Kerry Middleton BSc MSc

DIALOGICAL APPROACHES TO HELPING PEOPLE WHO HEAR DISTRESSING VOICES: WHAT ARE THEY AND HOW DO THEY WORK?

SECTION A: *Talking with voices.*
A scoping review of relational, dialogical approaches to helping people who hear distressing voices.

SECTION B: *"It allowed us to let our pain out".*
A qualitative study exploring the experience of the 'Talking with Voices' approach: Perspectives from voice hearers and their voices.

Overall word count: 15,191

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

May 2021

SALOMONS INSTITUTE FOR APPLIED PSYCHOLOGY CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I would like to acknowledge and thank all of the people and voices who participated in the qualitative study. It was a real privilege to hear about your experiences. I sincerely hope that I have been able to honour these and provide a platform for them in my reporting.

Thank you to my supervisors, Anne Cooke and Rufus May for their many pearls of wisdom in this project and generous time-giving.

Lastly, thanks to my partner, Will, who has been an all-round gem in supporting me throughout this research journey.

Summary of the Portfolio

Section A

Section A is a scoping review of relational, dialogical approaches to helping people who hear distressing voices which are a new wave of therapeutic approaches which encourage and actively support dialogue between people and their voices. The review examines six extant dialogical approaches according to their similarities and differences in theory and implementation, together with empirical evidence of effectiveness.

Section B

Section B is a qualitative study which presents findings on a novel, dialogical approach stemming from the Hearing Voices Movement, The 'Talking with Voices' (TwV) approach. The study explored experiences of the TwV approach from the perspectives of 10 voice hearers and also 10 of their voices using Interpretative Phenomenological Analysis. Results are presented according to participants' experiences of change as a result of the approach, along with consideration of barriers of and facilitators to change. The findings provide support for the acceptability of dialogical approaches for helping people who hear distressing voices. The study itself also demonstrates how perspectives of voice hearers and voices can be centred in future evaluation in this area.

List of contents

Section A: Literature Review Page no.

List of Figures

Abstract

Recent psychological approaches to helping people who hear distressing voices address interpersonal processes within the relationships that people often hold with their voices. Dialogical therapies, which encourage and actively support dialogue between hearers and voices, represent the newest wave of such approaches. A number have been developed, with variations both in theoretical underpinnings and in implementation. However as yet no overview has been attempted. This paper presents a scoping review of the various dialogical approaches to voice hearing, examining similarities and differences in theory and implementation, together with empirical evidence of effectiveness. A protocol for conducting the review was developed using the 'PRISMA' Extension for Scoping Reviews checklist. The review identified six extant dialogical approaches. These broadly clustered into two groups: those which aimed to increase assertiveness towards voices (Avatar Therapy, Virtual Reality Assisted Therapy and Relating Therapy) and those which placed more emphasis on developing an understanding of voices (The Maastricht Approach, Talking with Voices, Compassion Focused Therapy for Psychosis). All approaches differed in terms of both theoretical underpinnings and practical application, and were at different stages of empirical development. Future research needs to further investigate similarities and distinct 'active' ingredients of each approach, develop measures to better capture dialogical aspects of the hearer-voice relationship, and further consider how these approaches can be implemented in services.

Keywords: voice-hearing, dialogical approaches, psychological therapy, psychosis

A note on terminology

There is a debate about terminology which reflects the underlying theoretical debates in this field. When reporting findings, this review uses the language adopted in the original papers in order to reflect the dominant perspectives through which voice-hearing was viewed at the time the research was conducted, and the stance of the respective authors. Elsewhere, and in my own writings, I choose to adopt the terminology commonly used by researchers associated with the Hearing Voices Network (HVN).

Introduction

Hearing a voice or voices which other people cannot hear is a common experience which appears to occur in most cultures and societies across the world, with 5-15% of the adult population estimated to experience voice-hearing at some point within their lifetime (Beavan et al., 2011). Voice-hearing can be experienced as something which is fleeting and mundane or as something much more profound; in the latter case often leading to a fundamental change in the way in which the sensory world is perceived and understood (Bell et al., 2010). Throughout human history, voice-hearing has been described and understood in a variety of ways, including as a medical, spiritual, and psychological phenomenon (McCarthy-Jones, 2012). Medical understandings view the experience of voice-hearing as a symptom of mental illness requiring drug-based treatments (McCarthy-Jones et al., 2013). In contrast, spiritual understandings see voices as representing a higher self or supernatural entities with the potential to bring about spiritual awakening, or even as signifying shamanic potential in the hearer (Grof & Grof, 1989; Murphy, 1976, as cited in McCarthy-Jones et al., 2013). Psychological understandings focus on the meaning of voices within the context of personal life events (Johnstone & Dallos, 2006), or as disturbances in perception (e.g. Larøi & Woodward, 2007). People can therefore come to understand their voice-hearing experience in very different ways. This in turn influences how a person relates to that experience and the likelihood that they will seek support from statutory health services (Iudici et al., 2018).

