy.
Critical Appraisal
Critical appraisal of the research process

I initially became interested in the phenomenon of hearing voices whilst undertaking my undergraduate psychology degree. In one of my third year modules we were introduced to the topic and shown a video involving the differing perspectives of professionals on what caused the voices and how they should be treated. The video also explored the perspectives of voice hearers and their strategies for dealing with both the distress and the voices. It struck me at the time that regardless of the causes the actual experience of hearing voices was very distressing and that the intrusion of the voices caused many practical problems for the clients. It was at this point that I realised that I wanted to work in this area and I wanted to learn more about ‘auditory hallucinations’.

Once I had finished my degree I attended some of the events run by the Hearing Voices Network (HVN) and I was both amazed and extremely moved by the many stories I heard of people such as Jacqui Dillon, Chair of HVN and Peter Bullimore, Chair of the Sheffield HVN. In listening to people’s stories at these events it became apparent that each and everyone of them had experienced severe trauma. In attending workshops run by Marius Romme and Sandra Escher, I felt sure that for many people, these voices represent some of the most traumatic experiences of their lives. It is because of this interest that I have pursued a career in counselling psychology and this is the reason for undertaking my research in this area.

I knew all along that my thesis would involve some form of research on the topic of hearing voices. Everyone else on the course was envious of my early decision about this as they were all struggling to think of a topic. However, as the topic is huge it was very difficult for me to make a decision about what I could actually do justice to in a thesis. I decided that in order for my research to be of any use to clients it would be
best to look at how they felt about their diagnosis. I then felt that maybe it would be useful to include treatment in this as this is something that as a counselling psychologist would be useful to me in my clinical practice and obviously as diagnosis informs treatment, both are equally important.

I decided early on that I would want to include both professionals and clients in my study as I felt that this would provide a more complete picture of how professionals’ attitudes to diagnosis and treatment could affect the clients. In sharing this with colleagues and university staff I was warned of the problems I would have getting both university and NHS ethical approval as the clients would be considered as vulnerable. At this stage I was advised that perhaps just focusing on professionals would be the best option. I thought about this for a while but there was something inside me that made me feel that this was not right. The very reason I was interested in the topic was because I felt strongly about the needs of the clients and I felt that by leaving them out of the study I was letting them down in some way. Maybe this was a foolhardy and emotional decision but nevertheless I made it any way. My supervisor, who was much more pragmatic about the whole thing as a seasoned researcher, backed my decision because he felt that a doctoral thesis warranted this level of investigation. Therefore, the decision was made, mine emotional, and his academic. What a good team we have made!

I was especially concerned about this as I wanted to interview clients who had a fresh view of the mental health system. Although I had contacts from the HVN I really wanted to try and avoid their members as participants as I felt that there was an ethos of anti-diagnosis and a level of empowerment that would skew the data. Although I felt the perspectives of the members were valid and important in their own right I wanted to
try and seek out the perspectives of the majority of clients that would not have gained this support. Gaining university ethical approval was not problematic as I ensured that I considered all aspects of potential risk and how I would deal with this. My proposal got through all university committees first time around. The next stage was dealing with the NHS IRAS system. There was no one at the university that could help me with this as I was the first trainee to have to go through this new system. I found the technicalities of the system difficult but I manoeuvred my way through it. I was dreading attending the NHS ethics committee meeting but I found it to be a very positive experience. I can honestly say that I felt very proud of the fact that I had only three minor amendments to make and that these were administrative in nature. The fear that had been induced by the comments of people around me was unwarranted and I would have no hesitation in applying for NHS ethical approval in the future. I believe that this fear is the reason why many trainees avoid using real clients as participants in studies and I feel that this is a real shame.

In my naivety, I believed that getting NHS ethical approval was the major barrier however in reality it was actually getting the participants that was the real struggle. It was not too difficult getting the psychologist participants as I feel that they may have understood the pain I was going through in getting participants for research. The psychiatrists were a little more difficult to recruit, possibly because they have little time in their schedules. The nightmare I had was gaining client participants. Many of the care coordinators were very protective of me interviewing their clients, even though I had gained ethical approval, they were still reticent about putting forward names. My clinical supervisor suggested that I contact the wards as their patients would be easier to access. As I had decided that I was going to interview people that were still hearing voices it became more obvious that I had a tricky dilemma on my hands. I had to try
and find clients that were still hearing voices but that weren’t so distressed by them that they were too ill to talk to me. One of my research supervisors suggested that I should perhaps leave the client participants out of my study, at this stage, and just focus on the professionals. There was a point in my struggles to recruit that I thought that maybe she was right but there was a feeling in the pit of my stomach that this wasn’t right, as I had felt at the outset of the research. I carried on with recruitment and found some clients. The compromise, however, is that I feel that the clients’ interviews are lacking in the length and depth that I gained from the professionals’ interviews. I still feel, however, that it was important to include the clients and I believe that although their interviews were shorter in length there are some very important findings that make the study more complete and that link up well with the professionals’ findings. My findings are extensive and I feel sorry that I can not do justice to them in the word count of this thesis. My word count was so far over the limit that I had to make a hard decision and reduce what I had. The theme that had emerged on “thinking on recovery” was really interesting and is an extremely important issue, however, it was not essential to the aims of my research therefore I mad the difficult decision of not including it in this report. It will be a theme I will return to and extend upon in the future. My supervisor will ensure that I do that!

The objective of my research study was to explore how clients and professionals felt about diagnosis and treatment. I felt it important to also explore, with professionals, their feelings about the causes of auditory hallucinations as my literature review found that there was a lack of a scientific explanation and as a result the differing opinions of professionals in the field creates inconsistency in diagnosis and treatment. I felt the best way of achieving a full exploration of the perspectives of both clients and professionals would be to use interpretative phenomenological analysis (IPA) as my methodology.
Smith & Osborn (2003) argue that a suitable approach for investigating how individuals are making sense of their personal and social world is through using this approach (Smith, 1996; Smith, Jarman & Osborn, 1999). As will all methodological approaches there are positives and negatives. Willig (2001) argues that language constructs, rather than describes, reality and I found that a inevitable pitfall of IPA is the impossibility of gaining direct access to another person’s experience. I struggled with this concept all the way through the analysis, always questioning if I was reading into people’s explanations what I wanted to hear for my research. It is acknowledged that analysis of the data requires a close interaction between the analyst and the text and IPA acknowledges the theoretical preconceptions brought by the researcher to the data analysis process. The problem that I experienced was that I became so caught up in worrying about my own preconceptions that at one point in the process I became totally blocked. It was at the point where I had decided to redo all of my theme titles that my supervisor realised that I was experiencing what most novice researchers do, a lack of confidence. There is a level of positivity that has emerged from this lack of confidence and that it my certainty that I have engaged with each individual text, as I have listened several times to each interview and I have read and re-read the text. As a result I have become very familiar with each text and could ‘hear’ the individual’s voice and remember their expressions every time I engaged with the case. Detailed transcription notes also helped to bring each interview to life.

In relation to the interpretative process of the study, it is important to note that, as a novice, the researcher struggled with the idea that there may be too many pre-existing assumptions about the meanings behind the content of the interviews. In order to ensure that the analysis would be as objective as is possible the researcher made summary notes immediately after each interview and kept self-reflective notes throughout the
research. When reading, and re-reading, the IPA guidelines the researcher realised that this was possibly not a negative thing in itself. Through the self reflection that went alongside the analysis it became evident that the time and effort that had been devoted to the attempt to give justice to the participants’ accounts had brought the researcher closer to the texts. Smith & Osborn (2007) summarise the difficulties the researcher encountered:

“…access depends on, and is complicated by, the researcher’s own conceptions; indeed, these are required in order to make sense of that other personal world through a process of interpretative activity. Thus, a two-stage interpretation process, or a double hermeneutic, is involved. The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world” (p.53).

As a novice researcher it took a while to feel comfortable with this philosophy, however, in careful consideration and reflection of the whole research process, the researcher feels comfortable with the overall decisions made in the process of analysis. It is felt that the decision to undertake the analysis of the professionals’ and clients’ transcripts separately worked well for this particular study as there would have been the possibility of losing the perspectives of the clients because the professionals interviews were that much longer. As already mentioned one of the issues the researcher faced was finding an ethical balance between gaining the perspectives of clients who were in differing stages of their illness alongside providing them with the opportunity to voice their opinions. The researcher believes that in analysing the clients transcripts separately she has uncovered themes that are particularly pertinent to the clients. In this study none of the clients had worked with a psychologist therefore the two participant
groups had not shared any specific experiences of diagnosis and treatment.

My clinical work has really benefited from this research. My research has also benefited from the placements that I have undertaken. As a result of my research, I realised early on that I both wanted, and needed, to work with clients with psychosis. My work with the early intervention team has enabled me to have a clinical understanding of what it is like to work with clients who hear voices. I have found this extremely beneficial in understanding the perspectives of the professionals and the clients in this study. As a counselling psychologist I firmly believe that a collaborative approach to formulating the clients’ issues is extremely important. I am pleased with my research, it is by no means perfect, but I believe that I have managed to illuminate some of the important issues in diagnosis and treatment for both professionals and clients.
References


Bach, P. & Hayes, S.C. (2002). The use of acceptance and commitment therapy to


Chadwick, P. D.J. & Lowe, C. F. (1990). The measurement and modification of


hallucinations: a comparison between patients and non-patients. *Journal of Nervous and Mental Diseases*, 186, 646-651.


Meaden, A. & Van Marle, S. (2008). When the going gets tougher: the importance of


http://schizophreniabulletin.oxfordjournals.org/content/33/1/192.full - xref-ref-28-1#xref-ref-28-1


Appendices Contents

Appendix 1  NHS ethical approval letter
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Appendix 6  Client participants’ information sheet
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Appendix 14  Psychologists’ theme tables
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Appendix 17  Copies of notes for contributors
20 July 2010

Ms Dawn L Gearing
Counselling Psychologist (In training)
South Staffordshire & Shropshire Foundation Trust
Foundation House
St George’s Hospital
Stafford
ST16 3AG

Dear Ms Gearing

Study Title: “Diagnosing and Treating the Voices: The patient and professional perspective.”

REC reference number: 10/H1206/49

Thank you for your letter of 19 July 2010, responding to the Committee’s request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.rdforum.nhs.uk](http://www.rdforum.nhs.uk).

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation’s involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

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<thead>
<tr>
<th>Document</th>
<th>Version</th>
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<td>Investigator CV</td>
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<tr>
<td>Protocol</td>
<td>1</td>
<td>07 June 2010</td>
</tr>
<tr>
<td>Letter of Invitation</td>
<td>1</td>
<td>07 June 2010</td>
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<tr>
<td>REC application</td>
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<td>Interview Schedules/Topic Guides</td>
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<td>Advertisement</td>
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<td>07 June 2010</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
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</tr>
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<td>Participant Information Sheet</td>
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<td>19 July 2010</td>
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<tr>
<td>Response to Request for Further Information</td>
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<td>Participant Information Sheet: Professional Information Sheet</td>
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<td>Participant Consent Form</td>
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<tr>
<td>Evidence of insurance or indemnity</td>
<td></td>
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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.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1206/49 Please quote this number on all correspondence

Yours sincerely

Dr Rex J Polson
Chair

Email: Karen.Green@westmidlands.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to:

Professor John Darling
Dean of School of Applied Sciences
University of Wolverhampton
Wulfruna Street
Wolverhampton, WV1 1LY

Professor Eleanor Bradley
South Staffordshire & Shropshire Foundation Trust
R&D Block 7
St. Georges Hospital
Corporation Street
Stafford, ST16 3AG

This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England
Appendix 2 – University of Wolverhampton RES20B form

RES 20B
(October 2003)

School of Applied Sciences Ethics Committee: submission of project for approval

- This form must be word processed – no handwritten forms can be considered
- ALL sections of this form must be completed
- No project may commence without authorisation from the School Ethics Committee

**CATEGORY B PROJECTS:**

There is identifiable risk to the participant’s wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an *a priori* assessment.

All Category B projects are assessed first at Divisional level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

<table>
<thead>
<tr>
<th>Title of Project:</th>
<th>“Diagnosing and Treating the Voices: The patient and professional perspective.”</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><em>Working title study 1:</em> Experiences of diagnosis and treatment in people that hear voices</td>
</tr>
<tr>
<td></td>
<td><em>Working title study 2:</em> Mental health professionals’ experiences of working with people that hear voices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Supervisor: (for all student projects)</th>
<th>Dr Nick Hulbert Williams</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anne Crawford Docherty</td>
</tr>
<tr>
<td>Name of Investigator(s):</td>
<td>Dawn Gearing</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Location of Research:</td>
<td>DcounsPsych / Professional Training in Counselling Psychology</td>
</tr>
<tr>
<td>(Module code, MPhil/PhD, Staff)</td>
<td></td>
</tr>
<tr>
<td>Qualifications/Expertise of the investigator relevant to the submission:</td>
<td>BA Business Studies, BSc (Hons) Psychology, Counselling Psychologist in Training</td>
</tr>
</tbody>
</table>

**Participants:** Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.

<table>
<thead>
<tr>
<th>Study 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six participants will be recruited. All participants must be people that have heard voices for at least 1 year, preferably with a diagnosis of psychosis. I will not recruit people that are deemed unstable by their care coordinator, due to the sensitive nature of the interview questions. I plan to recruit participants as follows:</td>
</tr>
<tr>
<td>o Through the Hearing Voices Network (I have been given verbal permission to advertise and recruit through this group but I will not attempt to recruit until I have written permission). Written permission will be appended to my final thesis.</td>
</tr>
<tr>
<td>o Through local NHS trusts primarily Shropshire and South Staffordshire Foundation Trust (SSSFHT) as I have good links here due to my current clinical placement.</td>
</tr>
<tr>
<td>o I will introduce myself to care coordinators in SSSF and any other trusts that I may need to recruit from.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six participants will be recruited, preferably split equally between psychiatrists and psychologists. I plan to recruit participants as follows:</td>
</tr>
<tr>
<td>o Through local NHS trusts primarily Shropshire and South Staffordshire Foundation Trust (SSSFHT).</td>
</tr>
<tr>
<td>o Through emailing psychologists and psychiatrists working in adult mental health in the trusts that I need to recruit from.</td>
</tr>
<tr>
<td>o Through talking to psychologists and psychiatrists that I already have links with as part of my clinical placement.</td>
</tr>
</tbody>
</table>

Please attach the following and tick the box provided to confirm that each has been included:

- Rationale for and expected outcomes of the study
- See attached sheet – ‘Supporting Information’
| Details of method: materials, design and procedure | ✓ |
| See attached sheet – ‘Supporting Information’ | |
| Information sheet* and informed consent form for participants | ✓ |
| *to include appropriate safeguards for confidentiality and anonymity | |
| See attached Information Sheet and separate Consent Form | |
| Details of how information will be held and disposed of | ✓ |
| See attached sheet – ‘Supporting Information’ | |
| Details of if/how results will be fed back to participants | ✓ |
| See attached sheet – ‘Supporting Information’ | |
| Letters requesting, or granting, consent from any collaborating institutions | ✓ |
| See attached sheet – ‘Supporting Information’ | |
| Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16 | N/A |

Is ethical approval required from any external body? YES
If yes, which Committee? NHS REC (SSSFT in first instance)

*NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.*

Signed: ___________________________________________ Date: ________________
(Investigator)

Signed: ___________________________________________ Date: ________________
(Supervisor)

**Except in the case of staff research, all correspondence will be conducted through the supervisor.**

**FOR USE BY THE SCHOOL ETHICS COMMITTEE**

Divisional Approval Granted: ___________________________ Date: ________________
(Chair of Divisional Ethics Committee)

School Approval Granted: ___________________________ Date: ________________
(Chair of School Ethics Committee)
Supporting Information for Res20(b)

Rationale for study and expected outcomes

Romme & Escher (2000) have estimated that about 4% of the population experience auditory hallucinations (AHs). The DSM-IV-TR (2000) defines a hallucination as a sensory perception that has a compelling sense of reality of a true perception, but occurs without external stimulation of the relevant sensory organ. Asaad & Shapiro (1986) define an AH as a false perception of sound and argue that these are the most common forms of hallucinations. Romme, Honig, Noorthroom & Escher (1992) explain that traditionally AHs have been considered by clinical psychiatry as one of the major symptoms of schizophrenia. Walker & DiForio (1997) argue that this illness is seen as one of the most biologically based mental disorders and that as a result alleviation of the patient’s distress in terms of treatment has focused primarily on a medical model approach of suppression via medication. However, as Thomas (1997) argues research suggests that medication provides significant benefits to only 35% of people that are distressed by their voices and that research indicates that medication can have serious, sometimes irreversible, side effects and in some cases can trigger psychotic episodes.

Asaad & Shapiro (1986) have found evidence that indicates that not all people find AHs distressing, for example, they found evidence to support the fact that not all voice hearers access the mental health system. Jenner, Rutten, S, Beuckens, Boonstra & Sytema (2008) found evidence that suggests that a proportion of this population actually find the experience of AHs a positive one. Sanjuan, Gonzalez, Aguilar, Leal & van Os (2004) have found evidence to support the fact that some people find AHs as a pleasurable one experience. There is also evidence to support the idea that AHs have many more potential causes. Nicolson, Mayberg, Pennell & Nemeroff (2006) have also found that AHs have been linked to many life circumstances, including religious phenomena, bereavement, drug use, sensory deprivation, and near-death experiences. In research in relation to the stress diathesis model of mental illness Read, Perry, Moskowitz & Connolly (2001) amongst others have paid particular attention to the similarities between the effects of traumatic events on the developing brain and the biological abnormalities associated with schizophrenia. More recent research, for example, Andrew, Gray & Snowden (2008); Read (1997); Read, van Os, Morrison & Ross (2005) has considered the high prevalence of child abuse found in adults diagnosed with schizophrenia. Read et al (2001) & Andrew et al (2008) argue that the clinical implications of this are that it is
important to assess patients with psychotic disorders for co-morbid PTSD to ensure that it is detected and treated to ensure a correct diagnosis is reached and that there is also an argument that assessment of individuals diagnosed with schizophrenia should include an in-depth gathering of abuse information.

