

TOM PAYNE, BSc Hons

# AN INVESTIGATION INTO THE EXPERIENCE OF HEARING VOICES NETWORK GROUPS

Section A: Outcomes, processes and change mechanisms in hearing voices groups: A review of the evidence
Word count: 7925 (179)

Section B: How people experience Hearing Voices Network groups and the connection to group processes and recovery.
Word count: 7998 (332)

Overall word count: 15923 (511)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology
APRIL 2015

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Blank page

Blank page

**Acknowledgements**

I would like to thank my two fantastic supervisors, Doctor Jo Allen and Professor Tony Lavender. Their support has been both tireless and containing. This has sustained me over the long haul and enabled this project to flourish.

I would also like to say a special thanks to all the project participants. Their stories were greatly moving and their experience brought a unique dimension of expertise to this research.

Thank you to my family for being so understanding and supportive during the course of this big project.

## Summary of MRP

A systematic review and qualitative synthesis of literature was conducted in section A to determine impact, processes and change mechanisms implicated in hearing voices groups (HVGs). Robust outcome evidence only existed for CBT-based hearing voices groups, which mainly consisted of voice-related measures. Tentative evidence existed for other types of HVGs from uncontrolled studies. Qualitative research evidence revealed important group processes in HVGs. Change mechanisms were posited in the literature but evidence was inconclusive. The relevance of other theoretical frameworks (therapeutic factors and personal recovery) and the possibilities of qualitative research for investigating meaningful changes were discussed, along with epistemological issues.

Section B described a qualitative study into how eight attendees of Hearing Voices Network affiliated groups (HVNGs) experienced change within two groups and how these changes influenced their lives. Data from semi-structured interviews were analysed using interpretative phenomenological analysis and yielded four main themes: 'healing', connecting with humanity; group as an emotional container; making sense of the voices and me; and freedom to be myself and grow. These themes were discussed and related to previous literature on HVNGs, and links were drawn with literature on therapeutic factors and personal recovery. Relationships, safety, exploration of voices and group ownership were posited as key components of HVNG. Future research and clinical implications were discussed.

# Contents

**Section B**

# List of Tables

List of Appendices

# Section A:

# Outcomes, processes and change mechanisms in hearing voices groups:

# A review of the evidence

## Abstract

Voice hearing has a varied and polemic history and is currently defined as symptomatic of a psychiatric illness. Alternative approaches to 'treatment' include hearing voices groups (HVGs), consisting of ongoing peer-support (Hearing Voices Network groups; HVNGs) or treatment-based interventions. The evidence base for HVGs is small, especially for HVNGs, and mainly comprises outcome research.

A systematic review and qualitative evidence synthesis was conducted to determine impact, processes and change mechanisms implicated in HVGs. Literature searches yielded 128 studies. Thirty-three were included for review following exclusion criteria. Robust outcome evidence only existed for CBT-based HVGs, as measured by voice-related outcomes, but significant improvements in anxiety and depression were absent in these groups. Tentative outcome evidence from uncontrolled studies existed for other types of HVGs including mindfulness-based groups and HVNGs. Qualitative research revealed important group processes across different types of HVGs. There is support for the presence of therapeutic factors (such as universality/normalising) and personal recovery processes, so these theoretical frameworks could inform future research into HVGs. Evidence of change mechanisms in HVGs was inconclusive.

The least is known about HVNGs, so future research should focus on these groups. Further investigation could employ qualitative methodologies to elucidate processes in HVNGs which lead to meaningful and measurable changes.


**Keywords:** hearing voices groups, voice hearing, group processes, change mechanisms.

# Introduction

## The problem for voice hearers today

Voice hearing (VH) or 'auditory hallucinations' today are typically defined as symptoms of psychiatric illnesses requiring treatment, yet understandings have varied substantially across history and culture (Leudar & Thomas, 2000; McCarthy Jones, 2012), and continue to be contested. VH is not synonymous with suffering but can be experienced as distressing (Chadwick & Birchwood, 1994), and finding the most valuable way of managing this distress is complicated by the lack of a common definition of VH itself. Explanatory frameworks vary from the spiritual and supernatural to a myriad of biopsychosocial theories, each of whose merits or truth claims changes according to the professional discipline it originates from. Current dominant understandings of VH as symptomatic of a psychotic illness mean that individuals who report VH (particularly when accompanied by distress or culturally unusual beliefs) end up in mental health services, frequently taking anti-psychotic medication. Although supported by NICE recommendations (NICE, 2009), this presents substantial health risks (Hutton, Weinmann, Bola & Read, 2013; Goldacre, 2013) including increased mortality (Weinmann & Aderhold, 2010) and frequently fails to resolve the underlying issues (Schizophrenia Commission, 2012). Many would argue further that aspects of professional intervention have been actively harmful, leading to voice hearers internalising an illness identity, experiencing stigma, missing life opportunities and feeling hopeless about the future (Johnstone, 2000; Bentall, 2004; Schizophrenia commission, 2012). These effects have given rise to socio-political pressure groups and movements such as psychiatric survivors (Corrigan, Roe, Tsang, 2011), recovery (Davidston, Rakfeldt & Strauss, 2011), peer support (Campbell, 2005), critical psychology (Fox, Prilleltensky & Austin, 2009) and

critical psychiatry (Thomas & Bracken, 2004). These have collectively challenged systems in which service users are passive recipients of professionally-led care with little agency in shaping their lives.

**Beyond the biomedical: alternative approaches to managing voices**

There is great diversity in understandings and experiences of VH, so naturally there is substantial variation in the coping strategies employed by voice hearers for managing any distress associated with their experiences. In fact, VH is highly idiosyncratic. It can refer to the perception of unusual sounds as well as hearing distinctive voices which vary in physical characteristics (or 'topography', such as volume and tone), identity and perceived malevolence/benevolence (McCarthy-Jones et al., 2014). Coping strategies include approaches such as ignoring or distracting oneself from voices, and putting boundaries in place to limit their influence (Romme, Honig, Noorthoorn & Escher, 1992). Voice hearers have been encouraged to experiment with different approaches to find what works best for them on an individual level (Baker, 1995). Such approaches may take into account individual differences in the voices they experience. Similarly, the needs associated with different 'phases' that voices hearers may find themselves in regarding their experiences can also be considered (Romme & Escher, 1993).

The proliferation of these relatively new approaches to managing voices are one product of a significant movement away from traditional psychiatry's stance of VH as a meaningless symptom of pathology. Such a departure has mainly stemmed from socio-political movements and increased research. Following on from pharmacotherapy, alternative clinical approaches to managing voices have emerged, the most popular of which is cognitive-behavioural therapy (CBT). CBT for voices is delivered on an individual and group basis (e.g. Wykes et al., 2005), frequently in the

context of treatment for psychosis (Barrowclough, Haddock, Lobban & Jones, 2006). However, another increasingly widespread approach is for voice hearers to meet and explore experiences in ongoing and flexible support groups.

These hearing voices groups (HVGs) have their roots in the 'Hearing Voices Movement' which grew from a seminal study (Romme & Escher, 1989). This study challenged the disease model of VH by demonstrating that a substantial minority (34%) 'could cope' with voices and that coping determined membership of the clinical population. Soon after, the Hearing Voices Network was established in England in 1990. The movement encouraged voice hearers to 'reclaim' their experiences (Dillon & May, 2002) by disseminating coping strategies, promoting alternatives to dominant biomedical explanations, educating society, reducing stigma and bringing voice hearers together (Romme & Escher, 1993) through peer-support based HVGs. There is increasing evidence of the instrumental role of HVGs in providing a supportive, therapeutic and empowering space, as reflected in their growing popularity, with over 200 Hearing Voices Network affiliated groups (HVNGs) now being run in England (Dillon, Bullimore, Lampshire & Chamberlin, 2013).

**Evaluating hearing voices groups**

The evidence base for HVGs is relatively small and evaluation across groups is complicated by the differing models of HVGs that exist. The most recent review of HVGs (Ruddle, Mason and Wykes, 2011) found that methodologically rigorous studies employing standardised outcome measures have only found evidence for the impact of CBT-based groups. Empirical research into other types of HVGs has mainly consisted of survey-based evaluations, case studies and qualitative exploration of attendees' experiences of groups. The contrast between the two models of ongoing peer-led support and time-limited treatment-based interventions

mean HVGs vary considerably in aims, structure and even ontological stances regarding VH. Consequently, understanding key ingredients of HVGs and evaluating them accordingly is complex. It does not merely involve isolating independent variables according to 'treatment' type and refining outcome measurements within a clinical paradigm: questions regarding the nature and fundamental aims of different groups need addressing first. It is unsurprising evidence is currently greatest for CBT-based groups: set up in a clinical context, their theoretically-driven rationale naturally produces measurable variables which are conducive to rigorous evaluation. In contrast, fundamental principles regarding the flexibility of HVNGs (e.g. open-format, ongoing, drop-in) conflict with protocol-driven requirements of highly-controlled evaluations such as RCTs (Corstens, Longden, McCarthy-Jones, Waddingham & Thomas, 2014). Even if robust group evaluations were designed, determining widely acceptable outcomes could be challenging due to differences in the aims/philosophy of different HVGs, and contrasting conceptualisations of recovery between service users and providers (Silverstein & Bellack, 2008).

## Potential frameworks for investigating hearing voices groups

### Group processes and therapeutic factors

Given the paucity of research into HVGs, consideration of other theoretical frameworks may increase our understanding of processes and outcomes implicated in groups. Variables influencing outcomes include group attendees and leaders themselves, structural elements, formal change theory (e.g. CBT) and group processes (Burlingame, MacKenzie and Strauss, 2004). Group process research has centred on therapeutic factors (Yalom & Leszcz, 2005) and group development theories (e.g. Tuckman, 1965). Yalom and Leszcz (2005) built on Corsini and Rosenberg's (1955) 'dynamic processes' to produce the following 'therapeutic

factors': instillation of hope, universality (discovering you are not alone with a problem), imparting information, altruism, corrective recapitulation of the primary family group (resolution of conflict rooted in early familial interrelating patterns), development of socialising techniques, imitative behaviour (learning through others modelling particular behaviours), interpersonal learning (developing new ways of being with others), group cohesiveness (akin to therapeutic alliance), catharsis and existential factors.

Therapeutic factors in HVGs are yet to be thoroughly investigated, but have been considered within some studies. Chadwick, Hughes, Russell, Russell and Dagnan (2009) found universality, guidance (on mindfulness) and hope to be most important factors, while Meddings et al. (2004) described the worth of 'universality, instillation of hope, self-disclosure, mutual support and improved social functioning' (p. 14). Potential for further investigation of therapeutic factors in HVGs is evident in these studies as well as in the conceptual overlap between therapeutic factors and HVNG principles (e.g. promotion of hope and togetherness).

**Personal recovery theory**

Personal recovery theory may have particular significance to HVNGs: the shared socio-political underpinnings of the recovery movement (Anthony, 1993) and Hearing Voices Movements mean they share both social/community values and emancipatory aims (Romme, Honig, Noorthoorn & Escher, 1992). Research into personal recovery in mental health has focused on defining and quantifying its dimensions. In a recent synthesis of this research following a systematic review, Leamy, Bird, Le Boutillier, Williams and Slade (2011) developed a 'conceptual framework for personal recovery' and isolated three main categories from 87 studies: characteristics, processes and stages of recovery. This provided a useful

organisational framework for considering these three dimensions in recovery. Thirteen characteristics were described, the most commonly occurring of which described recovery as 'active', 'individual/unique', 'non-linear' and 'a journey'. The processes were: 'connectedness', 'hope', 'identity', 'meaning in life' and 'empowerment' (spelling the acronym CHIME). Stages were mapped onto Prochaska and DiClemente's (1982) transtheoretical model of change. The pertinence of this framework to HVGs is evident as these recovery dimensions closely mirror the role of HVGs. For instance, their description as supportive, hopeful, peer-led and encouraging exploration of voices (Dillon & Hornstein, 2013) can be located in the 'CHIME' framework.

**The focus of this review**

Ruddle, Mason and Wykes' (2011) review of HVGs comprehensively examined evidence for HVGs including outcomes, mechanisms and predictors of change, so this paper will be discussed and critiqued here. Their review placed most emphasis on controlled, outcome-based studies according to NICE (2006) grades of evidence, which resulted in greater coverage of treatment-based HVGs (mainly CBT groups). Given the relative lack of robust research into HVNGs, this review will provide greater coverage of research into this type of group. One of the principal conclusions in Ruddle, Mason and Wykes' (2011) review was that research needed to focus on isolating mechanisms of change. This review will provide more coverage of the qualitative research into HVGs which elucidates group processes, and more of which has emerged in recent years. In addition to reviewing outcome-based evidence of HVGs, this differential focus thus aims to further explore processes implicated in groups, and provide greater scope for understanding different types of HVGs,

particularly HVNGs. It will also be an update (to 2015) of Ruddle, Mason and Wykes' (2011) review. Specifically, the following three questions will be addressed:

1. What is the impact of HVGs on its attendees?
2. What processes are in operation during HVGs?
3. What processes are associated with impact outcomes?

For question one, formal outcome-based evaluations as well as small-scale studies limited to brief qualitative description will be reviewed. To address question two, in-depth qualitative studies (as defined by the inclusion of formal methodologies) will be reviewed because of their focus on intra-group experiences and processes. Finally, question three will examine links between intra-group processes (from question two) and impact (from question one). This will be addressed in two parts. Firstly, research explicitly investigating change mechanisms in HVGs will be reviewed. Secondly, given the scarcity of this research, the qualitative research reviewed here will be re-examined to identify evidence of within-group processes which are explicitly linked to impact outside of the group. Such an approach linking process to outcome has been endorsed by a number of group psychotherapy reviewers (Burlingame, MacKenzie and Strauss, 2004; Bednar & Kaul, 1994).

## Methodology

The following searches were performed of titles of papers in PsychInfo, Medline and Web of Science: "hearing voices group"; and (using Boolean search terms) "group" AND ("auditory hallucinations" OR "hearing voices" OR "voices"). Google Scholar was searched with the term "hearing voices group*" to capture further studies. No time restriction was put on searches due to relative scarcity of this research. References of papers fitting the search criteria were examined to obtain further

studies. All empirical studies of HVGs were included and the following exclusion criteria was applied: not related to voice hearing (clearly not relevant); purely theoretical paper; not in English; not fully written up; unobtainable. This process (see Appendix A) yielded a total of 33 studies. This included one systematic review paper (Ruddle, Mason and Wykes, 2011) describing 28 papers, including 25 of HVGs and three of psychosis groups. Twenty-two of these papers fit this review's criteria. An additional two quantitative evaluations of treatment-based HVGs and four in-depth qualitative studies were included (all published since 2011) and five small-scale HVNG studies which did not feature in Ruddle, Mason and Wykes (2011). As outcome research into treatment-based HVG was comprehensively examined in Ruddle, Mason and Wykes (2011), these studies will be considered in the context of a review of their paper.

A mixed methodology review will be employed consisting of a systematic review and a qualitative evidence synthesis (Grant & Booth, 2009). Quantitative research will be assessed using Meltzoff's (1998) criteria and qualitative research will consider Yardley (2000; see Appendix B). The review paper will be assessed using Crombie's (1996) criteria. Although studies will be reviewed critically, weighting criteria increasing coverage of higher quality evidence (Crombie, 1996) will not be applied due to the focus of this review on qualitative and HVNG research.

Studies will be reviewed chronologically within each subsection, which is based on Ruddle, Mason and Wykes' (2011) categorisation of HVGs into four broad types.

## The impact of HVGs

### Outcome-based research on treatment-based HVGs

#### CBT groups

Eleven published studies of CBT-based groups for voices are described here, including five uncontrolled studies and six RCTs. Primary outcomes are typically voice-related measures of topography (PSYRATS; Haddock, McCarron, Tarrier & Faragher, 1999), beliefs (BAVQ; Chadwick & Birchwood, 1995) and psychotic symptomatology (e.g. PANSS; Kay, Flszbein & Opfer, 1987), though other measures are reported.

Five uncontrolled studies were described first. In a sample of 22 outpatients, Chadwick, Sambrooke, Rasch and Davies (2000) reported significant improvements in voice control and omnipotence, while Pinkham, Gloege, Flanagan and Penn (2004) found significantly reduced distressing beliefs in 11 inpatients. In a third study, voice topography only approached significance (Lee, Hannan, van den Bosch, Williams and Mouratoglou, 2002). In the first of two wait-list control studies, Wykes, Parr and Landau (1999) found significant improvements at post-treatment and follow up in global voice-related symptoms compared to a wait-list control. Similarly, a second-wait list control study found significant improvements in voice topography, power and control (Newton et al., 2005). Although this research provides support for the impact of CBT-based HVGs on various voice-related measures, there were no significant improvements in anxiety and depression. Furthermore, the evidence in these studies was limited by relatively small sample sizes and lack of control groups.

Six RCTs were critiqued by Ruddle, Mason and Wykes' (2011), though three of these were CBT for psychosis groups targeting voices, and although their content was similar to HVGs, this difference represented a small limitation of the review. Notwithstanding, results of the six RCTs were synthesised and critiqued in reasonable detail. Overall, in these methodologically more robust studies with larger sample sizes, fewer significant findings were reported. Of the six studies, only the

one with the smallest sample size (n = 22) McLeod, Morris, Birchwood & Dovey (2007a; 2007b) reported significantly reduced voice frequency and power (and trend-level reductions in distress). The other RCT studies found significant improvements in various other measures of symptomatology and external change indicators. Wykes et al. (2005) found significant improvements in 'social behaviour' at six-month follow up compared to treatment as usual (TAU), while Penn et al. (2009) found reduced psychotic symptoms compared to supportive therapy. Interestingly, this study showed greater reductions in perceived malevolence and resistance to voices in the supportive therapy group, raising interesting questions regarding change processes implicated in these different groups. In the first of the three psychosis groups targeting voices, Barrowclough et al. (2006) found significant improvements in hopelessness and self-esteem compared to TAU. Similarly, in an early-onset group comparing CBT with social-skills training, Lecompte et al. (2008) found significant increases in self-esteem, as well as improvements in overall symptomatology and coping. Finally, Bechdolf et al. (2004) reported significantly fewer hospital admissions in a six-month follow-up period for CBT groups for psychosis compared to psychoeducational groups. At post-treatment and follow up, both groups resulted in significant improvements in psychopathology, but no significant between-group differences were found. A follow-up study reported significant improvements in quality of life for both groups (Bechdolf et al., 2010). Overall, there was some promising evidence of the beneficial impact of CBT-based HVGs according to various measures of voice-related measures and other indicators. However, Ruddle, Mason and Wykes' (2011) concluding commentary regarding CBT groups puts evidence in perspective by highlighting that the apparently more significant voice-related findings of non-randomised studies were

not so promising when compared with the more moderate results of RCTs. Of note was that studies did not report significant improvements in anxiety and depression, which questioned the extent to which voice-related measures translated into improvements in well-being.

### Problem-solving and skills based groups

Ruddle, Mason and Wykes (2011) briefly outlined the rationale for skills-based HVGs (skills acquisition leads to attentional resources competing with voices), then reviewed one study publishing an outcome-based evaluation (Trygstad et al., 2002) and its one year follow-up study (Buccheri et al., 2004). Significant improvements in anxiety, depression and voice frequency, clarity, tone, self-control, distractability and distress were reported. At follow up, many improvements in voice characteristics and anxiety (up to 9 months) were maintained. The review stated that reasonable sample size (N = 72) and the follow-up reduced the chances of confound, but that absence of control limited conclusions that could be drawn regarding this approach.

### Mindfulness groups

A single published study on mindfulness-based HVGs is a randomised feasibility trial of a ten-session mindfulness training group with 22 subjects by Chadwick, Hughes, Russell, Russell and Dagnan (2009). No significant improvements compared to the control group were found. However, secondary pre-post analyses of both treatment groups revealed significant improvements in clinical functioning (measured by the CORE) and mindfulness of distressing images and thoughts, indicating some potential clinical benefits for this approach.

### Psychodynamic groups

One study described a long-term psychodynamic HVG run in a therapeutic community. The group ran with two facilitators and targeted self-isolating individuals

diagnosed with psychotic disorders (Mannu & Borri, 2004). Despite the research being a case study focusing on a single attendee's experiences, pre-post outcome measures were taken (a year apart), and showed a 10-point increase in IQ, a reduction from 20 to 12 in the 'thought disorder' (from the Brief Psychiatric Rating Scale) and various changes in personality (measured by the MMPI-2) including indications of increased adherence to social norms and reduced paranoia. Even for a case study, evidence was significantly limited by the therapeutic community context as it was impossible to know how much the HVG contributed to the changes measured.

**Person-based cognitive therapy**

The only outcome-based evaluation of a HVG published since Ruddle, Mason and Wykes (2011) reported on a person-based cognitive therapy (PBCT) intervention which "utilises a framework of acceptance of voices and self to enhance wellbeing and reduce distress and perceived voice-control" (Dannahy et al., 2011, p. 111). Intention-to-treat analysis was conducted on 62 individuals assigned to nine groups of 8-12 sessions. Significant improvements were found post-group and at one-month follow-up in clinical functioning (measured by the CORE), and voice control and distress. Absence of a control group limited the conclusions that could be drawn from this study, but provided further tentative support for the role of mindfulness-based strategies in managing voices.

**Evaluations of Hearing Voices Network groups**

In their brief coverage of 'unstructured open-ended support groups' only one study met Ruddle, Mason and Wykes' (2011) criteria for review (Meddings et al., 2004), though two others are mentioned (Conway, 2004; Mannu and Borri, 2004, covered in the ‘outcome-based research…’ section here). Given the paucity of robust evidence

for this model of HVGs, upon whose foundation all subsequent HVGs have arguably developed, greater coverage of research into these groups was included. Indeed, a looser inclusion criteria was consistent with Dillon and Hornstein (2013) observation that the 'profound' effects of HVNGs are not easily visible through the lens of traditional research paradigms. A total of seven studies using survey-based, descriptive and exploratory evidence were reviewed here.

The first evaluation of HVNGs by Pennings, Romme and Steultjens (1997), published in Dutch but described by Romme (2009) in English, investigated ways in which attendees valued discussing VH. Key findings were: participants could more easily discuss voices with other voice hearers; 'nearly all' were able to identify with each others' experiences, especially the negative experiences; 58 % of clinic-based and 78 % of home-based voice hearers became 'more accepting' of voices; improved coping, especially changes in attitude and relating to voices; finally, over 80 % would recommend groups to other voice hearers. Whilst these results were promising, without the original study in English, it was not possible to fully evaluate this study.

Another early paper by Martin (2000) described the development and evaluation of an ongoing HVNG, which was informed by principles of the Hearing Voices Movement and Parse's 'human becoming' theory of nursing (where quality of life/'being with' is prioritised over 'doing for'; Parse, 1995). A particular strength of this study was the respect shown for the group attendees, and that there was an emphasis on creating an environment conducive to safety and sharing. Issues of practitioner/service user power imbalance were acknowledged and positive risk-taking was encouraged. Ownership of the group by its users was also encouraged. In a co-produced report on experiences of the group, attendees described the

importance of open sharing, support and closeness, reduced isolation, and strengthened identity from greater understanding of their voice hearing. Although this informal approach to the group's evaluation was respectfully chosen to reduce the 'burden' and limitations of standardised instruments, the brevity and lack of methodological rigour limited the conclusions that could be drawn.

Another brief study investigated the experiences of an ongoing and closed HVG, which became user-led over time. Using a focus group, Jones, Hughes and Ormrod, (2001) found two main themes: 'safety' and 'sharing'. Safety came from trusting others in a confidential space, while sharing pertained to identifying with others, normalisation, experiencing catharsis and a resulting acceptance of self. The study's strengths included use of a methodology which privileged attendees' views and inclusion of the focus-group questions. Further tentative evidence of the importance of safety and sharing in HVNGs was indicated here, but the study's brevity and lack of description at how themes were extracted was limiting. Downs' (2005) evaluation asked people their reasons for attending HVGs, found that the opportunity to discuss voices and increased coping was key too. Participants in this study further reported the compassionate, non-judgemental environment of support and positive feedback to be central.

Case studies of ongoing HVGs focused on experiences of professionals setting up the groups, (such as the service context, rationale and evolving challenges). Such studies did not report formal outcomes but nevertheless provided useful evaluative feedback from attendees. Conway's (2004) paper described setting up an inpatient-based HVNG which evolved from a 12-week group to an ongoing one. Examples of feedback sought from attendees highlighted universality and increased confidence from sharing in the group. A further observation was that 'good copers'

communicated more about voices. Another case study of a small inpatient HVNG (with an average of four attendees) by Drinnan (2004) described a 12-week pilot group which later became ongoing. The author stated difficulties finding 'meaningful' outcome measures, but outlined attendees' qualitative feedback of benefits: having a safe space to talk, sharing coping strategies and facilitation of social support.

Despite a lack of methodological rigour in these studies, their descriptions were consistent with theoretical literature on HVNGs (e.g. Romme & Escher, 1993) that attendees value the groups' dual functions of increasing coping strategies and providing a compassionate space for sharing and identifying with others.

These benefits were also evident in Meddings et al.'s (2004) evaluation of a HVNG with twelve attendees which, despite being unpublished, was the most methodologically robust study to date in its inclusion of pre-post and follow-up measures, as well as semi-structured interviews. Quantitative outcomes indicated significant improvements in several kinds of coping strategies and various voice-related measures including reduced frequency and powerfulness, and increased coping, self belief and control. Furthermore, significantly decreased hospital bed use following group attendance, and increased self-esteem and 'consumer empowerment' were reported at an 18-month follow up. Although this study provided the best evidence for HVNGs, its small sample size and absence of a control group still limited conclusions that could be drawn.

In summary, these studies were broadly consistent with the benefits and key processes described in theoretical literature (Romme & Escher, 1993; Romme, 2009; Dillon & Hornstein, 2013). Normalisation, sharing and exploration in a safe environment appeared to be key themes, as well as the positive impact of improved coping and feelings of empowerment. As previously noted, however, studies

evidencing these findings were limited by their small sample size and absence of control groups. Further investigation is needed to verify these benefits and understand how they are manifested.

## What processes are in operation during HVGs?

Although research evidences benefits of HVGs, it is still unclear exactly how they manifest themselves and whether they reflect the full value of attending a group. Currently, more methodologically robust evidence exists for treatment-based HVGs, but this largely consists of symptomatic reductions regarding voices themselves (e.g. voice topography/beliefs) and clinical functioning. Qualitative data allude to a more complex set of intra-group processes than can currently be inferred from quantitative measure alone. Newton, Larkin, Melhuish and Wykes (2007) pointed out that "quantitative studies employing structured questionnaires can only tell us whether people's symptoms have been reduced; they say nothing about the meaning of such numerical changes for our service users" (p. 130). For example, attendees frequently allude to the importance of interpersonal or group processes such as sharing and universality. This review examined in-depth qualitative research into attendees' experiences of HVGs with the aim of elucidating a fuller gamut of intra-group processes.