Therapeutic approaches for voice-hearing in the UK

In today's UK clinical settings, voices are typically termed 'auditory verbal hallucinations' (AVHs) and classified under the umbrella term 'psychosis' as a symptom of one of a range of psychiatric disorders such as schizophrenia (American Psychiatric Association, 2013). This medicalised understanding emphasis eliminating voices by means of antipsychotic medication McCarthy-Jones et al., 2013). This is in contrast to the aims of psychological

approaches where the emphasis is on reducing distress associated with voices as opposed to reducing or eliminating the voices themselves (Johnstone & Dallos, 2006).

Over the past 30 years, psychological approaches to voice-hearing have become increasingly accepted within services (Johnstone & Dallos, 2006; Thomas et al., 2014). Current guidelines therefore recommend a combination of medical and psychological approaches for people who experience psychosis, i.e. antipsychotic medication in conjunction with Cognitive Behavioural Therapy for Psychosis (NICE, 2014). However, the integration of psychology into a medically dominated treatment culture has not been without its challenges, and the compatibility of these approaches continues to be called into question (e.g. Heriot-Maitland, 2010).

Likewise, voice hearers themselves have increasingly contested the dominant medical/psychological approach. This led to the founding of a peer-led movement of voice-hearers, clinicians and researchers engaged in research, training and facilitating peer-support Hearing Voices Groups (HVGs), collectively known as the Hearing Voices Network (HVN; Corstens et al., 2014). This work was first instigated by a Dutch psychiatrist, Marius Romme, a science journalist, Sandra Escher and a voice hearer, Patsy Hage, and has grown exponentially from a small number of peer-support groups in the Netherlands in 1987 (James, 2001) to the work being established within 35 countries worldwide (Intervoice, 2021).

The Network frames all explanations of voice-hearing as accepted and valid (Corstens et al., 2014; Higgs, 2020). Empowering people to focus on their own personal and social recovery through centring the knowledge of those with lived experience of voice-hearing is therefore favoured over the psychiatric approach of reducing symptoms (Styron et al., 2017).
Alongside this peer-led, recovery-oriented approach, there has been increasing interest within the scholarly literature in qualitative and narrative explorations of voice-hearing. Much

research has been undertaken by voice hearers and academic allies working together, with the ultimate aim of transforming services (Styron et al., 2017).

The development of relational approaches for voice hearers and their voices

Most recently, parallel developments in the HVN and academia have led to the emergence of a group of therapeutic approaches which consider the interpersonal aspects of the voice-hearing experience (Pérez-Álvarez et al., 2008; Thomas et al,, 2014). These approaches represent a shift in focus from considering a voice as a sensory stimulus about which the hearer holds beliefs (e.g. Beck & Rector, 2003), to viewing it as a person, entity or part of self, with whom the voice hearer has a relationship (Beavan, 2011; Hayward et al., 2011). This has been an important development, given that many voice hearers report relating to their voices, in the same way as they relate to other people (Holt & Tickle, 2013). Taking this analogy, these newer relational approaches to voices propose extending existing ideas about understanding distress in the context of past and/or current relationships to the hearer-voice relationship (Hayward, et al., 2018). One example is 'Cognitive Therapy for Command Hallucinations' (CTCH) where the therapist encourages the hearer to question their beliefs about the power of persecutory voice/s in order to promote more assertive ways of relating to them (Birchwood et al., 2018). Beyond this, there are approaches which actively encourage the voice-hearer to build or change a relationship with their voice(s) through dialoguing with a voice, or representation of a voice, in sessions. These latter can broadly be called dialogical approaches, and are examined further below.

Dialogical approaches for voice hearers and their voices

Dialogical approaches for voice hearers and their voices in services are at varying stages of theoretical and empirical development but can be broadly clustered into two overlapping

strands of therapy. The first originates in traditional academic and clinical settings and consists of: 'Avatar Therapy' (AT; Leff et al., 2014), 'Virtual Reality assisted Therapy' (VRT; Percie du Sert et al., 2018), and 'Relating Therapy' (RT; Hayward et al., 2017). The second stems from the Hearing Voices Movement (HVM) and includes the 'Making sense of Voices' (MsV; Steel et al., 2020) approach, also called 'Experience Focused Counselling' (EFC; Schnackenberg et al., 2017) and the 'Talking with Voices' (TwV; (Longden et al., 2021a) approach. Lastly, 'Compassion Focused Therapy for Psychosis' ('CFTp' Heriot-Maitland, 2020), otherwise termed 'Compassion for voices' (KCL, 2015), appears to offer a fusion of these two strands (Heriot-Maitland et al., 2019).