Read, Hammersley & Rudegeair (2007) found evidence to suggest the fact that mental health professionals have traditionally not asked for information in relation to traumatic events and that there is little evidence to indicate that this has changed more recently.

A study undertaken by Young, Read, Barker-Collo & Harrison (2001) of what patients think about being asked about childhood abuse found that although 64% had experienced abuse in some form, 78% had not been asked about this at initial assessment.

The psychiatrist plays an integral role in the diagnosis of a person who has AHs. As Shear, Greeno, Kang, Ludewig, Frank, Swartz & Hanekamp (2000) explain most clinicians evaluate patients using an unstructured, open-ended approach, with limited training in evidence-based assessment methods, and that inaccurate diagnosis may be common in routine practice. There is a large body of research on the inconsistency of psychiatric diagnoses. However, as Schwartz, Fennig, Tanenberg-Karant, Carlson, Craig Galambos, Lavelle & Bromet (2000) & Spitzer, Endicott & Robins (1978) have found, there are a number of factors that can lead to diagnostic changes over time, for example the changes may reflect the evolution of an illness, the emergence of new information or unreliability of measurement.

Research on inconsistency of psychological assessment of psychosis, such as that by Meyer, Finn, Eyde, Kay, Moreland, Dies, Eisman, Kubiszyn & Read (2001) indicates that clinicians who rely exclusively on interviews are prone to an incomplete understanding of the client’s issues. As Woolfe, Dryden & Strawbridge (2003) make an important point in that not all people who experience psychotic symptoms will be referred to a psychologist.

Mental health care is delivered through a relationship between a clinician and a patient. Although this therapeutic relationship is of central importance for mental health care, McGuire, McCabe & Priebe (2001) argue that this appears to be relatively neglected in psychiatric research. There is little research that gains the views of mental health professionals about their experiences of working with people that have AHs and how this affects them both professionally and personally. For example, stress is a major component of working with people that are psychotic especially when the person is self harming or experiencing suicidal ideation.
Research on patient’s perspectives of diagnosis is limited and has focused more on satisfaction of care rather than exploration of the meaning and helpfulness of diagnosis to the patient. Barker, Shergill, Higginson & Orrell (1996) have found evidence that indicates that there are levels of dissatisfaction within the patient population in relation to issues regarding their care. Noble, Douglas & Newman (1999) found evidence to support the fact that patients normally feel inhibited about making requests, and that psychiatrists often fail to identify what their patients want.

There has been a vast amount of quantitative research in this area into many aspects of AHs creating much debate over their cause, assessment, diagnosis and treatment. This project is focusing on assessment and diagnosis in relation to AHs as it is argued that it is here where research can have most impact in terms of exploring potential implications for future clinical practice. There has been a distinct paucity of qualitative research in this area and moreover very little research into the exploration of clients’ and professionals’ views of the assessment, diagnosis and treatment of hearing voices. There is a gap in research in terms of gaining specific information on the implied inconsistencies in the way assessment is carried out both within and between professions leaving the field wide open to criticisms of misdiagnosis.

There is also a lack of information in relation to how clients and professionals feel about diagnosis and its usefulness in understanding the issues faced by the client. This study aims to begin to address the gap in this research and has the following aims:

This project involves two studies and aims to investigate patients’ experiences and professionals’ experiences around the diagnosis and treatment of auditory hallucinations (AHs). The project aims to better understand:

**Study 1: From the client’s perspective:**

- Perceptions and interpretations of the reasons for their voices
- Perceptions about their story being heard by the mental health professionals
- Perceptions of how the relationship with the professional helps
- Perceptions of the helpfulness of the diagnosis in understanding their experiences and in its affect on everyday life
- Perceptions of how the treatment they were offered helped with the distress associated with their voices
- Perceptions of what else they feel would have helped
Study 2: From the professional’s perspective:

- Experiences of the challenge associated with working with AHs
- Perceptions of how their relationship with the patient helps
- Perceptions of the patient’s insight into their issues
- Perceptions of how the diagnosis helps the patient
- Perceptions of how the patient feels about their diagnosis and treatment
- Perceptions of the long term prognosis for the client

Details of method: materials, design and procedure

Design

This project will use Interpretative Phenomenological Analysis (IPA) (Smith, 2008). This approach explores how people make sense of the world and how they experience events. It aims to understand and represent “the experiences and actions of people as they encounter, engage and live through situations”. This is particularly suited to this study as it aims to explore how patients and professionals encounter and engage with issues around AHs. IPA shares the same aims to data analysis as other phenomenological approaches, such as idiographic, eidetic and transcendental, in that it wishes to capture the quality and texture of individual experience and because it focuses on the world as it is subjectively experienced by individuals within their particular social, cultural and historical contexts and so it enables the researcher to investigate the diversity and variability of human experience.

IPA studies typically recruit between 6 and 12 participants, depending on the breadth of data obtained in each interview (Smith, 2008). This project aims to recruit 6 participants for study 1 and 6 participants for study 2. This will provide sufficient data allow a rich and interpretative analysis at both an in-depth idiographic level, and allow some analysis of the similarities and differences between participants.

Materials

The researcher will use open ended question within the interviews. Most IPA work has been conducted using semi-structured interviews which enable the participant to provide a fuller, richer account than would be possible with a standard quantitative instrument and allow the researcher considerable flexibility in probing interesting areas which emerge in an empathic way. Even though the strategy for interviews is to encourage the participant to speak with very little
prompting from the researcher an interview schedule will be produced (See Appendix 1(a) and 1(b)). Interview schedules are important for IPA studies as they ensure that the researcher has thought about what areas are hoped to be covered and more specifically what potential difficulties may arise and how these will be handled. Smith (2008) suggests that a schedule with between 6 and 10 open questions. It is to be noted that interview schedules are prone to change as the research develops it is sometimes necessary to change the questions.

**Procedure**

Once all necessary approvals have been obtained, the researcher will undertake a trawl of patient information and management system (PIMS) database to find 6 patients that meet the inclusion criteria. The care coordinator will be contacted to ensure that the client is stable enough to be interviewed. Each client will be contacted personally by a phone call which will then be followed up by a letter (Appendix 3a) which will have an attached information sheet (Appendix 3b) and consent form (See appendix 3c). The researcher will email all psychiatrists and psychologists within the trust to gain some idea of the numbers who will be willing to take part in the study. The researcher will randomly choose 3 psychiatrists and 3 psychologists from this group. Each professional will be contacted by telephone which will be followed up by a letter (Appendix 4a), an information sheet (Appendix 4b) and a consent form (Appendix 4c).

Following a positive reply, a pilot interview will be undertaken with a client and a professional as a practice run. Once any issues that arise from the pilot have been dealt with then the studies will commence. The researcher will undertake the project in two stages. The first stage will involve the client interviews and the second stage will involve the professional’s interviews (see Appendix 2 for timetable).

For both studies one-to-one interviews will be arranged by telephone at a mutually convenient time and location. Prior to interview, participants will be given the opportunity to ask any questions, and provide informed consent. Interviews are expected to last around 60 minutes All interviews will be audio recorded, transcribed, and then subjected to detailed qualitative analysis, attempting to elicit key themes in the participant’s talk. The issue of validation of themes will be dealt with through the project supervisors.
Ethical considerations:

Access to research materials:

As the data will be collected by methods of an interview, there are no other research materials, and thus there is no need for external permission to access such.

Measures that will be taken to deal with participant vulnerability:

Participants for Study 1 will be current patients that have been referred to a Community Mental Health Team (CMHT). All patients cared for by a CMHT are assigned a named care coordinator whose job is to make sure that they are getting all the support and treatment that they need, and that the different people involved in their care know what is happening. The care coordinator is the main point of contact for the patient and usually has regular appointments with the patient. The study will involve a great deal of communication between the researcher and the patient’s care coordinator to ensure that the patient is firstly well enough to be interviewed and that the patient has support once the interview is conducted.

The participants will be given a brief written overview before participation, stating the nature and purpose of the investigation, assuring anonymity and voluntary participation, together with stating the ability to withdraw at any time from the study up until a week after participation and information on how to so. The participants will be informed that the researcher will not be asking questions that may direct them into areas that they feel are uncomfortable but that in any event the participant can stop at any time and can request the researcher to contact someone that can either sit with them or take them home and that the researcher will stay with the participant until such person arrives.

Participants will be provided with the researchers' contact details, for the purpose of receiving feedback or if any questions arise as a result of the information sheet (see Appendix 3a for sample participant information letter and Appendix 3b for information sheet). Each participant will be asked to complete and sign a consent declaration form (see Appendix 3c).

Participants for study 2 will be assured of confidentiality and anonymity and will also be provided with the researchers contact details (See Appendix 4b)
**Detail of how information will be held and disposed of:**

Data will be stored in accordance with the Data Protection Act (1999) and University Policies and will be destroyed five years after the end of the project. Through the course of the study, data will be held by the researcher; an electronic documents will be password protected, and written documents that could potentially identify participants will be stored separately. Once the project is submitted, data will be held by the University of Wolverhampton in a similarly secure manner.

Details of how results will be fed back:

**A summary of the completed study will be made available on request by contacting the researcher by email. These will not be available until September 2010.**
References


Our Ref: AB/R155
26 July 2010
Ms Dawn Gearing
21 Eagle Street
Pennfields
Wolverhampton
WV3 7DN

Dear Dawn

**Diagnosing and Treating Voices: Patient and professional perspective**

We have considered your application for access to staff and patients from within this Trust in connection with the above study.

On behalf of the Trust the Lead Officer for Research Governance (Eleanor Bradley), and the Responsible Care Professionals within the Psychological Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the REC dated (20/07/2010), which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

[Signature]

Professor Eleanor Bradley
Head of Research and Development

Cé Felix Davies, Director of Psychological Services
South Staffordshire and Shropshire Healthcare

NHS Foundation Trust

Psychology Department
Foundation House
St George’s Hospital
Corporation Street
Stafford
ST16 3AG
Tel: 01785221408

Invitation to participate in research: Voice hearer’s experiences of their assessment and diagnosis

Date:

Dear Participant

You are invited to participate in a study looking at your experiences in relation to your diagnosis by a mental health professional. The research is being conducted through the University of Wolverhampton and is being supervised by Dr Nick Hulbert-Williams (contact at n.hulbertwilliams@.chester.ac.uk) and Dr Nicky Hart (contact at n.hart@wlv.ac.uk). The postal address for the university is:

School of Applied Sciences
University of Wolverhampton
City Campus - South
Wulfruna Street
Wolverhampton
WV1 1LY
Tel: 01902 321000

The purpose of this study is to gain an insight into voice hearer’s experience of what they found helpful and unhelpful in the care they were given to cope with the problems they experienced as a result of their voices. The information you provide us will help increase our understanding of what mental health professionals can do to improve the care they provide for people that are diagnosed with a mental illness.

Please read the attached sheet for more detailed information about the study.

We hope you will participate in the study and ask you to read and sign the enclosed consent.

Yours faithfully
Dawn Gearing

Principal Investigator
Appendix 5 Client participants’ consent form

South Staffordshire and Shropshire Healthcare

Research study: Experiences of diagnosis in relation to my voices

CONSENT FORM

I have been recruited to participate in a study, which looks at individuals’ who hear voices experience of the care provided by mental health professionals within the NHS.

My consent to participate in this study involves an interview asking a few questions about my experience of the treatment I received by mental health professionals within the NHS. The time to complete the interview should be between 45 and 60 minutes.

I wish to participate and will therefore complete and sign this consent declaration form, stating that:

1. I confirm that I have read and understood the information sheet for the above study.

2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason and that withdrawal from the study will not affect my current or future treatment.

3. I understand that I can gain independent advice about participating in research from the Hearing Voices Network whose details can be found in the accompanying letter.

4. I understand that my interview will be recorded and that this recording will be treated with strict confidentiality and that I will be anonymous in any written reports from the research. The tape will be kept in a locked cabinet and given a number which is known only to the researcher. Following transcription the tapes will be destroyed. Any identifiable information or names will be removed from the transcripts to protect your identity.

5. I understand that the researcher will keep everything that I say within the interview confidential and that the only time that the researcher may need to break this confidentiality will be if I discuss any illegal activity with her or unless she feels that I am a possible danger to myself or to others and that if this is the case the researcher will inform me of her need to do this before she tells anyone.

6. I understand that my personal details (e.g. name, contact details)
will be treated with strict confidentiality, stored securely and will not be passed on to any individual within or outside the University of Wolverhampton.

7. I understand that I can bring someone along with me to support me.

8. I understand that if I do become upset at any time during the study I can stop talking and the researcher will ensure that I have someone to support me.

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

_________________________________________ __________________________
Name of Participant Date Signature

_________________________________________ __________________________
Name of Researcher Date Signature

Supervisors name’s: Nick Hulbert-Williams (contact at n.hulbert-williams@chester.ac.uk) and Nicky Hart (contact at n.hart@wlv.ac.uk).
Appendix 6  Client participants’ Information Sheet

South Staffordshire and Shropshire Healthcare

Information Sheet
Experiences of people who hear voices

Invitation
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. Please take time to read the following information carefully and discuss it with friends, relatives, support workers, professionals or anyone you feel that you can trust. Ask the researcher (Dawn Gearing - contact details at end of this sheet) if there is anything that is not clear or if you would like more information or if you would like independent advice about participating in such research you can contact the Hearing Voices Network at Sheffield Hearing Voices Network, Limbrick Day Service, Limbrick Road, Sheffield, S6 2PE or at info@hearing-voices.org or telephone 0114 271 8210.

Background and study purpose
This study aims to explore how people that hear voices feel about their diagnosis and treatment within the NHS. This project is an attempt to find out what patients and professionals find helpful in the diagnosis and treatment of distress associated with voice hearing and I will also be conducting a study looking at professionals’ experiences in relation to diagnosing and treating people who hear voices.

Why have I been chosen?
We have contacted a sample of patients within South Staffordshire and Shropshire Foundation Trust that have been diagnosed as having psychosis for more than one year. From these patients we hope to interview between 6 and 8 individuals for the study.

What does the study involve?
If you agree to take part, I will contact you to arrange a time that is convenient for us to meet. The research is qualitative in nature in that it is about collecting detailed descriptions and explanations of a person’s experiences. In order to gain this detail it will be necessary to interview you, in an informal manner for approximately 60 minutes without asking too many questions in order to provide you with the opportunity to talk about issues you feel are important in understanding your experiences. Obviously, the length of interviews may vary as some participants may have a lot more to say than others, and that is fine. Your interview will be audio recorded, but only my project supervisors and I will hear these recordings.

After the interview, your anonymized interview recording will be analysed for the most important ‘themes’ and these will be compared with the interviews of other professionals in an attempt to identify important issues.

How will I benefit from the study?
Although this study may not change anything directly for you, the information gained may provide professionals in the field with a better understanding of how clients feel about their care within the NHS.

Confidentiality
The information provided by you will be used only for the purposes of this
research. Only myself, my supervisors, Dr Nick Hulbert-Williams and Dr Nicky Hart and possibly two course examiners will have access to the data. This information will be kept confidentially and securely, and you will remain entirely anonymous in any written reports. Data will be stored in line with the Data Protection Act (1999) and University Policies and will be destroyed five years after the end of the project. Taped recordings will be destroyed after transcription. The only time confidentiality would be broken would be if you talked about anything illegal that you were involved in or if you talked of harming yourself or anyone else. The researcher will talk to you about this before you begin the interview to ensure that you understand this and that you are reminded of this.

**What will happen to the results of the study?**
A report will be written from this study which will provide the basis of a doctoral thesis. From this, academic papers will be written and submitted to appropriate journals. Some results may also be presented at clinical and academic meetings and conferences. In all results, all participants will remain anonymous. If you would like a short summary of the results, please contact me to arrange this.

**Who is organising the research?**
The research is being undertaken by Dawn Gearing, a counselling psychologist (in training) at the University of Wolverhampton. Dr Nick Hulbert Williams and Dr Nicky Hart will be supervising Dawn, the principal investigator on this project.

**Where can I get further information.**
Please feel free to contact Dawn for more information. Our postal address is: Division of Psychology, School of Applied Sciences, University of Wolverhampton, Millennium City Building, Wulfruna Street, Wolverhampton, WV1 1SB. Dawn can be contacted at d.gearing@wlv.ac.uk. Nick can be contacted at n.hulbert-williams@chester.ac.uk and Nicky can be contacted at n.hart@wlv.ac.uk (telephone: 01902 321000). For independent information on being involved with research please contact the Hearing Voices Network (contact details in invitation section above).

**What are the potential risks?**
I do not aim in directing you into areas in which you may feel uncomfortable or upsetting. However in research such as this there is always the possibility of beginning to talk about things that are emotional as it is an emotional subject. If you do feel that you are getting upset at any time and do not wish to continue then I will stop the interview and you can ask me to contact a member of family or a friend to come to collect you. In this situation I will sit with you until that person arrives.

**What if something goes wrong?**
If you wish to make a complaint about any aspect of this research, or how you have been treated as a participant, please make these to the Subject Group Leader, Division of Psychology, School of Applied Sciences, University of Wolverhampton. You can also make a complaint to the Patient and Liaison Service (PALS) on 01785 221469.