### Qualitative research on treatment-based HVGs

#### Qualitative research on CBT groups

Newton, Larkin, Melhuish & Wykes (2007) explored eight adolescents' experiences of group CBT for 'early onset voice hearing'. The authors reasoned that qualitative investigation would better elucidate meanings of quantitative changes by capturing service users' perspectives of what works. The method of interpretative phenomenological analysis (IPA) was employed, which articulates how people make

sense of personally significant life experiences. The analysis yielded two superordinate themes. The first ('a place to explore shared experiences') concerned experiential group aspects and included the following subthemes: a safe place to talk; normalising and destigmatising; learning from and helping others; the role of facilitators. These themes provided support for the presence of therapeutic factors (e.g. universality, interpersonal learning). Personal recovery was also resonant in the authors' discussion, where the role of 'hope' derived from seeing others model recovery was emphasised. The second theme ('an inductive account of coping with auditory hallucinations') was more interpretative and posited a cyclical relationship of four aspects of attendees' experiences of the voices themselves, which extended beyond the CBT framework to incorporate systemic factors. Overall, this first IPA study of a HVG provided support for the salience of therapeutic processes and the potential of this methodology for investigating attendees' experiences.

**Qualitative research on person-based cognitive therapy groups**

Further evidence of processes implicated in HVGs came from two studies of PBCT-based groups. The first study used grounded theory to analyse experiences of 18 participants derived from five focus groups (Goodliffe, Hayward, Brown, Turton & Dannahy, 2010). Four themes were described in detail and the ways in which they interrelate were usefully illustrated. Attendees sharing distressing aspects of VH (including emotional impact, disempowerment, loss of control, isolation and fear of madness) described in theme one were hypothesised as setting the context for other processes. The second theme, 'developing a group identity', further underlined the salience of group processes, specifically highlighting social inclusion, normalisation, support and containment. After sharing difficulties paved the way for the development of a group identity, it was hypothesised that experiences of 'learning to

cope with voices' and 'development of a sense-of-self beyond voices' (themes three and four) then unfolded. Improved coping was said to come from an acceptance and understanding of voices. An increased repertoire of coping strategies and goal setting was also part of learning to cope. Development of an identity beyond voices was illustrated by participants' shifting concepts of illness, self-concept and separation of voices from their personality. PBCT's focus on appraisal of self and voices inevitably shaped the themes, but authors stated that group processes may have provided the most powerful effect of this intervention. Particular strengths of this study included sensitivity to context through the use of a service user co-facilitator in focus groups. Good reflexivity increased transparency regarding the data analysis, but absence of triangulation was a limitation to data quality.

A second investigation into experiences of ten attendees of PBCT groups was conducted using thematic analysis (May, Strauss, Coyle & Hayward, 2014). Noting a lack of evidence for the emergence of mindfulness-based elements of PBCT, groups were extended by four sessions to include more mindfulness practice. Analysis revealed three relational themes reflective of the intervention model itself: relating to voices, self and others. Learning to respond differently to voices increased feelings of power and control. Mindfulness was conceptualised as a process which facilitated changed relationships in voices and a specific coping strategy which could be used in a given moment.

**Qualitative research on Hearing Voices Network groups**

Qualitative data from Meddings et al's (2004) evaluation provided further support for processes operating in HVGs. Analysis of semi-structured interviews extracted several themes. 'Helpful aspects of the group' highlighted the enjoyment and social benefits it provided, including a supportive environment and feelings of universality

('being with people in the same boat'). 'Least helpful aspects' were 'very individual', but included the group's intensity and conflict related to people complaining or speaking tangentially. Positive changes 'as a result of the group' were social benefits (a greater number and quality of relationships) and improved confidence, which for one person led to voluntary work. Other themes outlined attendees' recommendations for those considering the group (to persist although it was 'daunting when you don't know people') and perspectives on the group of participants' significant others ('my partner says I've totally changed since I've been in the group') and their voices ('the voices don't like it that I'm going to the group...it's a way of defeating them so they don't like it'). Particular strengths of this mixed methods study were the improved quality of findings from triangulation of data, and employment of service user consultation in the design and write-up. Whilst useful in providing evidence of processes in HVNGs, this study's qualitative component was limited by its relatively small scale and absence of clear methodological description. In the first methodologically rigorous qualitative research published into HVNGs, Oakland and Berry (2015) interviewed eleven group attendees about their experiences and analysed data using thematic analysis. Five superordinate themes reflect attendees' personal journey in relation to the group experience. 'Discovery' described the initial anxiety at entering the unknown, juxtaposed with the motivation to gain benefits of attending, while other themes portrayed resonant group processes: 'acceptance of experiences' illustrates attendees' sense of feeling normal, while 'acceptance of the social person' was an affirmation of identity; 'hope' depicted the inspiration felt from witnessing others' recovery. The importance of the group set-up was articulated in the theme 'group structure'. Here, power imbalances between professionals and service users and the importance of group ownership

were described under subthemes of 'facilitation' and 'group control'. The final theme of 'group benefits' was consistent with other evaluative research of HVGs in its description of benefits perceived by attendees: opportunities to talk, increased coping and resultant growth in confidence and identity beyond the group. A particular strength of this study was 'commitment to rigour', particularly through 'sensitivity to context' (Yardley, 2000) in its collaboration with the HVN in the research design. Authors showed good reflexivity, but a noted limitation is that self-selected sampling meant participants were less likely to critique the group. This was reflected in the absence of challenges or difficulties reported by participants in their experience of the group.

Another recent study examined the accounts of four HVNG attendees' using IPA (Dos Santos & Beavan, 2015). The authors provided good contextual information for their study, situating it soundly within literature on voice hearing, peer support and the hearing voices network. Similarly to Oakland and Berry (2015), results were well synthesised, describing attendees' experiences across three stages in three corresponding themes: upon joining the group, within the group itself and then beyond it. The first theme briefly highlighted early fears about attending and discussing voices with others, while the second theme, containing seven subthemes, described salient experiences 'within the groups'. Several themes were evident in the analysis which are also consistent with other evidence on HVGs thus outlined. These included the opportunity to network and socialise ('social connections'), sharing experiences with others, and receiving their feedback and support. Experiencing a sense of 'community' enabled attendees to feel cared for, while obtaining feedback allowed for reality testing and increased coping. Facilitators' 'gentle guidance' was also felt to be valuable. Finally, attendees' experiences of the groups' impact on their

lives were described in 'beyond the group'. Increases in willingness to relate to voices and talk about them with others were reported, along with examples of improved self-esteem and a 'sense of agency' in recovery. Findings of this research were a valuable confirmation and extension of evidence regarding attendees' experiences of HVNGs. Authors noted limitations of the small sample size and self-selected sample, which were likely to have contributed to reduced coverage of challenges and difficulties of attending. Emergence of experiences 'beyond the group' were a useful inclusion of this research in their elucidation of possible pathways to change in HVNGs. Interestingly, the authors observed that attendees' experiences beyond the group became more idiosyncratic in contrast to their similarities within the group. Overall, more research is needed to further understand processes within the group and pathways to change beyond.

**Summary of themes from qualitative research into HVGs**

A fuller picture of intra-group processes emerges when themes across these studies of HVGs are considered collectively, as in Table 1. Unsurprisingly, themes pertaining to the evolving experience of VH itself (e.g. power, control and coping) feature more in protocol-driven treatment-based groups and provided evidence for their underpinning cognitive theories. However, the interpersonal context within which benefits are experienced were evident across studies, adding support to the broader role of group processes in HVGs. Processes which emerged as important included safety, normalisation, catharsis, sharing, exploration and mutual support. A number of themes relating to group set-up, such as facilitation and attendee ownership, may help give rise to these. Themes such as improved coping and strengthened identity seem to reflect effects beyond the group (as explicitly covered in Dos Santos and Beavan, 2015) and will be discussed in section 5.

Table 1. Themes from in-depth qualitative investigations into hearing voices groups

| Study | Method | Main themes | Subthemes |
|---|---|---|---|
| CBT groups | | | |
| Newton, Larkin, Melhuish & Wykes, 2007 | IPA | 1. a place to explore shared experiences;<br>2. an inductive account of coping with auditory hallucinations; | 1. safe place to talk; normalising and destigmatising;<br>2. content of voices; preferred explanations and beliefs about source of voices; perception of power of/control over voice; emotional responses; coping repertoire; |
| PBCT groups | | | |
| Goodliffe, Hayward, Brown, Turton & Dannahy, 2010 | grounded theory | 1. sharing negative characteristics of hearing voices;<br>2. developing a group identity;<br>3. learning to cope with voices;<br>4. development of sense of self beyond voices; | 1. emotional reactions; power of voices; lost control; being judged by others; isolation; developing concept of 'madness' in group;<br>2. social inclusion; normalisation; group support and containment;<br>3. altered expectations; acceptance and understanding; reflecting on power of voices; increased use of coping strategies; goal setting and graded exposure;<br>4. re-evaluating 'illness'; separating voices from identity; re-evaluating perspectives of self; |
| May, Strauss, Coyle & Hayward, 2014 | thematic analysis | 1. relating to voices;<br>2. relating to self;<br>3. relating to other; | 1. developing mindfulness skills; strength/power over voices;<br>2. identity beyond voices; establishment of positive self;<br>3. no subthemes; |
| HVN groups | | | |
| Meddings et al., 2004 | thematic analysis | 1. helpful aspects of the group;<br>2. least helpful aspects of the group or potential improvements;<br>3. what has changed as a result of the group;<br>4. what group members would say to someone thinking about group; | no subthemes |

| Study | Method | Main themes | Subthemes |
|---|---|---|---|
| | | 5. what participants' significant others would say about the group;<br>6. what the voices would say about the group; | |
| Oakland and Berry, 2015 | thematic analysis | 1. discovery;<br>2. group structure;<br>3. acceptance;<br>4. hope;<br>5. group benefits; | 1. introductions/motivation; "it's like a big step";<br>2. facilitation ("no-one has power over you"); group control;<br>3. acceptance of experiences; acceptance of social person;<br>4. "inspiration to know you can do it";<br>5. opportunity to talk, "let off steam"; experienced trial and error; coping beyond the group; |
| Dos Santos and Beavan, 2015 | IPA | 1. first experiences first discoveries;<br>2. within the groups;<br>3. beyond the group. | 1. secrecy at onset of voices; discovering group through others; first experience of group;<br>2. social connections; sharing; feedback; supportive nature of group; facilitators; other members; importance of attending;<br>3. willingness to share with others; improved self -esteem; relating to voices; sense of agency in recovery. |

**Quantitative research on therapist characteristics and group alliance**

Qualitative research evaluated thus far underlines the importance of certain group characteristics and processes in HVGs. These have included the role of the facilitator and the supportive, non-judgemental nature of the group. Such factors implicated in attendees' positive experience and engagement in groups ('group alliance'; Budman et al., 1989) are particularly important given their association with clinical outcomes (Johnson, Penn, Bauer, Meyer & Evans, 2008). Building on this,

one line of research investigated the association of therapeutic alliance with client and therapist characteristics in HVGs.

Johnson, Penn, Bauer, Meyer & Evans (2008) used hierarchical linear modelling to investigate whether particular individual and group-level characteristics predicted group alliance in cognitive-behavioural and supportive therapy HVGs. They found higher perceived alliance at the group midpoint to be predicted by increased group-level 'insight', lower 'autistic preoccupation' and lower social functioning. Insight was measured by the Beck Cognitive Insight Scale (Beck, Baruch, Balter, Steer & Warman, 2004) which assessed self-reflexivity relating to unusual experiences and self-certainty regarding erroneous judgements. Consequently, greater alliance may have reflected engagement implicated in individuals' willingness to hold uncertainty and explore personal experiences within the group. Similarly, as a measure of cognitive disorganisation, lower 'autistic preoccupation' may have indicated that cognitive disorganisation negatively impacts attendees' ability to engage in the group context. As suggested by the authors, the association of lower social functioning with higher alliance (contrary to the study's hypothesis), may have shown that impoverished social networks increased the value of the group, leading to greater engagement.

Using the same sample, Harper Romeo, Meyer, Johnson and Penn (2014) investigated whether certain therapist characteristics would predict group alliance. Using the Vanderbilt Psychotherapy Process Scale (O'Malley, Suh & Strupp, 1983), higher average 'therapist warmth and friendliness' and lower average 'negative therapist attitude' predicted increased group alliance, while 'therapist exploration' did not predict alliance. Even though the associations were modest (trend-level), this was broadly consistent with HVG attendees' accounts of the importance of

facilitators' roles and parallels research into the well-established Rogerian conditions of congruence, empathy and unconditional positive regard (Rogers, 1957). However, lack of association between 'therapist exploration' and alliance highlighted the need for greater understanding into how group attendees' perceptions of facilitators/therapists' impact their experience of the group.

This research evidenced a rigorous methodology, reporting use of validated measures and good levels of inter-rater reliability, but limitations included the possibility of effects being related to group-level processes rather than therapist characteristics due to the small number of therapists involved in the research. More research would be needed to see whether these associations were also present across different types of HVGs.

## Processes associated with impact outcomes

### Research examining change mechanisms in HVGs

Change mechanisms in HVGs have been explicitly examined in two studies to date. Firstly, Ruddle, Mason and Wykes (2011) described five possible change mechanisms implicated in HVGs based on quantitative outcome measures employed in 12 studies: beliefs about voices, relationship with the voice, coping strategy enhancement, social activity levels and self-esteem. This research suggested distress was mediated by both perceived power of and control over voices. Moreover, the reviewed studies all reported increases in coping strategies, levels of social activity and self-esteem, though these increases were not correlated with other outcomes such as distress. Consequently, they underlined the likely significance of coping strategies and beliefs, but concluded that pathways to change were still to be established. Building on this, the review summarises qualitative data from six studies in order to look for further possible mechanisms of change.

However, as already noted, this was not the focus of their review and further evidence of this type has since emerged (as outlined in greater depth here in section three).

Secondly, a small-scale study by some of the same authors (Ruddle et al., 2014) explored change mechanisms in a case series methodology of a CBT-based HVG. Distress, negative beliefs about voices, effective coping strategies and activity levels were measured over twelve time points from pre-therapy to one-month follow-up. No conclusive outcome predictors were found, but therapeutic improvements approaching significance were predicted by stronger negative beliefs about voices and lower self-esteem, providing further information about who may benefit most from HVGs. A principal aim of this study was to elucidate pathways to change by observing patterns and co-variations in different outcome measures. However, there was no clear instance of change in one variable preceding changes in another. Although consistency with current research on HVGs and cognitive theory was evident in this study (in the most notable improvements of negative beliefs and coping strategies), overall, this further underlined the potential complexity and heterogeneity of change mechanisms in HVGs. Further research is needed with more highly-powered samples across different types of HVGs to better understand these effects.

**Potential change mechanisms evident in qualitative research**

For the purposes of elucidating further potential change mechanisms for this review, the results sections of the qualitative research into HVGs (reviewed in question 2) were re-examined for instances where participants had articulated how impact beyond the group had resulted from processes within the group. These potential change mechanisms are outlined in Table 2, which shows the group processes

articulated by participants (column one) as enabling change (impact) to occur (column two). For a fuller version of this table including illustrative quotes and themes see Appendix C.

The evidence presented here was intended as exploratory and limited by lack of independent validation in selection of quotes. It is further underlined that these studies were not explicitly investigating links between processes and impact so the evidence here reflects the product of a specific filter being applied rather than the full richness of the original findings. Notwithstanding there were several noteworthy points.

There was no conclusive pattern of intra-group processes preceding particular impact variables beyond the groups across these studies, which was consistent with the heterogeneity of change mechanisms in HVGs highlighted by Ruddle et al. (2014). However, a number of tentative change mechanisms could be posited, falling into four broad categories: universality/normalising; improved understanding of voices; acceptance; and sharing.

Table 2. Potential change mechanisms in hearing voices groups

| Process identified within the group | Impact identified as resulting from this process | Study |
|---|---|---|
| <u>CBT groups</u> | | |
| universality/ normalising | strengthened identity | Newton, Larkin, Melhuish and Wykes (2007) |
| improved understanding of voices | increased occupational functioning | Newton, Larkin, Melhuish and Wykes (2007) |
| <u>PBCT groups</u> | | |
| perceived support/ containment | increased occupational functioning | Goodliffe et al. (2010) |
| acceptance of 'illness' | strengthened identity | Goodliffe et al. (2010) |
| acceptance of voices | increased coping | Goodliffe et al. (2010) |
| mindful acceptance of voices | reduced distress | May et al. (2014) |
| sharing and learning from | increased coping | May et al. (2014) |

| Process identified within the group | Impact identified as resulting from this process | Study |
|---|---|---|
| others | | |
| universality/ normalising | strengthened identity | May et al. (2014) |
| HVN groups | | |
| universality/ normalising | increased hope for the future | Meddings et al. (2004) |
| improved understanding of voices | improved control over voices | Oakland and Berry (2015) |
| sharing and learning from others | increased coping | Oakland and Berry (2015) |
| sharing experiences about voices | increased confidence to discuss voices | Dos Santos and Beavan (2015) |
| improved understanding of voices | improved control over voices | Dos Santos and Beavan (2015) |

Universality/normalising was present across three types of HVGs, and was linked with strengthened identity in CBT and PBCT groups, and with increased hope in HVNGs. Of equal salience was improved understanding of voices, which was linked with improved control over voices in the two HVNG studies and increased occupational functioning in the CBT study. In PBCT groups, processes of acceptance (of illness/voices) were most consistently linked with impact, namely strengthened identity, increased coping and reduced distress. Finally, sharing/learning from others was linked with increased coping in both PBCT and HVNGs, and sharing about voices in the group was linked with increased confidence to share outside the group in HVNGs.

Certain processes identified here were consistent with the formal change theories of the groups they emerged from, such as improved understanding of voices (cognitive restructuring in CBT) and acceptance (mindfulness in PBCT). However, it was noteworthy that the link between improved understanding of voices and improved control over voices was most evident in HVNGs, even though this is an explicit aim of CBT-based HVGs. Also of note was the salience of Yalom and Leszcz's (2005) therapeutic factors across different types of HVGs, such as 'universality' and

'imparting information' (related to 'sharing and learning from others'). Overall, key processes are yet to be adequately established in HVGs, but this evidence posited some potential change mechanisms and further indicated that certain processes may unfold independently of group type or aims.

## Summary and Conclusions

### Review summary and implications

A systematic review of the evidence base pertaining to HVGs was conducted, including an examination of outcome-based evaluations, qualitative studies of attendees' experiences of groups and evidence of change mechanisms. This has highlighted groups' impact on attendees, the processes implicated within groups, and some tentative evidence of pathways to change.

Outcome-based evidence supported the beneficial impact that CBT-based HVGs have in reducing distressing experiences of VH as measured by voice-related outcomes, though this was not evident in all rigorously controlled studies. Few studies demonstrated evidence of significant improvements in areas of psychological wellbeing such as anxiety and depression. There was tentative evidence for the beneficial impact of other types of HVGs including mindfulness-based groups and HVNGs, but more in-depth and larger scale research is needed.

The qualitative research reviewed here represented an important step forward in broadening the evidence base pertaining to HVGs because it has started to articulate the processes in operation during groups, particularly HVNGs, about whose impact the least is known. There was support for the presence of various group processes across all types of HVGs, many of which can be understood in terms of therapeutic factors such as universality (normalising), cohesiveness, imparting information (e.g. new coping strategies), imitative behaviour (trying out

new coping strategies), interpersonal learning and development of social skills. This underlined the potential usefulness of this framework for understanding the contribution of group processes to the impact of HVGs. Moreover, the salience of group processes across different types of HVGs provided further evidence that generalised processes contributed to impact/outcome in addition to components of their 'formal change theory' (Burlingame, MacKenzie and Strauss, 2004), such as changed beliefs about voices in CBT-based groups.

Future research should further develop our understanding of the processes operating in HVGs and the nature of change brought about by groups. Further investigation should elucidate what processes are operating in groups and which of these processes lead to tangible (and measurable) changes. In addition to more quantitative research evaluating change, qualitative research should be conducted which deepens our understanding of processes and is grounded in the perspectives, values and hopes of HVG attendees themselves. Such an approach could improve the validity of research, contribute to the development of more meaningful outcome measures and better illustrate commonalties and differences between group types. Ideally this could also contribute to the refinement of the different types of HVGs. Given groups' distinct models of ongoing peer support and treatment-based approaches, this is likely to be a more sanguine approach than polarising them in efficacy trials (Ruddle, Mason & Wykes, 2011).

**Research challenges and some proposed solutions**

Even though these are good aspirations, a number of inherent challenges in researching HVNGs exist, which have been described by Corstens, Longden, McCarthy-Jones, Waddingham and Thomas (2014), together with some suggested solutions. As already discussed, key characteristics of HVNGs are less conducive to

controlled research paradigms than treatment-based HVGs. They further highlighted that group benefits may be most evident after sustained attendance or at particular phases of the group as it matures or evolves in response to particular configurations of attendees. Whilst this review has focused on the relevance of therapeutic factors in HVGs, further understanding may result from research informed by group development theories such as 'stages of group development' (Tuckman, 1965) or destructive group processes (Bion's 'basic assumption group', Bion, 1952; or Nitsun's 'anti group', Nitsun, 1996).

In response to the challenge of selecting and developing more valid outcomes, Corstens, Longden, McCarthy-Jones, Waddingham and Thomas (2014) proposed that progress could be made through stronger alliances between service users ('experts by experience') and professionals to help bridge the gap between different conceptualisations of key issues and ways forward for voice hearers. They further recommended the use of qualitative and narrative research methodologies to facilitate a more flexible approach to understanding these issues and evaluating responses to them accordingly. These recommendations were consistent with broader issues in psychotherapy research. For example, Goldfried (2013) pointed out that 'empirically supported treatments' are largely underpinned by research addressing the outcome-based question, ‘does therapy work?’, but neglects process research into ‘how successful therapy works’ and basic psychopathology/human functioning research addressing ‘what needs to be changed?’. These observations supported the conclusions of this review that research needs to focus on better understanding the key ingredients in groups and the nature of their impact.

**Qualitative research and IPA: proposals for future research**

The socio-political movements influencing approaches to VH have been paralleled by developments in research which has seen a rise in the use of qualitative methodologies. Underpinned by post-modern epistemologies, such approaches have helped disempowered individuals reclaim agency by repositioning their subjectivity as central to the definition of their experiences. The qualitative research reviewed here has brought service users' experience of HVGs into the foreground using thematic analysis, grounded theory and IPA which enable themes to emerge.

The methodology of IPA (Smith, Flowers, Larkin, 2009) investigates how people make sense of personally resonant life experiences. As a phenomenological approach it is concerned with the essence of experience, or human life as it is experienced 'in its own terms' (Smith, Flowers, Larkin, 2009, p. 1). Within this research context, IPA is being used to further our understanding of experiences such as voice hearing, otherwise typically understood as 'hallucinations' in the context of 'psychosis' or 'schizophrenia'. Thomas, Bracken & Leudar (2004) have articulated the rationale of a 'phenomenological-hermeneutic' approach to voice-hearing:

> We should be aware of accounting for voices only in terms of biology, psychology or culture. We should also beware of practices that identify experiences like evidence of disorder, deterioration, and degeneration. A concern with meaning makes it possible for us to wonder at how the person integrates puzzling and distressing experiences within his or her life. We may then understand how some people cope with their experiences, and others do not. From this point on recovery becomes a possibility (p. 22).

Thus far, experiences of CBT-based HVGs (Larkin, Melhuish and Wykes, 2007) and HVNGs (Dos Santos and Beavan, 2015) have been explored using IPA which has started to provide support for the value of these groups as defined by their

attendees. In particular, Dos Santos and Beavan's (2015) study illuminated experiences of HVNGs, about which less is known. Nonetheless, more studies are needed to build on this. Previous research into HVNGs coupled with theoretical knowledge of group processes and personal recovery provide a roadmap of the experiences which merit more in-depth exploration. Engagement in how attendees' make sense of VH (and other resonant issues) in the unique context of HVNGs, and how they experience meaningful changes is a line of investigation which IPA research is well placed to address. This could lead to more nuanced understandings of experiences, key components and change pathways implicated in HVNGs. The relevance of group process and personal recovery theories to these understandings could also be investigated.

## References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychiatric Rehabilitation Journal*, *16*, 11-23.doi: 10.1037/h0095655

Baker, P. (1995). *The voice inside: A practical guide to coping with hearing voices.* Manchester, UK: Hearing Voices Network.

Barrowclough, C., Haddock, G., Lobban, F., Jones, S., Siddle, R., Roberts, C. & Gregg, L. (2006). Group cognitive–behavioural therapy for schizophrenia randomised controlled trial. *The British Journal of Psychiatry*, *189*, 527-532. doi: 10.1192/bjp.bp.106.021386

Bechdolf, A., Knost, B., Kuntermann, C., Schiller, S., Klosterkötter, J., Hambrecht, M., & Pukrop, R. (2004). A randomized comparison of group cognitive- behavioural therapy and group psychoeducation in patients with

schizophrenia. Acta Psychiatrica Scandinavica, 110, 21-28. doi: 10.1111/j.1600-0447.2004.00300.x

Beck, A. T., Baruch, E., Balter, J. M., Steer, R. A., & Warman, D. M. (2004). A new instrument for measuring insight: The Beck Cognitive Insight Scale. *Schizophrenia Research, 68*, 319-329. doi: 10.1016/S0920-9964(03)00189-0

Bednar, R. L. & Theodore, J. K. (1994). Experiential group research: Can the canon fire? In A. E. Bergin & S. L. Garfield (Eds*.). Handbook of psychotherapy and behavior change (4th ed.)* (pp. 631-663). Hoboken, NJ: John Wiley & Sons.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. London: Penguin, UK.

Bion, W. R. (1952). Group dynamics: A review. *International Journal of Psychoanalysis, 33*, 235-247.

Buccheri, R., Trygstad, L., Dowling, G., Hopkins, R., White, K., Griffin, J. J. & Hebert, P. (2004). Long-term effects of teaching behavioral strategies for managing persistent auditory hallucinations in schizophrenia. *Journal of Psychosocial Nursing and Mental Health Services*, *42*, 18-27. doi: 10.3928/02793695-20040301-10

Burlingame, G. M., MacKenzie, K. R. & Strauss, B. (2004). Small group treatment: Evidence for effectiveness and mechanisms of change. In M. J. Lambert (Ed.). *Bergin & Garfield's Handbook of psychotherapy and behavior change* (pp. 647-696). Hoboken, NJ: John Wiley & Sons.