Given the recent and growing theoretical interest in, and increased use of dialogical approaches for voice-hearing in both clinical and peer-support settings, there remains a need to further understand the similarities and differences among these approaches and to examine the emerging evidence base of this new wave of therapeutic approaches.

Aims

The aims of this scoping review are therefore twofold:

- Systematically to map the emerging literature on dialogical approaches to voice-hearing, with a focus on clarifying the similarities and differences between theories and their practical application; and
- To critically examine empirical studies of these approaches to date.

It aims to answer the following questions:

1. What are the main theoretical similarities and differences between the various dialogical approaches to voice hearing?
2. What are the similarities and differences in the practical application of these approaches?

3. What is the empirical evidence that each of these approaches can be helpful to people who hear voices?

Positioning statement

Finlay & Gough (2008) stress the need for authors to acknowledge their own pre-existing position on the topic studied in order for readers to be able to judge the analyses and conclusions in the light of this. The author of this review has a background in working alongside peers and clinicians within academic and clinical settings and also within the Hearing Voices Network (HVN). Typically, the author takes a critical position with respect to the current status of mental health services and advocates for more holistic approaches to mental health, including the exploration of novel dialogical approaches. The author's supervisors take a similar position and are influential within the academic field of psychosis and work of the HVN. One of the author's supervisors has personal associations with HVN-led dialogical approaches.

Method

The 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews' (PRISMA-ScR) checklist (Tricco et al., 2018; see Appendix A) and the scoping review framework outlined in the Joanna Briggs Institute (JBI) Reviewer's Manual (Peters et al., 2020) were used to synthesise and present the data in this review. A scoping review was chosen for the following reasons:

- To clarify and map the theoretical and empirical literature on dialogical approaches, given the recent diversification of these approaches,
- To examine *how* the research in this area has been conducted to date as well as what it has found, and

- In doing the above, to provide a precursor to a systematic review.

Search strategy

The search strategy for this review was carried out in three stages:

1) An electronic search was made of ASSIA, PsychINFO, PubMed and Web of Science databases. Studies published from earliest available records to March 2021 were identified by using the following search terms: (relation* OR dialog* OR talk*) AND (voice hear*OR psychosis OR schizophrenia OR auditory hallucination* OR voices) AND (therap* OR treatment OR peer OR support OR services). Document titles and abstracts were initially screened, and the remaining full texts were then read for selection. The reference lists in key papers, as well as book chapters and theses were hand searched to ensure no relevant literature was missed from the database search. Where the evidence base was limited, an author of a selected paper was contacted to investigate whether further unpublished or published papers were available. Both published and unpublished literature was included.
2) Grey literature and grey 'data' (e.g. websites) (Adams et al., 2016) were searched for by conducting structured searches of the 'OpenGrey' database, relevant websites and contacting relevant individuals associated with the Hearing Voices Movement training and research.
3) Peer-reviewed journals relevant to the final research question were identified within the search results.

Figure 1. presents a PRISMA flowchart of the search and selection process.