Dawn Gearing
Principal Investigator

*Thank you for reading this information sheet. Please keep a copy for your records.*
Appendix 7  Professional participants’ invitation to participate letter

South Staffordshire and Shropshire Healthcare

Psychology Department
Foundation House
St George’s Hospital
Corporation Street
Stafford
ST16 3AG
Tel: 01785 221408

Invitation to participate in research: Professionals experiences of working with people that experience auditory hallucinations

Date:

Dear Participant

You are invited to participate in a study looking at your experiences in relation to working with people that hear voices. The research is being conducted through the University of Wolverhampton and is being supervised by Dr Nick Hulbert-Williams (contact at n.hulbertwilliams@chester.ac.uk) and Nicky Hart (contact at n.hart@wlv.ac.uk). The postal address for the university is:

School of Applied Sciences
University of Wolverhampton
City Campus - South
Wulfruna Street
Wolverhampton
WV1 1LY
Tel: 01902 321000

There has been a vast amount of research in relation to auditory hallucinations but there is less qualitative research on how professionals feel about working with this client group. The purpose of this study is to gain an insight into professionals’ experiences of the potential difficulties in working with such a client group and how this impacted on them both personally and professionally. It may also give the researcher some insight into how different professionals work with people that hear voices.

Please read the attached sheet to gain more detailed information pertaining to the study.

We hope you will participate in the study and ask you to read and sign the enclosed consent form.

Yours faithfully

Dawn Gearing
Principal Investigator
Information Sheet

Mental health professionals’ experiences of working with people that hear voices

Invitation
You are being invited to take part in some research. Before you decide it is important for you to understand what the research is about. Please take time to read the following information carefully. The researcher (Dawn Gearing) will be happy to answer any questions you may have about the research (contact details at end of this sheet).

Background and study purpose
This research aims to explore how professionals feel about diagnosing and treating people that hear voices. This study is part of a bigger project that intends to also investigate voice hearer’s perceptions of their diagnosis and treatment. This project is an attempt to find out what patients and professionals find helpful in the diagnosis and treatment of distress associated with voice hearing.

Why have I been chosen?
I have contacted all psychiatrists and psychologists within Shropshire and South Staffordshire Foundation Trust and Wolverhampton Primary Care Trust to ask for professionals that have worked with people who hear voices to be interviewed. I hope to interview between 6 and 8 individuals for the study.

What does the study involve?
If you agree to take part, I will contact you to arrange a time that is convenient for us to meet. The research involves qualitative methodology and will involve you being interviewed, in an informal manner for approximately 60 minutes. Obviously, the length of interviews may vary as some participants may have a lot more to say than others, and that is fine. Your interview will be audio recorded, but only myself and my project supervisors will hear these recordings.

After the interview, your anonymised transcript will be analysed for the most important ‘themes’ and these will be compared with the interviews of other professionals in an attempt to identify important issues.

Confidentiality
The data provided by you will be used only for the purposes of this research. Only myself, my supervisors, Dr Nick Hulbert-Williams and Anne Crawford-Docherty and possibly my course examiners will have access to the data. Information provided by you will be kept confidentially and securely, and you will remain entirely anonymous in any written reports, scientific papers, or study summaries. Data will be stored in accordance with the Data Protection Act (1999) and University Policies and will be destroyed five years after the end of the project. Taped recordings will be destroyed after transcription.

What will happen to the results of the study?
A report will be written from this study which will provide the basis of a doctoral thesis. From this, academic papers will be written and submitted to appropriate journals. Some results may also be presented at clinical and academic meetings and conferences. In all results, all participants will remain anonymous. If you would like a short summary of the results, please contact me to arrange this.

Who is the research team?
The study is being led by Dawn Gearing, a counselling psychologist (in training) at the University of Wolverhampton. Dr Nick Hulbert Williams and Dr Nicky Hart will be supervising Dawn, the principal investigator on this project.

**Where can I get further information.**
Please feel free to contact Dawn in the first instance for more information. The postal address is: Division of Psychology, School of Applied Sciences, University of Wolverhampton, Millennium City Building, Wulfruna Street, Wolverhampton, WV1 1SB. Dawn can be contacted at d.gearing@wlv.ac.uk, Nick can be contacted on at n.hulbert-williams@chester.ac.uk and Nicky can be contacted at n.hart@wlv.ac.uk.

**What if I’m not happy with the way the research is conducted?**
If you wish to make a complaint about any aspect of this research, or how you have been treated as a participant, please make these to the Subject Group Leader, Division of Psychology, School of Applied Sciences, University of Wolverhampton.

Dawn Gearing
Principal Investigator

*Thank you for reading this information sheet. Please keep a copy for your records.*
Appendix 9 Professional participants’ consent form

South Staffordshire and Shropshire Healthcare

Research study: Professionals’ experiences of working with people that experience auditory hallucinations

CONSENT FORM

I have been recruited to participate in a study, which aims to explore the experiences of professionals who have worked with people that hear voices.

My consent to participate in this study involves an interview asking a few questions about my experience of working with people that have auditory hallucinations. The time to complete the interview should be approximately 60 minutes but may be considerably less depending on the time I have available and what I have to say.

I wish to participate and will therefore complete and sign this consent declaration form, stating that:

1. I confirm that I have read and understood the information sheet for the above study.
2. I understand that my participation is voluntary and that I am free to withdraw up to a week after completion of the interview, without giving any reason.
3. I understand that the transcript from the interview will be treated with strict confidentiality and that I will be anonymous in any written reports from the research. The tape will be kept in a locked cabinet and given a number which is known only to the researcher. Following transcription the tapes will be destroyed. Any identifiable information or names will be removed from the transcripts to protect your identity.
4. I understand that my personal details (e.g. name, contact details) will be treated with strict confidentiality, stored securely and will not be passed on to any individual within or outside University of Wolverhampton.
5. I agree to take part in the above study.

__________________________________________  __________________________  _________________________
Name of Participant                        Date                     Signature

__________________________________________  __________________________  _________________________
Name of Researcher                        Date                     Signature
Appendix 10 Client participants’ interview schedules

Study 1 (Patients)

Interview Schedule

1. How long have you heard voices?
   Possible prompts: Have you been given a diagnosis? What diagnosis have you been given? How do you feel about this?

2. Can you tell me how you feel about how you have been helped by your mental health team in alleviating the distress associated with your voices?
   Possible prompts: Did they help you gain better control, did you feel well supported, how did you feel at that time about how you were being helped

3. Do you feel that you were given the opportunity to fully explain how your voices were affecting your life and how they had come about?
   Possible prompts: did you feel listened to?, did you feel that you were time?

4. Did you feel that the professionals had enough information to fully understand your problems?
   Possible prompts: Did they ask what the voices were saying? Did you feel understood? Did they ask if you knew what was causing them?

5. How do you feel about your diagnosis?
   Possible prompts: Was it useful? Did it help? how did it make you feel?

6. How do you feel about the treatment you received for your voices?
   Possible prompts: Did you feel better? Less distressed? What were you offered?

7. Is there anything you feel would have helped more in your care?
   Possible prompts: what else? More options? What would they be?
Appendix 11 Professional participants’ interview schedule

Study 2 (Professionals)

Interview Schedule

1. How long have you worked with people that have mental health issues?
   Possible prompts: Do you find the work rewarding? Can it be stressful at times? What have been some of your most interesting cases?

2. How have you found working with people that have auditory hallucinations (AHs)?

3. What explanation would you give for the AHs?
   Possible prompts: Does it depend on person’s background, does it depend on what the voices are saying? Does it depend whether voices inside/outside of head? Does it depend on whether the voices are someone else’s or the person’s own voice?

4. What do you feel are important factors in successfully engaging a person with AHs?

5. What do you think about diagnosis and AHs?

6. How important do you feel diagnosis is for the patient?
   Possible prompts: helps them make sense? Need for treatment? Anytime unhelpful? Have patients ever said?

7. What do you feel are important treatment options for someone with AHs?

8. In your experience, how likely do you feel it is that someone will completely recover from AHs where they no longer require professional intervention?
Possible prompts: Do you know patients that have? Is it possible? Does it depend on type of illness?
Appendix 12 Supervision log

POSTGRADUATE DOCTORAL RESEARCH MANAGEMENT FORM
(Module Code PS5018)

Student: __Dawn Gearing__

Supervisor: Nick Hulbert Williams / Anne Crawford Docherty

Thesis Title: “Diagnosing and Treating the Voices: The patient and Professionals' perspective.”

Academic Year: _2009/2010_

Guidelines for use:
1) The number of meetings held between supervisor and student during the course of the thesis will depend on a number of factors including the nature of the thesis, and the amount of experience the student has in that research area. It is likely, therefore to be different for each thesis.
2) A brief note of each meeting should be recorded in the table provided. Both the student and supervisor should initial each meeting to confirm that it is a true record of items discussed.
3) The student and supervisor may find it beneficial to arrange the date and time of their next meeting. This is however, optional and is dependent to a large degree on the nature of activities currently being pursued.
4) If a meeting is arranged in advance, but is postponed to a different date, a note of the reasons should be made under items discussed.

<table>
<thead>
<tr>
<th>Action from Last Meeting</th>
<th>Items Discussed</th>
<th>Action for next meeting</th>
<th>Date / Time of next meeting</th>
<th>Initials</th>
</tr>
</thead>
</table>
| 14th Sept 2009: DG & NHW (30 mins) | Background to topic of AHs, where gap in research, what I interested in exploring and how  
Discussion of methodology  
How joint supervision will work and formal arrangements i.e. minutes, schedule of meetings and progress reports | Rationale to be developed for methodology  
Literature search  
DG to contact Anne CD to set up a schedule of future meetings | 22/9/09  
NHW/ DG | |
<p>| 22nd Sept 2009: DG &amp; NHW; Apols from ACD (30 mins) | | | | |</p>
<table>
<thead>
<tr>
<th>Anne CD contacted to let her know about meeting and points to be discussed</th>
<th>Further development of how research will be conducted and decision made</th>
<th>Proposal to be developed along with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature search commenced</td>
<td>Decision made on methodology being IPA, initial thinking of mixed method approach shelved</td>
<td>Participant info sheet and letter</td>
</tr>
<tr>
<td>Rationale begun</td>
<td>Decision on participant numbers and recruitment method made</td>
<td>Interview schedule (IPA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethical issues to be dealt with at this stage as client group considered vulnerable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be thinking about next stage of uni ethical approval and to look at IRAS forms to ensure all areas covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contact to be made with Anne CD to arrange another meeting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>28th Sept 2009:</strong> DG, NHW &amp; ACD (45 mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft proposal prepared along with supporting documentation</td>
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<tr>
<td>IRAS form considered in identifying ethical issues</td>
</tr>
<tr>
<td>Consideration of ethical issues included in proposal</td>
</tr>
<tr>
<td>Changes to proposal to ensure unbiased language</td>
</tr>
<tr>
<td>Other changes to be made relating to methodological issues and ethical issues</td>
</tr>
<tr>
<td>Other changes to be made relating to grammatical and language issues</td>
</tr>
<tr>
<td>Proposal to be amended along with suggested amendments to relating documentation ready for presenting to RIHS</td>
</tr>
<tr>
<td>To email to Yvette and cope to NHW and ACD</td>
</tr>
<tr>
<td>Completion of RES20b and supporting information</td>
</tr>
</tbody>
</table>

| **26th Oct 2009:** DG & NHW; Apols from ACD (20 mins) |
| --- | --- | --- |
|  |  |  |

<p>| 29/9/09 | NHW/ DG |
| 26/10/09 | NHW/ ACD/ DG |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9th Nov 2010:</td>
<td>DG &amp; NHW; Apols from ACD (20 mins)</td>
</tr>
<tr>
<td></td>
<td>Approval of first stage of uni ethics</td>
</tr>
<tr>
<td></td>
<td>DG gained list of SSSFT R&amp;D priorities</td>
</tr>
<tr>
<td></td>
<td>NHS ethical issues and potential problems</td>
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<td></td>
<td>R&amp;D Issues</td>
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<td>IPA methodological issues</td>
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<tr>
<td></td>
<td>To make contact with NHS R&amp;D department</td>
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<tr>
<td></td>
<td>NHW to submit to next stage of uni ethics</td>
</tr>
<tr>
<td></td>
<td>DG to contact ACD to arrange a further meeting</td>
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<td>11th Nov 2010:</td>
<td>DG &amp; NHW; Apols from ACD (20 mins)</td>
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<tr>
<td></td>
<td>NHW submitted to BSEC but still not heard decision</td>
</tr>
<tr>
<td></td>
<td>DG contacted R&amp;D and got appointment to meet with Eleanor Bradley to discuss her</td>
</tr>
<tr>
<td></td>
<td>project and how it meets their priorities.</td>
</tr>
<tr>
<td></td>
<td>Started to complete IRAS form</td>
</tr>
<tr>
<td></td>
<td>NHW contacted BSEC who informed us that RES20b had been “missed off” agenda and</td>
</tr>
<tr>
<td></td>
<td>would need to be approved by KM/NM</td>
</tr>
<tr>
<td></td>
<td>NM came into meeting and talked about potential problems with gaining NHS</td>
</tr>
<tr>
<td></td>
<td>approval as a result of issues with sponsorship</td>
</tr>
<tr>
<td></td>
<td>Discussion about how project meets list of R&amp;D priorities.</td>
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<tr>
<td>25th Jan 2010:</td>
<td>DG &amp; NHW; Apols from ACD (30 mins)</td>
</tr>
<tr>
<td></td>
<td>NHW contacted BSEC who informed us that RES20b had been “missed off” agenda and</td>
</tr>
<tr>
<td></td>
<td>would need to be approved by KM/NM</td>
</tr>
<tr>
<td></td>
<td>NM came into meeting and talked about potential problems with gaining NHS</td>
</tr>
<tr>
<td></td>
<td>approval as a result of issues with sponsorship</td>
</tr>
<tr>
<td></td>
<td>Discussion about how project meets list of R&amp;D priorities.</td>
</tr>
<tr>
<td>DG met with R&amp;D and established that project meets priorities</td>
<td>Discussion about IRAS form.</td>
</tr>
<tr>
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</tr>
<tr>
<td>IRAS form completed but can not progress as issues with sponsorship form</td>
<td>Keeping up to date with literature search through mim zetoc alerts</td>
</tr>
<tr>
<td>NHW confirmed that project passed university ethics</td>
<td>Starting introduction and methodology sections</td>
</tr>
<tr>
<td>NHW suggested amendments to IRAS form</td>
<td></td>
</tr>
</tbody>
</table>

**3rd Feb 2010: DG & NHW (Apols ACD) (15 mins)**

<table>
<thead>
<tr>
<th>Final version of IRAS form now complete</th>
<th>Discussed ongoing issue of Sponsorship – IRAS submission is ready to go otherwise. Discussed NHWs resignation and it’s impact.</th>
<th>NHW and DG to chase up sponsorship.</th>
<th>9/03/10</th>
<th>NHW/DG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NHW to discuss supervision with YL / NH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**9th March 2010: DG & NHW (15 mins)**

<p>| | | | | |</p>
<table>
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<td>Date</td>
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</tr>
<tr>
<td>301</td>
<td>NHW has discussed ongoing supervision. Initial agreement for external arrangements from Grad School but still not final decision at departmental level. Still no solution to sponsorship: RIHS option was not acceptable to NHS.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>24(^\text{th}) April 2010: DG &amp; NHW (20 mins)</td>
<td>Discussed supervision arrangements after NHW leaves Wolverhampton. NHW to hopefully be kept on as external supervisor: Dawn to arrange meetings in Chester. Need to arrange adequate supervision in Wolverhampton alongside. Use down-time with empirical study to work on lit review. Aim for completed draft by summer. DG to meeting with NH and YL re supervision and sponsorship.</td>
<td></td>
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</tr>
<tr>
<td>28.7.10: DG &amp; NHW (60 mins)</td>
<td>Query possibility of LOA. NHW to carry on supervising alongside NH (on WLV side). ACD no longer supervising as doesn’t have time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft Literature review</td>
<td>NHW to read</td>
<td>NHW to provide feedback</td>
<td>15.9.10</td>
<td>NHW</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>IRAS form submitted, DG attended REC meeting, REC given NHS ethical approval</td>
<td>DG to begin recruitment</td>
<td>DG to email list of psychiatrists given to her by medical secretary</td>
<td>15.9.10</td>
<td>DG</td>
</tr>
<tr>
<td>IPA methodology</td>
<td>Questions and answers</td>
<td>DG to talk to care coordinators in CMHTs</td>
<td>15.9.10</td>
<td>DG</td>
</tr>
<tr>
<td>Interview schedules</td>
<td></td>
<td>DG to undertake pilot interview</td>
<td>15.9.10</td>
<td>DG</td>
</tr>
</tbody>
</table>

**15.9.10: DG & NHW (20 mins)**

| NHW no longer able to travel to Wolverhampton for supervision | DG to start writing some of the sections of thesis that she is able to while awaiting sponsorship issues to be resolved | ASAP | DG |
| Ongoing | DG |

**18th December 2010: DG & NH (40 mins)**

| New research timetable to be developed | DG to send to NHW | 30.9.10 | DG |


<table>
<thead>
<tr>
<th>Literature Review</th>
<th>Recruitment</th>
<th>Methodology Section</th>
<th>Recruitment</th>
<th>Analysis</th>
<th>External Examiner</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH gave ideas for lit review and provide feedback.</td>
<td>Problems with recruiting clients was discussed. NH suggested setting a deadline and if no clients recruited by then to just do professionals.</td>
<td>NH to read draft lit review.</td>
<td>DG to set deadline.</td>
<td>DG to look at other ways of recruiting clients such as HVN.</td>
<td>NH to read draft lit review.</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
</tr>
</tbody>
</table>