Campbell, J. (2005). The historical and philosophical development of peer-run support programs. In S. Clay, B. Schell, P. Corrigan, R. O. Ralph. *On our own, together: Peer programs for people with mental illness.* (pp. 17-64). Nashville, TN: Vanderbilt University Press.

Chadwick, P. & Birchwood, M. (1994). The omnipotence of voices. A cognitive approach to auditory hallucinations. *The British Journal of Psychiatry*, *164*, 190-201. doi: 10.1192/bjp.164.2.190

Chadwick, P. & Birchwood, M. (1995). The omnipotence of voices. II: The Beliefs About Voices Questionnaire (BAVQ). *The British Journal of Psychiatry, 166*, 773-776. doi: 10.1192/bjp.166.6.773

Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and cognitive psychotherapy*, *37*, 403-412. doi: 10.1017/S1352465809990166

Chadwick, P., Sambrooke, S., Rasch, S., & Davies, E. (2000). Challenging the omnipotence of voices: Group cognitive behavior therapy for voices. *Behaviour Research and Therapy, 38*, 993-1003. doi: 10.1016/S0005-7967(99)00126-6

Conway, T. (2004). Hearing voices: An experience of group work in a medium secure psychiatric hospital. *Practice: Social Work in Action*, *16*, 137-145. doi: 10.1080/09503150412331313105

Corrigan, P. W., Roe, D., & Tsang, H. W. (2011). *Challenging the stigma of mental illness: Lessons for therapists and advocates*. Hoboken, NJ: John Wiley & Sons.

Corsini, R. J., & Rosenberg, B. (1955). *Mechanisms of group psychotherapy: Processes and dynamics.* The Journal of Abnormal and Social Psychology, *51*, 406-411. doi: 10.1037/h0048439

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R. & Thomas, N.

(2014). Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. *Schizophrenia Bulletin, 40*, S285-S294. doi: 10.1093/schbul/sbu007

Crombie, I. K. (1996). Appraising review papers. In I. K. Crombie (Ed.). *The pocket guide to critical appraisal: A handbook for health care professionals (*pp.56-61*)*. London: British Medical Journal Publishing Group.

Dannahy, L., Hayward, M., Strauss, C., Turton, W., Harding, E., & Chadwick, P. (2011). Group person-based cognitive therapy for distressing voices: Pilot data from nine groups. *Journal of Behavior Therapy and Experimental Psychiatry*, *42*, 111-116. doi: 10.1016/j.jbtep.2010.07.006

Davidson, L., Rakfeldt, J., & Strauss, J. (2011). *The roots of the recovery movement in psychiatry: Lessons learned*. Hoboken, NJ: John Wiley & Sons.

Dillon, J., Bullimore, P., Lampshire, D. & Chamberlin, J. (2013). The work of experience-based experts. In J. Read & J. Dillon (Eds.). *Models of madness: Psychological, social and biological approaches to psychosis* (pp. 305-318). Hove: Routledge.

Dillon, J. & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *Psychosis*, *5*, 286-295. doi: 10.1080/17522439.2013.843020

Dillon, J. & May, R. (2002). Reclaiming experience. *Clinical psychology, 17*, 25-77

Dos Santos, B. & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *The Journal of Mental Health Training, Education and Practice*, *10*, 26-38. doi: 10.1108/JMHTEP-07-2014-0017

Downs, J. (2005). *Coping with voices and visions.* Manchester: The Hearing Voices Network.

Drinnan, A. (2004). A secure base? A group for voice hearers on an inpatient ward. *Clinical Psychology, 36*, 19-23.

Fox, D., Prilleltensky, I. & Austin, S. (2009). *Critical psychology: An introduction*. London: Sage.

Goldacre, B. (2013). *Bad pharma: How medicine is broken and how we can fix it.* London: Fourth Estate.

Goldfried, M. R. (2013). What should we expect from psychotherapy? *Clinical Psychology Review, 33,* 862-869. doi: 10.1016/j.cpr.2013.05.003

Goodliffe, L., Hayward, M., Brown, D., Turton, W. & Dannahy, L. (2010). Group person-based cognitive therapy for distressing voices: Views from the hearers. *Psychotherapy Research, 20*, 447-461. doi: 10.1080/10503301003671305

Haddock, G., McCarron, J., Tarrier, N. & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: The psychotic symptom rating scales (PSYRATS). *Psychological Medicine, 29*, 879-889. doi: 10.1017/S0033291799008661

Harper Romeo, K., Meyer, P. S., Johnson, D. & Penn, D. L. (2014). An investigation of the relationship between therapist characteristics and alliance in group therapy for individuals with treatment-resistant auditory hallucinations. *Journal of Mental Health*, *23*, 166-170. doi: 10.3109/09638237.2013.869568

Hutton, P., Weinmann, S., Bola, J. & Read, J. (2013). Antipsychotic drugs. In J. Read & J. Dillon (Eds.). *Models of madness: Psychological, social and biological approaches to psychosis*. (pp. 105-124). New York: Routledge.

Johnson, D. P., Penn, D. L., Bauer, D. J., Meyer, P. & Evans, E. (2008). Predictors

of the therapeutic alliance in group therapy for individuals with treatment- resistant auditory hallucinations. British Journal of Clinical Psychology, 47, 171-184. doi: 10.1348/014466507X241604

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*. London: Routledge.

Jones, S., Hughes, S., & Ormrod, J. (2001). A group evaluation of a hearing voices group. *Clinical Psychology Forum, 8,* 35-38.

Kay, S. R., Flszbein, A., & Opfer, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin, 13*, 261-276. doi: 10.1093/schbul/13.2.261

Leamy, Bird, Le Boutillier, Williams & Slade (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*, 445-452. doi: 10.1192/bjp.bp.110.083733

Lecomte, T., Leclerc, C., Corbiere, M., Wykes, T., Wallace, C. J., & Spidel, A. (2008). Group cognitive behavior therapy or social skills training for individuals with a recent onset of psychosis?: Results of a randomized controlled trial. *The Journal of Nervous and Mental Disease*, *196*, 866-875. doi: 10.1097/NMD.0b013e31818ee231

Lee, K., Hannan, C., van den Bosch, J., Williams, J. & Mouratoglou, V. (2002). Evaluating a hearing voices group for older people: Preliminary findings. *International Journal of Geriatric Psychiatry, 17,* 1079-1080. doi: 10.1002/gps.679

Leudar, I., & Thomas, P. (2000). Voices of reason, voices of insanity: Studies of verbal hallucinations. London: Routledge.

Mannu, J., & Borri, G. (2004). The" voices group": A therapeutic group for psychotic patients in a therapeutic community. *Therapeutic Communities, 25,* 153-168.

Martin, P. J. (2000). Hearing voices and listening to those that hear them. *Journal of Psychiatric and Mental Health Nursing*, *7*, 135-141. doi: 10.1046/j.1365-2850.2000.00276.x

May, K., Strauss, C., Coyle, A., & Hayward, M. (2014). Person-based cognitive therapy groups for distressing voices: A thematic analysis of participant experiences of the therapy. *Psychosis*, *6*, 16-26. doi: 10.1080/17522439.2012.708775

McCarthy-Jones, S. (2012). *Hearing voices: The histories, causes and meanings of auditory verbal hallucinations.* New York: Cambridge University Press.

McCarthy-Jones, S., Trauer, T., Mackinnon, A., Sims, E., Thomas, N., & Copolov, D. L. (2014). A new phenomenological survey of auditory hallucinations:

Evidence for subtypes and implications for theory and practice. *Schizophrenia Bulletin, 40*, 231-235.

McLeod, T., Morris, M., Birchwood, M., & Dovey, A. (2007). Cognitive behavioural therapy group work with voice hearers. Part 1. *British Journal of Nursing*, *16*, 248-258. doi: 10.12968/bjon.2007.16.4.22995

McLeod, T., Morris, M., Birchwood, M., & Dovey, A. (2007). Cognitive behavioural therapy group work with voice hearers. Part 2. *British Journal of Nursing*, *16*, 292-295. doi: 10.12968/bjon.2007.16.5.23005

Meddings, S., Walley, L., Collins, T., Tullett, F., McEwan, B., & Owen, K. (2004). Are hearing voices groups effective? A preliminary evaluation. Unpublished manuscript, Sussex, UK. Retrieved 6 April 2015 from: http://www.intervoiceonline.org/wp-content/uploads/2011/03/Voiceseval.pdf

Meltzoff, J. (1998). *Critical thinking about research: Psychology and related fields.* Washington, DC: American Psychological Association.

National Institute for Health and Clinical Excellence (2006). The guidelines manual. Chapter 7: Reviewing and grading the evidence. Retrieved 6 April 2015 from: www.nice.org.uk/niceMedia/pdf/2006GuidlinesManualChapter7.pdf

National Institute for Health and Clinical Excellence (2009). Schizophrenia (update): Core interventions in the treatment and management of schizophrenia in primary and secondary care. Retrieved 6 April 2015 from: http://www.nice.org.uk/guidance/cg82

Newton, E., Landau, S., Smith, P., Monks, P., Shergill, S., & Wykes, T. (2005). Early psychological intervention for auditory hallucinations: An exploratory study of young people's voices groups. *The Journal of Nervous and Mental Disease, 193*, 58-61. doi: 10.1097/01.nmd.0000149220.91667.fa

Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and psychotherapy: Theory, research and practice, 80*, 127-149. doi: 10.1348/147608306X110148

Nitsun, M. (1996). *The anti-group: Destructive forces in the group and their creative potential*. London: Routledge.

O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology, 51*, 581-586. doi: 10.1037/0022-006X.51.4.581

Oakland, L., & Berry, K. (2015). “Lifting the veil”: A qualitative analysis of

experiences in Hearing Voices Network groups. *Psychosis*, 7, 119-129. doi: 10.1080/17522439.2014.937451

Parse, R. R. (1995). *Illuminations: The human becoming theory in practice and research.* New York: National League for Nursing Press.

Penn, D. L., Meyer, P. S., Evans, E., Wirth, R. J., Cai, K., & Burchinal, M. (2009). A randomized controlled trial of group cognitive-behavioral therapy vs. enhanced supportive therapy for auditory hallucinations. *Schizophrenia Research, 109*, 52-59. doi: 10.1016/j.schres.2008.12.009

Pennings, M., Romme, M., & Steultjens, B. (1997). *Gespreksgroepen voor mensen die stemmen horen.* University of Maastricht.

Pinkham, A. E., Gloege, A. T., Flanagan, S., & Penn, D. L. (2005). Group cognitive-behavioral therapy for auditory hallucinations: A pilot study. *Cognitive and Behavioral Practice, 11*, 93-98. doi: 10.1016/S1077-7229(04)80011-7

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, *19*, 276-288. doi: 10.1037/h0088437

Romme, M. A. (2009). Hearing voices groups. In M. Romme, S. Escher, J. Dillon, D. Corstens & M. Morris (Eds.). *Living with voices: Fifty stories of recovery*. (pp. 7-22). Ross-on-Wye: PCCS books.

Romme, M. A., Honig, A., Noorthoorn, E. O. & Escher, S. (1992). Coping with hearing voices: An emancipatory approach. *The British Journal of Psychiatry*, *161*, 99-103. doi: 10.1192/bjp.161.1.99

Romme, M. A. & Escher, A. D. (1989). Hearing voices. *Schizophrenia Bulletin*, *15*, 209-216. doi: 10.1093/schbul/15.2.209

Romme, M. & Escher, S. (1993). *Accepting voices*. London: MIND publications.

Ruddle, A., Livingstone, S., Huddy, V., Johns, L., Stahl, D. & Wykes, T. (2014). A case series exploring possible predictors and mechanisms of change in hearing voices groups. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*, 60-79. doi: 10.1111/j.2044-8341.2012.02074.x

Ruddle, A., Mason, O. & Wykes, T. (2011). A review of hearing voices groups: Evidence and mechanisms of change. *Clinical Psychology Review*, *31*, 757-766. doi: 10.1016/j.cpr.2011.03.010

Schizophrenia Commission. (2012). The abandoned illness: A report from the Schizophrenia Commission. *London: Rethink Mental Illness*. Retrieved 6 April 2015 from: https://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf

Silverstein, S. M. & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, *28*, 1108-1124. doi: 10.1016/j.cpr.2008.03.004

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Thomas, P. & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, *10*, 361-370. doi: 10.1192/apt.10.5.361

Thomas, P., Bracken, P. & Leudar, I. (2004). Hearing voices: A phenomenological-hermeneutic approach. *Cognitive Neuropsychiatry*, *9*, 13-23. doi: 10.1080/13546800344000138

Trygstad, L., Buccheri, R., Dowling, G., Zind, R., White, K., Griffin, J. J., & Hebert, P. (2002). Behavioral management of persistent auditory hallucinations in schizophrenia: Outcomes from a 10-week course. *Journal of the American Psychiatric Nurses Association*, *8*, 84-91. doi: 10.1067/mpn.2002.125223

Tuckman, B. (1965). Developmental sequence in small groups. *Psychological Bulletin, 63*, 384–399. doi: 10.1037/h0022100

Weinmann, S. & Aderhold, V. (2010). Antipsychotic medication, mortality and neurodegeneration. *Psychosis, 2,* 50-69. doi: 10.1080/17522430903501999

Wykes, T., Hayward, P., Thomas, N., Green, N., Surguladze, S., Fannon, D. & Landau, S. (2005). What are the effects of group cognitive behaviour therapy for voices? A randomised control trial. *Schizophrenia Research*, *77*, 201-210. doi: 10.1016/j.schres.2005.03.013

Wykes, T., Parr, A. M., & Landau, S. (1999). Group treatment of auditory hallucinations. Exploratory study of effectiveness. *The British Journal of Psychiatry*, *175*, 180-185. doi: 10.1192/bjp.175.2.180

Yalom, I. & Leszcz, M. (2005). *The theory and practice of group psychotherapy.* New York: Basic Books.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215-228. doi: 10.1080/08870440008400302

# Section B:

# How people experience Hearing Voices Network groups and the connection to group processes and recovery

For submission to the journal

Psychology and Psychotherapy: Theory, Research and Practice

## Abstract

**Study context and objectives:** Voice hearing has a diverse history but is currently understood as symptomatic of a disease within psychiatric frameworks. Alternatives to 'treatment' include peer-support 'Hearing Voices Network groups' (HVNGs) which have grown in popularity and exist alongside treatment-based hearing voices groups. Few studies have investigated processes underlying change in HVNGs. Established research into therapeutic factors and personal recovery may provide frameworks elucidating change processes.

This study aimed to investigate how HVNG attendees experienced change within the group and how this change influenced their lives.

**Design:** A qualitative design was employed using interpretative phenomenological analysis (IPA) to elucidate group processes through immersion in the perspectives of group attendees.

**Methods:** Semi-structured interviews were conducted with eight individuals who were purposively sampled from two HVNGs. Interviews lasted from 34 to 54 minutes, were recorded on a Dictaphone and later transcribed verbatim.

**Results:** Four superordinate themes emerged: 'healing', connecting with humanity; group as an emotional container; making sense of the voices and me; and freedom to be myself and grow.

**Conclusions:** Relationships, safety, exploration of voices and group ownership are key components of HVNG and fit into frameworks of therapeutic factors and recovery processes. Development of HVNGs should take these processes into account. Future studies should further elucidate processes.


**Keywords:** hearing voices groups, voice hearing, group processes, recovery, IPA.

# Introduction

## The polemic of voice hearing and why it matters

Currently referred to as 'auditory hallucinations' in mainstream mental health contexts, voice hearing (VH) has a rich history which is underpinned by shifting sociocultural, spiritual and scientific frames of reference (McCarthy Jones, 2012). Although psychiatric understandings dominate modern clinical practice around VH (American Psychiatric Association, 2013), conceptualisations and approaches to working with voices are subject to ongoing debate (Beavan, 2011; Longden, Madill & Waterman, 2012).

VH is not always experienced negatively (Honig et al., 1998; Woods, Romme, McCarthy-Jones, Escher & Dillon, 2013), but voice hearers reporting distress are typically defined as 'ill' and treated for psychotic illnesses with anti-psychotic medication. While endorsed by national recommendations (NICE, 2009) and some consumers (e.g. Carrick, Mitchell, Powell & Lloyd, 2010), long-term use involves considerable health risks (Hutton, Weinmann, Bola & Read, 2013; Goldacre, 2014) and their proliferation has been subjected to extensive multidisciplinary critique (Johnstone, 2000). Furthermore, issues such as increased stigma, reduced mortality and poor life opportunities are ongoing challenges for those diagnosed with schizophrenia (Cooke, 2014; Schizophrenia Commission, 2012). Many users of mental health services experience them as actively harmful, sometimes to the extent that they describe themselves as 'survivors' of services (Wallcraft & Bryant, 2003).

Various sociopolitical and professional groups responded to these concerns. Within the climate of the 1960s civil rights movement, 'mentally ill' individuals undergoing invasive treatments in large institutions united in pressure groups such as psychiatric survivors (Corrigan, Roe, Tsang, 2011) and peer support (Campbell, 2005). Parallel

movements amongst mental health professionals also emerged, notably critical psychiatry (Thomas & Bracken, 2004) and more recently, critical psychology (Fox, Prilleltensky & Austin, 2009). The surmountable nature of mental illness emerged as a defining characteristic of this paradigm shift and was exemplified by the recovery movement (Anthony, 1993).

Although the difficulties experienced by voice hearers fell within the concerns of these groups, it was the Hearing Voices Movement (HVM) which engaged with their specific cause (James, 2001). Its foundation stemmed from a key study demonstrating that 34% of voice hearers coped with VH experiences and were not mental health service users (Romme & Escher, 1993). The HVM was a socio-political endeavour driven by 'emancipatory' aims (Romme, Honig, Noorthoorn & Escher, 1992): promoting alternative explanations of VH, reducing stigma and uniting voice hearers in peer-led support groups, or 'hearing voices groups' (Romme & Escher, 1993).

**Hearing voices groups and evidence**

Hearing Voices Network affiliated groups (HVNGs) are popular. Over 200 groups now run in England (Dillon, Bullimore, Lampshire & Chamberlin, 2013) and a growing body of literature attests their benefits, such as the provision of safe, supportive and empowering spaces for voice hearers (Dillon & Longden, 2012). Alongside their proliferation, cognitive theories of VH developed (Chadwick & Birchwood, 1994), leading to clinical interventions such as cognitive-behavioural therapy (CBT) for VH, delivered individually (Bentall, Haddock & Slade, 1995) and in groups (Wykes, Parr & Landau, 1999).

A systematic review of the evidence for all such groups (generically referred to as 'hearing voices groups'; HVGs) found that only methodologically robust outcome

evidence existed for CBT-based HVGs (Ruddle, Mason & Wykes, 2011). This evidence mainly consisted of significant improvements in voice-related measures (topography and beliefs), though these effects were reduced for more controlled studies. Furthermore these groups showed no significant improvements in anxiety or depression. Research into other types of HVGs included skills-based groups (Trygstad et al., 2002), mindfulness groups (Chadwick, Hughes, Russell, Russell & Dagnan, 2009), person-based cognitive therapy groups (Dannahy et al., 2011) and HVNGs (Meddings et al., 2004). Evidence for certain voice-related measures and clinical improvements was found, but consisted of smaller scale or uncontrolled studies.

Despite the proliferation of HVNGs, robust evidence from traditional research paradigms is yet to emerge. Although sometimes co-facilitated by clinicians, HVNGs are principally peer-led, ongoing and driven by HVM principles (Romme & Escher, 1993) rather than clinical outcomes. In the only study utilising formal outcome measures, Meddings et al. (2004) reported reduced frequency and power of voices, decreased hospital bed use (at 18-month follow-up), and improvements in coping, self-esteem and consumer empowerment. Until most recently, other studies mainly limited their evaluation to informal qualitative descriptions. Despite their limitations, findings broadly support the theoretical literature, such as the importance of sharing, safety and support (Martin, 2000; Jones, Hughes & Ormrod, 2001; Downs, 2005), improved coping (Drinnan, 2004) and identification with others (Pennings, Romme & Steultjens, 1997; Conway, 2004).

**What are the change mechanisms in HVGs?**

As evidence for HVGs mainly consists of outcome-based research, processes implicated in change are yet to be adequately investigated. Only one exploratory

study of a (CBT-based) HVG investigated change mechanisms to date and found no conclusive pathways to change (Ruddle et al., 2014). Ruddle, Mason and Wykes' (2011) review extracted five possible change mechanisms implicated in HVGs (beliefs about voices, relationship with voices, improved coping, social activity levels and self-esteem), but these were based on all types of HVGs. Research needs to take into account differences between the two models of HVGs (ongoing peer-led support and outcome-driven interventions) as groups' differing aims may mean their underlying processes differ too.

Most research has been on clinical, outcome-driven HVGs, so it is important that HVNGs are investigated further. Moreover, studies should investigate change processes in addition to seeking outcome-based evidence. Existing research into HVNGs has highlighted the importance of group processes, particularly therapeutic factors (Yalom & Leszcz, 2005) such as 'universality' (Conway, 2004) and 'imparting information' (e.g. coping strategies; Drinnan, 2004). The theoretical frameworks of group processes may provide an interpersonal focus which is particularly relevant to HVNGs given their emphasis of ongoing peer support.

Given the common roots of the HVM and recovery movement, key elements in HVNGs could be elucidated using research into personal recovery as a framework. Leamy, Bird, Le Boutillier, Williams and Slade's (2011) systematic review and narrative synthesis of recovery described different dimensions of recovery into mental health. These included characteristics such as 'active', 'individual/unique', 'non-linear' and 'a journey' and five key processes: 'connectedness', 'hope', 'identity', 'meaning in life' and 'empowerment' ('CHIME'). As these concepts are reflected within HVNG research, then this framework could be used to inform investigations into change processes in HVNGs.

**The role of qualitative research**

Qualitative research has the potential for furthering understandings of HVNGs. Not only can it elucidate processes implicated in groups through detailed investigation, but it privileges viewpoints of group attendees as ‘experts by experience’ (Dillon, Bullimore, Lampshire & Chamberlin, 2013). This is consistent with calls for stronger alliances between service users and professionals to drive more meaningful change for voice hearers (Corstens, Longden, McCarthy-Jones, Waddingham and Thomas, 2014). For a recent account of such an alliance, see Woods et al. (2014).

Rigorous qualitative studies have recently emerged. Using thematic analysis, Oakland and Berry (2015) found five important themes: discovery (of group), group structure ("no-one has power over you"), acceptance (of people and their experiences), hope and group benefits (including 'opportunity to talk', "let off steam" and 'experienced trial and error'). In the most recent study, Dos Santos and Beavan (2015) reported experiences in three main themes using interpretative phenomenological analysis (IPA): starting the group (including feelings of secrecy, first group experiences); during the group (including social, supportive, sharing and elements); and beyond the group (including improvements in self-esteem, relating to others/voices and agency in recovery).

IPA is a qualitative approach which articulates the personally resonant concerns of a homogenously-defined group of people through a detailed examination of their accounts of particular phenomena. Through reflective interpretation and immersion into participants' meaning-making experiences a final account is derived. In emphasising Binswanger's framework of empathy (Mitsein or 'being-with'; Binswanger, 1963), which relates to one of IPA's principal hermeneutic underpinnings, Smith, Flowers and Larkin (2009) highlight the strength of this

approach in foregrounding the insider view. Through immersion in attendees' perspectives, such an approach is well positioned to improve our understanding of processes which underlie meaningful change in HVNGs.

### Aims of this study

Recent qualitative investigations of experiences of HVNGs have further highlighted groups' benefits and articulated potential key processes. Established theories of therapeutic factors and personal recovery tell us what may be of value to group attendees. Consequently, investigation using these frameworks could provide further insight into these processes in HVNGs. This study will investigate how attendees of HVNGs experience change within the group context and how this translates into changes in their lives. The following questions will be addressed:

1. What are participants' most salient experiences of attending a Hearing Voices Network Group?
2. How did the group influence attendees' understandings of their VH (and other difficult experiences)?
3. How was the group perceived by attendees to impact upon their lives?

## Methodology

### Design

A qualitative approach using IPA was employed to gain an in-depth understanding of attendees' experiences by focusing on personal meaning-making.

Semi-structured interviews were used to elicit participants' experiences. This format provided structure whilst allowing sufficient space for the development of rapport and flexible exploration of experiences (Willig, 2013). An interview schedule was developed to explore participants' experiences of attending HVNGs, and their perceptions of the group's impact on their voice hearing experiences and other areas

of their lives. The questions were further developed with supervisors and endorsed by a member of the Salomons Advisory Groups of Experts (SAGE) who was a voice hearer and gave general feedback on the thoughts and feelings which the questions could potentially evoke during interview. Questions were added and prompts changed following a pilot interview with a colleague (group facilitator; see Appendices D and E).

**Participants and sampling**

Purposive sampling was used to capture participants with experience of attending a HVNG (Smith, Flowers & Larkin, 2009). Table 1 provides details of the eight individuals who agreed to take part. They consisted of four females and four males ranging from 26 to 60 years old. One participant defined their ethnicity as European, and seven as British or English (four specifying White, one Black, one White Jewish). Group attendance ranged from two months to five years. All participants were voice hearers, but in keeping with Hearing Voices Network values, diagnosis was not sought (see also Oakland & Berry, 2015). However, during the course of the interviews four participants disclosed a diagnosis of schizophrenia and all eight divulged past or present contact with mental health services. To further situate the sample and provide information on 'transferability' (Lincoln & Cuba, 1985), participants completed the Mental Health Recovery Measure (MHRM; Young & Bullock, 2003; see Appendix F). Administration was done at the end to avoid influencing participants' answers within the interview. This 30-item instrument, co-produced by service users and possessing good psychometric properties (Bullock, 2005), assesses personal recovery process on a 120-point scale where higher scores indicate greater perceived recovery. Recent normative data yielded a mean of 80 and a standard deviation of 20 (Bullock, 2005). Scores ranged from 46 to 110

with a mean average of 74.75, though six participants scored between 63 and 84, indicating that most perceived themselves to have made reasonable progress in their personal recovery journey.