### 2nd February 2011: DG & NHW (60 mins)

<table>
<thead>
<tr>
<th>Lit review</th>
<th>Feedback provided</th>
<th>2nd Draft of lit review to be sent to NHW</th>
<th>Feedback to be given</th>
<th>Organise last psychiatrist interview</th>
<th>Further 4 client interviews to be undertaken</th>
<th>1st exploratory stage to be completed</th>
<th>List of possibilities discussed</th>
<th>Liaise with NH about this</th>
<th>ASAP</th>
<th>DG</th>
</tr>
</thead>
<tbody>
<tr>
<td>DG</td>
<td>NHW</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>DG</td>
<td>ASAP</td>
<td>DG</td>
</tr>
</tbody>
</table>

### 12 March 2011: DG & NH (45 mins)

<p>| | | | | | | | | | | |
| | | | | | | | | | | |
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<table>
<thead>
<tr>
<th>Literature Review</th>
<th>Recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH gave ideas for lit review and provide feedback</td>
<td>Problems with recruiting clients was discussed, NH suggested setting a deadline and if no clients recruited by then to just do professionals</td>
</tr>
<tr>
<td>NH to read draft lit review</td>
<td>DG to set deadline</td>
</tr>
<tr>
<td>DG to look at other ways of recruiting clients such as HVN</td>
<td>Jan 2011</td>
</tr>
<tr>
<td>Deadline set for end of Feb</td>
<td>ASAP</td>
</tr>
</tbody>
</table>

**9th May 2011: DG & NHW (60 mins)**
<p>| Research Dossier                                                                                         Appendices |
|---------------------------------------------------------------|-------------------|
| <strong>Lit Review</strong>                                               | <strong>Analysis</strong>      |
| Lacking effective structure                                 | Exploratory analysis ok now |
| Question needed to structure                                 | Need to move on to identifying themes and superordinate themes. |
| Write ten bullet points to form the structure of the review  | Produce thematic table, organising one participant’s speech against themes and email to Nick |
| Restructuring lit review                                     | check this and comment back |
| Restructuring lit review                                     | Thematic charts to be finished |
| Results section                                              | Complete results section and email to NHW |
| Full draft                                                   | Sent to NHW |
| <strong>6th September 2011: DG &amp; NH (40 mins)</strong>                    | <strong>Sent to NHW</strong>   |</p>
<table>
<thead>
<tr>
<th>Themes</th>
<th>NH contacted some of the names on the list no one interested yet</th>
<th>NH to look through her list of contacts</th>
<th>ASAP</th>
<th>NH</th>
</tr>
</thead>
</table>
| Analysis       | Theme tables ok
Talked about need for memos – decided enough analysis had been done in developing master theme tables | Check IPA guidelines to ensure memos not a mandatory part of IPA | 13.9.11 | DG |
| Results section| Looked at some of analysis – ok                                  | Condense results section               | 20.9.11 | DG |

**11th November 2011: DG & NHW (90 mins)**

<table>
<thead>
<tr>
<th>Draft methodology/analysis/discussion</th>
<th>NHW provided detailed feedback on methodology/analysis/discussion</th>
<th>Amendments to be made as discussed.</th>
<th>Jan 2012</th>
<th>DG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lit Review</td>
<td>Already provided some feedback on this which has been dealt with.</td>
<td>NH’s opinion to be gained</td>
<td>Jan 2012</td>
<td>DG</td>
</tr>
<tr>
<td>Intro/conclusion/critical appraisal</td>
<td>Discussion about the contents of these</td>
<td>DG to write and email to NHW for comment</td>
<td>Feb 2012</td>
<td>DG</td>
</tr>
<tr>
<td>External examiner</td>
<td>Ann Detheridge may do it but NH not got formal approval</td>
<td>DG to contact NH to ensure this is in place</td>
<td>ASAP</td>
<td>DG</td>
</tr>
</tbody>
</table>

**12th March 2012: DG & NH (60 mins)**
<table>
<thead>
<tr>
<th>Draft thesis</th>
<th>Concerns about not having memos</th>
<th>External examiner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over word limit, talked about reducing</td>
<td>Already been discussed IPA methodology checked and not stipulated, agreed that nothing would be gained from this extra work</td>
<td>Mark Hayward agreed formally to do it and NH has completed appropriate paperwork for RIHS</td>
</tr>
<tr>
<td>DG to reduce</td>
<td>ASAP</td>
<td>DG</td>
</tr>
</tbody>
</table>
Appendix 13

Transcription Protocol

1. I listened to the interview again before beginning transcription to familiarise myself with the narrative and fully immerse myself in the data.

2. I transcribed each of the tapes myself. I listened to a short section of the interview and transcribed by hand.

3. Once I had transcribed the full interview I would listen to the interview again whilst reading through the transcript to ensure an accurate copy had been made.

4. The transcription includes pauses, interruptions, repetition of words and incomplete sentences.

5. Pauses are indicated by a series of full stops (for example ‘…’).

6. Non verbal communication (for example sighing, crying or hand gestures) are included in brackets.

7. I denotes interviewer and P denotes participant.

8. All identifiable information has been removed from the transcripts and participants and their families given pseudonyms.
### Appendix 14  Psychologists’ theme tables

<table>
<thead>
<tr>
<th>Theme</th>
<th>Participant 1 “John”</th>
<th>Participant 2 “June”</th>
<th>Participant 3 “Janet”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Ambivalence</td>
<td></td>
<td></td>
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<tr>
<td>Challenging yet satisfying</td>
<td>“it’s challenging because of the distress that people are experiencing and it’s rewarding when you sort of feel perhaps you've made a bit of a difference so yeah but sometimes when you think I wish I hadn’t done this I wish I’d done something else (laughs)” (Line 9-13)</td>
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<tr>
<td></td>
<td>“I like working with people who hear voices particularly  erm yeah more so than say people with mood disorders erm because it sort I always feel there is something solid to work on really erm there’s actually a defined thing that you can tackle almost I think it’s actually quite erm deceptive because I think it is harder actually to work with people who hear voices than people who have say paranoid beliefs or something like I think”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Lack of training and experience | “well certainly in my training we have not been trained very much to actually deal with this client group I don’t know about your training?” (Line 84-86)  
“Clinical psychology training you tend to start off quite gently and its only if you have a particular interest that you would then perhaps work with people that hear voices” (Line 88-90)  
“and so what I’ve found in sort of my career I know didn’t do very much of that at all and then you know working within CMHTs you can’t really avoid it…well I’ve not been able to (laughs) I mean people don’t always tell their GP do they?”(Line 90-93)  
“one is the experience and having the time to read up on it yourself because you haven’t been trained in it so it has to be self directed” (Line 96-97)  
“I used to have safety issues” | working with voices can be worse or more difficult” (Lines 17-23) |
because of my own sort of not prejudices but my own misconceptions because of my lack of experience of working with the client group I don’t feel at all in any way threatened but I guess as a newly qualified psychologist I would have been a bit less likely to erm put myself forward to take on those sorts of clients” (Lines 110-116)

**Difficulties in engaging**

“it can be quite difficult erm with some patients to decipher whether they are really hearing voices” (lines 3-5)

“my experience is that some people it’s very easy to say that you hear a voice and then you don’t need to work” (Line 6/7)

“…make some judgement as to whether I feel it it’s genuine or not…” (line 11)

“and so I have become maybe a little sceptical and maybe a little bit sort of questioning and challenging when people tell me they hear voices I tend to be a bit more wanting to know more about the voice in a way to try and erm sort of make a

“I actually found it was quite difficult to engage, quite difficult psychologically because erm to do the psychological work I needed the person to be with me in the room and it felt like she was constantly distracted erm she was responding to the voices she was hearing erm, she was arguing with them and so I found it was really difficult to actually work psychologically with her because she wasn’t able to concentrate because of the voices” (Lines 11-16)
<table>
<thead>
<tr>
<th>Problems in team working</th>
<th>Professional tensions</th>
<th>The power of psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>judgement as whether I think it’s genuine or not” (Lines 8-12)</td>
<td>“…they try to ignore them and they find them very difficult and you can see them trying to concentrate on the dialogue between you and them and every once in a while their eyes flick because a voice has said something that is very difficult to ignore so that can take the emphasis away from the session” (Lines 123-127)</td>
<td>“Well I must admit that our service here is pretty good for that because I have had quite a few referrals for people that hear voices because of the group that espouse those models are actually a very</td>
</tr>
<tr>
<td>“…they try to ignore them and they find them very difficult and you can see them trying to concentrate on the dialogue between you and them and every once in a while their eyes flick because a voice has said something that is very difficult to ignore so that can take the emphasis away from the session” (Lines 123-127)</td>
<td>“No that is definitely not the case. I think sometimes by chance cos something else has happened or another issue has cropped up the person might end up for a psychological assessment so maybe they don’t routinely refer because they think medication is the answer, they’ve got it right the diagnosis is erm that they need this medication…”</td>
<td>“…what’s interesting is it’s power is just as great as it always was because the group that espouse those models are actually a very</td>
</tr>
</tbody>
</table>
the distress of the voices and rather
than trying to manage them
psychiatrically only there is a bit
more of a multidisciplinary
approach here so it is quite good and
I think that is probably driven by
the psychiatrists” (Lines 102-106)

<table>
<thead>
<tr>
<th>Varying Theories on causes of voices</th>
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</thead>
<tbody>
<tr>
<td>Stress-vulnerability</td>
</tr>
<tr>
<td>“people that genuinely hear voices have a very very troubled backgrounds” (Line 31)</td>
</tr>
<tr>
<td>“I think that the voices that they hear are probably the voices they have internalised from childhood or based in childhood that are coming back to haunt them I think it’s interesting because often the content of the voices is persecutory and..so that when you talk to people about their childhood experience it’s often persecutory and so I think there is some sort of reflection in the voices to their childhood or some sort of echo from the past…” (Lines 32-37)</td>
</tr>
<tr>
<td>“I think that there probably has been a trauma on top that has acted as a trigger” (Line 49/50)</td>
</tr>
<tr>
<td>“they tend to feel that they’ve got some kind of special powers as a kind of protective measure sometimes erm those kinds of beliefs they hear voices erm the voices can be erm either encouraging of that or you know more more paranoid types of voices you know we’re coming to get you we’re gonna burn your house that’s usually people that have been assaulted” (Lines 54-59)</td>
</tr>
<tr>
<td>I think there are erm people for whom the voices that are entirely negative and are often related to the trauma they have undergone you then tend to get people who have got some positive voices that are simply more nurturing more caring often fulfilling roles they</td>
</tr>
</tbody>
</table>
“Yes and in fact I would say that was probably 90% but then again that might be because we don’t get referred that 10% you know if you talked to a psychiatrist he might have the 90% and 10% the other way. (Lines 55-57)

“the diagnostic criteria for PTSD would be met there” (Lines 224-225)

“I have one client who has a very very strong beliefs that the Mormon church have a conduit into her mind and they were talking to her all the time in fact the subject they were talking to her about was the sexual abuse that she experienced as a child so when we are having conversations and you know trying to very gently get to the point of talking about these things erm she just clams up and you know can you tell me what’s happening she says oh the voices are getting louder no she doesn’t say louder scrub that she says the voices are erm are going…what does she say…err I think she says the voices are getting worse and I think I get the wished caregivers had have fulfilled erm and then sometimes you get people in addition to that have kind of neutral voices that are just there for the ride (Lines 66-72)

“that idea that voices might have meaning and might be symptomatic of underlying issues whether that’s kind of trauma sexual abuse or physical abuse or bullying… or getting you know attacked down the pub on a Saturday when you were kind of 18 and I don’t think it runs counterintuitive to the stress-vulnerability models. I still kind of go with stress vulnerability in that you might have a vulnerability to hearing voices but that tends to get triggered by some kind of distress, so there are people cos we know any of us can hear voices cos if I deprive you of enough sleep you will hallucinate, when you are ill you can hallucinate so we all have that in us cos we can all hallucinate. I think it’s around erm what was I going to say… oh that, so I don’t think it’s counterintuitive to stress vulnerability but I do think that you
impression that that’s because they seem to be in the distance and as we start talking about the abuse they come closer” (Lines 131-141)

know these things can work together and I think that the advantage is helping people to look at what is going on and it could be just it…it doesn’t have to be major trauma it could be just the way they see themselves you know you tend to see your own hang ups don’t you?…and I think that sometimes it might be underlying anxieties or it might be depressive it might be depression. If you tend to think negatively about yourself without necessarily having a major trauma…just as we know some people can have a trauma happen to them and actually carry on and not ever need any sort of mental health help. there are those who don’t need a huge amount of trauma to hear voices so…” (Lines 263-284)

“I think there’s another group of people you know where you get it depends on there’s another group of people where I think they’ve been put in vulnerable situations and they’ve been assaulted not to do with abuse erm sexual abuse erm and often they tend to feel that they’ve got some kind of special
powers as a kind of protective measure” (Lines 51-55)

“I can think of one guy whose voices were coming to get him but he was in situation I think where he was becoming unwell, combined with getting beaten up because he was acting oddly.” (Lines 327-330)

“I have erm I think there are some recurring sort of or seem to be recurring themes… I think from my experiences of working with people would suggest that a lot of people where the content of the voices actually reflects either some trauma or some issues that person has got or has had” (Lines 32-36)

I’m trying to think of people I’ve worked with in recent years…all of them have some kind of trauma (Lines 59-61)

“I think it is certainly a model that people shouldn’t be discounted I think they should be actively considering that it’s useful to inform practice I wouldn’t say that I am one of those people who erm I’m not an absolutist so I am
not going to be saying that is the only thing that we should be thinking about and everything else is a pile of old rubbish so I think we should be looking at erm….”.(Lines 69-74)

“So while you can see why the voices were talking about what they were talking about I’m not sure that he’s sort of had flashbacks that time I’m trying to think of other people so I don’t think it’s always the case and maybe that’s what actually made the difference I hadn’t thought about that before…. I would have thought that if you deal with people who have got trauma where they are getting more dissociative stuff and or flashbacks and voices then I think resolving trauma makes a difference where the trauma is.” (Lines 330-337)

“so for example erm I know people who’ve had erm been sexually abused perhaps you know a male on male abuse will often their voices will tell them for example that their gay when in fact they believe they are heterosexual the
voices will tell them their homosexual and torment and often that seems to be because people erm often you get with child abuse was it something that I did is there something about me that looks gay that appears gay and that’s why I was targeted that’s why it happened to me erm and often you get that with childhood abuse you know what did I do as a child what was I doing that made that adult wanted to have sex with me and actually feeling that somehow it was their fault and often what you get I think you get that projected out in the voices that stress the unbearable feelings are projected out and heard as voices similarly you know you get with girls who are sexually abused by a male it’s often that they’re a slut they’re a tart they’re a whore, the voices don’t tend to talk about other things so there’s that, there’s that kind of group” (Lines 32-51)

“It can often just be a manifestation of those issues some people that don’t hear voices and so therefore well they express their distress in another way and so often people
that hear voices or dissociate because of that perhaps aren’t cutters perhaps don’t cut say you know… I tend to see it as a symptom of the internal distress” (Lines 101-108)

**Biological/organic**

“I think there are some people that the biological model probably does fit better” (Line 42)

“I do think that there are a very small proportion of clients where there is a biologically driven erm component” (Line 45/46)

“oh god in America there are masses of people who are cannabis induced so I can see in a way that it can be biological but then you think why are people smoking cannabis in this way unfortunately in my experience it affects the intervention because there are a lot more to the formulation it is very difficult then to have an intervention tailored to that formulation because the cannabis does get in the way cos they’re not here they’re not present and certainly I’ve had a few clients come to me hearing voices and they see it as a direct result of the cannabis and

“Erm I don’t know whether it ever happens naturally but I guess I suppose it does if there, if there some sort of genetic predisposition erm, with this particular lady it was drugs, she’d taken drugs or think smoked cannabis and actually erm she’d had a psychotic episode following smoking cannabis and actually never really escaped from it from that point.” (Lines 19-23)
they’ve stopped smoking cannabis
and the voices have stayed for a
while and they’ve gone and they
start smoking cannabis again and
they come back and you think…”
(Lines 163-173)

“…so how can you say that it’s just
biological you know there has to be
some huge cultural issues going
along there related to what we
consider illness to be and how we
treat it…” (Lines 193-195)

2.4 Uncertainty

“my own sort of theory of why
people hear voices” (Line 30)

“I couldn’t say because it would
have to be client specific” (Line
43/33)

“I am not sure that the biological
component can exist by itself” (Line
48)

“so if you are hearing voices it could
be schizophrenia, it could just be a
psychotic episode, it could be
psychotic depression, it could be
bipolar and it could be related to a
manic episode and it just seems so
variable” (Lines 200-202)

“there have been in the past a group
of people who also had voices in
addition to that negative voices
would either have some positive
voices which seemed to be
reassuring or would have some kind
of neutral voices that rambled on
about the weather that sort of
commented on what they were
doing and were neither positive nor
negative so it’s not entirely clear
out” (Lines 61-66)