**Procedure**

Prior to recruitment, ethical approval was sought from an NHS Ethics Committee and from the Research and Development department of the NHS Trust involved with the groups (Appendices G-K). A particular consideration was the potentially distressing nature of experiences that could arise during interviews. This was highlighted to potential participants

Table 1. Participant details

| Participant | Gender | Age (at interview) | Ethnicity (self-defined) | Length of time attending group | MHRM score |
|---|---|---|---|---|---|
| HVNG 1 | | | | | |
| Helen | female | 50 | White British | 5 years | 70 |
| Lara | female | 55 | White English | 2 years | 81 |
| HVNG 2 | | | | | |
| Clark | male | 57 | British | 4 years | 84 |
| Kim | female | 34 | British | 2 months | 110 |
| Harry | male | 60 | White British Jewish | 4 years | 63 |
| Greg | male | 49 | European | 1 year | 68 |
| Jenny | female | 26 | Black British | 3 years | 76 |
| Walt | male | 52 | White British | 2 months | 46 |

and those who agreed to take part were encouraged to indicate if they preferred not to answer questions experienced as overly distressing. Their right to withdraw was also highlighted.

Participants were drawn from two peer-led HVNGs, co-facilitated by an NHS staff member, in a large UK city. After permission to approach the group was obtained from the facilitators, the project was briefly introduced to attendees. A Participant Information Sheet (whose content and accessibility had been checked by a peer facilitator of a HVNG) was distributed (see Appendix L). Interested participants left telephone/email details and were contacted at least 24 hours later to confirm their interest and arrange interviews, seven of which were held at an NHS site (where a group facilitator was based) and one on the premises of a third-sector organisation. All participants were given the choice of these two locations. Upon meeting, the purpose of the study and what it involved was re-iterated and written consent was obtained (Appendix M). Demographic details were also sought (Appendix N). Interviews, which ranged from 34 to 54 minutes in duration, were recorded on a Dictaphone and later transcribed verbatim.

**Data analysis**

Following transcription interviews were analysed using IPA, which aims for a detailed understanding of experience through a series of steps (Smith, Flowers & Larkin, 2009). Following immersion in the particulars of each case, more generalised assertions are reached through cross comparison within a homogenously-defined group (obtained through purposive sampling). Informed by hermeneutics (interpretation), IPA is described as a 'double hermeneutic' as the data passes through the dual filter of the researcher's interpretation of a person's understanding of their experiences.

Using Smith, Flowers and Larkin (2009) as a guideline, transcripts were intensively read and re-read to produce notes capturing phenomenological aspects of participants' accounts ('descriptive comments') and then interpretative observations

('conceptual comments') which were annotated in transcript margins to ensure their grounding in the data (see Appendix O). Emergent themes from these notes were developed and categorised into superordinate and subordinate themes by hand. Themes and associated quotes were later passed onto NVivo software (Version 10, QSR International, 2012) and further refined, which allowed for further immersion in the data (see Appendices P and Q for data trail and extended quote list).

**Quality assurance**

Using Yardley (2000), certain criteria for ensuring quality were attended to. 'Sensitivity to context' was aimed at by grounding the study in relevant literature pertinent to different models of HVGs. Participant perspectives were privileged through choice of methodology and ethical issues were attended to through a stringent set of approval processes. Thorough immersion in the data and analysis using recommended steps ensured 'commitment and rigour'. 'Transparency' was maximised through clear description of the data analysis, inclusion of an example annotated transcript and an audit trail to illustrate theme development. To increase validity ('credibility'; Lincoln & Guba, 1985), themes were discussed and cross checked with the first author's supervisors. A summary was sent to participants to obtain 'respondent validation' and provide them with feedback. Two participants responded and endorsed the themes (see Appendix R). A process of ongoing reflexivity was undertaken to bring personal factors and assumptions of the first author to light. This was completed prior to data collection through a bracketing interview with a colleague guided by Ahern (1999), which highlighted a number of points (see Appendix S). These included a strong sense of identification with service users' disempowerment, a desire to champion the groups (related to a strong personal socialist agenda), and anxiety about being intrusive in the role of

researcher. Ongoing reflections were captured in a research diary (see Appendix T). Finally, 'impact and importance' was evident in the need for more research into HVGs and the potential impact their development could have on the lives of attendees.

## Results

Four superordinate themes emerged from the analysis containing a total of nine subthemes. These are presented in Table 2.

Table 2. Superordinate themes and subthemes

| Superordinate themes | Subthemes |
|---|---|
| Healing: connecting with humanity | The 'nurturing' effect of connecting |
| | Challenges to connecting |
| Group as an emotional container | Safety to unload |
| | 'Always there': ongoing presence |
| Making sense of the voices and me | An 'inspiring' opportunity to explore |
| | Gaining wisdom |
| | 'Clearer in myself': personal growth |
| Freedom to be myself and grow | 'The group shapes the group': ethos of ownership |
| | 'Fun sometimes': group as a play space |

Each superordinate theme was represented in at least six of the eight participants' accounts while each subtheme was present in at least five participants' accounts except 'an inspiring opportunity to explore', as shown in Table 3. Certain themes inevitably resonated more with certain participants. Less representation of Kim and Walt's accounts was consistent with them being relative newcomers to the HVNG, while more complete representation for Helen, Lara and Clark seemed to reflect their longevity in the group. Absence of 'making sense of the voice and me' for Harry reflected the predominance of other elements in his account, particularly socialising. For larger samples (over six), Smith, Flowers and Larkin (2009) advocate a group level analysis that maintains idiographic detail but which summarises the most

salient features of the analysis. Accordingly, while it was beyond the scope of this work to discuss each subtheme in relation to each participant, the following related the most resonant elements of each theme using illustrative quotes.

Table 3. Presence of themes across participants*

| Superordinate Theme | Subtheme | Helen | Lara | Clark | Kim | Harry | Greg | Jenny | Walt |
|---|---|---|---|---|---|---|---|---|---|
| Healing: connecting with humanity | The 'nurturing' effect of connecting | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| | Challenges to connecting | ■ | ■ | ■ | ■ | ■ | | ■ | ■ |
| Group as an emotional container | Safety to unload | ■ | ■ | ■ | ■ | | ■ | ■ | |
| | 'Always there': ongoing presence | ■ | ■ | ■ | | ■ | ■ | ■ | |
| Making sense of the voices and me | An 'inspiring' opportunity to explore | ■ | | ■ | | | ■ | | |
| | Gaining wisdom | ■ | ■ | ■ | ■ | | ■ | ■ | |
| | 'Clearer in myself': personal growth | ■ | ■ | ■ | | | ■ | ■ | |
| Freedom to be myself and grow | 'The group shapes the group': ethos of ownership | ■ | ■ | ■ | ■ | | ■ | | |
| | 'Fun sometimes': group as a play space | ■ | ■ | | ■ | ■ | ■ | ■ | ■ |

*presence of themes indicated by shaded area

**Healing - connecting with humanity**

This theme illustrated the strong sense of bonding or 'connecting' which occurred as attendees opened up to one another's concerns. This connecting was characterised

by the humane qualities of acceptance, compassion, identification and nurturance which dominated participants' accounts and appeared integral to feelings of wellbeing derived from the group. This theme conveyed the main characteristics of this process and barriers to it unfolding.

### The 'nurturing' effect of connecting

The sense of wellbeing derived from sharing experiences and connecting with others was articulated by Lara:

*It's having people remember your experience and be open to it - I was talking about something last week and Bob [pseudonym], one of the members, um, was just nodding and kind of agreeing, but I think we were talking about hallucinations and um, just him nodding and agreeing felt, kind of nurturing. I know that sounds really corny, but I don't talk about my hallucinations much. I don't even talk about them with my friend because they're too spooky, you know, they're too weird.*

In describing the effect of identification with a fellow attendee as 'nurturing' (literally meaning to protect and care for when growing), Lara evoked the image of a vulnerable child receiving parental care. Thus, the feeling of ‘nurturing’ seemed to be a reparative emotional experience. In the haven of the group Lara found someone who genuinely understood her 'spooky' experiences, which protected her from the isolation of keeping them to herself. The self-conscious tone (it 'sounds really corny') illustrated the tenderness of this nurturing feeling.

Helen concurred that identification with others was central to the experience of the group, but emphasised the importance of a humane and nurturing attitude from others:

*I think I felt that people were on your side and, you know, had similar experiences but also cared about you and how it was for you*.

The value placed on having people know ‘how it was for you’ resounded here, and suggested that the peer-support element of the group was key. The importance of having people 'on your side' may reflect a previous absence of such compassion before the group due to the stigmatised nature of VH (Knight, Wykes & Hayward, 2003).

The humane attitude which enabled connecting to occur was described by some in terms of acceptance. Lara described both the essential nature of this as well as the process she underwent to accept others:

*There must be an acceptance there, an unconditional acceptance.*

*It took me humbling myself and accepting that other people, as well as feeling accepted - that was really important, to accept them, accept their story and...to not feel anxious about them but to be open to other people's stories and other people's interpretations of what their voices mean to them.*

Although the importance of acceptance for therapeutic change is an established concept (Rogers, 1957), Lara’s experience articulated both the salience of this within the group context and the challenges that needed overcoming to achieve this, such as overcoming one's fears (‘not feeling anxious’).

Another facet of connecting unfolded with good listening. When describing the most resonant interpersonal aspects of the group, Clark singled this out (*'it's the people being listened to that does the business*') and described the mechanics of this process:

*So when the group functions as it should do, er, the person feels more listened to and they're able to feel a sense of completion about what is happening to them.*

This ‘sense of completion’ suggested that feeling listened to triggered a meaningful internal change in relation to experiences brought to the group, and could be conceptualised as the moment the speaker felt connected with.

The sense of nurturance from connecting also came across in accounts of closeness which developed between group members:

*When I was talking to her after the group we had so much in common that I thought, 'wow, we should become good friends because we can really help each other out'.*(Kim)

*I suppose we got closer, a little bit closer from the first day that I attended the first group up to now, I've got closer to certain people. We exchange phone numbers, meet up in the cafe sometimes, yeah.* (Greg)

Kim revealed the explicit thought process that led to seeking closeness and strengthening a connection: the appeal of a close and reciprocally beneficial friendship. Greg's account of developing relationships conveyed how the process of 'connecting' developed over time ('from the first day...up to now').

Whilst nurturing and connecting reflect core human needs, the salience of this in participants' experiences of the group appeared to reflect a previous absence or loss of this in their lives before or outside of the HVG. Given the stigmatisation and social marginalisation implicated in voice hearing (Longden, Corstens & Dillon, 2013), the group may be fulfilling a fundamental human need which promoted healing.

### Challenges to connecting

Several challenges to connecting emerged within the group, such as initial apprehension about attending and various interpersonal struggles. Whilst acceptance, identification and bonding characterised positive emotional experiences of connecting, barriers often manifested as the reverse of these qualities, such as

fears of rejection and conflicting viewpoints. For most, the first barrier to connecting was the initial attendance, as described by Helen:

*I was very nervous. And I, and a little bit, very anxious, a little bit scared, I wasn't quite sure, I mean I had had it explained to me but I still didn't quite know what I was going into, what it would be like, so I think I was quite quiet for a while.*

Apprehension and feeling overwhelmed were captured in Helen's dialogue here as she switched back and forth between 'very' and 'a little bit'. Entering an unknown space when already in an anxious state typifies the 'double whammy' attendees often contend with upon starting the group. As Helen has described, this experience had a silencing effect.

Closeness was often achieved amongst group members, but integrating into an open group as a new member could be challenging. Walt related a sense of purposelessness at being a relative outsider in the group initially:

*Before I just felt a bit like a loose key. You know, everybody else had been, er, been in the voices group for a long time and they were all friends, and there was me, a bit sort of on their own* (Walt).

Although the HVG was generally found to be supportive, as a relatively new member Walt showed his vulnerability by contrasting being 'on his own' with the others who 'were all friends'. Related to this vulnerability at feeling isolated within a new group, many experienced similar feelings of vulnerability as they struggled to be heard or validated within the group. For example, while listening was experienced as curative, the reverse was also true:

*I nearly, me, myself nearly had a relapse in the group. Because my questions weren't answered properly, so I felt like, roaring out.* (Jenny)

*Some people talk too much and I can't get to talk about what I want to talk about yet.* (Walt)

Jenny's expression 'roar out' suggested an acute sense of frustration upon feeling ignored, while Walt exemplified a particularly strong theme across participants' accounts of competing to speak. Similarly, some felt shut out when certain topics or beliefs about voices were marginalised or overtly rejected:

*I talk more about how there's a spiritual dimension to voices...but it's usually swamped out by people who have the opposite experience with their voices.* (Clark)

*Well, sometimes I mention religion, and er, usually I get a negative reaction.* (Harry)

The ongoing negotiation of group culture often involves people vying for position as groups' purposes and norms are set out ('storming'; Tuckman, 1965). This process within the group may be accentuated for those feeling marginalised in the world outside the group.

Whilst difficulties arose from these interpersonal tensions and negotiation of the group culture, another barrier to connecting was the generation of negative emotions which came through exposure to others' emotional struggles:

*..it's distressing, so to hear about it can be really heavy...especially if somebody's talking about something that's distressed them, and you're sitting there thinking 'yeah, I remember I went through that about three years ago', so it's a trigger for your own distressing and, and, confusing experiences.* (Lara)

*Sometimes, I find that certain people are in a very, very down on and difficult mood, and they kind of, bring the energy of the group...the energy of the group gets into a very different sort of stressed place sometimes - if people are feeling distressed it can be distressing in the group.* (Clark)

Clark made a simple but astute observation which seemed to reflect an intrinsic challenge to support groups whereby people are drawn together through common difficulties: namely, that another person's stress can become one's own. Lara gave an example of this here by describing how identification with others' distressing experiences did not always lead to a pleasant sense of 'universality' (Yalom & Lezcsz, 2005), but could actually trigger memories of her own difficulties, causing 'distress' and 'confusion'. Similarly, the 'heaviness' (Lara) and the 'energy of the group...into a stressed place' (Clark) seemed to illustrate how others sharing their distress could influence the emotional climate or 'mood' within the group. These observations are consistent with the importance placed on 'group cohesiveness' as a key factor in the functioning of groups (Forsyth, 2010).

**Group as an emotional container**

This second theme described how attendees derived safety from the group. The term 'emotional container' reflects Bion's (1962) notion of containment, as participants attested to the group's ability to withstand difficult emotions: it was a place where people could express feelings of utter wretchedness and cathartic release could occur. Another dimension of safety reflected in this theme related to the group's continuity and reliability of occurrence.

**Safety to unload**

For Lara, this sense of containment was expressed in her reflection on how one of the attendees was able to share their experiences of feeling suicidal with the group: *...better that you can go to the group and say that, that he could be open [about feeling suicidal] rather than going 'keep that to yourself, and just put on a brave face', see what I mean? It's quite a compliment of the group that people can go there and say 'I'm at the end of my rope here'.*

The group was seen to provide a place of safety where people could go at their moments of greatest vulnerability ('at the end of my rope') and allow full expression of their feelings. The group's success in fulfilling this purpose was singled out ('quite a compliment'). Some, like Clark, considered this to be unique in their lives:

*I did have people outside of the group who I talked to about the situation but I had to be very careful not to overwhelm people with stressful stuff really, whereas in the group, there's more liberty to, um, to talk through that kind of material, really.*

Clark's illustrated the safety of the group by contrasting the care needed not to overwhelm those outside of the group with the 'liberty' he felt within it. The group also allowed Clark the opportunity to keep his relationships outside of the group safe (as well as himself) by protecting them from what he perceived 'stressful stuff'.

Certain elements related to the running of the group were also described as integral to the safety it provided, such as the role of facilitators or the use of ground rules:

*I just found it interesting cos it was laying down some structure, and I thought 'well, if we didn't, if we didn't have those rules, will we be safe?'* (Kim)

By laying down boundaries, structure provided by elements such as facilitator interventions or ground rules made the group more predictable are more conducive to feeling safe. As well as structure, this safety came from the interpersonal processes within the group, such as having others reframe distressing or paranoid experiences, as Greg articulated:

*You tend as a schizophrenic to hyper everything you know, blow out of proportion things ... and it helps at putting it into perspective, into focus without all that racing in your head going on, and getting paranoid about this and that...*

Here Greg obtained his sense of safety through reduced anxiety or reassurance from a specific intervention by the group who provided him with the 'perspective' to regain

his focus. Overall, the defining concept of containment in which overwhelming emotions are processed and returned in digestible form was reflected in these accounts: the group (its members) facilitated this emotional processing.

**'Always there' - ongoing presence**

The ongoing nature of the group appeared key to the sense of safety it provided:

*It's sort of there in the background as a source of support.* (Clark)

*It's there at this time in my week every week and it's something I can rely on....that the group's always there...*(Helen).

The group was a continuous ('there in the background') and reliable source of help that could be called upon whenever needed. Helen gave an insightful reflection regarding the group as a permanent fixture in her life:

*I think for me, especially in my childhood, I didn't really have people I could rely on or trust to sort of be there in a positive way for me and so, I think it's something that's quite important to me.*

For the second time, an image of parental care was evoked, this time reflecting the idea that safety derived from the group was akin to the emotional wellbeing provided within a family unit. For Helen, it was the availability of the group which appeared to be key to the sense of safety it provided. Jenny captured the effects of having this continuity in her life:

*It's just that I've got strength, I've got more strength now to carry on with daily living. And every week when I go to the hearing voices group it's the same people that's there. And that's like an inspiration to me.*

The continuity provided by the group gave 'inspiration' and 'strength to carry on with daily living'. A key notion in attachment theory is that the provision of safety in the form of a 'secure base' later enables the emotional wellbeing which makes

exploration or functioning out in the world possible (Bowlby, 1988). Indeed, the function of HVNGs as a secure base was suggested before (Drinnan, 2004).

**Making sense of the voices and me**

The third superordinate theme described the opportunity provided by the HVNG to explore personally challenging experiences, gain deeper understandings of them and achieve personal growth. Although attendees' exploration usually related to VH, other experiences were brought to the group such as visual hallucinations, paranoia and stigma.

**An 'inspiring' opportunity to explore**

For many the opportunity to explore VH was new and consequently had a strong impact. Helen stated her surprise upon first attending the group:

*I was really amazed, I sort of sat there and thought 'oh my word, people are just talking openly about this*.'

She contrasted this with the sense of shame and taboo she felt before attending:

*...when I first started hearing the voices, I felt, I didn't feel I could really tell people. I felt quite ashamed and, as if there was something wrong with me. It wasn't something that you could really talk about... but coming to the group, and er, there were people I could talk to and it could come out in the open and it wasn't a shameful thing or it wasn't, you know, it wasn't the end of the world.*

Being able to 'come out in the open' seemed to remove the sense of shame. Her description of what VH ceased to be in the group ('it wasn't a shameful thing', 'it wasn't the end of the world') suggested that before attending, VH was indeed experienced as shameful and even catastrophic ('end of the world'). The group was therefore a particularly liberating experience for Helen.

**Gaining wisdom**

The benefits of exploring voices has been highlighted (Beavan & Read, 2010) and tools have been developed for this purpose (Romme & Escher, 2000). The HVG provided voice hearers with an audience of experts with lived experience who could support one another to gain insight, as illustrated by Greg:

*...anxiety, also relieving and, um, glad to share, and, you don't just share, it's not just a one-way thing, then there's comments all around and you make sense of it, so yeah, it's good...you feel great about it, you know, good about it.*

Greg's experience of meaning-making in the group conveyed that having the courage to share could lead to positive cognitive ('you make sense of it') and emotional ('you feel great about it') changes, despite feelings of ambivalence (anxiety/relief).

Clark gave an example of a belief about a voice he worked through with the group:

*I began to see that there was a message within the voice, and the message was telling me about how people with disabilities and mental health problems are oppressed in society, er, and that's a legitimate message...which is different from saying that the government specifically wants us to go out and kill ourselves.*

By identify the underlying meaning of oppression in the voice, Clark was able to reframe the explicit message of violence (the government wanting to kill himself) for one which was more legitimate and less threatening. This particular example of increased understanding of voices attained through the group reflected the dual function of HVNGs: as support groups to assist with distress and as a form of social emancipation in which VH experiences can be 'reclaimed' (Dillon & May, 2003).

### 'Clearer in myself' - personal growth

The experience of attending the group often led to tangible personal development in the form of returning to work or developing new relationships. Some participants were able to identify links between exploring VH and this personal development:

*I have an understanding of what my voices are and where they come from and, because, as I've been able to cope with them better, and as I've got better in myself and they've reduced then that's made life a lot better, because I don't have these voices all the time.* (Helen)

Helen's personal journey in relation to VH portrayed a series of links, from identifying meaning to increased coping and wellbeing. Feeling 'better in myself' highlighted how improved understanding and coping led to a strengthened sense of identity. For others, this personal growth was articulated as improved confidence:

*I've got more confident in my ability to listen to other people and I've got more confident in my ability to sort of listen to myself, to deal with my own issues*. (Clark)

The confidence Clark acquired from greater clarity about his voices enabled him to trust his own judgement and manage difficulties himself, suggesting that the positive effects of attending the group translated to life beyond the group.

**Freedom to be myself and grow**

The emancipatory ethos of the HVN was such that attendees of HVGs were encouraged to take joint ownership of the running, agenda and culture of their group. This ethos of group ownership and flexibility resonated strongly in participants' experiences. The freedom to hold one's own beliefs about the meaning of their voices was strongly valued. This freedom extended the group beyond a place for discussing problems to a fun, sociable and creative space; a place where people could feel more validated as individuals and less inhibited compared to the world

beyond the group, where VH was taboo and the threat of being misunderstood or judged seemed high.

### 'The group shapes the group': ethos of group ownership

Evident in participants' experiences was an ethos of ownership characterised by flexibility, choice and a joint approach to running the group:

*It's very, er, relaxed, there isn't any pressure to do anything.* (Greg)

*I've known people to arrive ten minutes before the end, and they're still glad that they came for the last ten minutes because they still get something out of it.* (Kim)

*Anybody could, kind of, chip in and make facilitatory remarks.* (Clark).

Ownership of the group may be of particular value for attendees who, by contrast, are frequently prescribed 'treatments' for 'auditory hallucinations' or 'psychosis' over which they have relatively little influence. In this context, an individual's ability to shape the group agenda and exercise choice in their level of participation was key to feeling empowered (Masterson & Owen, 2006). Themes of power were reflected strongly in these narratives, where the importance of joint group ownership and individually owning one's explanatory framework for VH were expressed:

*Other people have different views of where - you know - what their voices are and where they come from and there's no one set answer in hearing voices group.* (Helen)

*That's one thing I love about this group, it's there's no control - it's, it's about the group. The group shapes the group. Er, it's not X or whoever's facilitating that week who shapes the group - it's the group itself. It belongs to the group.* (Lara)

The importance of such empowerment was consistent with recent research underlining its importance in personal recovery (Leamy, Bird, Le Boutillier, Williams and Slade, 2011).

### 'Fun sometimes': group as a play space

The ethos of joint group ownership enabled attendees to negotiate a safe and supportive space where VH was the norm and high levels of mutual understanding existed . Within this context the group could become a 'play space'. Issues of VH were transcended, giving way to fun and creativity so that individuality could emerge. This ranged from socialising ('chat time') to artistic expression (readings of creative writing). Fun was emphasised:

*The group is quite packed full of interesting things*. (Kim)

*It can just be fun sometimes...everyone was talking about football the other week, um, which they enjoyed, cos everyone's into the football. And that just helps everyone get to know each other and relax as a group*. (Lara)

Given the risk of social isolation experienced by voice hearers (Ng, Chun & Tsun, 2012), this space to socialise appeared to be important. Furthermore, development of social skills was also highlighted as a therapeutic factor by Yalom and Leszcz (2005). The 'creative slot' which existed in one HVNG was described by a number of participants:

*We have people read, reading short stories at the end, so, er, Jim [pseudonym]...he always tells a story. They're very short stories, about ten lines. They're always great fun. And everybody claps appreciatively, and that's nice*. (Walt).

*Yeah, you know, it cheers you up a bit [listening to the poetry]. You know, it gets your head off of stuff and be able to focus and to let it in, and enjoy it basically*. (Greg).

*...just my gift, one of my talents, and I got some praise. Everybody was clapping their hands, and some admiring me*. (Jenny).

There were multiple functions of this aspect of the group, including fun, distraction and the opportunity to showcase skills. This created a 'play space' within the group where people felt liberated. Attendees such as Jenny who read out their writing could feel validated as people with talents. This opportunity to develop a positive sense of self contrasted sharply to the problem-saturated identity of 'patient'.

## Discussion

The aims of this study were to explore people's experiences of attending a HVNG. This investigation included (i) an overarching consideration of participants' most salient experiences of the group, focusing in particular on (ii) how the group influenced attendees' understandings of their VH (and other difficult experiences) and (iii) how the group was perceived by attendees to impact upon their lives. The findings will be discussed in relation to these aims and the main issues highlighted in the introduction. As these areas of enquiry were found to overlap considerably, much of the discussion will address them collectively.

### Linking findings to aims and previous literature

Participants experienced HVNG as compassionate and empowering spaces where voice hearers can 'heal': nurturance from a socially validating environment and the opportunity to work through overwhelming experiences in safety are fertile conditions for personal growth. Attendees' most salient experiences as evident in four key themes were: the healing effects of 'connecting' with others, as illustrated by the value of building and having relationships in the group (and the distress when this process was interrupted); the sense of safety derived from group containment and continuity; the valued opportunity to explore VH (and other difficult experiences), thereby gaining greater understandings about these experiences and oneself; and the 'freedom to be myself and grow', which described the importance of peer-defined

joint ownership of the group and the resultant space for creativity, enjoyment and individuality.

This supported previous research suggesting that relational processes are key elements of HVNGs. 'The healing effect of connecting' was consistent with themes from other studies including universality and sharing ('helpful group aspects'; Meddings et al.,2004), social connections, sharing and support (Dos Santos & Beavan, 2015), and 'acceptance' of people and voices (Oakland & Berry, 2015). 'Making sense of the voices and me' supported other research showing the value attendees placed on exploring voices, such as 'opportunity to talk', (Oakland & Berry, 2015) and importance of 'feedback' (Dos Santos and Beavan, 2015). The 'ethos of ownership', which highlighted choice and freedom, supported Oakland and Berry's (2015) themes “no-one has power over you” and 'group control'. Safety, a key theme in this study, was less emphasised in other HVNG studies, but were key themes in other HVG research (CBT: Newton, Larkin, Melhuish and Wykes, 2007; PBCT: Goodliffe, Hayward, Brown, Turton & Dannahy, 2010). As well as being consistent with previous research into HVGs, these findings also supported the presence of group and recovery processes in HVNGs.

In terms of this study's original aims, the influence of the HVNG upon attendees' individual understandings of their VH was most explicitly evidenced in the theme 'making sense of the voices and me'. Greater understanding of VH was made possible by the novel space provided by the HVNG for open exploration with the assistance of other voice hearing experts (by experience). For some, this led to a greater understanding of the experiences and of themselves, and supported the value of 'meaning' and 'identity' in personal recovery, as highlighted in the 'CHIME' framework (Leamy, Bird, Le Boutillier, Williams and Slade, 2011).

Given the context of vulnerability, stigma and isolation experienced by many attendees, this study also illustrated that exploration of VH (and other personal growth occurring within the group) was made possible through the creation of strong relationships and a sense of safety. The experiences outlined in 'connecting...' support the presence of many of Yalom and Leszcz's (2005) therapeutic factors. In line with other research into HVNGs (Meddings et al., 2004), 'universality' appeared to be vital, as this set the context for feeling understood ('people on your side'; Helen), which enabled connecting, safety and exploration. The 'nurturance' of these relationships and the safety derived from groups' 'reliable' and ongoing presence appeared to be emotionally reparative aspects of attendees' experiences, and supported groups' potential role in their 'recapitulation of the primary family group' (Yalom and Leszcz, 2005). The presence of other therapeutic factors was also supported. The relevance of 'group cohesiveness' was implicit in the theme 'connecting with humanity'. While positive processes of connecting were conducive to group cohesiveness, negative emotions generated by exposure to others' distress were sometimes a barrier to this cohesion and could put the group in a 'stressed place' (Clark). The subtheme 'safety to unload' illustrated 'catharsis'. Additionally, the theme 'making sense of the voices and me', which outlined exploration of voices and self, involved the use of others' perspectives (imparting information) and trying out new ways of being (imitative behaviour) which led to self-knowledge (interpersonal learning). Finally, 'the freedom to be myself and grow' afforded opportunities for the 'development of socialising techniques'.

The fourth theme, 'freedom to be myself and grow' reflected key concepts from the field of personal recovery and developmental psychology. The value placed on the group's 'ethos of ownership' was evident in the running of the group (e.g. the

practical set-up, open agenda and peer-support context) and the promotion of personal choice in explanatory frameworks for VH. The value of ownership that permeated participants' experiences supported the significance of 'empowerment' in the 'CHIME' framework. For HVNG attendees, empowerment equated to flexibility and control of the group, which allowed individuals to engage in personal recovery which was 'active', 'individual/unique', 'non-linear' and 'a journey' as characterised by Leamy, Bird, Le Boutillier, Williams and Slade (2011).

The 'group as a play space' articulated how the group became a place for enjoyment and creativity. The significance of this was captured by Winnicott: "it is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self" (Winnicott, 1971, pp. 72–73). It was, thus, hypothesised that principles of ownership within the group ultimately facilitated the freedom to develop as an individual.

**Study critique**

There were a number of strengths and limitations to this study. IPA allowed for detailed analysis through immersion in attendees' experiences, but the scope of this write-up meant the full richness of the data was not portrayed in the results. Furthermore, the interpretative nature of IPA added variability into the data, so another researcher may have extracted different themes. Conducting one interview per participant meant their accounts represented a snapshot in time, reducing the possibility of exploring evolving perspectives of groups. Another weakness was the smaller sample which limited the generalisability of findings. Service user feedback was obtained on the interview schedule, but consultation (particularly with the Hearing Voices Network) could have improved its development. The sample was

reasonably situated but would have been improved by recording attendees' length of contact with mental health services. Another possible limitation was considering attendees' experiences of HVNGs in relation to both recovery and group processes: focusing on one area may have yielded more in-depth analysis.

**Research implications**

The results of this study suggested that relationships, safety, exploration and ownership were key components underpinning change in HVNGs. Future studies should aim to further elucidate these key ingredients. Qualitative studies could aim to replicate these findings and add to the body of evidence highlighting the key elements of HVNGs. Given that this study supported the presence of therapeutic factors (Yalom & Leszcz, 2005) and personal recovery processes (Leamy, Bird, Le Boutillier, Williams and Slade, 2011), these theoretical frameworks could be used to inform the focus of future investigations. The 'challenges to connecting' found in this study could be further explored using theoretical frameworks of destructive group processes (e.g. Bion's 'basic assumption group'; Bion, 1952) to understand what inhibits attendees' progress in groups. IPA allowed access to participants' perspectives through immersion in their narratives, so future studies should consider this approach, which also endorses calls for greater alliances between service users and professionals.

Future quantitative research could use these findings to select or develop more valid outcome measures for HVNGs. Existing tools measuring personal recovery (Shanks et al., 2013), empowerment (Wowra & McCarter, 1999) or group cohesion (MacKenzie, 1983) may be appropriate outcome measures, but development of tools to measure perceived containment and ability to explore VH in the group may also prove useful. Finally, despite poor compatibility between controlled research

paradigms and HVNG principles of flexibility, a matched subjects study with a treatment as usual control group would provide more rigorous outcome evidence for HVNGs.

### Clinical implications

The key processes highlighted in this study should be taken into account in the development, facilitation, promotion and evaluation of HVNGs. Facilitators should prioritise relationship-building, safety, exploration and principles of ownership within groups. Given the importance of universality and building trust, processes of 'connecting' arguably set the context for the groups' most valuable work. Facilitators should therefore ensure that conflict and negative emotions are attended to so the positive aspects of connecting can unfold. Given the importance of ownership and the value of insider perspectives, group development should be user-led or built on user-professional alliances. In light of the value derived from long-term attendance of HVNGs (development of relationships, containment from group continuity), integration of services should be prioritised so users of time-limited HVGs are given the opportunity to later attend ongoing HVNGs. Finally, despite differences in HVGs, these findings may be useful in the development of treatment-based HVGs.

## Conclusions

This investigation of the experiences of HVNG attendees added to the relatively small evidence base pertaining to these groups. The main themes of this research supported the interpersonal/relational, safety-related, exploratory and empowering elements of the group as central to the experience of attending. The interpersonal dimension of the group captured in the first theme consisted of several relating processes ('connecting') characterised as nurturing, while safety (theme two) was derived from the emotional containment and the ongoing presence of the group.

Both of these were posited as emotionally reparative elements of the HVNG. The valued opportunity to explore VH, reflected in theme three, appeared to lead to wisdom and personal growth. 'Freedom to be myself and grow' (theme four) articulated the ethos of group ownership, and enabled the group to be a space for enjoyment, creativity and expression of individuality. Using theoretical frameworks of group processes and personal recovery, this research provided evidence for certain processes underpinning these experiences. Many therapeutic factors (Yalom & Leszcz, 2005) appeared to be present in the group, including universality, group cohesiveness, recapitulation of the primary family group, catharsis, imparting information, imitative behaviour, interpersonal learning and development of socialising techniques. This study endorses elements of Leamy, Bird, Le Boutillier, Williams and Slade's (2011) synthesis of personal recovery, particularly processes of connectedness, meaning, and empowerment from the 'CHIME' framework.

## References

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9,* 407-411. doi: 10.1177/104973239900900309

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychiatric Rehabilitation Journal*, *16*, 11-23. doi: 10.1037/h0095655

Beavan, V. (2011). Towards a definition of “hearing voices”: A phenomenological approach. *Psychosis, 3,* 63-73. doi: 10.1097/NMD.0b013e3181d14612

Beavan, V. & Read, J. (2010). Hearing voices and listening to what they say: The

importance of voice content in understanding and working with distressing voices. *The Journal of Nervous and Mental Disease, 198*, 201-205.

Bentall, R. P., Haddock, G. & Slade, P. D. (1995). Cognitive behavior therapy for persistent auditory hallucinations: From theory to therapy. *Behavior Therapy*, *25*, 51-66. doi: 10.1016/S0005-7894(05)80145-5

Binswanger, L. (1963). *Being in the world.* London: Souvenir Press

Bion, W. R. (1952). Group dynamics: A review. *International Journal of Psychoanalysis, 33*, 235-247.

Bion, W. R. (1962). *Learning from experience*. London: William Heinemann Medical Books, Ltd

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. Abingdon: Routledge

Bullock, W. A. (2005). Measuring the promise of recovery. In T. Campbell-Orde, J. Chamberlin, J. Carpenter & H. S. Leff (Eds.). *Measuring the promise of recovery: A compendium of recovery measures. Volume II.* The Evaluation Centre@HSRI: Cambridge, MA.

Campbell, J. (2005). The historical and philosophical development of peer-run support programs. In S. Clay, B. Schell, P. Corrigan, R. O. Ralph. *On our own, together: Peer programs for people with mental illness.* (pp. 17-64). Nashville, TN: Vanderbilt University Press.

Carrick, R., Mitchell, A., Powell, R. A., & Lloyd, K. (2004). The quest for well- being: A qualitative study of the experience of taking antipsychotic medication. Psychology and Psychotherapy: Theory, Research and Practice, 77, 19-33. doi: 10.1348/147608304322874236

Chadwick, P. & Birchwood, M. (1994). The omnipotence of voices. A cognitive

approach to auditory hallucinations. *The British Journal of Psychiatry*, *164*, 190-201. doi: 10.1192/bjp.164.2.190

Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy*, *37*, 403-412. doi: 10.1017/S1352465809990166

Conway, T. (2004). Hearing voices: An experience of group work in a medium secure psychiatric hospital. *Practice: Social Work in Action*, *16*, 137-145. doi: 10.1080/09503150412331313105

Cooke, A. (2014) (Ed.). *Understanding psychosis and schizophrenia : Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help.* Division of Clinical Psychology of the British Psychological Society. Retrieved 7 April 2015 from: https://www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/understanding_ psychosis_- _final_19th_ nov_2014.pdf

Corrigan, P. W., Roe, D., & Tsang, H. W. (2011). *Challenging the stigma of mental illness: Lessons for therapists and advocates*. Hoboken, NJ: John Wiley & Sons.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R. & Thomas, N. (2014). Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. *Schizophrenia Bulletin, 40*, S285-S294. doi: 10.1093/schbul/sbu007

Dannahy, L., Hayward, M., Strauss, C., Turton, W., Harding, E. & Chadwick, P.

(2011). Group person-based cognitive therapy for distressing voices: Pilot data from nine groups. *Journal of Behavior Therapy and Experimental Psychiatry*, *42*, 111-116. doi: 10.1016/j.jbtep.2010.07.006

Dillon, J., Bullimore, P., Lampshire, D. & Chamberlin, J. (2013). The work of experience-based experts. In J. Read & J. Dillon (Eds.). *Models of madness: Psychological, social and biological approaches to psychosis* (pp. 305-318). Hove: Routledge.

Dillon, J., & Longden, E. (2012). Hearing voices groups: Creating safe spaces to share taboo experiences. In M. Romme & S. Escher (Eds.). *Psychosis as a personal crisis: An experience based approach* (pp. 129-139). London: Routledge

Dillon, J. & May, R. (2002). Reclaiming experience. *Clinical Psychology, 17*, 25-77

Dos Santos, B. & Beavan, V. (2015). Qualitatively exploring hearing voices network support groups. *The Journal of Mental Health Training, Education and Practice*, *10*, 26-38. doi: 10.1108/JMHTEP-07-2014-0017

Downs, J. (2005). *Coping with voices and visions.* Manchester: The Hearing Voices Network.

Drinnan, A. (2004). A secure base? A group for voice hearers on an inpatient ward. *Clinical Psychology, 36*, 19-23.

Forsyth, D. R. (2010). *Group dynamics (5th ed.).* Belmont, CA: Cengage Learning.

Fox, D., Prilleltensky, I. & Austin, S. (2009). *Critical psychology: An introduction*. London: Sage.

Goldacre, B. (2013). *Bad pharma: How medicine is broken and how we can fix it.* London: Fourth Estate.

Honig, A., Romme, M. A., Ensink, B. J., Escher, S. D., Pennings, M. H. & Devries,

M.W. (1998). Auditory hallucinations: A comparison between patients and nonpatients. *The Journal of Nervous and Mental Disease, 186,* 646-651. doi: 10.1097/00005053- 199810000-00009

Hutton, P., Weinmann, S., Bola, J. & Read, J. (2013). Antipsychotic drugs. In J. Read & J. Dillon (Eds.). *Models of madness: Psychological, social and biological approaches to psychosis*. (pp. 105-124). New York: Routledge.

James A. (2001). *Raising our voices: An account of the Hearing Voices Movement*. Gloucester: Handsell.

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*. London: Routledge.

Jones, S., Hughes, S., & Ormrod, J. (2001). A group evaluation of a hearing voices group. *Clinical Psychology Forum, 8,* 35-38.

Knight, M. T., Wykes, T. & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health, 12,* 209-222. doi: 10.1080/0963823031000118203

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*, 445-452. doi: 10.1192/bjp.bp.110.083733

Lincoln, YS. & Guba, EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Longden, E., Corstens, D., & Dillon, J. (2013). Recovery, discovery and revolution:

The work of Intervoice and the hearing voices movement. In S. Coles, S. Keenan & B. Diamond (Eds.). Madness contested: Power and practice (pp. 161-180). Ross-on- Wye: PCCS Books.

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: toward a new conceptualization of voice hearing. *Psychological Bulletin, 138*, 28-76. doi: 10.1037/a0025995

MacKenzie, K. R. (1983). The clinical application of a Group Climate measure. In R. R. Dies & K. R. MacKenzie (Eds.). Advances in group psychotherapy: Integrating research and practice (pp. 159-170). New York: International Universities Press.

Martin, P. J. (2000). Hearing voices and listening to those that hear them. *Journal of Psychiatric and Mental Health Nursing*, *7*, 135-141. doi: 10.1046/j.1365-2850.2000.00276.x

Masterson, S., & Owen, S. (2006). Mental health service user's social and individual empowerment: Using theories of power to elucidate far-reaching strategies. *Journal of Mental Health, 15*, 19-34. doi: 10.1080/09638230500512714

McCarthy-Jones, S. (2012). *Hearing voices: The histories, causes and meanings of auditory verbal hallucinations.* New York: Cambridge University Press.

McCarthy-Jones, S., Thomas, N., Strauss, C., Dodgson, G., Jones, N., Woods, A., …& Sommer, I. (2014). Better than mermaids and stray dogs? Subtyping auditory verbal hallucinations and its implications for research and practice. *Schizophrenia Bulletin, 40,* S275-S284.

Meddings, S., Walley, L., Collins, T., Tullett, F., McEwan, B., & Owen, K. (2004). Are hearing voices groups effective? A preliminary evaluation. Unpublished

manuscript, Sussex, UK. Retrieved 6 April 2015 from: http://www.intervoiceonline.org/wp-content/uploads/2011/03/Voiceseval.pdf

National Institute for Health and Clinical Excellence (2009). Schizophrenia (update): Core interventions in the treatment and management of schizophrenia in primary and secondary care. Retrieved 6 April 2015 from: http://www.nice.org.uk/guidance/cg82

Ng, P., Chun, R. W., & Tsun, A. (2012). Recovering from hallucinations: A qualitative study of coping with voices hearing of people with schizophrenia in Hong Kong. *The Scientific World Journal*. doi: 10.1100/2012/232619

QSR International Pty Ltd (2012). NVivo (Version 10) [qualitative data analysis software].

Oakland, L., & Berry, K. (2015). "Lifting the veil": A qualitative analysis of experiences in Hearing Voices Network groups. *Psychosis*, *7*, 119-129. doi: 10.1080/17522439.2014.937451

Pennings, M., Romme, M., & Steultjens, B. (1997). *Gespreksgroepen voor mensen die stemmen horen.* University of Maastricht.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103. doi: 10.1037/h0045357

Romme, M. & Escher, S. (1993). *Accepting voices*. London: MIND publications.

Romme, M. & Escher, S. (2000). *Making sense of voices.* London: Mind.

Romme, Honig, Noorthoorn, & Escher (1992). Coping with hearing voices: An emancipatory approach. *The British Journal of Psychiatry*, *161*, 99-103. doi: 10.1192/bjp.161.1.99

Ruddle, A., Livingstone, S., Huddy, V., Johns, L., Stahl, D. & Wykes, T. (2014). A

case series exploring possible predictors and mechanisms of change in hearing voices groups. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*, 60-79. doi: 10.1111/j.2044-8341.2012.02074.x

Ruddle, A., Mason, O. & Wykes, T. (2011). A review of hearing voices groups: Evidence and mechanisms of change. *Clinical Psychology Review*, *31*, 757-766. doi:10.1016/j.cpr.2011.03.010

Schizophrenia Commission. (2012). The abandoned illness: A report from the Schizophrenia Commission. *London: Rethink Mental Illness*. Retrieved 6 April 2015 from: https://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf

Shanks, V., Williams, J., Leamy, M., Bird, V. J., Le Boutillier, C., & Slade, M. (2013). Measures of personal recovery: A systematic review. *Psychiatric Services*, *64*, 974-980. doi: 10.1176/appi.ps.005012012

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Thomas, P. & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, *10*, 361-370. doi: 10.1192/apt.10.5.361

Trygstad, L., Buccheri, R., Dowling, G., Zind, R., White, K., Griffin, J. J., ... & Hebert, P. (2002). Behavioral management of persistent auditory hallucinations in schizophrenia: Outcomes from a 10-week course. *Journal of the American Psychiatric Nurses Association*, *8*, 84-91. doi: 10.1067/mpn.2002.125223

Tuckman, B. (1965). Developmental sequence in small groups. *Psychological Bulletin, 63*, 384–399. doi: 10.1037/h0022100

Wallcraft & Bryant (2003). *The mental health service user movement in England.*

London: The Sainsbury Centre for Mental Health. Retrieved 7 April 2015 from: www.centreformentalhealth.org.uk/pdfs/policy_paper2_service_user_movement.pdf

Willig, C. (2013). *Introducing qualitative research in psychology.* Maidenhead: Open University Press.

Winnicott, D. W. (1971). *Playing and reality.* London: Tavistock Publications Limited.

Woods, A., Jones, N., Bernini, M., Callard, F., Alderson-Day, B., Badcock, J. C., ... & Fernyhough, C. (2014). Interdisciplinary approaches to the phenomenology of auditory verbal hallucinations. *Schizophrenia bulletin*,*40*, S246-S254. doi: 10.1093/schbul/sbu003

Woods, A., Romme, M., McCarthy-Jones, S., Escher, S. & Dillon, J. (2013). Special edition: Voices in a positive light. *Psychosis, 5*, 213-215. doi: 10.1080/17522439.2013.843021

Wowra, S. A., & McCarter, R. (1999). Validation of the empowerment scale with an outpatient mental health population. *Psychiatric services, 50,* 959-961. doi: 10.1176/ps.50.7.959

Wykes, T., Parr, A. M., & Landau, S. (1999). Group treatment of auditory hallucinations. Exploratory study of effectiveness. *The British Journal of Psychiatry*, *175*, 180-185. doi: 10.1192/bjp.175.2.180

Yalom, I. & Leszcz, M. (2005). *The theory and practice of group psychotherapy.* New York: Basic Books.

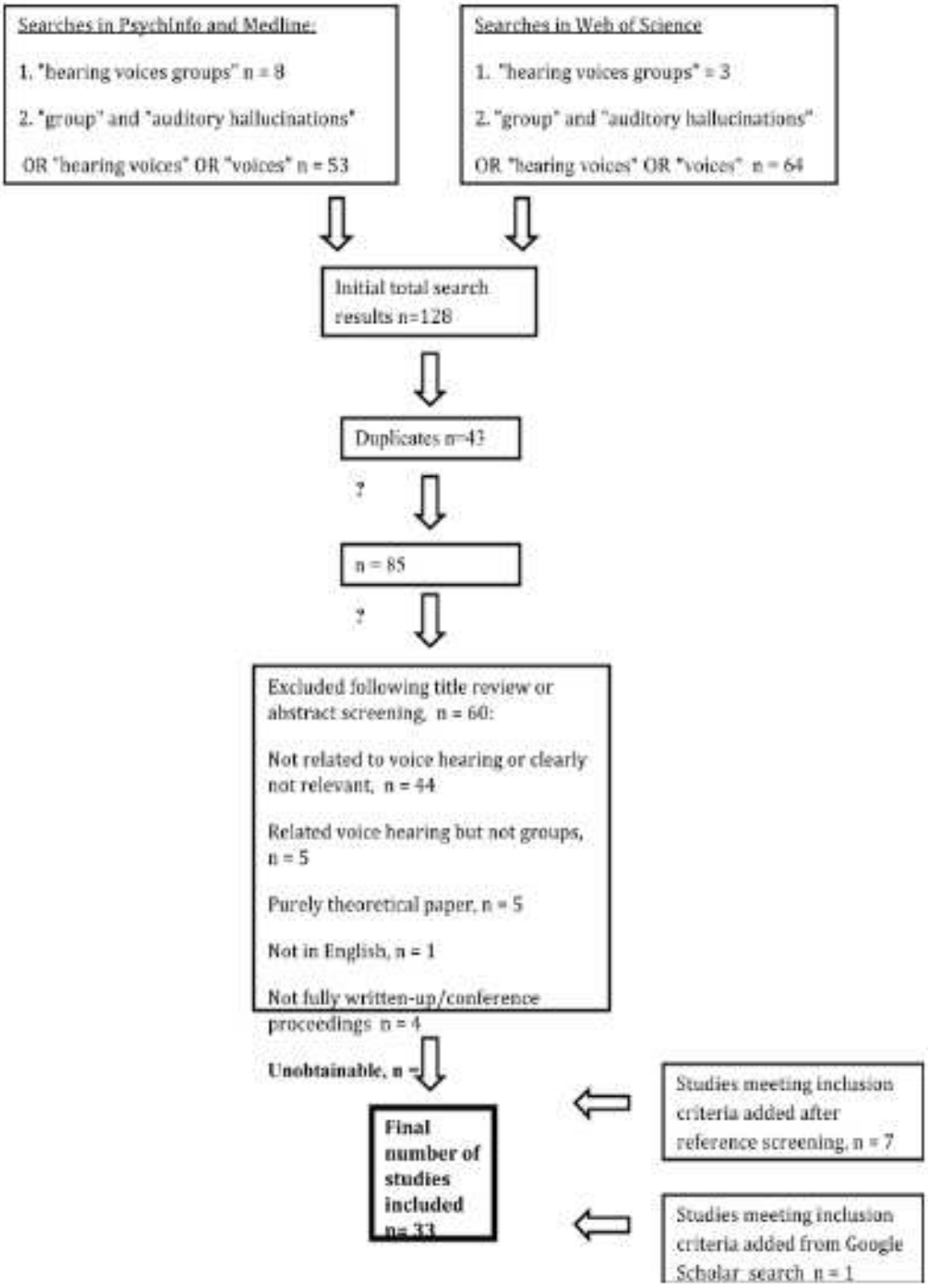
Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215-228. doi: 10.1080/08870440008400302

Young, S. L. & Bullock, W. A. (2003). *Recovery and the role of mental recovery measure in outcomes research.* Ohio: Ohio University Press

# Section C:

## Appendices of supporting material

**Appendix A: Diagram depicting full literature search strategy**



**Appendix B: Yardley's (2000) quality criteria for qualitative research**

| Criteria | Examples |
|---|---|
| Sensitivity to context | Theoretical; relevant literature; empirical data; sociocultural setting; participants' perspectives; ethical issues. |
| Commitment and rigour | In-depth engagement with topic; methodological competencelskill; thorough data collection; depth/breadth of analysis. |
| Transparency and coherence | Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity. |
| Impact and importance | Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers). |

Taken from Yardley (2000, p. 219)

**Appendix C: Potential variables associated with impact beyond group, complete with illustrative quotes**

| Process identified within the group | Impact identified as resulting from this process | Illustrative quote (from study participants) | Theme from which quote taken | Study |
|---|---|---|---|---|
| <u>CBT groups</u> | | | | |
| universality/ normalising | strengthened identity | "...I'm not the only person that's got this problem, so I don't have to feel like I'm crazy or anything like that." | a safe place to talk | Newton, Larkin, Melhuish and Wykes (2007) |
| improved understanding of voices | increased occupational functioning | "I could see what helped and what didn't...now I can see why playing football, watching TV, going out, helps." | role of facilitators | Newton, Larkin, Melhuish and Wykes (2007) |
| <u>PBCT groups</u> | | | | |
| perceived support/ containment | increased occupational functioning | "We went to the club for the first time in about 10 years [...] I wouldn't have done that had I not come to this group." | group support and perceived containment | Goodliffe et al. (2010) |
| acceptance of 'illness' | strengthened identity | "I was bitterly bitterly resentful toward myself, that this illness had come into my life. And now I'm learning to accept this. I'm quite a lot happier in myself now that I've accepted it." | acceptance and understanding of the experience of voices | Goodliffe et al. (2010) |
| acceptance of voices | increased coping | "once you accept it it's easier for you to look at ways of coping" | learning to cope with voices | Goodliffe et al. (2010) |
| mindful acceptance of voices | reduced distress | "If you do mindfulness…if you can reach a mindful state…then everything slowly begins to relax." | developing mindfulness skills | May et al. (2014) |
| sharing and learning from others | increased coping | "People were picking up on other people's ideas and experiences and just giving it a try from themselves and finding out that they, they could do things that they never thought they could do | strength and power over voices | May et al. (2014) |

| Process identified within the group | Impact identified as resulting from this process | Illustrative quote (from study participants) | Theme from which quote taken | Study |
|---|---|---|---|---|
| | | before." | | |
| universality/ normalising | strengthened identity | "... I am still a person, still have my own, my identity...I was beginning to lose that a bit, you know before I did the group." "I think it did affect the way I was feeling about myself because um, mainly because of the group sort of like feeling the same as I did...just have somebody saying "well no you, it's not you that's evil it's the voices" [...] so I didn't feel quite as bad about myself." | identity beyond voices | May et al. (2014) |
| <u>HVN groups</u> | | | | |
| universality/ normalising | increased hope for the future | "realising you're not strange, a weirdo, it happens to other people – members of the group have enabled me to normalise and to know you can have a fulfilling life even with voices" | helpful aspects of the group | Meddings et al. (2004) |
| improved understanding of voices | improved control over voices | “I was so afraid of the voices, whereas now I feel when it does happen I’m more empowered to deal with the situation than I was when I first started.” | “I’m doing things now”: coping beyond the group | Oakland and Berry (2015) |
| sharing and learning from others | increased coping | "I heard about placing a shield over the voices and it just literally captured my imagination...it did for me what I needed it to do." | 'Somebody who knows from experience': Experienced trial and error. | Oakland and Berry (2015) |
| sharing experiences about voices | increased confidence to discuss voices | "I am more comfortable to talk with them (my parents) and my grandparents and my auntie and uncle, and that's from the group that I can talk". | 'Willingness to share with others'. | Dos Santos and Beavan (2015) |

| Process identified within the group | Impact identified as resulting from this process | Illustrative quote (from study participants) | Theme from which quote taken | Study |
|---|---|---|---|---|
| | | "I just pulled everyone that I work with aside and I said this is what's happening...and that turned folks, everyone was really good about it...I don't mind talking about it." | | |
| improved understanding of voices | improved control over voices | "Not being angry, not being fearful, why should I be afraid of the voices...It's made me question my own beliefs and I understand my triggers now."<br><br>"...since going to the group and reading all the books and leaning all the theory...I'm not at all scared that I hear voices anymore." | relating to voices | Dos Santos and Beavan (2015) |

**Appendix D: Interview schedule version 1**

Interview Schedule

1. What is it like going to the group? (Prompt: how would you describe it to a friend?)
2. What were the experiences that lead you to going to the HVG? (Prompt: what was going on in your life around the time you decided to go?)
3. Which experiences have you had in the group which most stick in your head? (Prompt: describe particularly good/bad/emotional/useful/unhelpful moments.)
4. How has your understanding of your voice hearing (or any other) experiences changed since attending the group? How has the group changed this? (Prompt: what other experiences have you talked about in the group?)
5. What are your hopes for your (voice-hearing) experiences in the future? (Prompt: would you like them to change in any way?)
6. How would you describe any changes in your life (if any) as a result of going to the groups? How did going to the group bring about this change? (Prompts: is there anything better or worse about life since attending?/Has it helped you to 'recover' in any way?)
7. How would you describe relationships in the group (both your own and others)? How have they changed over time? (Prompt: what role have people played in the groups.)