“I haven’t got a theory on what the
neutral voices are about..”(Lines 72-
73)
<table>
<thead>
<tr>
<th>diagnosis and formulation</th>
<th>“I think it does get in the way because …and again this depends on the client it can get in the way because some times people come and see you and say that I’m here for help with my voices when actually what they are not recognising is all the other stuff around them that are probably contributing to their voices so everything then gets attributed to the fact that they’re hearing voices rather than the fact that they live in terrible circumstances they have an awful background and you know they are depressed and anxious and smoking cannabis” (Lines 155-162)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;psychiatric diagnosis is based on categorising rather than being able to deduce from an array of information” (Lines 173-174)</td>
<td>“I think for me the problem comes that a lot of this information is gathered in order to make a diagnosis but actually it can get lost there’s always been a very strong tradition in psychiatry for psychoanalysis and often that information tends to get used but I think it tends to get it’s useful information its there but I don’t think it gets used in as good a way as it could be…diagnosis itself the downside is we put people into these categories and I think increasingly you get a lot of people that don’t fit into these categories and erm what happens then is people get stuck well what’s the diagnosis you’ve got to find the diagnosis when actually what you’ve got to look at is people’s needs their emotional distress so while psychiatric categories are very useful because people normally try and categorise things we do that naturally the downside of it is that it tends to be quite reductionist so it’s sort of you know you fall into this category so therefore this is your treatment oh&quot;</td>
</tr>
<tr>
<td>&quot;diagnosis doesn’t take that into consideration factors such as sexual abuse having trauma like symptoms it’s only a diagnostic category for symptoms background factors are rarely in there” (Lines</td>
<td></td>
</tr>
<tr>
<td>The utility of psychological formulation</td>
<td>“Well that’s because we have different aims don’t we? the psychiatrist is looking for information will look for information to categorise and I will be looking for information that will shed light on how they got here in the first place” (Lines 177-180)</td>
</tr>
<tr>
<td>“wanting to know more about the voice in a way to try to erm make some sort of judgement” (Line 10/11)</td>
<td>“I would be asking people about...”</td>
</tr>
<tr>
<td>“I think it’s because of the medical model itself rather than psychiatry and the medical model is find the problem and treat it so when you find the problem you give it a name and because it has that name this is the treatment for it” (Lines 214-217)</td>
<td>you don’t fall into this category I’m not quite sure what’s going on and now I don’t know what to do so it’s and that’s being very simplistic I appreciate erm but I think that’s the danger of diagnosis so while it’s helpful to have some kind of system of categorising so you can help people understand a bit of what might be going on it can be too reductionist it has the effect sometimes of stopping people thinking more widely thinking out of the box and thinking in a free way that might be actually more helpful to the client so that’s a bit of a long winded explanation” (Lines 118-139)</td>
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“one thing I do find is that obviously the more people that you work with that hear voices you can kind of see a pattern” (Lines 13-15)

“it’s important to tease out that whether it is their own voice or their own thoughts or whether it is coming from inside or outside! (Line 18-20)

“does the voice have a gender, how many voices are there, what sorts of things do they say, do they keep you awake at night, do they wake you up in a morning or during the night you know that kind of stuff” (Lines 22-25)

“to have an intervention tailored to that formulation” (Lines 167-168)

“erm obviously about trauma but not just that I would be taking a full psychological history so you would be asking people all the things you would be asking any other person who comes through the door the same way you would ask people with anxiety and depression about childhood experiences relationships about bullying how they got on at school you should try and make assessment about their interaction with others their interpersonal relationships you should be routinely asking people about trauma anyway not matter what your professional background you should be asking people about abuse any way erm so you should be doing a full sort of psychological assessment looking at the way people feel about themselves about their place in the world about how they think other people see them so you should be doing a full psychological assessment and that would give you hopefully some ideas of whether feel shame embarrassment humiliation whether people have been traumatised whether they’ve got interpersonal much more to a person than…So it’s about asking, in fact thinking about it with this particular woman the thing that really enabled her to engage better was when I started to take her away from the here and now and ask about her history and asked about her schooling and her friends, what she liked what she didn’t like and getting a better picture of her as a person. That was when she engaged better and I saw more of who she was erm so I could better understand her distress now with the hallucinations because I then had a picture of her as a whole person and you know the actual erm personality came through more and the way she responded in the here and now made more sense in that context so its about getting the whole picture…” (Lines 49-63)

“I would say there is an absolute necessity to not just have a psychiatric assessment to have a psychological assessment as well so that you don’t miss things”
skills and you build up your formulation that way and the voices (Lines 88-101)

“I was reflecting on this last week, we were in the office and we were talking about a client and Sean said something and I thought bloody hell he sounds like me and I thought actually yeah course he sounds like me cos I have been battering away at this for 10 or 12 years, that kind of slow sort of… and I think people are thinking much more psychologically in our team now because I’ve been. gradually over the years with some of these people, you talk about it you put in your two penneth and people are thinking about things in a way that they weren’t thinking about before so… I think you can have psychologically informed care. If you have a psychologist around who is doing formulations who is contributing to those discussions in clinical meetings it doesn’t have to be face to face formulations where you are doing assessments with a client, it can be done in other ways as well erm and I think that’s why all teams (161-164)

“No that is definitely not the case. I think sometimes by chance cos something else has happened or another issue has cropped up the person might end up for a psychological assessment so maybe they don’t routinely refer because they think medication is the answer, they’ve got it right the diagnosis is erm that they need this medication, they’ve got auditory hallucination or whatever and this is the treatment and therefore they wouldn’t even consider psychology, so it might be that or it might be that psychology has a long waiting list and they might think well I can treat this and I won’t refer cos they’ll have to wait a long time any way. So it might be a number of factors why they don’t but erm in an ideal world they should have both in my view.” (Lines 166-175)

“Yes yes oh yes they knew about the child abuse but didn’t make the psychological formulation. In fact when you looked at the
should have psychologist erm who work with psychosis or who knows about psychosis and can help shape those kind of conversations “ (Lines 212-227)

hallucinations they were very much about the abuse they were the abuser threatening saying don’t you tell anyone I’ll kill you if you tell so it was that sort of… it was directly connected to the abuse erm but it was treated as an hallucination as if it didn’t connect.. it was bizarre” (Lines 196-201)

“Yes that no connection was made there no PTSD suggestion even. It was a sense of this persons got this happening therefore they are hallucinating” (Lines 203-204)

So you’re able to explain it, so the psychological formulation would come in there so it wouldn’t be a case of you are this person who’s ill in this way. It would be a case of saying this event that happened to you this trauma, this drug abuse or whatever it was. This is the thing that has triggered you becoming ill and this is the sort of thing that might help you and this might be medication or it might be treatment to help you in a cognitive way to help you with what your experiencing” (Lines
## The inconsistency of diagnosis

“so if you are hearing voices it could be schizophrenia, it could just be a psychotic episode, it could be psychotic depression, it could be bipolar and it could be related to a manic episode and it just seems so variable” (Lines 200-202)

Yes that’s the danger so you end up you know with misdiagnosis you know people will say I think they’ve got schizophrenia so we’ll treat them this way when actually they could do they could potentially benefit from having erm…I’m just thinking of a client of mine who had a diagnosis of schizophrenia and I sort of always thought there was this impulsivity this slightly manic sort of aspect sometimes this person would become disinhibited as their mental health deteriorated they would become slightly disinhibited and erm I felt that not recognising that wasn’t helpful to the client so they’ve now changed the diagnosis and that’s fine so that person now has a diagnosis of schizoaffective disorder you know

## The acknowledgement of misdiagnosis

“in other places I have worked it has been the flavour of the month diagnosis so if you are hearing voices it could be schizophrenia” (Lines 199-200)

Yes that’s the danger so you end up you know with misdiagnosis you know people will say I think they’ve got schizophrenia so we’ll treat them this way when actually they could do they could potentially benefit from having erm…I’m just thinking of a client of mine who had a diagnosis of schizophrenia and I sort of always thought there was this impulsivity this slightly manic sort of aspect sometimes this person would become disinhibited as their mental health deteriorated they would become slightly disinhibited and erm I felt that not recognising that wasn’t helpful to the client so they’ve now changed the diagnosis and that’s fine so that person now has a diagnosis of schizoaffective disorder you know

“…however I have certainly come across a number of people who have been misdiagnosed so they’ve been treated as if they are psychotic but actually they’ve got post traumatic stress disorder. So if somebody has got post traumatic stress disorder they might appear to be psychotic in that they are reliving a traumatic. So reliving a traumatic experience might mean that they hear the voice or the sounds, say somebody that’s been at war might hear the sounds of the bomb and the crying and the pain and they might hear all of that and they might react to it and be treated as they are psychotic.” (Lines 130-138)
having flashbacks are now being labelled as something different so that’s what happens” (Lines 217-221)

“so actually it would make a lot of sense if a lot like I’ve said before a lot of people with auditory hallucinations do have a troubled background and repeated prolonged periods of stress erm so it wouldn’t surprise me that you know that the diagnostic criteria for PTSD would be met there…there are also a lot of people with OCD on antipsychotics” (Lines 221-225)

“erm…it made a bit of difference to the treatment options I suppose …erm…yeah”(Lines 144-155)

“so actually what happens is things like trauma sometimes gets sidelined because our understanding is evolving in a way that diagnostic categories can’t evolve because they are very long standing and defined around medical models of understanding but actually our understanding as different professionals has actually I think gone beyond diagnosis so that diagnosis now has a small… smaller role but (Lines, 147-152)

“er so it might be that they’ve got a PTSD presentation but its not your obvious you know war or road traffic accident or assault or you know one of those things that you’d think they’d be traumatised by erm it. It could be something that you or I might be perfectly fine with but this person has been traumatised by it and is affected by it and they keep reliving it and so it can be misdiagnosed. I mean one of the things, one of the treatments for PTSD would be an antipsychotic medication to suppress the symptoms so that you can then work with the person so that they will be less likely to have flashbacks and nightmares and dissociate erm so an antipsychotic medication even though it’s a misdiagnosis the medication might be useful erm but only if you are going to treat them psychologically and get them over those issues so.” (Lines 151-161)

“Yeah yeah that is something, that definitely down the line I have picked up. I can think of one individual who I picked up and
she had been treated for probably 10 years as psychotic on an antipsychotic actually she had childhood sexual abuse and she had PTSD. So when eventually she came through to me, very clearly she had PTSD and we worked on that and her medication was gradually reduced and she is functioning very well working etc…” (Lines 183-188)

“I mean another example, I went to a ward review the psychiatrist actually asked me to go to it because there was someone on the ward who was presenting as psychotic but he wasn’t quite sure and actually their diagnosis, the staff on the ward and the psychiatrist, was that this woman’s gone psychotic and you know they were medicating her. I sat in on this review and asked her a few pertinent questions to do with what had happened to her just before the onset because she’d never been ill before erm this illness and actually it was clear that she’d had a really bad trauma, so I was able to say look I think there might be PTSD
here and then I took her away and assessed and yeah she’d got PTSD. She literally had 4 sessions of EMDR and was back to normal so she could have been in the system and still being treated…”(Lines 213-223)

“Because PTSD the problem with PTSD is that it doesn’t get right on its own, if it doesn’t get treated it doesn’t get better. It was being treated with antipsychotic drugs so it would have been suppressed and it would never got better so she would have come off them down the line maybe and she would have immediately been reliving it again” (Lines 225-229)

“I would suspect that there are a lot out there and I would suggest that what be a very good idea would be education more education on the psychiatric training about PTSD because I think historically PTSD used to be called shell shock and it wasn’t a treatable state. With trauma focused CBT and EMDR which are now NICE guidelines recommenced those treatments are
### The utility of diagnosis

<table>
<thead>
<tr>
<th>“Yeah I think it has a use from time to time” (Lines 184-185)</th>
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<tr>
<td>“I think it is a diagnosis versus formulation sort of way of thinking about things I think that erm when people use the words auditory hallucinations it immediately medicalises it cos we don’t use the word auditory in real life unless you’re a speech and language therapist or audiologist and hallucination itself is a psychiatry interpretation erm so I think err using that language is immediately psychiatric I think as well when someone has that label it’s very difficult to draw back from that personally to drawn them back you know they’ll say my voices I think the diagnostic label can get in the way of therapy” (Lines 147-154)</td>
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<td>“I feel often that traditional psychiatry does brilliant brilliant assessments if you read a psychiatric report what you get is a he amount of information absolutely fantastic I think that you need some form of categorisation because that’s what psychologically people do we put things into we make patterns and we order things so I think you also get some kind of diagnostic system…” (Lines 100-105)</td>
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<td>“Erm I think for some people it can be a real disadvantage I think for this chap it would have been real disadvantage but I think you see the other thing is it doesn’t have to be about direct formulation and working with people one of the things that I think is really interesting” (Lines 230-233)</td>
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<td>“…understand and actually I think a diagnosis that follows a formulation an explanation in other words is helpful and they have been relieved because they’ll say now I know what’s going on and now I know there is something we can do whatever it might be that’s useful but it isn’t useful in isolation without the formulation does that make sense?” (Lines 101-105)</td>
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<td>“I think sometimes diagnosis is not helpful because if you turn around and tell somebody they are psychotic, schizophrenic they immediately think that’s it I’m mad, it’s the end and it’s a very negative thing to tell them erm. Sometimes it can be a relief because they didn’t know what was going on and I only think it’s a relief if you put it in context.”</td>
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Yeah I think it has a use from time to time because I think if you’re hearing voices it can be quite terrifying and for someone to be able to give you a label of why that is… I think it can reduce the distress. I don’t think it helps the hearing voices itself, it can go both ways can’t it? it can be useful for some people” (Lines 175-179)

“And the worry that they may get carted off to St George’s” (Line 93)

“and it can be a hindrance for others when someone has a label it almost takes away err they become passive and rather than actively wanting things to be different erm when a psychiatrist tells you that this is your label now then you can see people sitting back and thinking okay well that’s that then I think what is wrong with that label is the psychiatric ideas around it that that’s it now you’ll be on these drugs for life” (Lines 180-185)

“in that way I don’t think it’s very helpful and as well quite a few people I have seen this idea of hearing voices and they are unsure of “I was thinking actually I know a client that has found it really helpful it’s really helped him understand what’s going on erm and has helped him understand and helped him move his life on but partly actually cos I was the care coordinator so actually I’m not sure how much of that is down to me helping him understand his experiences which is a much broader conversations than just the diagnostic and the medical thingy about that so whether that’s helped” (Lines 168-175)

“I think it can be unhelpful for some people, I remember once it was kind of a long, long time ago now and I remember the doctor went to break the news to this young girl that she’d erm got a diagnosis of schizophrenia and she freaked out understandably because she thought that people with schizophrenia were axe murderers, so she was very very scared quite traumatized by that thought that it meant that she was going to turn into some kind of violent character. Cos I can remember seeing her a couple of “yeah … so I think diagnosis can be useful maybe more from the clinician’s point of view because it gives you a sense of what might be going on here. It’s not always useful to give that label to the client because I think that can be a very negative thing for them especially if you don’t give them a formulation, so that’s I hope that has answered the question” (Lines 89-93)

“I’ve er yes what I’ve found is that when I’ve worked not necessarily with hallucinations as such but generally clients that have been given a diagnosis maybe of PD maybe of psychosis, whatever it was by the psychiatrists very often they will come to their therapy in a very distressed state because they have been told that they’ve got this heinous thing going on and actually they don’t know why, they don’t understand” (Lines 96-101)
whether it’s their own voice or whether it’s a psychotic phenomenon” (Lines 203-204)

hours after that in the afternoon and she was saying Kate…you know they are saying, you know, I’ve got this schizophrenia thing. Does that mean I am going to become violent and I said well are you violent now and she said no…so I doubt very much you’ll suddenly become…she was an inpatient on a rehab ward so she’d obviously gone through acute inpatients, gone on to a rehab ward and only then was finding out what her diagnosis was and she was completely freaked out by that, but of course I mean if you’ve been acutely unwell and you’ve not been violent its unlikely you are going to suddenly become a violent axe murderer which was what her take on it was, so which is what she thought she would be. I think there are other people that talk about the stigma of having that diagnosis, they don’t want other people to know they’ve got that diagnosis so I think it can be, and there’s the whole thing about hope as well. It’s one of those hopeless sounding sort of diagnoses you’ve got schizophrenia, you’ve got paranoid schizophrenia, you know erm there are a lot of conceptions
about it you know and **there’s this whole thing about redefining who you are as a person** isn’t there and that’s where I think it can be unhelpful because **the role of paranoid schizophrenic has got a lot of stigma attached to it** for some people if they don’t attach the stigma it can be really helpful because they can think **I’ve got this difficulty that I need to deal with and if I deal with it in this way and this way actually I can get on with my life** but for other people it carries a hefty stigma and it can be unhelpful (Lines 175-205)

“Erm **I think it’s probably more useful for professionals** because a lot of clients even though they’ll say I’ve got schizophrenia don’t actually know what that means erm I know people that have mental health problems who’ve got no idea what about the diagnosis and don’t actually care erm” (Lines 160-163)

“I think it’s useful for professionals as they are the ones who sort of think I’ve got this person I need to provide some kind
of intervention or treatment to sort of make things better for them erm and **diagnostic categories make people feel much more secure whether the clients** erm a lot of them find it particularly helpful I don’t know I know” (Lines 183-187)

| 5. Perspectives on medication | “yes but sometimes the difficulty is I think that often people can’t do that work **people struggle to do that kind of work without being on medication** because their mental health deteriorates without it and they can be a danger either to themselves and others so **in order to do the trauma work they need medication**” (Lines 159-163) | “I think obviously as I mentioned medication can be useful as it can bring the symptoms down…”(Lines 108-109) |
| Medication is essential | “often they are multiple erm concoction or cocktail err I think that yeah sometimes I’ve had erm there’s almost like a paradox here because they’re on medication and the voices dampen down it means you can then work with the voices because they’re not bothering them so much any more so they don’t want to go there and” | “…but I think for the voices to go away you are looking at a combination of therapy and medication” (Lines 322-323) |
| Medication and therapy essential | | |
| Problems with medication | “...I have had the odd occasion when the people have so highly medicated that they are not able to engage in anything...” (Lines 122-124) | “She ended up on the ward erm she as medicated erm she actually put on lots and lots of weight you know because of the medication erm. She went from being an independent person living in her own flat erm with a job to a person that ended up having to go and live with her parents and erm well she lost her job, she lost her friends, she lost her self esteem really because she just became erm a very different person and a constant battle in her head with these voices that were quite derogatory of her so that was that was what went on for her.” (Lines 23-30) | “...I mean it’s brilliant but what a loss you know those 10 years, 10 years. Yeah so not functioning particularly, highly medicated, side effects of the medication cos quite hefty medication yeah ten years...” (Lines 190-192) |
“and we mustn’t forget about patient choice and there is the need for the client to be consenting to treatment. You can’t force a client to engage in therapy and likewise you can’t force them to take medication so the only way you can force them and I’ve seen this when they’re sectioned. So somebody is at risk because of their psychotic episode they can be sectioned and medicated against their will and I have treated people for the trauma of that because it totally traumatises them erm but at the end of the day it is being done for their own safety.” (Lines 112-119)

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<th>6. The utility of therapy</th>
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<tr>
<td>1. Uncertainty about the role of therapy</td>
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<tr>
<td>2. Different therapeutic approaches</td>
<td>“I don’t really find it useful to work on one specific thing because it will depend on the formulation if the thing that troubles the client most is the voices then I will do some very basic work erm on them managing</td>
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<td>“It’s difficult cos you kind of have your ideas your kind of model of treatment I think there’s the kind of erm I think there’s a whole load of psychological that is generally done by the psychologist that is better</td>
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<td>“…Erm well I think that when someone is hearing voices or hallucinating in some way if you don’t engage with what their experiencing and you try and negate it, you try and say it’s not</td>
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<td>Line Numbers</td>
<td>Extracted Text</td>
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<td>63-66</td>
<td>“I would more work on a practical level erm you know very pragmatic suggestions of distraction of listening to music of you know talking on the phone” (Line 65-67)</td>
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<td>67-71</td>
<td>“you know but actually the way I tend to work more with voices rather than CBT or anything else is from an ACT approach so we look at what the voices are and learn to accept those voices that we don’t need to make any meaning from the voices and we don’t need to make any judgements about what the voices are saying I have found that once people get the gist of that that their distress about hearing the voices reduce so I guess I would say I would probably work more with the stress about hearing the voices than the voice themselves” (Lines 67-71)</td>
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<td>143-144</td>
<td>“…so what I did with her was get her to write a load of stuff down rather than talking about it because that was easier for her to do…” (Lines 143-144)</td>
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<td>230-234</td>
<td>“I think that if someone is hearing voices and erm I don’t think you should collude so I don’t think you should agree with people erm oh well you know erm the voices are telling to do such and such I think you should do it you know in case they come and hurt you you can’t do that kind of thing I don’t think you can use the voices to your own end you can’t get patients to do things you want them to do to appease voices because it suits you however I think what you have to practice is sitting on the fence I mean your job is to hear what someone says not to tell them its rubbish but to uncover what it is those voices might be talking about what it is that is significant so you don’t want to be colluding and you know erm but you need to be respectful and to hear what people are saying and to ask them more about it I think it’s very rude to dismiss them and not talk about it real and tell them off, tell them their wrong actually you’re on a losing battle as they will not engage with you so in order to engage and to actually work with what she was experiencing, whether it was real or hallucinatory erm it was about asking her to describe what is it that your hearing, where are you hearing it? is it inside your head or outside your head? Is it your voice or someone else’s. In her case it was a man’s voice and it was that was telling her that she was no good and it was about asking how that made her feel and working with what she presented, rather than try and tell her no your ill you’ve got this thing it isn’t real, there’s not someone in the room shouting at you. So it was about allowing her to be as she was and to present you what she was experiencing, so accepting it and not trying to put her straight as I have seen done on the wards from medical staff…” (Lines 33-46)</td>
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“…OCD work is pretty erm I’ve not really seen a lot of evidence that erm psychiatric medication is particularly helpful and **I have seen evidence that psychological therapy is…**” (Lines 228-230)

| at all after all that’s one of the things that’s distressing them I mean if they distressed by voices telling they are gonna come and kill them there is no point sort of ignoring that because that’s the distress the person’s with presenting at the same time you don’t want to say I’ll have a quick word and tell them not to bother you cos you can’t you can set up an experiment where you’re gonna test out the power of the voices you know in the context of exploring whether these voices can actually do what they say they can do you can actually do that kind of thing but on the basis that the client knows you’re sitting on the fence you don’t you know you can’t understand how this can be I think that’s fair enough to sort of say I can’t understand how that can happen so I’ve got a client and he knows I can’t understand how come people from films that are eighty ninety years old can talk about him while they are showing on the film on the television and he knows it’s pretty weird as well he thinks that he aggress with me that that is an incredibly weird thing to happen and he can see why I struggle to |
understand how that can be real right but he knows I am interesting and I am sitting on the fence but he knows I can’t understand that he can’t understand it either but he’s prepared to go along with it cos you know he says well it’s true I can see why you can’t buy into it Kate you know I can see why that’s a problem for you and it’s a bit of problem for me but it’s happening so I’m going with it it must be true but that’s not me colluding that’s me being quite clear I don’t understand how this can be happening I’ve not had that sustained experience but I’m interested because it’s brought him in here so I think you can set up experiments to test the power of the voices cos and things like that cos we did that with him we set up some experiments he’s quite relieved cos in a way now the voices are just irritating they’re not frightening anymore cos they don’t he knows they not really gonna come and kill him cos they are not able to and he’s noticed how the voices have changed over time and how they were saying this but nothing ever happens erm so he’s much… now finds them just
irritating which makes it easier for him to work to carry on with his life because these are now just an annoyance which irritate him  but bearable as opposed to irritating and frightening and he’s now not in constant fear of his life so I think you need to be careful of how you word it…and most psychiatrists now that I’ve come across would see that as being perfectly valuable” (Lines 261-308)

“because the voices themselves become the evidence for the beliefs that underpin them so it can be a bit harder” (Lines 17-25)

“that idea that voices might have meaning and might be symptomatic of underlying issues whether that’s kind of trauma sexual abuse or physical abuse or bullying or getting you know attacked” (Lines 240-242)

“I mean your job is to hear what someone says not to tell them its rubbish but to uncover what it is those voices might be talking about what it is that is significant” (lines 268-270)
<p>| “Difficult because the client group I’m working with is the client group where its very very entrenched, so in my experience treatment won’t make the voices go away. It gives people a sense of power over the voices so the voices reduce in frequency and severity and the people I work with can go on to work or go to college and I can think of people where that has happened” (Lines 317-322) |
| “…I think resolving trauma makes a difference where the trauma is…where they haven’t got that, I think you can work with them using CBT on their sort of negative views about themselves and you’re using that as one of the things as part of your formulation but you’re not actually working on the trauma because the trauma itself isn’t providing that level of distress. So I can think of people where there was maybe some things where you can see why they are contributing towards the negative views of themselves so that would be working on their views about themselves using |</p>
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<tr>
<th>7. Thinking on recovery</th>
<th>CBT so in that sense that would work as well and it kind of reduces the severity and the frequency but it doesn’t always get rid of it all together so yeah…” (Lines 336-346)</th>
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<tr>
<td>“I was really interested to look at something the other day that talked about cure rates of psychosis and what the piece I was looking at was saying it was something like 10 and 15% but in other countries it’s 60 or 70% and that’s a massive difference”</td>
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<td>“I would suspect there are a lot of people who hear voices that don’t get professional help any more and so it must be possible I think that unfortunately our system is such that once people hear voices they get wrapped up in a system and its very difficult to get I think the idea of a cure I’m not really into the idea of a cure” (Lines 254-258)</td>
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<td>“I’m not really sure about that for any psychological issue because that would then suggest we should never be anxious or sad and that would… cos the trouble is that the clients I see have got ongoing symptoms and always have had so it’s about them coming into a period where they’ve still got some symptoms but they are actually in a period of recovery because they’re always gonna have some level of voice hearing really at times of stress it comes on and goes off comes on and goes off so they can have voices several times week cos they’re always gonna have them but they’re just different they’re not as severe but people I’m working with are more complex generally so I can imagine there are people in the CMHT where you could easily get some resolution of the voices altogether especially at the other end people sometimes people who have got some bad experiences you can tie the ends up with them people who have bad experiences of”</td>
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<td>“I would say that if they continue to have the auditory hallucinations they potentially need to carry on with the medication maybe for ever erm..” (Lines 129-130)</td>
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<td>“In reality they are not they are traumatised they are reliving, they’re associating with the trauma so therefore erm they can recover because they can be properly diagnosed treated for PTSD and the symptoms can go so they can recover erm. I don’t know whether erm somebody with a diagnosis of schizophrenia does recover I do wonder whether perhaps there is some evidence for symptoms getting less in later life but I don’t know I don’t know..” (Lines 138-144)</td>
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<td>take away our humanity and so I don’t go along with that idea of a cure anyway but I think reducing the stress is probably more that I would see as a therapeutic aim and that is possible because” (Lines 260-264)</td>
<td>the mental health services and they get more entrenched as well and its different at the other end of the spectrum (Lines 346-359)</td>
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## Appendix 15 Psychiatrists’ theme tables

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<tr>
<th>Theme</th>
<th>Participant 4 “Harry”</th>
<th>Participant 5 “Matthew”</th>
<th>Participant 6 “James”</th>
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<tbody>
<tr>
<td><strong>1. Professional Ambivalence</strong></td>
<td>“I mean it is challenging, it is difficult and er and at the same time it is also interesting…” (Lines 4-5)</td>
<td>“I find it can be very challenging in many ways, the patients are usually very distressed and staff struggle to know how to work with them…” (Lines 4-6)</td>
<td>“I mean the literature is suggesting that CBT works with people with psychosis and obviously as psychiatrists our therapeutic…”</td>
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<tr>
<td>Challenging yet satisfying</td>
<td>“I mean er most of the patients I have seen have actually been quite distressed by their voices and er….” (Lines 213-215)”</td>
<td>“...I think command hallucinations those who get command voices I think that in itself becomes a very important factor for risk assessment as well not only for self but for others..” (Lines 115-117)</td>
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<tr>
<td>Difficulties in engaging</td>
<td>“I mean er most of the patients I have seen have actually been quite distressed by their voices and er….” (Lines 213-215)”</td>
<td>“...I think command hallucinations those who get command voices I think that in itself becomes a very important factor for risk assessment as well not only for self but for others..” (Lines 115-117)</td>
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<tr>
<td>Lack of training and experience</td>
<td>“I have seen cases on long term basis but what I am trying to admit is, regarding the CBT concept of tackling the voices I have only a theoretical knowledge. I’ve just read the literature that people are doing CBT with people hearing voices and with delusions as well but I don’t have myself training in”</td>
<td>“staff struggle to know how to work with them…I think there is minimal training in working in this area” (Lines 4-6)</td>
<td>“I mean the literature is suggesting that CBT works with people with psychosis and obviously as psychiatrists our therapeutic…”</td>
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</table>
### 2. Problems in team working

| Professional tensions | “…we always try to work with psychologists but **I don’t think psychologists usually want to touch patients with acute psychosis** and I think er there is a resistance from psychologists to see such patients and **it is extremely difficult for erm for us to get patients seen anyway by a psychologist** so I don’t think I think it’s easier to see a psychiatrist” (Lines 180-184) | “…yes indirectly nursing staff say on the wards, oh we have seen this man talking to the walls or talking to the bushes, but that is obviously not reliable information in some sense because some normal people you see walking down the road…” | “…so that level is fine but **it is unfortunate that still psychiatrists they won’t be very keen.** That doesn’t mean it is not happening because there are some service problems as well **if you refer a patient for psychotherapy to Sue or Kath err they have waiting lists.** So there are some practical problems **but still I think that keenness and enthusiasm on the** | “…but with all due respect I have not had many patients that I have referred for a number of reasons, for example the waiting lists are like over 6 months long and at times have been more than a year so referring someone that needs help now would be a waste of time, erm and some psychologists won’t work with people with psychosis, I’m not sure if this is to do with their training or what it is, I mean I know that some psychologists do like X in assertive outreach and forensics and I know that is what you are doing in X but I’m wondering if they are a minority.” (Lines 39-49) |
“there are some psychologists who perhaps are not so well trained to deal with these issues I think mostly psychologists would prefer the normal case which I would call the normal case which would be a straightforward CBT case or something with depression or other issues but I think in forensic psychology the er I think they see slightly different patients and are trained much more to deal with extreme behaviour and personality issues and so on…” (Lines 190-195)

“…and we have had her seen by psychology but I also think that a psychologist can jump into…you should have a target if you can’t take on one patient, because then that would be a lifetimes work, because she is that sort of patient, so I think there are always limitations…” (Lines 204-208)

part of the psychiatrists should be more. I think if everyone is showing interest.” (Lines 85-90)

“So what I was trying to say was we haven’t had this experience of referring a patient first of all waiting lists and all that and also I don’t know, with due respect Dawn whether you know apparently in this area? I think S and probably K are also following this sort of protocol but the psychologists here, they don’t see people with schizophrenia…” (Lines 124-128)

“…and there is another very good psychologist C erm he has distributed a paper on diagnostic problems, you know with diagnosis there is a controversy er about whether psychiatry diagnosis is appropriate or not and I confronted him and said that means you are doing a paper saying there shouldn’t be a diagnosis and at the same time in your practice you refuse to see schizophrenia patients? What I would agree with psychologists and psychotherapists about is that they believe that

“Erm, well they may have an OT assessment, that can work well on a practical level, and they generally get to see the nurses who may use some therapeutic techniques, but really their priority is medication adherence…Well staff on the wards are not really that well up on it I don’t feel, I know now that they are getting some psychological input and that may help a little, but I’m not sure how much time they have to do anything really because mostly patients are in and out and even if you had trained staff to do anything the timing can be problematic…” (Lines 53-59)
people who are acutely unwell, they are acutely florid, they are suicidal, they are aggressive, I don’t want my colleagues to see those. But people who suffer with schizophrenia, if they are calm and they are stabilised, then what are we here for we are here to help and psychotherapists should be catering for those clients needs who have voices where they’re not floridly acting or floridly a threat to themselves, I think we shouldn’t be saying no I’m not seeing this patient because he’s hearing voices. So that’s unfortunately…” (Lines 129-141)

“one thing which makes me not very happy is that most of the doctors, most of the psychiatrists they don’t have interests in psychotherapy and they don’t have that sort belief that psychotherapy works and I do not think that most of them are as keen as I am. For example, I know that you work with patients that hear voices, I would be very glad to send my patients to you rather than just relying on my medical expertise but unfortunately many psychiatrists,
| The power of psychiatry | “We do usually erm ask for psychological assessments **but not as a clarification for diagnosis** I don’t think I would do that I don’t think we would do that…” (Lines 164-165) | “Er yes if I thought that the client had say depression or some underlying personality issue **that I felt appropriate for a psychologist I would refer…erm…”** (Line 39-40) |
| 3. Theories on causes of hearing voices | “Quite often we see people who have had traumatic experiences in the past or have had specifically sexual abuse in the past who present with voices but these voices...” (Lines 39-41) | “Being trained psychodynamically, past is very important, **childhood experience, attachment in significant relationship with parents...**” (Lines 26-28) |
| Stress Vulnerability /Trauma | I mean even if they have had **childhood abuse or sexual abuse or any such emotional trauma**, you would always want to make a diagnosis at that moment in time, but with help from historical indicators from the past. So it doesn’t necessarily mean that somebody who has childhood abuse will not go on to develop schizophrenia or psychosis. (Lines 85-89) | “…and any traumatic experiences, whether emotional, physical, mental abuse or neglect, parental conflict. So I think all sorts of things are very significant and can make people vulnerable to future mental problems.” (Lines 26-30) |
| | “**Very often people that present with auditory hallucinations have had a troubled life and usually at the time they become ill there is something, some stress that is going on for them** that has made things worse.” (Lines 16-19) | “…obviously we would keep that in mind when diagnosing but it would not directly impact on the diagnosis. **I personally would look for signs of reliving the trauma, such as nightmares, flashbacks etc but auditory hallucinations are usually associated with psychosis.**” (Lines 25-28) |
“I would say that it’s a symptom but then it indicates severity …. As I said a misperception or a symptom like this should be in the context of their history as you said someone with a traumatic experience such as returned from war and then is reliving those events that would not fall into psychosis” (Lines 94-98)

“there does seem to be a great deal of these patients that have experienced abuse, be it sexual, emotional or sometimes neglect so I would say that there may certainly be a link but I’m not sure whether that in itself would cause the hallucinations…” (Lines 22-25)

<table>
<thead>
<tr>
<th>Biological/organic</th>
<th>“…and sometimes they can have organic causes as well say for instance delirium and dementia which are also responsible for auditory hallucinations or yes substance misuse or withdrawal from drugs withdrawal from alcohol as I mentioned delirium tremors…” (Lines 32-36)</th>
<th>“…so voices could be for various reasons alcohol, drugs, psychosis, depression and obviously there are organic causes as well” (Lines 16-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic illness</td>
<td>“Often auditory hallucinations will be a symptom of psychotic illnesses say schizophrenia or other psychotic illnesses sometimes we have hallucination in those who have depression and those who have mood disorders so those three would be the commonest causes of hallucinations” (Lines 16-19)</td>
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</table>
“As I said erm once you take a history and do a mental state examination hallucinations must be seen in the context of the patient’s illness and er the history so if it arises in the setting of depression then you want to know whether depression predated the hallucinations or whether the hallucinations arose on their own first and if it is in the context of mood disorder then you look for signs of hypermania or mania” (Lines 21-26)