**Appendix E: Interview schedule version 2**

Interview Schedule (version 2)

1. What happens in a group? What is it like? (Prompt: how would you describe it to a friend? )

2. What were your first impressions of the group? How did these impressions change over time (if at all)? (prompt: did they turn out to be true or not?)

3. What were the experiences that lead you to going to the HVG? (Prompt: what was going on in your life around the time you decided to go?)

4. Which experiences have you had in the group which most stick in your head? (Prompt: describe particularly good/bad/emotional/useful/unhelpful moments. Describe a recent memorable experience in the group)

5. How has your understanding of your voice hearing (or any other) experiences changed since attending the group? How has the group changed this? (Prompt: what other experiences have you talked about in the group?)

6. What are your hopes for your (voice-hearing) experiences in the future? (Prompt: would you like them to change in any way?)

7. How would you describe any changes in your life (if any) as a result of going to the groups? How did going to the group bring about this change? (Prompts: is there anything better or worse about life since attending?/Has it helped you to move towards where you want to be in life in any way?)

8. How would you describe relationships in the group (both your own and others)? How have they changed over time? (Prompt: what roles or tasks have people played in the groups.)

9. If, for whatever reason, the group was no longer there or you could not attend, what would you most miss about it?

10. Could you share any other experiences of going to the group that we have not talked about so far today?

**Appendix F: Mental Health Recovery Measure**

*This has been removed from the electronic copy*

**Appendix G: REC provisional opinion letter**

*This has been removed from the electronic copy*

**Appendix H: Reply to REC provisional opinion letter**

*This has been removed from the electronic copy*

**Appendix I: REC approval letter**

*This has been removed from the electronic copy*

**Appendix J: Ethics approval from Research and Development Office, SLAM**

*This has been removed from the electronic copy*

**Appendix K: Ethics approval from Psychosis CAG, SLAM**

*This has been removed from the electronic copy*

**Appendix L: Participant information sheet**

## Information about the research

Title: How people experience Hearing Voices Network groups and the connection to recovery and group processes.

Hello. My name is Tom Payne and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.

### Part 1:

### What is the purpose of the study?

This study is part of my Doctorate training as a Clinical Psychologist at Canterbury Christ Church University.

The purpose of this study is to explore people's experiences of going to Hearing Voices Network groups. It will help us to understand what goes on in the groups, what people get out of attending them, and how this may help them in their day-to-day lives or their 'recovery'.

### Why have I been invited?

As somebody who attends the groups, your first-hand experience and knowledge make you an ideal candidate for this study. I am interested in understanding attendees' experiences (rather than health care professionals). You are one of about eight people I am hoping will participate.

### Do I have to take part?

It is up to you to decide to take part in the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw

at any time, without giving a reason. This would not affect the standard of care you receive.

**What will happen to me if I take part?**

If you agree to take part I will contact you to arrange a time that is convenient for you to come and be interviewed. There is just one interview and it will take place at one of three staffed NHS locations near to the where the group is held (details will be given). There is no specific benefit for taking part, but £10 will be paid towards the cost of any travel expenses for coming to the interview. It should take approximately one hour.

During the interview I will ask you some questions about your different experiences of coming to the Hearing Voices group, including what it's been like and how it's helped or not. All you have to do is answer the questions in the most open way you feel comfortable doing. The more openly you can answer the questions the better, but it is important to understand that you do not have to talk about anything that makes you feel uncomfortable.

At the start of the interview I will take some basic demographic information such as age, gender etc. I will also ask you to complete a short questionnaire about recovery which will take around five minutes. This information will not include your name or anything that will identify you. I will collect it to help people who read about the study understand the findings better.

Your participation and everything you say in the interview will be treated with strict confidentiality (there are always some 'limits' to confidentiality if you say something which shows yourself or someone else to be at risk of harm - these limits will be fully explained). With your consent I will record the interview and afterwards transfer it onto a password protected memory stick, so that no-one will be able to listen to it. Taking part in this research will not affect any of your treatment or future attendance of the groups in any way.

**Part 2 of the information sheet**

**What will happen if I don't want to carry on with the study?**

You have the right to withdraw from the study at any stage without there being any consequences for you, any treatment you have or your

attendance at the groups. If you withdraw during the interview, I will ask you if I can use the part of the interview we have recorded for my study, but you have the right to say no.

**What if there is a problem?**

**Complaints** .

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (you can contact me on 0333 011 7070 by leaving a message, stating both my name and your name and I will get back to you). If you remain unhappy and wish to complain formally, you can do this by contacting the head of the research department of my university:

Professor Paul Camic, Research Director, Department of Applied Psychology, Canterbury Christ Church University, Runcie Court, Broomhill Road, Tunbridge Wells, TN3 0TF

Telephone: 03330 117 114

Email: paul.camic@canterbury.ac.uk

**Will my taking part in this study be kept confidential?**

As previously noted, the recordings from this interview with be passed onto a password protected memory stick to protect your confidentiality.

When I type up the interviews I will also password protect the document with the interview on so that no-one else can read it. Any information which you mention which could give away your own or others' identities or personal information such as names or addresses will be removed or changed so no-one can recognise it. Myself and my university will each keep a copy of the data on a password protected CD for ten years after the study as part of the university's rules. The CDs will be kept in a secure place.

After I have typed up the interview my two supervisors - Jo Allen and Tony Lavender - will read some of them in order to help me write up my study. There is a small chance someone from a department called R & D (which stands for Research and Development) from the NHS would listen if they are doing an audit (an audit is an investigation into an organisation's work to check the quality and ways of doing things).

You have the right to check the accuracy of data held about you and to correct any errors.

**Involvement of Healthcare Professionals (e.g. keyworkers)**

Before taking part, I would like to ask you if there is anyone involved in your wellbeing or care, or someone close to you who I could contact on your behalf if you were to feel unwell or distressed around the time of the interview. I would only do this with your permission.

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

The type of research I am doing will involve typing up the interviews and reading them many times to understand what people are saying in detail. I will do this with all of the interviews and write up the findings as part of my university project. The aim will be to help others understand the features of Hearing Voices groups better. This may be published in a journal, but you will not be identified in any way. I may use quotes from the interviews in the published project.

**Who is organising and funding the research?**

The research is part of my Doctorate in Clinical Psychology at Salomons for Canterbury Christ Church University. The research is funded by the university and I have two supervisors - one from the university and one from SLAM (South London and Maudsley NHS Trust).

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the London City and East Research Ethics Committee.

**Further information and contact details**

**General information about research**

If you want to hear more about the Hearing Voices Network, including information about their groups, you can visit their website at:

www.hearing-voices.org

If you would like to speak to me and find out more about my study on Hearing Voices Network Groups and have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 0333 011 7070. Please say that the message is for Tom Payne and leave a contact name and number so that I can get back to you.

**Advice as to whether you should participate**

Talking about your experiences could bring up some difficult thoughts, feelings and memories. It may help to talk to someone about it such as a friend, family member or healthcare professional before deciding whether to take part.

**Who should you approach if you are unhappy with the study**

If you are unhappy with anything about the study then you can contact me on the above and I will be happy to respond to any of your concerns. Should I be unable to do this I will provide you contact details of my supervisors who will be able to give you further information.

**Appendix M: Consent form**

Version 2, 13/02/14

Canterbury Christ Church University

South London and Maudsley NHS
NHS Foundation Trust

Consent Form

Title of Project: How people experience Hearing Voices Network groups and the connection to recovery and group processes.

Name of Researcher: Tom Payne

Participant Identification Number for this study:

Please initial box

1. I confirm that I have read and understand the information sheet dated 13/02/14 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up until the end of September 2014 (before the write up of the research), without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of the data collected during the study may be looked at by my supervisors, Tony Lavender and Jo Allen. Tony Lavender is based at Canterbury Christ Church University where the researcher studies and Jo Allen works for South London and Maudsley (SLAM) NHS Trust where this research is planned to take place. They are both qualified Clinical Psychologists and their main role is to provide guidance and supervision on academic aspects of this study. I give permission for these individuals to have access to my data. ☐

4. I agree to my key worker being informed of my participation in the study [if applicable] ☐

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐

6. I agree to my interview being audio recorded and stored on a password protected memory stick until the end of the study, after which time the recording will be deleted. ☐

7. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

**Appendix N: Participant details sheet**

Hearing voices project - Participant details sheet

Name:
Date of birth:
Gender:
Ethnicity:
Length of time you have been attending hearing voices group:

**Appendix O: Example annotated transcript**

*This has been removed from the electronic copy*

**Appendix P: Theme development by hand**

Theme development stage one, writing out initial codes at participant level

Participant 1: Theme development, stage one

| | | |
|---|---|---|
| voice hearing shameful before group 1.10 | similar people with similar experiences 1.47 | nervous at first attendance 1.107 |
| voice hearing taboo prior to group 1.11 | supportive group nature: sharing, caring and helping 1.49 | establishment of safety 1.113 |
| a place to come out 1.16 | flexible agenda conducive to support 1.50 | 'people were on your side' 1.113 |
| group experience removes shame and 'end of world feeling' 1.17 | problem solving and explicit advice 1.60 | people cared about your experiences 1.114 |
| normalising: lots of people hear voices 1.18 | problem solving space 1.64 | feeling of confidentiality 1.117 |
| main impact: a place to talk about it 1.20 | sharing leads to identification and support 1.68 | confidentiality and support established safety 1.122 |
| space to talk openly is inspiring 1.24 | caring and encouraging through bad patches 1.74 | positive experience grew and remained 1.127 |
| initial fear of the unknown 1.31 | being there and listening is key 1.80 | angry incident provoked worry 1.130 |
| initially, just quiet and listened 1.34 | contact outside group created 1.82 | angry incident handled well by facilitator 1.135 |
| experience of group varies week to week 1.39 | social contact outside group 1.87 | exception to safe space 1.137 |
| group has regulars 1.41 | amazement: power of talking openly 1.95 | distressed members given one to one support 1.139 |
| different people make for different groups 1.44 | first impressions of group powerful 1.98 | angry incident didn't compromise safety 1.142 |
| regulars and non-regulars change group dynamics 1.42 | safe space established quickly 1.106 | Angry incident directed at facilitator 1.149 |

| | | |
|---|---|---|
| difficult times 1.149 | experience of chattery voices 1.200 | thought I was going mad before group 1.290 |
| momentary fear of violence in group 1.153 | involvement in mental health services 1.202 | potent feelings of guilt and shame before group 1.292 |
| empathy for others' suffering 1.155 | discovery of group through mental health services 1.211 | understanding experiences improved over time 1.296 |
| mixed empathy and fear for other member 1.153 | invitation to attend 1.216 | normalisation of voice hearing through group 1.297 |
| growth of relationships 1.163 | difficult moments as exceptions 1.234 | separation of voice hearing and mental health |

| | | |
|---|---|---|
| | | problems through group 1.299 |
| listening and learning from others' experiences and stories 1.170 | supportive and caring group input at times of distress 1.237 | understanding of voice hearing as linked to childhood abuse and trauma 1.302 |
| development of friendships 1.176 | memorable facilitator interventions 1.241 | voice hearing greatly reduced due to group 1.310 |
| breakdown and voice hearing prior to group attendance 1.181 | seeing caring in action is moving 1.250 | benefits from understanding own voice hearing 1.311 |
| related voice hearing to alcohol and drugs 1.184 | feeling for one another through bad patches is memorable 1.258 | understandings of voice hearing vary in group 1.313 |
| voice hearing reflected abusive mother's words 1.190 | mutual empathy 1.260 | no 'one set answer' in group 1.315 |
| worried about going made before group 1.195 | helping, not fixing 1.264 | opportunities to explore voice origins and identities 1.321 |
| voices told me to self harm 1.196 | optimism seeing others come out the other side 1.267 | understanding develops gradually over time 1.324 |
| friendship support before group 1.199 | confusion about voices before group 1.289 | understanding own voices can come from hearing others' stories 1.325 |
| some reach conclusions about voices 1.331 | it feels good to help others 1.402 | 'chatting about whatever': importance of just being normal 1.456 |
| exploration is long term 1.339 | using experiences to help others 1.404 | welcoming new members 1.461 |
| knowledgeable facilitators help explore 1.342 | co-facilitating is giving back 1.407 | sharing round and asking questions 1.461 |
| listening and reflecting over time 1.346 | plans to keep helping in future 1.414 | weekly check in 1.464 |
| understanding is not a standout moment 1.347 | voice hearing has changed over time 1.418 | sharing-time for everyone 1.468 |
| reflecting on voices between and in groups 1.352 | linking voice hearing to stress and mood 1.421 | group's given me confidence 1.478 |
| other ingredients: not just the group which helps 1.355 | managing voices by managing mental health 1.423 | less anxious about things 1.481 |
| paranoia as group topic 1.363 | hopes for voices to go 1.426 | confidence from combination of groups and therapy 1.484 |
| experiences of depression discussed in group 1.378 | progress through counselling and group | confidence from open sharing 1.485 |

| | | |
|---|---|---|
| | combined 1.430 | |
| suicidal feelings discussed 1.387 | learning coping strategies are key 1.438 | personal growth from co-facilitation 1.488 |
| suicidal feelings dealt with by services 1.389 | self care and distractions help 1.441 | critical voices less intense and frequent 1.492 |
| limitations of group containment 1.389 | finding strategies that work for you 1.447 | repaired self-esteem 1.495 |
| aspirations to help others 1.396 | importance of planned chat time 1.454 | ability to let go 1.497 |
| new opportunities - voluntary work 1.501 | dynamics vary with infrequent attendees 1.563 | blessed with knowledgeable and experienced facilitator 1.639 |
| progress over the years 1.503 | conflict outside of group can enter group 1.568 | good facilitator is a resource 1.647 |
| progress from combination things 1.506 | An accepting group 1.574 | good facilitator helps explore issues 1.651 |
| made me able to help others 1.508 | 'fixing' behaviour hard to take 1.583 | good facilitator explores alongside you 1.665 |
| new opportunities - doing a course 1.514 | challenges of understanding others' group behaviour 1.584 | good facilitator promotes self discovery 1.670 |
| understanding and coping lead to a better life 1.520 | family roles come into group 1.586 | good facilitation: exploring not telling1.672 |
| better concentration is key 1.531 | fixing doesn't work 1.588 | group a valuable thing 1.686 |
| able to build relationships again 1.534 | caring roles in group 1.595 | progress returning to work 1.688 |
| renewed sense of self 1.535 | listening and sharing back roles 1.600 | progress returning to education 1.692 |
| for some it's just a group 1.541 | people skills 1.600 | progress starting voluntary work 1.694 |
| drop-in group for some 1.545 | role of socialising REMOVE (Interviewer) | not everyone experiences changes in their voices 1.695 |
| group configuration determines dynamics 1.545 | 'always there' - reliable presence of group 1.609 | most people progress 1.697 |
| group is welcoming 1.548 | permanent place to connect 1.614 | coping and progressing regardless of voices 1.700 |
| opportunities to build friendships 1.550 | safe space 1.617 | slow progress accumulates ovrtime1.705 |
| relationships sometimes confined to group 1.553 | the reliable family I never had 1.625 | |
| fixing instead of listening - frustrating 1.558 | reciprocal relationships built on being reliable 1.630 | |
| dynamics affected by different responses to | | |

| | | |
|---|---|---|
| distress 1.561 | | |

Participant 2, VL: Theme development, stage one

| | | |
|---|---|---|
| general chitchat and welcoming in 2.7 | supportive and informative 2.122 | overcoming own negative reactions to perceived attention-seeking 2.290 |
| welcoming in new members 2.15 | overcoming the realities of others' mental health problems 2.123 | group supported someone through suicidal phase 2.300 |
| facilitator senses group mood and shapes agenda 2.21 | humbling process of opening up to others' difficult stories 2.132 | containment of group through careful management of suicidal members 2.310 |
| relating topics to voice hearing 2.24 | nurturing effect of the group 2. 144 | suicide is heavy topic 2.312 |
| checking out members experience of the group at the end 2.31 | importance of accepting & non-judgemental ethos 2.145 | battling through the voices to attend 2.324 |
| reviewing members' problems 2.39 | ownership of meaning of your experiences 2.152, 2.387 | initial power of having people openly discuss voices 2.330 |
| a space to offload and unburden yourself 2.41 | acceptance of your experiences opens up exploration 2.158 | externalising the problem: I'm not mad it's a peculiar experience 2.345 |
| depression as a group topic 2.49 | others' openness to your experiences is nurturing 2.172 | identification with others' anger 2.357 |
| flexible agenda 2.52 | flexible agenda of group, voice hearing not compulsory topic 2.195 | impact of a compassionate and knowledgeable facilitator 2.361 |
| regulating group mood with humour 2.54 | others' distress can trigger your own 2.210 | initial challenge of reframing voice hearing meaning 2.365 |
| liberation through destigmatisation 2.61 | distress regulation through topic changing 2.214 | activities on and off topic of v. hearing meaningful 2.374 |
| normalisation, not feeling peculiar 2.72 | emotionally intense groups are tough, but productive 2.223 | importance of relating to voices as you choose 2.387 |
| feeling normal through open discussion 2.84 | group structure and predictability is emotionally containing 2.232 | individual trajectories with relating to voices are respected 2.391 |
| realising voices and visions are not unusual 2.90 | New members provide new slants 2.246 | group is the highlight of my week 2.404 |
| increased understanding from exploring triggers 2.94 | honestly critiquing group is difficult 2.253 | group has helped me learn to build trust in people 2.410 |

| | | |
|---|---|---|
| group is an accepting space 2.96 | a space to evaluate group at the end 2.265 | value of group motivated me to overcome fears and keep attending 2.417 |
| relief of close support at first attendance 2.109 | Initial positive impact of having clear choice not to have to share 2.286 | group is a space to feel normal 2.427 |
| feeling included and forming a significant part of something 2.433 | being a tight-knit group helps as each others' issues are more familiar 2.580 | A place to connect with people 2.682 |
| group is a necessity 2.470, 2.511 | smaller groups create intimacy and more talk time 2.594 | Group impact part of package with therapy 2.690 |
| seeing others managing their voices helps me progress 2.484 | knowing each other more leads to helping each other better 2.605 | Group and individual therapy complement one another 2.699 |
| learning that distress is transient 2.488 | New members create new slants 2.608 | Group normalisation has a positive impact on identity and confidence 2.714 |
| learning from experts by experience 2.491 | Challenges of members bringing minority positive voice hearing experiences 2.616 | limitations of having to address everyone's needs 2.723 |
| hope from seeing others move on to work and education 2.493 | silencing effect of others' experiences which cannot be identified with 2.625 | group mood and your needs incompatible at times 2.724 |
| facilitators shape the group culture 2.527 | encouragement through suicidal feelings 2.635 | inhibiting impact of new members 2.732 |
| The group belongs to the group 2.534 | value of skilled listeners 2.638 | group can be a space for fun too 2.742 |
| friendly space to get to know people 2.549 | nurturing people's self worth through sincere caring 2.646 | the group creates its own mood 2.758 |
| group relationships are based on mutual support 2.552 | group safe enough to express states of extreme dispair 2.658 | |
| Group is non-competitive and non-hostile 2.556 | Unconditionally accepting environment essential to group 2.662 | |
| people find things in common 2.559 | perspective: members remind you bad patches will pass 2.673 | |
| Facilitator's role to support Hearing Voices Network ethos 2.567 | An essential part of the week 2.679 | |

Participant 3, MC: Theme development, stage one

| | | |
|---|---|---|
| checking in with each other 3.12 | challenges of articulating problems 3.109 | smaller group less competition to speak 3.203 |

| | | |
|---|---|---|
| facilitators follow similar structure despite some variation 3.24 | best to focus on listening rather than contributing at times 3.114 | Reasons for coming to group: voices troublesome & on medication 3.215 |
| introducing ourselves as voice hearers to the group 3.26 | not finding moment to talk can leave you feeling left out 3.121 | Reasons for coming to group: stress of medical review and distressing beliefs about government 3.245 |
| seeing how people's voices have been 3.33 | moment to talk usually appears at some point in group 3.125 | Group a space to offload distress 3.269 |
| drop-in group format 3.37 | finding moment to talk by listening carefully 3.132 | group and medication a package to reduce stress from voices 3.278, 3.296 |
| drop-in format helpful for maintaining group contact if full 2 hours too much 3.47 | group changed over time due to size and different people 3.140 | exploration in group led to understanding legitimate message in voices 3.280 |
| free flowing agenda of group 3.58 | first impression of group - supportive and non-judgemental 3.144 | more liberty to offload in group than with friends 3.304 |
| group ends with mindfulness or positive focusing exercise 3.79 | facilitators with lived experience or training conducive to positive group environment 3.153 | group provided space to discuss issues not available elsewhere 3.321 |
| group endings vary 3.83 | facilitation by everybody conducive to positive environment 3.156 | cathartic space to talk: relief from release 3.325 |
| can opt out of group exercises 3.91 | flexibility and fluidity of facilitator role made group comfortable 3.163 | mere presence of group containing: there in background as source of support 3.327 |
| unpredictability of group material can be daunting 3.103 | bigger group increases variety of input 3.186 | group a space to be listened to 3.360 |
| hard to get word in edgeways 3.106 | bigger group decreases talking opportunity 3.188 | learning through seeing differences in others' experiences of distress 3.361 |
| silences in group 3.107 | bigger group: harder to keep track of different ideas 3.191 | characteristics and experiences of voice hearing diverse across group 3.384 |
| increased understanding of the diverse nature of voice hearing experiences from person to person 3.389 | discussing positive voice hearing experiences trigger negative voices and opinions in others 3.510 | group attendance led to confidence to set up peer support group 3.657 |
| some experience voices | discussing negative voices | seeing the positive |

| | | |
|---|---|---|
| as paranoia 3.397 | can trigger negative voices in others 3.534 | influence of good listening led to increased confidence 3.661 |
| challenge of intoxicated, abuse group member 3.415 | relationships in group generally positive 3.551 | lack of one-to-one support in group 3.663 |
| challenge of abusive member handled well 3.419 | individual distress can create a mood of distress in group 3.554 | advantage over CBT: ongoing and people with lived experience 3.665 |
| challenging incidents rare 3.421 | good listening helps people feel better 3.562 | main impact of group: support to manage voices 3.739 |
| group facilitators collectively dealt with incident of abusive member 3.430 | being listened helps people move on from difficult experiences 3.567 | in group learnt skills to help run other groups in 3.774 |
| difficult incident helped to develop ground rules in future 3.436 | reduced distress from gaining new perspectives 3.582 | group's importance of regular slot in week to unload problems 3.787 |
| members good at keeping to ground rules 3.448 | being listened to most important aspect of group 3.591 | group a place to gain alternative perspectives 3.787 |
| ownership over meaning of voices main principle 3.456 | increased understanding comes from being listened to 3.593 | overinvolvement with other members can be overwhelming 3.799 |
| positive voices not encouraged in group culture 3.487 , 3.756 | good listening is difficult when own issues dominate 3.601 | important to maintain personal boundaries with fellow attendees to avoid being overwhelmed 3.805 |
| assumption of voices as negative in group culture 3.490 | group has improved my listening skills 3.633 | |
| benefits of exploring spiritual dimensions of voice hearing 3.501 | group has lead to increased self-confidence 3.634 | |
| spiritual dimension of voices closed down by those with opposing views 3.503 | occasionally feel undermined by group 3.638, 3.741 | |