“Of course, of course I really think it’s an error of perception, hallucinations. So you would test a person’s perception because you’re not only just testing auditory hallucinations you are testing other hallucinations as well” (Lines 61-63)

So we have to be open and people with depression could later go on to develop depressive psychosis or psychotic depression or patients who have hyper mania could then become psychotic and have mood disorder with psychosis.” (Lines 89-
92)

“I have a **patient who has a diagnosis of psychotic depression** but she she is er she is in a slightly volatile relationship and she she’s basically lonely and alone and her children are grown up and she gets voices but er and **they are genuine auditory hallucinations and genuine psychotic phenomena** but she believes in she has her own beliefs basically and she is quite at peace…“Well she believes in different religions and she believes in a synthesis of different religions and she is quite at peace with these voices” (Lines 196-204)

**Uncertainty**

“I think the point of…you can only treat when you know what you’re treating. So an hallucination in itself is just a symptom of something and we need to know what that something is and er depending on the situation, depending on the severity, depending on the er… acuteness of the situation then the treatment will be different.” (Lines 124-128)

“And of course sometimes we change our mind about diagnosis, which can be helpful and unhelpful, because as we monitor the client and the client gets maybe more stable it may become apparent that they aren’t suffering from what we initially diagnosed or you get dual diagnosis, so someone may have an underlying
“As I said as I said there would be nobody who’s just hearing voices there will be something else say you have patient with schizophrenia also has some er some say has paranoid personality or a patient with delusional disorder has some some childhood issue or something..” (Lines 170-173)

“I think there are many people that hear their own voices which they call an inner voice but I think er that’s what we all do we all have some kind of voice I think it has to be seen in the context of mood and other symptoms” (Lines 211-213)

“personality disorder that may have gone unnoticed when they were severely psychotic or a person may become depressed” (Lines 90-95)

Dependent on location

“…when you talk about voices are you talking about true hallucinations or are you just talking about general voices?” (lines 41-42)

“I think er a psychiatrists instinct will be to differentiate whether the hallucinations are true hallucinations as we call it or pseudo hallucinations and I think er as you get more experienced at looking at a patient then you can differentiate between the two and initially it might be a bit difficult

“I usually start with location, so if a person is hearing voices inside their head it is less likely to be schizophrenia, as it is usually their internal thought processes and is more likely to be a mood disorder but if they are hearing voices outside of their head then it is more likely to be a symptom of psychosis…”
especially in the context of er sexual abuse or childhood abuse. There are patients who that they present with voices and they will reflect that the voices are inside and they can hear them inside their head or they will say that the voices are… When they are inside their head they are pseudo hallucinations and er but you kind of differentiate. It is also in the context of the history that they gave and the light of their personality so most people with say emotionally unstable personality will possibly have pseudo hallucinations or they arise in the context of depression. Also as I said I don’t think you would just look to see if hallucinations are pseudo or true but you would then do a full mental state examination and then place it in relation to what you have seen..” (Lines 46-59)

“…because a pseudo hallucination will go against a diagnosis of a true psychotic illness, whereas a real hallucination would always suggest that there is a psychosis.” (Lines 69-71)
“I think people who have voices that are inside their head erm doesn’t necessarily mean that they don’t have a psychotic illness, but it’s just that they don’t have a true hallucination. What an hallucination actually means is that there is a misinterpretation of a perception so while they are actually hearing, which we don’t hear when they talk to us, for them the experience is real just as if we hear this sound (taps the desk) we have created this, so we are interpreting that stimulus whereas in that case there is no stimulus so it is a misinterpretation.” (Lines 74-81)

4. Perspectives on diagnosis and formulation

| The reductionist nature of diagnosis | “I mean traditionally, because my basic training is psychiatry, so we follow like the DSM IV or ICD 10 criteria and the diagnosis would only be based on just one symptom, which I hope you will agree is not a good thing anyway to diagnose people on one or two symptoms without putting into context with other symptoms, patient history er current mental state…” (Lines 12-16) |
| The utility of psychological formulation | “…I think we should have this erm psychotherapeutic model for every patient, there should be every patient we see, **there should be a psychodynamic formulation for every patient**, rather than just this patient, this medication…” (Lines 65-68)  
“that’s important, especially for clients and **subjective experience of clients absolutely so you’re asking people to be subjective**.” (Lines 23-24) | “…What I have found interesting when I have referred, or the team have referred to psychology, is the different perspective that psychologists take, or some psychologists take, where they will see things outside of the medical viewpoint, you know, I’m not suggesting that I always agree with them but I do think sometimes that fresh look at a client can be the very thing that is needed…” (Lines 96-102) |
| The inconsistency of diagnosis | “…however it is not always that clear cut as people can sometimes hear voices inside and outside of their head at the same time…it’s then it gets a little bit more complicated to make a diagnosis…however it is not always that clear cut as people can sometimes hear voices inside and outside of their head at the same time…it’s then it gets a little bit more complicated to make a diagnosis…” (Lines 9-16) |
| The acknowledgement of misdiagnosis | “Yes that’s what I’m talking about and if in the context of a psychotic illness or if it’s like schizophrenia or a delusional disorder then the voices then we will assess accordingly so it’s a more…in every case of auditory hallucinations we do a holistic assessment and we look at the persons mental state and their past history and past psychiatric history and that’s how we assess the causes” (Lines 28-32) | “I’ll have a whole look at various symptoms and their history…” (Lines 18-20) | “So when we take a new patient, we take a full history, so I would definitely ask them about past traumatic experiences..” (Lines 30-31) | “…some people would not report that they are hearing voices because somehow society and the public or lay people, they have this idea that, I don’t want to use the word and I’m sure you don’t use it, like being | “We take a thorough case history detailing everything from childhood to the present day. I’m generally looking for clues to the trigger of the illness.” (Lines 8-9) | “oh and we have the patients that are relieved because they feel that they are not alone and there are others who have similar problems. For some it gives them the opportunity to do research and find out more about their illness so that they feel empowered in a way…” (Lines 82-85) |
| The utility of diagnosis | “And of course sometimes we change our mind about diagnosis, which can be helpful and unhelpful, because as we monitor the client and the client gets maybe more stable it may become apparent that they aren’t suffering from what we initially diagnosed or you get dual diagnosis, so someone may have an underlying personality disorder that may have gone unnoticed when they were severely psychotic or a person may become depressed” (Lines 90-95) | | | | | |
slightly volatile relationship and she’s basically lonely and alone and her children are grown up and she gets voices but er and they are genuine auditory hallucinations and genuine psychotic phenomena but she believes in she has her own beliefs basically and she is quite at peace…” (Lines 196-201)

“But there are, if there are some who believe that this can be a sign of mental illness and that there is a thing called mental illness, it depends what their educational background and what their approach to life is. If they believe that there is something called mental illness and they say yes it is mental illness and they can be relieved that it can be cured and it depends on the level of... the level we interaction with them and how much information we have shared with them and whether we have been able to establish some kind of relationship. As I say I recently saw a patient, the same one who was genuinely distressed, who was so distressed with his experiences that he couldn’t leave his house but when he started to feel better then he crazy is synonymous with hearing voices, but that is something...people...when somebody is hearing voices and they think they are crazy…” (Lines 33-38)

“I think maybe I do it so we have to have a patients er own description subjective that phenomenological analysis only then is possible isn’t it…” (Lines 44-46)

“All it can be mixed really, I mean I have known people get really distressed by it, you know, and they start crying and it can sometimes make their symptoms worse, just the diagnosis in itself can be a cause of stress for them...erm...I've had clients get really angry with me for even suggesting that they have psychosis but I think that is down to the public stigma that goes alongside some diagnoses such as schizophrenia because the general consensus is that these people are dangerous and that they are mad, you know? I'm not sure how er get around that really, I had one patient that thought that she may have to be locked up forever, you know, didn’t think that she would be able to go home to her family. Families can also be problematic as they get very stressed by the diagnosis and sometimes they are scared to have the patient home when they are discharged from hospital...or they become really obsessed about wanting the medication to be increased to
started to feel happier, even though the symptoms were still there because he felt there was some explanation…and that he’s not just going mad. So I think it depends on er it depends, it depends on the person, the severity of the illness, it depends on how we interact with them, it depends on how they interact with us, it also depends on insight.” (Lines 232-246)

make sure the patient is safe, that can be a problem. Many of these patients end up losing family and friends because they just can’t cope with them and then you end up with them being isolated which makes matters even worse because sometimes they need hell of a lot of care and they need reminding to take their medication, you see, this is how some patients end up on the assertive outreach caseload as they have no one to help them maintain their routine and routine can be very important for these patients.

I do believe if we provided more education and support for carers that maybe this would help as we wouldn’t end up with some of the problems that we have.” (Lines 61-81)

“I mean it affects their identity, you know, one day you’re someone that has problems and the next day you’re a schizophrenic…I’m not sure all psychiatrists fully take that on board when they discuss diagnosis with the patient? How in a few words we change someone’s life,
<p>| 5. Perspectives on medication | Medication is essential | “…it is very likely that a patient who suffers from depression, and the patient who suffers from depression with psychosis like derogatory voices telling the patient worthless and calling names and erm so treatment is different. You will add an antipsychotic and if like you’ve just, there is already an antipsychotic the next step would be to increase the dose…” (Lines 46-51) | “Erm well it depends, if someone has say a mood disorder we would look at either antidepressants or a mood stabiliser depending on the severity of any mania but if we thought the patient had a psychotic illness then we would normally prescribe an antipsychotic.” (Lines 30-33) |
| Medication and therapy essential | “It’s a bit like a patient coming to me with depression, I give antidepressants without treating or looking at the marital conflict that is going on, the financial stress, the children’s stress and the patients own abusive childhood. So it’s just treating the superficial…” (Lines 94-97) | “so I wouldn’t be surprised if with psychotherapy counselling skills the |</p>
<table>
<thead>
<tr>
<th>Problems with medication</th>
<th>“…and the side effects the more dose you give the more side effects…” (Line 52)</th>
<th>“…from their inside view being on medication, for example, may be detrimental to their feelings, you know their identity.”</th>
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<tr>
<td>6. Thoughts on working therapeutically</td>
<td>“I don’t think psychological treatment will work at that time but I think some kind of psychological work is already there which will start from say if the patient is living with family then they will say don’t worry so you know that is also a kind of… I personally feel that that’s a kind of technique to help the patient…” (Lines 131-135)</td>
<td>“I have done some CBT training therefore if I considered it to be of use I would do few sessions with the patient using that…” (Lines 35-37)</td>
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<tr>
<td>Uncertainty about the role of therapy</td>
<td>“…but I think when you get to a stage when the person is not distressed, when the person is not preoccupied with the voices, when the person is not so frightened, once that first phase is over then “one thing which makes me not very happy is that most of the doctors, most of the psychiatrists they don’t have interests in psychotherapy and they don’t have that sort belief that psychotherapy works and I do not think that most of them are as keen as I am. For example, I know that you work with patients that hear voices, I would be very glad to send my patients to you rather than just relying on my medical expertise but unfortunately many psychiatrists, and it's not just this trust, I have worked across England, and I worked for 8 years in Pakistan and I think it needs to go back to</td>
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psychological techniques can be utilised. But I don’t think most psychiatrists are actually aware of how it works they will tell you but I don’t think we really know, we know that CBT can be used in the treatment of say acute psychosis, but how is it done and how it’s done, how often it is done, I really don’t know but I think it is done informally without a label of let us say, somebody will say today we are going to do CBT for voices I think it’s already done in a slightly different way.” (Lines 137-145)

“Because your looking at cognition and behaviour and thoughts and I think that’s done from the first day and that’s part of our training and that’s part of our training as well, that’s part of everyone’s training you know look at the voices…” (Lines 145-148)

“you look at say there was a patient I’ve seen recently who was so convinced that we did not work for the hospital he did not believe that we were doctors and nurses that er he he pressed us so that we had to show him our ID cards I mean of

its grass roots…” (Lines 58-68)

“I think all psychiatrists, I think all psychiatrists should be interested because psychotherapy counselling, because I don ‘t believe in total medical model myself, there is always a place for therapy”(Lines 5-7)
<table>
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<tr>
<th>Different therapeutic approaches</th>
<th>course we should always do that but he was very paranoid and he had to be reassured many times and I think that reassurance is also a kind of technique..” (Lines 148-153)</th>
<th>“that’s important, especially for clients and <strong>subjective experience of clients</strong> absolutely so you’re asking people to be subjective.” (Lines 23-24)</th>
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<td>“Or when the medics or the nurses sit with the patient and they say don’t worry and <strong>you know it starts from that reassurance, will be actually the first thing</strong>…” (Lines 135-137)</td>
<td>“I think maybe I do it so we have to have a patients er own description <strong>subjective that phenomenological analysis</strong> only then is possible isn’t it…” (Lines 44-46)</td>
<td>“…going back to erm the content of the voices, yes that does help us to see the obviously the form as well as you know, the second person hallucinations and the third person and the content I think that is a reflection of the type of stress that the patient is going through…”(Lines 38-41)</td>
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<tr>
<td>“…I think I’ve always been taught to look at the content. I think without the content if you ask somebody are you hearing voices and they say yes and you just stop it, it doesn’t mean anything you need to what is the person’s actually own perception of the voices as well.” (Line 119-122)</td>
<td>“…going back to erm the content of the voices, yes that does help us to see the obviously the form as well as you know, the second person hallucinations and the third person and the content I think that is a reflection of the type of stress that the patient is going through…”(Lines 38-41)</td>
<td>“So I think <strong>we should be doing more than distracting techniques you need to strike at the root</strong>.” (Lines 97-98)</td>
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“Yes and in terms of therapy CBT is looking at now at a superficial level and psychodynamic is looking at the core causes the fundamental causes, the primitive causes, which is unless they are that is as you know that is the aim of the psychodynamic psychotherapist to develop this insight into the patient to realise their problems and obviously help them to deal with them. So I would rather, and because I am biased as well because I am psychodynamically trained” (Lines 100-105)

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<tr>
<th>7. Thinking on recovery</th>
<th>“Unless they trust us and until we trust ourselves that we know what we are doing there will be no breakthrough” (Lines 248-249)</th>
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<tbody>
<tr>
<td>What does recovery mean?</td>
<td>“I think er some of the patient’s who have er been in the system for years are also the patients who haven’t had any symptoms for years but they are followed up because their er initial symptoms had been so severe it has led to a deterioration in their social skills and their personality and their</td>
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<td>“Erm…for the professional, for me, I would imagine recovery is where someone, even if they are still on medication, can live as near to the life they had before, or as near to a normal functioning life as possible, you know they can work or go to college, they can cook for themselves, they can basically look after themselves independently, for me that would be recovery…I’m wondering though if everyone would agree</td>
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cognition and it has in a sense isolated them from the routines of normal life. So there are many patients who I have seen, or I still see, who are childlike in their interactions and, or are quite mature but, are living that kind of life in which they are entrenched in the system and they know that they have to go and see this person after three months and take their medications and you try to make changes with certain patients but one is also a bit cautious in doing so. It becomes their life in a way and it also becomes a source of support for them because they have already been abandoned, by various or various things have happened to them in their lives or they’re all alone and they have been stigmatised in the past so if there is somebody who was diagnosed with psychosis in the fifties, I don’t think the reception he would have got in the fifties would have been nice in his own community.” (Lines 259-274)
### Appendix 16 Clients’ theme tables

<table>
<thead>
<tr>
<th>Theme</th>
<th>Participant 1 (Mark)</th>
<th>Participant 2 (Paul)</th>
<th>Participant 3 (Sara)</th>
<th>Participant 4 (Jo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings about diagnosis</td>
<td>“…people won’t tell if they can cope, because they will be told they’ve got schizophrenia and be given medication…being called schizophrenic hasn’t done me any good…”</td>
<td>“…Apparently schizophrenia for religious beliefs, and religion that makes me happy. I am a very happy person and I am a sad person because I haven’t seen my son for”</td>
<td>“I was quite shocked because I hadn’t really considered myself as that ill at all and also because of the negative social views of schizophrenia, I didn’t really want that,”</td>
<td>“Oh (laughs) I’ve had a few over the years…I call it my collection of illnesses, erm I’ve lost track to a degree, because I started to not take it seriously after a”</td>
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</table>
such a long time. He was 5 when I last seen him… that’s the biggest problem. If that wasn’t there I wouldn’t give a shit but it is there and he’s mine and I need him, but because I’ve been told I’m schizophrenic I can’t see him…” (Lines 8-12)

“I don’t know if I’m normal now, I think I’m normal, not abnormal, you know all I want is to chill and make people laugh…I don’t want to hurt people I would rather give them a huggle…it’s a good word isn’t it a huggle?” (Lines 40-42)

was shocked erm I felt sort of disappointment with myself erm and just really shock more than anything.” (Lines 25-28) while…erm let’s think, initially I think it was paranoid schizophrenia but then that got changed, I mean they were even thinking of bipolar at one stage, oh and then I had a personality disorder, I think I may still have that one, but now it’s been called schizoaffective disorder, I think that’s less severe, so I get the feeling I should be grateful (laughs). I mean how can you have faith in them if they can keep changing your diagnosis, do they really know what they are doing I wonder? The trouble is with this, it affects your life in every way, without even considering the distress that the voices can cause…I mean lets just put that to one side for the time being. The stress just being given a diagnosis of schizophrenia is something on its own. Well, first of all, I was in
hospital for years off and on, my children had to go and live with their dad, can you imagine the guilt that goes with that? I'll never be able to make those years up for them…I mean they sort of understand now they're teenagers but my ex still uses it against me, you know, oh well you can't cope with this and this because you're ill. So that's just patronising aint it? Erm…I think what affects me the most now is that if I need to go to my GP, like I have thyroid problems, and I need to go for check ups so that I can get my tablets and I dread going, I hate going, because every time I go, she gets out her depression checklist and I have to answer the stupid questions, well if I'm feeling low, if I'm having a low patch, I won't go because I am scared that she will pick up on it and
have me put back in hospital, so half the time I don’t get my medication which, I’ve been told by a friend can also affect my mood, which is a bit chicken and egg thingy isn’t it? (Lines 27-51)

“…I mean I’ve met some very strange people on the wards, much, much worse than I ever was and yet they had the same diagnosis as me! I thought bloody hell, is that what I’m going to end up like if I stay in here!..” (Lines 57-60)

“Yes! That’s exactly what it is isn’t it? Why couldn’t someone just say that to me rather than just telling me I’ve got this illness or I’ve got that illness? I mean you’re going to feel like a loony if you’re told you’ve got schizophrenia aren’t you? I mean if you’d just got schizophrenia without anything
| My perspective was disregarded/disagreement about diagnosis | “No... no one has asked what I think caused them... it was a bad trip in Great Yarmouth, that’s what I think triggered it off... I’ve told Dan (CPN) about it...” (Lines 27-28) | “...but I am not psychotic because if I was would I be talking like this, would I be able to look at you and have a conversation with you. They know who I am they are just disbelievers... I’m not a paranoid schizophrenic they don’t believe me... I’ve been diagnosed because of my beliefs...” (Lines 27-30) | “Erm I don’t recall them asking me very much really, they sort of asked how things were and how things had been going erm and I think they were concerned because I was very delusional I had a lot of delusions... I think they must have asked my mom and dad stuff... because I can’t remember very much and because at the time I was hearing things they weren’t saying, I may have been thinking other things were going on... erm we went back and looked at the various symptoms...” | “I told them what the voices were saying... you see I knew who my voices belonged to, they were my abusers.” (Lines 63-64) | “Well... erm... it’s got to have something to do with my abuse otherwise the voices wouldn’t be my abusers, surely, I’ve thought about this a lot, and I’ve looked up things on the internet, it seems to me that there’s no definite answer to that question, you know what I mean? If there was then surely there would be a cure? You know like, cos the medication hasn’t really made a great deal of... er... change really, although it has helped dull them out at times but as happening to you, then I can understand that, because obviously then you have nothing, no excuses...” (Line 140-145) |

“Yeah I know what triggered it... I think it was stress about what happened in Great Yarmouth, I found what happened really upsetting but no one has really listened to me about that...” (Lines 30-32) |

“No the psychiatrist doesn’t know, they haven’t asked, they don’t know why I started hearing voices, like I said R (CPN) knows what happened in Great Yarmouth...” (Lines 34-35) |

“Yes they did ask about my abuse and they didn’t take any notice even though it has affected me, do you think I’m normal?” (Lines 37-38) |

“...erm... it’s got to have something to do with my abuse otherwise the voices wouldn’t be my abusers, surely, I’ve thought about this a lot, and I’ve looked up things on the internet, it seems to me that there’s no definite answer to that question, you know what I mean? If there was then surely there would be a cure? You know like, cos the medication hasn’t really made a great deal of... er... change really, although it has helped dull them out at times but as
soon as I get stressed then they come back really. They’re not too bad at the moment as things are pretty stable…er…but I’m always waiting for the next thing…you know…I think having the kids staying with me more now helps as I feel less guilty, and less lonely I suppose…I mean surely anyone that has been abused like I was would have problems wouldn’t they? You can’t go through that and not have problems, I mean I think what has helped me more recently has been the fact that my mother has admitted that it could have happened…she hasn’t outright said it did but at least she’s considering it now, that helps me cos the thing is, you know, to not be believed is the worst feeling, it’s hard enough building up the guts to tell but then to be told it didn’t happen and that you imagined it, well can you
“Bad in it really? Cos it just carried on after that you know...my saving grace was my gran, she believed me, she wanted to go to the police but I was too scared because they said they would kill me if I told...I used to stay as much as possible at my gran's, but then sometimes they’d be waiting outside school for me...so I couldn’t always escape...most of em are dead now, including my dad. You should have seen his funeral, he was a teacher you know, and all these people turned up to his funeral, the church wasn’t big enough. I remember thinking if only they knew, mind you some of them that were there were my abusers so I started to think maybe everyone in there was a sick like him...I mean I haven’t told them this in
this detail because, well I don’t erm, erm I don’t think I had the opportunity” (Lines 102-112)

“A little, I told the psychiatrist the facts, but not really how I felt, I talked to Rose (CPN) about it a bit too. I’ve mainly talked to my friends, a couple of them have been abused too and we chat about this and that and it really helps…Like talking to you now I’m finding this helpful…” (Lines 114-117)

“Erm, actually I did get a booklet from MIND on distraction and coping with voices and I found that good….Like trying different things to help. I think more things like that and maybe just someone to talk to that wasn’t obsessed with bloody medication… yeah thinking about that
now and how just talking here mmm maybe that would have helped… because when your own mother doesn’t believe you, you sort of need some reassurance… cos part of me started thinking I had imagined it and that I was making it up somehow… but talking about it sort of cements it and like… now I’m thinking bloody hell no wonder I’m a loony, anybody that isn’t a loony after that would be even more of a loony, do you know what I mean?”

(Lines 129-138)

“Erm… all about my childhood, erm about my circumstances at the time I was taken into hospital, I can’t remember what else. I mean I told them everything because I really believed that I was going to die and I wanted them to help me so I was completely honest… erm
but it still didn’t seem to provide them with enough information to help them make a certain diagnosis… I mean I’ve met some very strange people on the wards, much, much worse than I ever was and yet they had the same diagnosis as me! I thought bloody hell, is that what I’m going to end up like if I stay in here! So erm coming back to what I told them, I told them about my abuse as a child, I told them how my mother wouldn’t believe me that my father, his brothers and his friends used to sexually abuse me… I told them what the voices were saying… you see **I knew who my voices belonged to, they were my abusers.** I mean they’re all dead now I think which helps me a bit…” (Lines 53-65)

“…you know like nothing you can say caused it but when you have got
something like sticking out like a big bloody sore thumb then surely you’d think that they’d sort of…oh I don’t know…but sort of try and explain it to you in a different way…like this happened and this has caused this and that has caused that sort of way…it’s like I watch that “Waking the Dead” programme and I know it’s probably all made up but I can see how some of these people come to murder because of the backgrounds they have had. I watched one with a woman with munchausen’s and you could see that because her mother had not shown her any love as a child that she just became an attention seeker, wanting people to take notice of her…most things have a link…erm so now erm well now I challenge my voices a
<table>
<thead>
<tr>
<th>Lack of explanation</th>
<th>bit more because I know I didn’t ask for that…erm to be treated that way…for those things to be done to me as a child…” (Lines 145-156)</th>
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<td></td>
<td>“…I mean how can you work on your self esteem when you have voices constantly telling you that you’re a slag, prostitute…you know? It’s a bit difficult fighting that one (laughs).” (Lines 124-127)</td>
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<td>“…but I don’t really know what triggered it, I’m not sure anyone knows what triggered it? Erm I suppose things possibly started to go wrong when I was bullied but I’m not sure if that would lead to that severe a problem. I know it’s probably the cause of the social phobia but I’m not sure it’s caused that, I think it maybe a separate thing. They helped me to work out the early warning signs but we haven’t looked at what</td>
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triggered it, we went back and looked at what happened before I was ill but there was no conclusion drawn. The only conclusion drawn was the early warning signs. To be honest I am confused about what has happened and why I have become ill. I would like to have been told what causes schizophrenia, and if they talked to me about that I don’t remember maybe because I was too ill. I just presumed that it just happened and that’s just how it is? I did get distracted quite easily by thoughts erm and sometimes I did manage to respond to questions. That’s been 3 years this year and I’m still not sure what caused it erm and I don’t tend to think about it too much…” (Lines 36-56)

“…the tablets seem to be working quite well but erm I think I would like to
know more about it but I didn’t really think it was something they could necessarily explain because it could just be a random thing like say I had a relative that had had it that I wasn’t aware of?” (Lines 56-59)

“Yes I think so but I would like to know more about what caused the schizophrenia and erm but I think, I thinking about it now I could do with an appointment perhaps with a psychologist to just work out what went wrong. Could I see a psychologist through my community mental health team? I think talking about it with you I think that it would be something I would find useful erm well then erm I’d feel sort of more secure to stop it happening again and I’d feel more resolved, so I would sort of have closure. (Lines 94-100)
<table>
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<tr>
<th>Feeling hopeless</th>
<th>“R says I am a schizophrenic and that makes me feel bad…makes me feel hopeless…like I’ll never get better ever…” (Lines 36-37)</th>
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<td></td>
<td>“Since I was about twenty when I went into hospital…I didn’t like it I was in there about 6 months I was sectioned twice because I wanted to kill myself…being called schizophrenic hasn’t helped me it’s just made me feel worse…like I’ll never get better…so I’ve sort of just accepted it but it’s not good…” (Lines 39-43)</td>
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<td>“nothing will stop the voices medication does the trick a bit, but it doesn’t do it completely…” (Lines 50-51)</td>
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<td></td>
<td>“I don’t think there’s much more they can do…” (Lines 83-84)</td>
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“They don’t know what happened in Great Yarmouth but it wouldn’t stop the voices. **Them understanding what happened in Great Yarmouth wouldn’t make the voices go away** medication does the trick a bit but not completely…” (Lines 54-56)

### Experiences of Treatment

<table>
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<tr>
<th>How professionals have helped</th>
<th>“...I’ve had pretty good care...” (Line 13)</th>
<th>“...you know I love kids and one of the psychiatrists said to me that I shouldn’t speak to kids, because people and kids would think I’m a paedophile” (Lines 52-54)</th>
<th>“...Erm...erm...I’m pretty happy with my CPN and my recovery worker...” (Line 70)</th>
<th>“Erm...well...I’m not sure I’d totally call it help, if you mean who have I seen in terms of professionals then I’d say, a psychiatrist, a CPN, oh the ward staff as well. You use the word help, I suppose they all thought they were helping me but looking back it didn’t really feel that way, at the time and now I’ve just sort of got used to having the voices and I’ve managed to cope with them myself, with the help of friends really...” (Lines 6-11)</th>
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<td>“...Quite good, ah he helps me with my voices...” (Line 17)</td>
<td>“...My mom don’t like it, I swear sometimes at the voices when they get bad and she don’t like it...My mom gets stressed, me Dad died a year ago from Alzheimers and my mom had to look after him and me really...he spent the last year of his life in a home...I think my mom...”</td>
<td>“...It made me f***ing angry because I love kids, I couldn’t have been insulted any more, I just looked at him and thought you are sicker than me ...someone called me a paedophile...I felt like sucking his eyeball out...that was a”</td>
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| The limited efficacy of medication | “He gives me medication injections… It helps a bit…” (Line 19-21) | “…like what happened | “and the tablets seem to be working quite well…” (Line 56) | “You know like, cos the medication hasn’t really made a great deal of… er… change really, although it has helped dull |}

|  | “…gets stressed by it all… but I can’t help it… she doesn’t understand much about it…” (Lines 67-71) | psychiatrist…” (Lines 56-59) | “…there was a girl on this ward a lovely girl and she has committed suicide she’s gone, she jumped in front of a train, it’s not good is it? How’s that care… she’s in hospital and supposed to be getting better… ends up killing herself… how’s that helping anybody… they just sit in that office…” (Lines 68-71) | “…What you want to do is go outside and watch people just sit there. Go in the office and pretend to write and watch you’ll be thinking what’s he doing? That’s not right… I mean I have met one nurse on here and she bothers with the patients these people they don’t…” (Lines 75-79) | “So erm… any way, on the whole, it hasn’t been a great experience, that is the care business…” (Lines 24-25) | “erm my CPN was okay, she would try to talk to me but I suppose, she probably did her best.” (Lines 11-12) |
before sometimes I haven’t took my medication because I want to see if I can get better and the voices have got worse and I’ve got paranoid cos I haven’t took my medication…I won’t let anyone come near me I wouldn’t let R come near me to give me my medication and the voices get bad and tell me to do all sorts of things” (Lines 45-49)

“but my medication is okay at the moment they’ve increased my medication.” (Lines 64-65)

“I’m Ok with my care really…I don’t think there’s much more they can do…I mean my medication is better than it used to be…” (Lines 82-84)

“nothing will stop the voices medication does the trick a bit, but it them out at times but as soon as I get stressed then they come back really.” (Lines 86-88)

“…He seemed more concerned about my medication and what dose I should be on. It got to the point where I used to lie and say that the voices were distant, when really they were quite bad, because if I told him that they were bad, he would increase my medication and then I wouldn’t be able to operate very well…” (Lines 13-17)
doesn’t do it completely…” (Lines 50-51)

“It tries to calm the voices, so you don’t hear them… but it doesn’t make them go away when I’m going out I think people can hear me…I’ve had electric shock treatment when I was sectioned that didn’t do any good either…” (Lines 23-25)

Problems with medication

“they’ve increased my medication now which has helped a bit but the side effects are pretty bad look” [shows how hands are shaking] (Lines 71-73)

“No I haven’t, I’m on an injection medication which I hate very much it’s devil dust…” (Lines 26-27)

“That first injection they gave me was so painful. I mean I took heroine for 13 years darling and I know that there’s devil dust in it. I see it pumped into me. I wish, I really wish that, please look at it, some big time people please look at it it's knackering people up this medication is…” (Lines 62-66)

“I wasn’t completely happy with the medication because I think I was kept on it for too long…erm but then it was quite a severe episode so I suppose…but I don’t really like being on the tablets as I had some psychosomatic problems with panic attacks around the time I took the table and I had trouble sleeping as well…the weight gain was bad too…I’m not sure if the panic attacks were side effects as the tablets are supposed to calm you
down so I think it was psychosomatic. I wouldn’t have wanted to go off them completely but if **something could have helped me other than the tablets that would have been better.** And erm we sort of reduced the tablets it to I think 600mg by the beginning of this year erm I think it was that but erm I think erm I don’t remember the exact doses but it just took a long time erm I think I was on 600mg for 6 months or a year or something and there was going to be a very slow process and this year I got a new doctor that is keener on reducing more quickly so that’s changed…I was relieved erm I’m on 400mg now. **I’ll be happier when I’m not on it.**” (Lines 70-84)

“Well the panic attacks at night, just in the morning, have gone so hopefully without sort of having them
<table>
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<tr>
<th>Lack of options</th>
<th>&quot;No but I think I’d be too shy to do that (Therapy)… I would struggle to talk I think…I find it difficult to talk to professionals…” (Lines 75-76)</th>
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<td></td>
<td>“No nothing like that…and I’m not sure I would anyway because I’m too shy… I don’t know anything about that… no one has mentioned having therapy or anything other than medication no one has”</td>
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<td>“Emotion would have helped me more…vision…do you know what vision is…you know…have you got children? I would like someone to sit down and talk to me the way you are talking to me now…” (Lines 44-46)</td>
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<td>“You know when one of your children does something wrong but you still love them but you have to tell them off and you do”</td>
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<td>“Quetiapine, they eventually sort of increased it to about 1000 mg a day but I can’t remember it gradually increased over time erm it took a while to work as they said I was treatment resistant erm they just stuck with increasing the quetiapine… but they didn’t offer anything else, oh I saw my CPN and a recovery worker?” (Lines 30-34)</td>
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<td>“I talk to Harriet about”</td>
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<td></td>
<td>“I think talking helps, well for me anyhow, I’m not sure about everyone…” (Lines 119-120)</td>
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<td>“Erm…I’ve been to the X Centre for some group work, I think it was a self esteem group that was running…that’s where I met one of my friends, to be honest erm I mean I’m not knocking it or anything but it was not much use for me I mean how can you work on”</td>
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...never seen a psychologist and I have lots of issues but I suppose I can only fix this myself, but I know I'm a good person...all I have is medication...” (Lines 60-61)

I mean things like garlic, cod liver oil, more natural things should be used for mental health... (Lines 79-80)

but you still love them...that's vision there's no feeling like that here...other than with the other patients...they just watch people and write stuff down...they don't sit down eye to eye like us...” (Lines 48-52)

“... never seen a psychologist and I have lots of issues but I suppose I can only fix this myself, but I know I'm a good person...all I have is medication...” (Lines 60-61)

things and my CPN meets with me regularly and I still see the psychiatrist about once a year erm and I've sort of been referred to X (an activity centre) and I go to MIND because mum took me there and they help me get some volunteering and erm I did a bit with the psychiatrist on intrusive thoughts but other than that no, I'm not sure what the difference is between a psychiatrist and a psychologist...erm I did lots of practical things but we did discuss the bullying but it was more about going out and going around town erm we tend to have focused more on the practical things...” (Lines 61-68)

your self esteem when you have voices constantly telling you that you're a slag, prostitute...you know? It's a bit difficult fighting that one (laughs).” (Lines 122-127)
Appendix 17 Copy of Notes for Contributors

Psychology and Psychotherapy: Theory, Research and Practice

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Edited By: Andrew Gumley and Matthias Schwannauer

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• Qualitative papers: 6000 words
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