Participant 4, AK: Theme development, stage one

| | | |
|---|---|---|
| group is an open format 4.10 | tensions from competing to talk in group 4.77 | support from peers who understand the issues is better than family 4.171 |
| group is set up by everyone 4.12 | drop in format reduces tension in group 4.84 | group is a place to network 4.176 |
| agenda negotiated by whole group 4.17 | first impression of group: wary of entering 'mental health realm' due to | learning that wellbeing is holistic requiring multiple input, not just psychiatric |

| | | |
|---|---|---|
| | setting 4.92 | advice 4.178 |
| group ends with readings of creative writing 4.20 | initially put off by age and gender differences 4.99 | others' desire to help key ingredient to own improvement 4.209 |
| initially scared by people's appearance and anger 4.30 | initially surprised by quietness of some members 4.103 | hearing voices group showcases successful recovery in people 4.214 |
| learning from experienced members 4.37 | made friends with other females early on 4.111 | experiences leading up to group: acute anxiety 4.230 |
| facilitators and group members provide info and ideas 4.43 | process of finding things in common helped me overcome prejudices about people 4.121 | support from group currently preferable to returning to work 4.247 |
| initially shocked and frightened by others' experiences 4.46 | sympathy helps overcome initial prejudices 4.126 | setting ground rules helps managing the group 4.263 |
| empathy comes from identifying with others' difficulties 4.48 | people in group are helpful and sympathetic 4.128 | ground rules create sense of safety 4.278 |
| opportunities to give updates on our lives 4.67 | trust leads to more valuable relationships 4.130 | ground rules help manage boundaries with others 4.282 |
| 'free to come and go' rule useful 4.70 | mid-group break allows you to recover energy 4.136 | ground rules create confidentiality 4.285 |
| group full of interesting activities 4.75 | learning to take group at a steady pace was useful 4.145 | sense of safety comes from being able to trust people 4.290 |
| 'free to come and go' rule useful if people experience distress during group 4.75 | prejudiced belief of family member that group was negative influence 4.158 | safety comes from not being obliged to speak 4.299 |
| safety comes from sensitive nature of people 4.300 | people generally do get the chance to contribute (speak) 4.427 | open and flexible format of group creates atmosphere of trust 4. 506 |
| people can be abrasive 4.307 | people struggle to articulate experiences at times 4.430 | group strengthened by containment of boundaries and structure 4.509 |
| facilitators sympathetic ear lifts people from bad ideas 4.317 | catharsis: release through expression 4.433 | facilitator ensures quiet ones are not left out 4.522 |
| kind and skilled facilitation inspires desire to help others 4.320 | catharsis occurs through acknowledgement of your experiences from others 4.438 | facilitator helps set agenda and democratic styles of group 4.538 |
| sharing can feel good even if you don't get reassurance 4.333 | expressing content of voices helps explore and understand them 4.441 | group important part of weekly routine 4.545 |
| effect of medication helped me to return to | wary due to being young female in group 4.455 | group 'like a good catch up with a friend' 4.548 |

| | | |
|---|---|---|
| group 4.349 | | |
| value of group increases as you learn when and how to speak 4.350 | uneasiness (of gender/age difference) helped by sense that people respect boundaries 4.460 | group provides moral support 4.555 |
| group inspires desire to build relationships 4.368 | people are polite in the group 4.466 | slot for sharing creative work helps get to know people 4. 566 |
| group inspires altruism 4.370 | group is a place to develop friendships 4.470 | creative slot broadens remit of group beyond mental health and support 4.572 |
| group is a collaborative give-and-take process 4.377 | potential for close and nurturing relationships in group 4.478 | creative slot shows value and productivity of people 4. 578 |
| group is part of a package which collectively improves my life 4.383 | need for human connection drives relationship-building 4.489 | creative slot is nice bonding time 4. 581 |
| group is a definite in my diary 4.402 | gender differences in group interactions: men debate more, women share their experiences more 4.500 | |
| group is a space to offload to people who understand and contain issues 4.421 | group strengthened by positive relationships 4.505 | |

Participant 5, RH. Theme development, stage one

| | | |
|---|---|---|
| opportunity to be in company 5.9 | place to share views of wrongful diagnosis of schizophrenia 5.137 | group keeps me from being a recluse 5.293 |
| group non-judgemental space 5.24 | place to explore own spiritual understanding of voices as alternative to 'chemical imbalance' view 5.145 | group part of inspiration to take writing further 5.303 |
| a place where you are noticed 5.25 | scope to explore spiritual views of voices limited in group 5.155 | trust leads to sharing and solving problems 5.316 |
| a place to be socially included 5.30 | place to share distressing experiences of coercive treatment 5.161 | the more you get to know people the more you can trust them 5.323 |
| non-judgemental space is a relief 5.35 | good not to have spiritual understandings of voices ridiculed 5.180 | attending group provides opportunities to feel involved and facilitate group 5.332 |
| group has a busy agenda 5.45 | social space to see familiar faces 5.193 | opportunities to contribute and facilitate group inspire feelings of altruism 5.344 |

| | | |
|---|---|---|
| talking is main activity 5.57 | group my only opportunity for regular social contact 5.199 | increased group size means greater opportunities to meet people 5.352 |
| positive reactions to creative writing from group a highlight 5.62, 5.67 | ongoing and permanent fixture of group important 5.204 | more people and increased conversation is useful 5.362 |
| group is only place where I am listened to 5.77 | contact inside group leads to contact outside 5.219 | easier relating to people with similar interests 5.375 |
| regularity of group helpful 5.84 | a place where people validate your contributions to group 5.227 | less familiarity with people reduces chances to share 5.383 |
| my experience of group consistently positive over the years 5.90 | group is a place to showcase creative skills 5.245 | people 'hogging' the group perceived as attention-seeking 5.391 |
| people eating during group off-putting and distracting 5.97 | concerns that people may react negatively to what you say 5.270 | interrupting upsets people 5.394 |
| opportunity to compare negative experiences of diagnosis and hospital treatment with others 5.121 | place to share grievances about mistreatment from mental health system 5.278 | group tensions are handled well 5.402 |
| group is a lively and vociferous place 5.408 | | |
| people coming and going can be distracting 5.409 | | |
| relationships in group are good 5.412 | | |
| not feeling criticised in group is important 5.417 | | |
| everyone participates in group 5.429 | | |
| group is better with facilitator 5.436 | | |
| facilitator draws people out by asking questions 5.442 | | |
| group gives me something to do during the week 5.458 | | |
| a unique place to talk a lot 5.466 | | |
| talking allows me to feel included in group 5.469 | | |
| mixed reaction in group when religion is mentioned 5.474 | | |
| main impact of group is | | |

| | | |
|---|---|---|
| being listened to 5.486, 5.517 | | |

Participant 6, PG. Theme development, stage one

| | | |
|---|---|---|
| group important part of weekly routine 6.14 | sharing experiences with others helps you understand them 6.145 | sharing experiences can bring anxiety as well relief 6.297 |
| group helps keep me grounded in reality 6.24 | understanding comes from engagement in others giving you explanations 6.150 | emotional transformation: anxiety of sharing and getting feedback turns to relief 6.300 |
| group helpful coping strategy to replace destructive coping of drinking and drugs 6.30 | understanding voices comes from discussing their content, timing, fluctuation and context in your life 6.157 | group is a form of treatment 6.313 |
| group flexible and relaxed structure 6.39 | disruptive group member made someone scared 6.170 | group's impact part of a package with other support groups 6.321 |
| place to explore impact of voices 6.43 | group has packed agenda of creativity, talking and mindfulness exercises 6.186 | group routine helps me snap out of trances more quickly 6.324 |
| group first opportunity to explore voices 6.49 | listening to creative slot lifts your mood 6.191 | group reduces harm in my life 6.345 |
| helpful being around people who understand your experiences 6.51 | routine of group keeps me focused and grounded 6.203, 6.350 | space to share each other's bizarre experiences of trances/dissociation 6.380 |
| impact of group 'as a whole' important 6.57 | group keeps me from staying indoors 6.225 | relationships in group are good 6.387 |
| main impact of group is routine, focus and social contact 6.63 | hope to help others through sharing experiences 6.248 | relationships are like acquaintances 6.394 |
| practical advice is helpful 6.66 | group helps you keep difficulties in perspective 6.260 | there are a mixture of personalities in the group 6.410 |
| apprehensive at first due to unknown quantity of group 6.72 | putting difficulties into perspective reduces paranoia 6.266 | group provides enough space for everybody to talk 6.418 |
| experiences before group (reasons for coming): nasty section 6.106 | sharing experiences helps you keep things in perspective 6.285 | empathy and identifying with each others' experiences is a natural process 6.427 |
| very anxious and vulnerable at first attendance 6.115 | containment of sharing distressing experiences internalised and recalled outside of group 6.289, 6.329 | relationships develop and get closer over time 6.446 |
| | | contact in group leads to contact outside of group 6.461 |

Participant 7 GG. Theme development, stage one

| | | |
|---|---|---|
| group place to discuss experiences of stigma and ill treatment 7.18, 7.26, 7.71 | group perceived as bigger because people more willing to discuss issues openly now 7.225 | |
| we share experiences of perceived misdiagnosis 7.40 | positive impact of receiving praise from group about creative writing 7.253, 7.264 | |
| discussing experiences of discrimination with other mental health sufferers helpful 7.83 | group has given me clearer insight into my anxious thoughts 7.283 | |
| sharing eases thoughts in my mind 7.92 | hearing inspiring stories of others gives me hope I can be a somebody of value 7.293 | |
| sharing reduces feeling of isolation 7.93 | receiving peer support makes me want to give it 7.323 | |
| not being with people of a similar age can make me feel left out 7.94, 7.99 | therapy needed as well as groups 7.345 | |
| others in group share my spiritual understanding of voices 7.126 | regularity of group and people have given me strength and inspiration 7.354 | |
| medication has calming effect but does not ease thoughts (compared to group?) 7.132 | group has increased my confidence by reducing my paranoia 7.369 | |
| group has fostered spiritual understanding of voices 7.151 | going to group reduces anxiety 7.461 | |
| group a place to learn and understand experiences better 7.163 | not being properly heard in the group is distressing 7.474 | |
| initially apprehensive to share with people I don't know 7.175 | | |
| takes time to get used to people in the group 7.183 | | |
| group open to all, unlike other services 7.211 | | |

Participant 8, HW. Theme development, stage one

| | | |
|---|---|---|
| people in group are nice 8.32 | friendliness and support of peer facilitator helped me | validation from group about real perceived meaning of |

| | | |
|---|---|---|
| | feel more accepted 8.221 | 'insight' (agreeing with psychiatrist) 8.412 |
| others talking too much mean I can't talk 8.32 | initially felt excluded as other members knew each other well 8.232 | people in the group are close to each other 8.479 |
| provision of refreshments is welcoming 8.34, 8.538 | hearing experiences of attempted suicide is saddening 8.249 | initially fitting into a well established group is difficult 8.517, 8.523 |
| frustration at not getting to core topic of voices 8.34 | group is sympathetic at times of distress 8.265 | finding the moment to talk is difficult 8.527 |
| difference in own voice hearing experiences compared to rest of group 8.44 | group consists of lots of talking 8.278 | some struggle with tiredness and memory in the group 8.557 |
| CPN persuaded me to come to group 8.57 | just listening to others can be frustrating 8.282 | the speed and detail in which people speak varies a lot 8.559 |
| friends and family not understanding my voices in the past inhibit me from sharing in the group 8.107 | creative slot is fun and appreciated by group 8.295 | |
| so far unable to discuss own voices in the group 8.118 | hearing others' creative work makes me think about my own 8.301 | |
| sharing the fact that my voices stopped gave other group member hope 8.123 | pets are an enjoyable group topic 8.315 | |
| first impression of group enjoyable and welcoming 8.178 | group guidelines are strange and tiresome 8.322 | |
| others talking stopped me from talking 8.181 | guidelines seem strange if not encouraging you to meet up 8.342 | |
| not being able to talk in group is frustrating 8.187 | group has increased motivation to explore own experiences 8.396 | |
| acceptance into group increases as people get to know you 8. 207 | frustration at not knowing how to use group 8.396 | |

Theme development stage two: developing emerging themes at participant level

| Participant | Emerging themes and subthemes (subthemes indented) |
|---|---|
| 1. JH | experiences and beliefs before attending group<br>first impressions<br>establishment of safe space<br>openness and coming out<br>first impressions |

| | |
|---|---|
| | an opportunity for building relationships<br>challenges to group<br>angry incident<br>limitations of group containment<br>effect of group is long term<br>group dynamics<br>conflicts and challenges<br>impact of group configuration<br>importance of good facilitation<br>listening<br>listening as learning<br>listening as helping<br>group is reliable<br>altruism and helping others<br>developing understanding<br>linking voices to the past<br>no one set answer<br>impact of the group<br>impact on functioning<br>optimism from progress<br>group is part of a package<br>impact on self<br>impact on voices<br>supportive and caring<br>connecting with others: normalising, empathy and sharing<br>group activities and content<br>coping strategies |
| 2. VL | challenges of first attending<br>group activities<br>group topics<br>welcoming and settling in new members<br>importance of flexibility<br>evaluating the group<br>influence of a good facilitator<br>challenges to group functioning<br>clash of group and individual needs<br>negative reactions to people and their stories<br>challenges of new members<br>nurturing self worth and identity<br>the value of the group in my life<br>group and personal therapy as a package<br>emotional containment of group<br>distress regulation<br>a space to relate and socialise<br>modelling: the positive impact of seeing others progress<br>acceptance and openness<br>members ownership of the group and their experiences<br>normalising impact of the group<br>advantages of a small group<br>exploring and learning |

| | |
|---|---|
| 3. MC | understanding through learning and exploring<br>humanely relating to one another<br>confidence and skills gained from group<br>the importance and positive impact of listening<br>the flexible, open nature of the group<br>containing space to offload problems and gain support<br>pros and cons of different group sizes<br>group is well run by both facilitators and attendees<br>challenges of the group<br>difficulty of maintaining boundaries with others<br>negative reactions of others<br>finding the moment to talk<br>group culture of voices as negative<br>dealing with distress in group |
| 4. AK | learning how to use the group increases its value<br>group is part of a package which helps<br>group as valued part of my week<br>exploring and learning from others in the group<br>positive impact of compassionate and humane attitude<br>the opportunity to build relationships and positive effects of this<br>salience of age and gender differences<br>importance of catharsis - sharing and release<br>give and take nature of group-support received and altruism inspired<br>challenges in group<br>negative first impressions of people and setting<br>tensions/abrasiveness of others<br>value of setting up and running the group well<br>balance between structure and flexibility valued<br>containment and safety of ground rules<br>skilled facilitation to regulate group important<br>there are valued group activities/elements<br>the creative slot: bonding, normalising, esteem-building |
| 5. RH | connecting and being in company<br>process of getting to know people and building trust<br>non-judgemental attitude important<br>value of being listened to and validated by others<br>validation of creative work<br>group a place to be included/part of something<br>sharing experiences of mistreatment in mental health system<br>the set-up and running of the group is good<br>larger size and busy-ness valued<br>regularity and ongoing presence valued<br>support and structure of facilitator valued<br>challenges to group cohesion<br>distractions and clashes with others<br>mixed reactions to religion |
| 6. PG | vulnerable state upon starting group<br>positive impact of exploring and understanding experiences with others<br>grounding impact of regularity and perspective provided by group<br>group replaces harm in my life |

| | |
|---|---|
| | a place to build relationships<br>group set-up and topics are engaging |
| 7. GG | place to share experiences of stigma and mistreatment<br>developing identity and hope for the future<br>developing understanding of voices and related experiences<br>group helps coping of anxiety and emotional wellbeing<br>lack of familiarity, similarity and acknowledgment of others inhibits engagement |
| 8. HW | frustrations/challenges of learning how the group works<br>(difficulties of) finding your moment to talk<br>fitting into a well-established group<br>negative reactions to guidelines<br>group is a welcoming and friendly place<br>creative slot is fun and thought-provoking |

Further theme development following use of NVIVO software

Theme development stage three: developing emerging themes at group level

| Themes | Subthemes |
|---|---|
| connecting and building relationships/(re)encounter with humanity and compassion | acceptance and openness to people and their experiences<br>opportunities to build relationships and socialise<br>processes of connecting (sharing, identifying, empathising, normalising and building trust)<br>supportive, caring and reliable nature of group<br>the importance of good listening<br>welcoming and friendliness |
| emotional container | containment through ground rules and structure<br>distress regulation of group through catharsis and perspective-gaining<br>establishment of safe space<br>ongoing nature and routine of group containing<br>welcoming and friendliness |
| exploring and learning | positive effects of exploring<br>understanding experiences promotes emotional processing<br>valuable opportunity to explore voices<br>linking voices to personal experiences |
| impact of group set-up and running on group experience | a diverse and engaging group agenda<br>advantage of group over other approaches<br>facilitator role highly valued by group<br>impact of 'who, how many and how often' on experience of group<br>joint ownership and flexibility of group valued<br>settling in: intros and catchup at start |
| challenges of the group experience | challenges to settling in and feeling accepted/integration<br>clash of group and individual needs<br>competing to talk (or be heard)<br>difficult moments (incidents and elevated distress) |

| | |
|---|---|
| | negative reactions to group members and setting |
| | tensions from negotiating group culture and set-up |
| | vulnerability upon starting the group |
| personal growth and gains from group | altruistic cycle- receiving promotes giving |
| | Coping and progress with personal goals |
| | fortified identity and greater confidence |
| | Gaining hope and optimism |
| | Group is one part of a recovery package |
| | valuable role of group in my life |

**Appendix Q: Extended list of quotes by superordinate theme/subtheme**

**Healing - connecting with humanity**

**The 'nurturing' effect of connecting**

**Helen**

1. But generally, I suppose, the experience is being with people that are similar to you, who are experiencing something very similar.

2. I think I felt that people were on your side and, you know, had similar experiences but also cared about you and how it was for you.

3. Generally if you're sharing about the voices and you're experiencing voices then other people relate to it and say 'yeah I've had that' or 'I get that' or, or 'mine's like this' and it just...yeah, it really helps. So you get that general support.

**Lara**

4. It's having people remember your experience and be open to it- I was talking about something last week and Ax, one of the members, um, was just nodding and kind of agreeing, but I think we were talking about hallucinations and um, just him nodding and agreeing felt, kind of nurturing. I know that sounds really corny, but I don't talk about my hallucinations much. I don't even talk about them with my friend M because they're too spooky, you know, they're too weird [*chuckles*].

5. There must be an acceptance there, an unconditional acceptance.

6. It took me humbling myself and accepting that other people, as well as feeling accepted - that was really important, to accept them, accept their story and...to not feel anxious about them but to be open to other people's stories and other people's interpretations of what their voices mean to them.

**Clark**

7. Well, people are being listened to, it's generally people being listened to– well I find, it's the people being listened to that does the business.

8. Sometimes you get a feeling that someone's understood what you're saying or people report having said that they feel their understanding has developed through the group, but I feel that comes from being listened to.

9. Well, it [relationships] varies a lot. It's very positive for some people and generally positive with everybody. There's nobody in the group who I have a problem with or difficulty with.

**Kim**

10. When I was talking to her after the group we had so much in common that I thought, 'wow, we should become good friends because we can really help each other out'.

11. Er, they [relationships] make the group supportive and positive. They– it's like good, a good bonding in the group.

12. I sympathise with all the people now that I've got to know them a bit better because, um, they're just in the same trap that I'm in - they're kind of stuck...

**Harry**

13. I suppose a problem shared, as the saying goes...um, if you feel you can trust someone in the group enough to tell them a concern then we get a bit of a comment.

14. I find I get on best with those I've got something in common with. So, um, for instance, if someone's studied a particular subject similar to my own, I find that I can talk a bit because there's something in common.

15. The moment it starts I'm in company because else...I'm mainly in my own company, but I get talking, which I don't do a lot [chuckles].

**Greg**

16. I suppose we got closer, a little bit closer from the first day that I attended the first group up to now, I've got closer to certain people. We exchange phone numbers, meet up in the cafe sometimes, yeah.

17. I, I have a good understanding with people. I get along fine with X, Y, Z, A & B [group members], yeah, C [group member] too, we get along just fine, we really do, we really do.

18. I found it very helpful to be around people with a similar condition, and at least there is someone who understands what I am talking about and vice versa.

**Jenny**

19. Jenny: A lot of the people that come to the group, all of them are, here are patients or have been patients in the past, and how they've been ill treated, and I discuss about how I've been ill treated, and the stigmas that I go through in my daily life.

Interviewer: OK. And what's it like talking about those things in the group?

Jenny: It's, it's, it's quite a good specific experience, because sometimes out there, the, the small majority of people have mental health problems.

**Walt**

20. It's good, I mean, people are nice.

21. Walt: There was someone who was talking about 'do you have insight?'...whether, they had, they'd been asked whether they had insight and I just said 'insight means you agree with, you're agreeing with them'. It doesn't mean 'insight', it means 'do you agree us?'.

I: Yeah, so what do, how did people react to you saying that?

Walt: I think they agreed [laughs].

### Challenges to connecting

**Helen**

1. I was very nervous. And I, and a little bit...very anxious, a little bit scared...I wasn't quite sure...I mean I had had it explained to me but I still didn't quite know what I was going into, what it would be like, so I think I was quite quiet for a while. I didn't really speak much, I just sort of listened a lot.

2. I think there's been one incident where somebody got really angry.. .and kind of, physically bashed the table. And, you know, a few of us were a bit worried that they were going to do something.

3. ...there was two people who had a falling out outside of group and that came into group a little bit. That was a bit awkward and then one just, and they both ended up stop coming cos they didn't want to see the other person then.

**Lara**

4. I was also quite scared at first, because people there do have mental health issues and I was scared that...their experiences, are, are kind of facing the reality of mental health problems, because with some people, you know, mental health issues also involve, you know, a period of illness where you're slightly insane and so I was scared of meeting people like that.

5. ...it's distressing, so to hear about it can be really heavy. It can be quite, um...especially if somebody's talking about something that's distressed them, and you're sitting there thinking 'yeah, I remember I went through that about three years ago', so it's a trigger for your own distressing and, and, confusing experiences.

6. I found it hard listening to other people who, who were discussing their voices in terms of something which I was interpreting as being a delusion. Erm, but as I told you I then learnt to deal with that.

**Clark**

7. Sometimes, I find that certain people are in a very, very down on and difficult mood, and they kind of, bring the energy of the group...the energy of the group gets into a very different

sort of stressed place sometimes - if people are feeling distressed it can be distressing in the group.

8. Sometimes it's very difficult to listen to other people in the group cos your own stuff is very, er, very dominant so I'm not, I'm making, it's not, um, it's not always– listening is quite a difficult thing to achieve.

9. I mean sometimes I feel a bit overwhelmed by the group. I feel as if I have to be careful not to, not to get too involved with people there otherwise it might become too much.

10. I talk more about how there's a spiritual dimension to voices...but it's usually swamped out by people who have the opposite experience with their voices.

**Kim**

11. At first I felt a little intimidated and frightened of people in the group because I was scared of their appearance sometimes or they looked like they had problems, like some of them have twitches, er, some of them are old, hunched over, more quiet.

12. Some people get agitated or bothered and they leave because maybe the voices come back or they are not being heard enough because they can't hog the limelight the whole time.

13. Some people can be a bit quiet, or they might be a bit repetitive or a little bit angry when they talk so that can be a bit abrasive.

**Harry**

14. Well, sometimes I mention religion, and er, usually I get a negative reaction.

15. Um, there might be, um, um another who perhaps is interrupting in the middle of speaking, it gets a bit upset, and you think 'you should be upset?' [chuckles heartily]

16. Er, you could have, say one would be talking, hogging for a little while, or maybe disrupting slightly, drawing attention to themselves, and you remember, you know [chuckles]?

**Jenny**

17. I nearly- me, myself nearly had a relapse in the group. Because my questions weren't answered properly, so I felt like, roaring out, cos I thought to myself 'this is very annoying' when the group was very small, when not much people had– when people had a lack of insight.

18. From the beginning, when I started going I was more paranoid and the reason why I was paranoid, because, from the beginning when we start a group you're not that open, because you're meeting new people, you don't know who is who, already yet. So I wasn't that open. I wasn't that confident to discuss all my mental health issues as I didn't know everybody.

19. The only times when I feel left out in the group, mindfully and wordfully, is when I can't see patients my own age group, that are going through this.

**Walt**

20. Some people talk too much and I can't get to talk about what I want to talk about yet.

21. ...before I just felt a bit like a loose key. You know, everybody else had been, er, been in the voices group for a long time and they were all friends, and there was me, a bit sort of on their own.

22. I suppose I'm more, more wanting to talk about my experiences, [pause] but I don't know how to and [pause], so I usually just stand there, I usually sit quite quietly rather than talk.

**Group as an emotional container**

**Safety to unload**

**Helen**

1. Depression, um, a few of us have had troubles with depression so sometimes we talk about that.

2. We really talking about, um, how difficult it is to be able to get to the group even, or to get up and get dressed and get out, and get to the group. And, and to function through the rest of

the week. So people, yeah, talking about being in that place and sometimes people talked about feeling suicidal.

**Lara**

3. But better that you can go to the group and say that, that he could be open [about feeling suicidal] rather than going 'keep that to yourself, and just put on a brave face', see what I mean. It's quite a compliment of the group that people can go there and say 'I'm at the end of my rope here'.

4. Somebody really helped me, um, a couple of weeks ago, by reminding me that 'this too will pass', cos I was very depressed...and I wrote that up and I put it up on my fridge to remind myself, 'yeah this too will pass', this is just a phase, this is depression.

5. I tend to stick to talking about the voices a lot because I've struggled with them and there's no-one else I can really talk to-I can talk to a friend about them but I don't want to burden her too much.

**Clark**

6. I did have people outside of the group who I talked to about the situation but I had to be very careful not to overwhelm people with stressful stuff really, whereas in the group, there's more liberty to, um, to talk through that kind of material, really.

7. I mean, it helped, being able to talk and have a space where I could talk about what was happening and I how I felt about the whole situation.

8. The group provided me with a space to talk through issues that I wasn't getting anywhere else...it was quite a relief really and quite a release.

**Kim**

9. I just found it interesting cos it was laying down some structure [ground rules], and I thought 'well, if we didn't, if we didn't have those rules, will we be safe?'

10. I think that expressing the content of your voices is helpful because it might release it...cos it's acknowledgement, because when you're trapped in the voices you can't get out of it.

11. I think just sharing the stories of your voices is really helpful because you can't really tell your friends or family about the content of the voices. One, because it's complicated and two, because they put up a front because it just sounds like nonsense or weirdness. But if you go to the hearing voices group you can talk about the content of your voices like we did this week.

**Greg**

12. You tend as a schizophrenic to hyper everything you know...blow out of proportion things, small things out of proportion, so it kinds of brings it down, you know, plays it down. Maybe it wasn't as bad as it was, and it helps at putting it into perspective, into focus without all that racing in your head going on, and getting paranoid about this and that, and so it's, it's a bit more objective, you know, more focused.

13. Interviewer: Can you think of any examples of when the group's helped you stop getting things...?

Greg: Er, sharing experiences. The smallest of things can sometimes send you in a trance, er, you know a trance, like, I don't know if you've heard of it...for, for days on end, a thing that has absolutely no importance whatsoever. If you like praying, your hand in your head, starts praying in your head and so, yeah, gee, I mean, the, the sharing of experiences and, and of course, the, the playing down of the...the, the making sense of them and, and objectively not, without blowing it out of proportion.

**Jenny**

14. It [the group], eases certain thoughts in my mind. It eases, it makes me to think and feel like I'm not really alone**.**

**'Always there' - ongoing presence**

**Helen**

1. Interviewer: If for whatever reason the group was no longer there or you couldn't attend, what would you most miss about it?

Helen: I think part- partly the kind of, routine, that it's there at this time in my week every week and it's something I can rely on...that the group's always there. It's only - it only ever doesn't meet at Christmas, but it's there all the other, you know, the rest of the year.

**Clark**

2. ...it's sort of there in the background as a source of support.

3. [If the group was no longer there] I'd miss having a sort of, regular slot each week where I can go and, and, if any of the voices are troubling me or bothering me then I can, um, verbalise and be listened to.

**Harry**

4. Well, I do have some friends and neighbours who visit me or I visit them and we do talk, but it's only so often. The group is few, and it's every week, so, that's more helpful, in some ways.

5. It's just an ongoing help to me, in terms of often being, sitting around with little to do. Once a week I can have this gap where I'm doing something and saying something.

**Greg**

6. Interviewer: You mentioned routine and regular, that sounds important...could you tell me a bit more about the importance of that?

Greg: Well, it stops me from leading myself astray. From, you know, in the past, like I said, I drank too much, I took drugs and that's just one aspect of it which was very detrimental for me and my health, for instance, but also other things. Big things, small things that needn't be done, I needn't be worrying about it. It's just nonsense stuff that with this routine, this group and other things that I go to, I manage to push that away and be focused, and 'Oh yeah, I don't need to worry about them sometimes. I won't go down that way.'

7. It's part of my routine, mental health support. Um, I find that it keeps me, er, keeps me focused, as far as my mental health is concerned.

8. You see as a schizophrenic, sometimes, a lot of, a lot of times you become oblivious that you have this illness. I'm walking down the street and if you say to me, er, 'you have this mental illness', say, well, I'd probably get upset and say 'I forget, literally, I forget' and so having a weekly group, for me, the, the, the most important thing is to keep that focus, about my mental illness.

**Jenny**

9. ...it's just that I've got strength, I've got more strength now to carry on with daily living. And every week when I go to the hearing voices group it's the same people that's there. And that's like an inspiration to me

**Making sense of the voices and me**

**An 'inspiring' opportunity to explore**

**Helen**

1. I found it, um, because when I first started hearing the voices, I felt, I didn't feel I could really tell people. I felt quite ashamed and, as if there was something wrong with me. It wasn't something that you could really talk about.

2. And I did talk to my best friend about it, she knew anyway, she could see...I did talk to her, but coming to the group, and er, there were people I could talk to and it could come out in the open and it wasn't a shameful thing or it wasn't, you know, it wasn't the end of the world.

3. I was really amazed. I sort of sat there and thought 'oh my word, people are just talking openly about this".

**Clark**

4. I was pretty favourable because I kept going, so I was favourably impressed by it when I first started going. Um, and I felt it was a good environment to– cos I– to, to talk through some of my issues that were going on, um, you know, in, in a helpful, kind of, space really.

**Greg**

5. A lot of the time we speak about voices, how they affect us...and about our experiences and that kind of thing.

6. For the first time in my life, I actually found a place that I could do that. I didn't even know these places existed before I started to attend.

**Gaining wisdom**

**Helen**

1. I don't know if everyone has an understanding or a view, some people, I think, think they're not really sure, but I think certainly, for some of us, we do come to some kind of conclusion.

2. I sort of see that it, for me, it's [voice hearing] linked to stress as well, and low mood, and other things

3. My main voice that says the really bad things to me - I think for me, I think that's something that...in my childhood I was very abused and I think it's kind of come from that. And it, and that's, so I, yeah, and the things that are said to me are the things that used to be said to me.

**Lara**

4. And you get information from X and from other members - it's sort of, well, 'that triggers my voices as well', so that means that's a common thread for voice hearers...and that helps you sort of feel, OK, well society may, may not accept this but in this group I feel accepted and in this group I feel...normal, if that makes sense?

5. So it's getting other people's wisdom and how they handled it which is so good about a group, cos it isn't necessarily in the books about voice hearing.

**Clark**

6. I began to see that there was a message within the voice, and the message was telling me about how people with disabilities and mental health problems are oppressed in society, er,

and that's a legitimate message, which is indistinguishable, which is different from saying that the government specifically wants us to go out and kill ourselves.

7. ... if someone's feeling very distressed and they have a space to talk through what is distressing them they might reach a point where they kind of feel OK about it, and they don't need to talk anymore about what has been upsetting them.

8. Interviewer: What would you say the experiences within that group are that most stick in your head?

Clark: It was mainly having a space to be listened to, and a space to talk through stuff, and also having the opportunity of, of similarities and differences from other people, I mean, the same kind of experiences... I mean, some people...not everybody gets triggered in the same way, for example, by the government experience. They might get triggered by other things.

**Kim**

9. It's cos it's acknowledgement, because when you're trapped in the voices you can't get out of it and it's like you want– especially women, they want to share experiences to try and make sense of the experiences, so by expressing your- the content of your voices you can make sense of it.

10. The good thing is that over the weeks I've got to know people and these are the people who've been going the group for years, and they are very enlightening in terms of what information and ideas they have about things for me, if I ask any questions.

**Greg**

11. A bit of both, anxiety, also relieving and, um, glad to share, and, you don't just share, it's not just a one-way thing, then there's comments all around and you make sense of it, so yeah, it's good, so you feel a bit anxious to begin with, but I guess, then, then you feel great about it, you know, good about it.

12. The sharing of experiences and, and of course, the, the playing down of the...the, the making sense of them and, and objectively not, without blowing it out of proportion - it's,

yeah, it is important because I remember those things when outside the group, the rest of the week. I can go back to the group remembering this is not as bad as it looks and so on.

**Jenny**

13. Interviewer: So it sounds like the group's helped you to think about...

Jenny: ...have a clearer insight and, yeah...because, before I never had a good insight. I never had a good insight, and I educationally really learnt something.

14. There's been experiences, that I've heard from other patients in the group that a bit, it, that's caused me to believe are spiritual, spiritually, humanity-wise that there is such a thing as spirits, and that certain priority of, of cultures have more of a better– I find that they have more of a better understanding, about spirituality and mental health, and often do come to the hearing voices group.

15. My mental health is um, there's no right, there's no rightful treatment for it cos I believe that there's a spiritual view of things...and I have heard of other people's views in the group, that they believe that there's a spiritual– most people in the group say that I believe there is a spiritual...

**'Clearer in myself' - personal growth**

**Helen**

1. I think because I was able to share about myself quite openly then that has really helped and it's given me more confidence.

2. I have an understanding of , of what my voices are and where they come from and, because, as I've been able to cope with them better, and as I've got better in myself and they've reduced then that's made life a lot better, because I don't have these voices all the time.

3. I'm able to build, sort of, relationships with people cos, again, I'm c- I'm a bit clearer in myself.

**Lara**

4. It seems sometimes you do go on a bit of a cycle, but each time you cope with the down period a bit better.

**Clark**

5. I've got more confident in my ability to listen to other people and I've got more confident in my ability to sort of listen to myself, to deal with my own issues.

6. I'm setting up this thing called [peer support group]...but I wouldn't have had the confidence– part of...attending the hearing voices group is partly what gave me the confidence to, to do that.

**Jenny**

7. Interviewer: Could you put into words how that, how that inspiration and that insight has changed things for you?

Jenny: It's, um. I'm a lot more confident. Cos, the difference is I was a lot more paranoid from the beginning of the groups.

8. Interviewer: What are your hopes for that in the future? That it'll change in any way or...

Jenny: Peer support. Joining peer support groups, getting out there supporting others. I believe that I have a lot of inspiration to offer.

**Freedom to be**

**'The group shapes the group' - ethos of ownership**

**Helen**

1. Other people have different views of where - you know - what their voices are and where they come from and there's no one set answer in hearing voices group.

**Lara**

2. That's one thing I love about this group, it's there's no control - it's, it's about the group. The group shapes the group. Er, it's not X or whoever's facilitating that week who shapes the group - it's the group itself. It belongs to the group. X sees his role as a facilitator - it's more

just structuring it rather than creating a culture. So it's up to the group members to be making their own group.

3. You interpret your experience how you interpret it and nobody sits there telling you 'no, that's not what it's about, it's about this or that', cos a Psychiatrist can sometimes do that...to you - the mental health profession can sometimes tell you what your experience is.

4. The group creates its own mood, it creates its own feeling.

**Clark**

5. Clark: Well it seemed to be very supportive, um, and non-judgemental.

Interviewer: OK. What helped to make it feel like that, do you think?

Clark: Um. Well largely that there was– the, er, facilitators were generally voice hearers themselves, or if not that they'd done the same training as the voice hearers. Um, that made quite a– and also the fact that it wasn't, sort of, it tended to be group-facilitated by everybody, not just by the named facilitators.

6. It's a drop-in group...it makes it better really because it means that if you're not really up for going for the full two hours you can just drop in and keep contact with the group. You might not feel that you've got the concentration or the energy to sit through the whole group, erm, so it's pretty helpful from that respect, I think

7. Well the main principle, one of the main parts of the culture of the group is that there's no one way of looking at voices that's considered to be correct or, um, most true, so people are allowed to have their own opinions about voices and what they mean and where they're coming from and you're not– without kind of, imposing their viewpoint on, um, everybody else.

**Kim**

8. I think that the style of the group, the open format, and the way we talk about everything makes, er, good, um a good atmosphere of trust and reliability in the group. Everyone knows

what to expect. People trust the boundaries and the limitations, their expectations are met, kind of thing.

9. And we're asked at the beginning what we want to cover in the group and then we get the opportunity to go round and all talk about our week, and we go through the agenda that we've come up with.

10. One thing is that you're free to come and go whenever you like, so people don't always arrive at [group start time]. I've known people to arrive ten minutes before the end, and they're still glad that they came for the last ten minutes because they still get something out of it.

**Greg**

11. You know, it's very, er, relaxed, there isn't any pressure to do anything. You come and leave as you please.

**'Fun sometimes' - group as a playspace**

**Helen**

1. We always have about the first half hour or so, we have as a planned social chat time, so that's while people are arriving and getting cups of tea and so on. And that, I think that's really important cos that's, that's part of just being normal and having a social time and chatting about whatever, you know.

**Lara**

2. It can just be fun sometimes. So I think a support group doesn't necessarily need to be about the topic, like I was saying before, it can sometimes just be, you know, the, the - everyone was talking about football the other week, um, which they enjoyed, cos everyone's into the football. And that just helps everyone get to know each other and relax as a group.

**Kim**

3. The group is quite packed full of interesting things.

4. Kim: There's a chance for us to present our creativity. Um, poetry or writing stories...I find them both very interesting, because I'm not particularly into poetry or science fiction but I do

like to hear them say their stories cos I know them, and because it's a way of getting to know them.

Interviewer: And what impact does that have, that section of the group?

Kim: It's just a nice bonding time.

5. They're not talking about mental health, they're just talking about experiences or the man is just talking about fiction, like science fiction.

**Harry**

6. It's increased in number a bit . There seem to be a few more, than were originally attending. And, er, there's a bit more opportunity for getting to speak to people, and get to know people, that sort of thing.

7. Um, what I like is when I get a positive reaction to myself which is very really rare for me [chuckles]. As far as I can see, yeah. Um, they seem to like my short stories - I do a couple every week.

8. I read them out loud as requested and, er, they seem to like, the group, the stories. They, er, give me a clap, or, call me, er, a positive comment. That's what I like about the group**.**

**Greg**

9. Greg: Sometimes we read poetry, sometimes there's a dialogue and, you know, do some mindfulness sometimes too.

Interviewer: OK. And how has that been like for your, listening to the poetry?

Greg: Yeah, you know, it cheers you up a bit. You know, it gets your head off of stuff and be able to focus and to let it in, and enjoy it basically.

**Jenny**

10. Jenny: There was a poem that I made up named '[omitted]'. It was in a magazine, right at the back of the magazine, my poem named '[omitted]', I made up that poem...I read it out to the whole group.

Interviewer: And what was that like?

Jenny: Very good. Very good. Everybody liked it.

**Walt**

11. There we have people read, reading short stories at the end, so, er, X [group member], do you know X? No? He always tells a story. They're very short stories, about ten lines. They're always great fun. And everybody claps appreciatively, and that's nice.

12. X [group member] talks about his cat, which is always very nice. He showed us a picture of his cat and one of them was called Fluffy [pseudonym] and she was particularly beautiful.

**Appendix R: Letter/summary of themes for participant feedback and validation**

Department of Applied Psychology
Canterbury Christ Church University
Runcie Court
Broomhill Road
Tunbridge Wells
TN3 0TF

Telephone: 0333 0117070

Email: tp127@canterbury.ac.uk

20th March, 2015

Dear …….,

Back in July/August 2014 you took part in my research project 'An Investigation into the Experience of Hearing Voices Network Groups' and were kind enough to do an interview with me where you shared your experiences of going to the group.

I am writing to you now to once again say a huge thanks because the project would obviously not have been possible without your involvement. It was both moving and interesting to hear everyone's experiences, and here, I am writing to let you know about the results that I have found.

From looking at all the experiences of everyone that took part, I have been able to draw out several main themes which make up the overall results. The themes here are meant to illustrate some parts of the discussion we had, representing experiences of attending the group and how this may have affected people's lives. However, because they represent the overall collection or mix of the conversations I had with everyone who took part, some of the themes may not represent your specific views. I would hope, though, that your views should be represented in at least some of the themes.

The themes are attached in this letter/email. There are four main themes and then some smaller 'subthemes' or mini-themes that make up the main ones. Under each one, there is an explanation of the main points.

I would be really grateful if you had any comments or thoughts about these themes or about what it was like taking part in the project. As such, if you could reply to this email/letter that would be great. If on the other hand, you would rather not comment that's absolutely fine - just let me know. You can contact me on the email, address or number (leaving a message stating my name) at the top of this letter.

Best wishes
Tom Payne
Trainee Clinical Psychologist

**Description of themes from study of people's experiences of Hearing Voices Network Groups**

**1. Healing: connecting with humanity**

**The 'nurturing' effect of connecting**

This described how open sharing and bonding with others was an important part of the group, and helped a lot of people move forward with their lives. An accepting, caring, and non-judgemental attitude helped this bonding to happen. Being listened to openly was also found to be important.

**Challenges to connecting**

Some people described various challenges of the group and bonding with others, such as feeling anxious about first going and feeling accepted in the group, particularly when they were new. Other difficult things about being in the group were when people had clashing opinions or found it hard to 'get a word in edgeways'. Another challenge was that the group could be an emotionally intense place.

**2. Group as an emotional container**

**Safety to unload**

Some found the group a safe place to be. One of the signs of this was the fact that people could go along and talk about feeling really low, without having to put on a brave face. Sharing difficult things in the group helped people not to 'blow things out of proportion'. In this way the group was able to withstand ('contain') the emotions that arose within.

**'Always there': ongoing presence**

One of the things which people really valued about the group and also made them feel safe was the fact that the group was always there. It something that could be relied on as it was there week after week.

**3. Making sense of the voices and me**

**An 'inspiring' opportunity to explore**

For most people, going to the group was their first opportunity to be able to talk about voice hearing (and other difficult experiences) as it felt like too much of a 'taboo' or stigmatised thing outside of the group. The opportunity to openly explore voices was completely new to some group attendees and consequently had a strong impact.

**Gaining wisdom**

By taking advantage of this opportunity many were able to come to better understandings about their voice hearing and other experiences, which seemed to be really important.

**Clearer in myself': personal growth**

Gaining greater understandings about experiences such as voice hearing helped people to feel like they understood themselves better. This seemed to help people to feel better about themselves and, in some cases, helped them to move forward with things that were important in their lives such as having better relationships.

**4. Freedom to be**

**'The group shapes the group': ethos of ownership**

Another important theme was to do with the group being run jointly by all of its members, and that you decided together what it should be about. Things like making ground rules together and people being allowed to decide what their voices meant for themselves were important.

**'Fun sometimes': group as a play space**

Finally, because what happened in the group was decided by the people in it, this made it sometimes quite a relaxing or liberating place where people could enjoy themselves as well as just talk about serious things. This enjoyment ranged from chatting about football to listening to each others' creative writing. This was important because it meant people could just be themselves.

**Appendix S: Main reflections from bracketing interview**

The following were guided by Ahern's ten tips for reflective bracketing (1999):

- Taken-for-granted assumptions associated with my background: the interviewees are drawn from a socioeconomically deprived area, so there is an assumption issues of stigma and prejudice will emerge. As someone from a non-deprived, white middle class background I may over-identify with such issues or amplify them as a way of compensating for this.
- Personal value systems: this research is likely to elucidate processes that promote peer support and suggests renegotiation of power between professionals and service users. I feel strongly identified with these issues and have highlighted a desire to 'fight for the underdog'. This are humanist, critical psychology/psychiatry and socialist agendas which I am aligned with and where my biases will naturally lie.
- Potential role conflict: i) this research is 'constructing knowledge' where meaning is contested and feeds into age-long debates regarding definitions and social responses to 'madness', so regardless of the findings there is potential for them to generate conflict; ii) researcher versus clinician role conflict exists as I am more accustomed to the latter, so I will need to prioritise respectful acquisition of data over emotional support in a setting and discussing a subject which may feel like a clinical interview.
- Feelings which could indicate lack of neutrality: avoidance of more 'difficult' or less articulate participants due to wanting to avoid conflict or get neater data - it will be important to select participants on a 'first come first serve basis'.

- Possible reasons for 'projecting onto data': wanting to advocate for the underdog due to past situations where I have felt disempowered (as some form of psychological re-enactment).

**Appendix T: Excerpts of research diary**
**5.12.13, reflections after the ethics panel**

Frustration. Afterwards I felt something akin to what you feel after an argument or confrontation, when you replay it in your head, think of clever, pertinent or quick-witted responses to their questions. I felt angry at the terminology used by the panel ('schizophrenic'), the ignorance shown ('we don't want you to get your head cut off by someone') and baffled at some of the questions ('How do the people you see know that they are hearing voices?') and frustrated at my potentially brusque reply to this ( 'frankly, we're into the realms of philosophy here').
I felt myself resisting the urge to want to answer back and lecture them about the need to exercise awareness of stigmatising attitudes and being risk aversive. On reflection, now that my initial frustration has passed a bit, I realise that much of my own reaction is related to the fact that I have become so attuned to the perspectives of voice hearers that I have lost touch with the more mainstream, less-informed, understandings of mental health difficulties (and phenomena perceived to be mental health difficulties).

**1.7.14, main impressions after interview 1**

The most important things to the interviewee (in no particular order):
1. the idea of a 'safe space'.
2. the idea of the group as something she could rely on which she did not have when she was younger.
3. people are caring and supportive to one another.
4. the groups help you to understand and make sense of your experiences

**17.7.14**

Stood up by an interviewee which cost me first half of the day. Absolutely gutted and my mood went into absolute freefall so unable to achieve anything else the rest of the day. This continued into the next day at the data coding workshop. Need to manage my expectations better as this is part and parcel of the process.

**19.7.14 - my thoughts after the Mars Project (film and debate about voice hearing at London cinema put on by the London Hearing Voices Network)**

This was a very provocative film. I identified the experiences of Khari (main character) with those of others who have experienced extreme states/psychosis and have been through the mental health system and found it unhelpful and unable to meet their needs to make sense of

their experiences.
The very open way in which the film was edited seemed to nicely reflect the way he was likely to be experiencing his voices and distress.
Khari appeared to be very lost, angry and far away from anyone who could really connect with him and help him to make sense of his experiences. I got a sense of despair and disconnection from watching film which I think reflected my own frustration that there was nothing for him and nobody he could talk to who would allow him to explore his understandings in his terms... why are we so far away as a society from creating ways to get on people's levels?
I enjoyed the psychiatrists' comments during the film... they were articulate about some of the problems pertaining to these fundamental issues - racism and repression; lack of scientific approach to experiences labelled 'psychosis'/'schizophrenia'; inability to connect with people on a human level as main problem.
The discussion about racism and psychiatry afterwards really open my eyes to the history of this type of repression... I was shocked at the extent to which I have overlooked this and how little I knew about it... it is clearly very relevant to my research because there are many parallels between the repression of ethnic minorities and the repression of people in the psychiatric system generally; also because my research is in diverse areas in London with many people from BME communities.
-It was good to be able to meet some members of the Hearing Voices Network at the film. I asked a question of the panel about what ingredients were needed to steer the paradigm shift which we appear to be in the midst of...X said she would be interested in hearing more about my research and explained to me some stuff about HVGs generally which, to be honest, I already knew, but I really appreciated her responding to my question. Y also responded to my question and I also appreciated his reply despite the fact that he seemed to partially mistake my own use of the phrase 'paradigm shift' (possibly because it was not the most accurate phrase to use): he said (I think) that what we need is more of a complete social change/revolution rather than a change in thinking scientifically...I guess that's what I was thinking.

**22.7.14 - interview 2, main points that jump out**

-'group is nurturing'; 'supportive'; uses the word 'normalising' a lot. The idea of being normal, feeling normal and that her experiences are not peculiar is very important. Use of psychological words and stating she had CBT, which also helped, shows high psychological awareness too, like interviewee 1.
-coming to terms with her reaction to other people; feeling their experiences to be weird felt important.
-" <u>something good is happening there</u>, that people can be that open. There must be an

acceptance there, an unconditional acceptance of one another"

**30.7.14 - reflection**

It occurred to me suddenly that my fairly lengthy experience of teaching psychoeducational groups has shaped my expections about what people will say about being in a group and the sorts of processes to expect.

**31.7.14 - interview impressions, interview 3**

Really knowledgeable. Knew loads about peer support, peer support groups generally. Made me think about the value of expertise by experience, having another service user with similar experiences available to talk to - this was the 'missing piece' in professional-led services, according to interviewee. In his presence I felt a sense of being a real novice in comparison to him. He also had some really important stuff to say about positive voices and how his group was not a good space to talk about them: underlined the idea that each group has its own set of people and corresponding culture (VL: 'the group creates the group')

**Main impressions, interview 4**

When we met before we started the interview recording, she said she'd had trouble with some 'psychiatric symptoms'. This use of medical terminology typified how her understanding of her experiences was dominated by professional-psychiatric concepts; this made me feel a bit hopeless for her. She talked about herself being 'schizophrenic' and talked about 'coming to terms with a lifelong illness'. I was torn between wanting to privilege her own understanding of her experiences (as hers), and feeling that she had been brainwashed or that her framework of understanding had been colonised by the mental health system. A moment which defined it for me was when she was talking about recently finishing work a couple of months ago, and how she was saying because she was 'ill' then perhaps the best thing was not to have the stress of work in order to stay 'well'. It struck me that that was the decision making that marked the possible commencement of a career as a mentally ill patient as opposed to a 'normal' life, though this is from my own frame of reference.
She was very open to talking and answer questions, but she wasn't very reflective or elaborative, so I had to think differently about how to best get the information from her.
I was struck by what seemed like her using the words of others; it didn't sound like her own voice.

**15.8.14 - general reflections:**

I've been wandering around Denmark Hill and Peckham Rye a lot over the last few weeks and this has immersed me in the environment of the people I've been interviewing. It's really a deprived area and you're exposed to a lot of gritty, difficult stuff. In a short space of time saw two unrelated incidents: one conversation about someone getting stoned when they should've been babysitting, and then a man half carrying/half escorting his very drunken or stoned friend into Ladbrokes in quite dramatic fashion. Even though I've lived in loads of placing including some rough areas, this is a very different world to the leafy town I grew up in. I need to remember the sociocultural context people are living in and what they are bringing to their experiences...

**14.12.14 - reflection**

Karpman's drama triangle: it struck me during some coding today that lots of people have now talked about how being helped in the group has inspired them to want to go on and help others. This suddenly made me think of the drama triangle in which the roles of 1. persecutor > 2. victim > 3. rescuer are played out such that people move from one to the other. In the groups people are going from victim to rescuer. This made me wonder about how the role of persecutor is complex and fluid, as in this context it will take in a range of mental health services (iatrogenic experiences), abusers from the past and other people in society from whom the sense of stigma relating to voices is strongest. For some, mental health professionals will be persecutors, particularly given the emancipatory values promoted in peer-support groups such as hearing voices groups, and for others they will be the rescuers if they feel services to be helpful. How complicated! This has profound implications for role conflict in managing and helping voice hearers.

**24.12.14 - off-top-of-my-head impressions of main themes following individual themes**

First thing's first: what am I doing working on Christmas eve?? I guess that's dedication to the cause! I am increasingly seeing myself as 'a researcher' at the moment, almost more than a clinician. This feels good: I am becoming a craftsman with a fatter identity. I'm developing research skills by possessing an authentic desire to understand more and then want to articulate this understanding in a clear and unpretentious manner. I'm also entering that fearless space where I'm prepared to abandon the structures of coding/theme-building I've painstakingly produced in order to re-immerse myself in the data and aim for a deeper comprehension. I will elaborate on and cross-check these initial ideas and find which, like icebergs, guard more substantial mass beneath the surface.

So, Jo made the deft suggestion that I outline my current sense of what the main themes in the data are. We agreed this would be a good exercise in starting to make out the emerging wood from the blinding thickness of trees. So here goes:

- Social/friendly/welcoming space where people value you as a person and can even learn to like you as a friend.
- A non-judgemental and flexible attitude is a precondition of therapeutic change
- Being listened to and having your experiences acknowledged is a healing experience
- Validation of you as a normal human being key (perhaps following such abnormal/pathologising experiences?)
- Empathy: people need to possess a genuine caring for others' distress/ does the group induce empathy?
- Altruism and wanting to help others is inspired by the experience of the group

- Vehicle for transitioning from victim to rescuer (as in Drama Triangle, Karpman; also reminiscent of 'victim to victor', Ron Coleman) - something about getting out of victim role.
- mutual support from peers is a therapeutic ingredient
- Identifying/sharing experiences of voice-related or iatrogenic distress (stigma, disempowerment, enforced illness identity)
- a place to increase understanding of voices and/or explore voice-hearing experiences;
- Grounding impact on people's lives (presence, permanence, regularity, part of routine)
- role of facilitator is key for containment of group by providing structure/usefully shaping group culture/drawing out individuals
- Competing to speak and not being listened to/acknowledged is a challenge to group cohesion.
- challenging material: voices as positive or religious, distress, suicide
- (not sure how to phrase this:) personal understandings of experiences framed by medical/psychiatric terminology and explanations.

## Appendix U: Author guidelines for Psychology and Psychotherapy: Theory, Research and Practice

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

5. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.
• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).
• Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).
For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

7. Supporting Information

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

8. Copyright and licenses

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services, where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

**For authors signing the copyright transfer agreement**
If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs.
**For authors choosing OnlineOpen**
If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

- Creative Commons Attribution Non-Commercial License OAA

- Creative Commons Attribution Non-Commercial -NoDerivs License OAA

To preview the terms and conditions of these open access agreements please visit the Copyright FAQs and you may also like to visit the Wiley Open Access and Copyright Licence page.
If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) or Austrian Science Fund (FWF) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with your Funder requirements. For more information on this policy and the Journal's compliant self-archiving policy please visit our Funder Policy page.

9. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded **here**.

10. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

11. OnlineOpen

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms
Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website at:https://onlinelibrary.wiley.com/onlineOpenOrder
Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

12. Author Services

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visithttp://authorservices.wiley.com/bauthor/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

13. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:http://www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

14. Early View

Psychology and Psychotherapy is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

**Appendix V: End of study notification and project summary report sent to REC**

*This has been removed from the electronic copy*