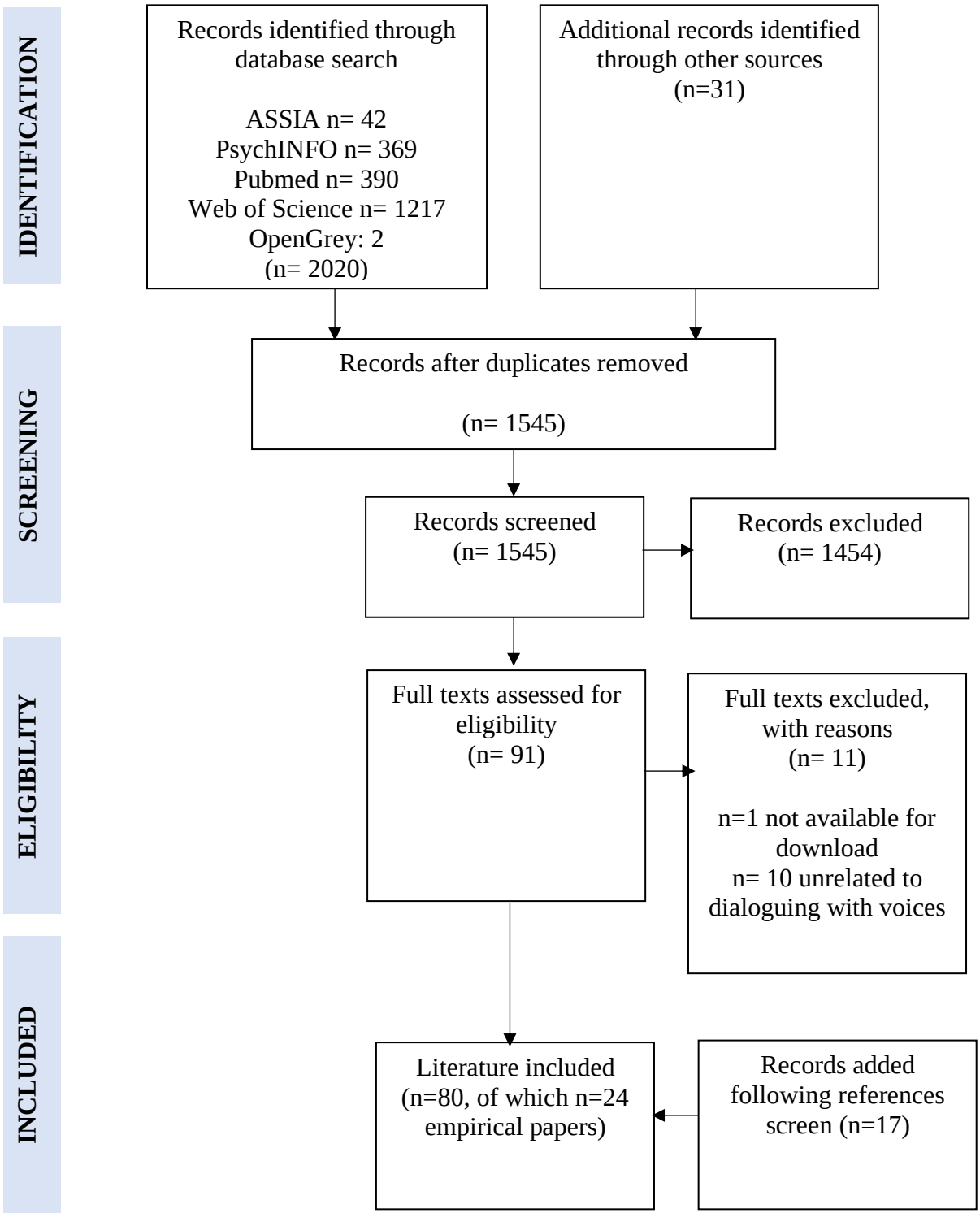


Figure 1. PRISMA flowchart of the search and selection process as cited in Peters et al. (2020).

Inclusion and Exclusion Criteria

Documents were included if they: (1) described a theoretical approach to voice hearing which underlay a therapeutic approach involving dialoguing with voices, (2) discussed the practical application of the approach in clinical or non-clinical settings and/or (3) systematically studied the therapy using specified outcome measures. Empirical studies using any quantitative or qualitative design were included providing they were available in English.

Main body of the review

The main body of the review is organised into three parts. The first part seeks to provide clarity regarding the theoretical underpinnings of the various dialogical approaches to voice hearing. A summary of therapeutic aims is provided for conceptual clarity. The second part provides an overview of the similarities and differences in the practical application of each approach. The third part critically examines the empirical evidence for each approach to date.

1. Dialogical approaches for voice hearers and voices: a theoretical overview

Each dialogical approach is underpinned by particular theories, which guide its clinical application. These vary between approaches but with substantial overlap. Broadly, they reflect a development of the traditional cognitive model (Birchwood et al., 2004) and consider other developmental frameworks which include interpersonal (Birtchnell, 1996, 2002; Gilbert, 2000) and attachment (Bowlby, 1980) theories. The more recently developed approaches of Talking with Voices (TwV) and Compassion Focused Therapy for Psychosis (CFTp) understand voices at least partly as dissociative phenomena (Van de Hart et al., 2006) and adopt the values of the Hearing Voices Network. The TvW approach makes use of a method derived from psychoanalytic theory, called the ‘Voice Dialogue Method’ (Stone & Stone, 1989).

Table 1 summarises the main dialogical approaches to voice hearing identified by the review, together with their respective theoretical underpinnings. Details of each theory are given below.

Table 1.

Summary of dialogical approaches to voice-hearing

Dialogical approach	**Founders of approach**	**Place of origin**	**Theory***
Avatar Therapy	Huckvale, Leff, & Williams (2013)	London, UK	- Extended cognitive model (Birchwood et al., 2004) - Social Rank Theory (Gilbert, 2000)
Virtual Reality assisted Therapy (VRT)	Percie du Sert et al. (2018)	Montreal, Canada	
Relating Therapy	Hayward, Overton, Dorey & Denney (2009)	Sussex, UK	- Extended cognitive model (Birchwood et al., 2004), - Relating Theory (Birtchnell, 1996, 2002). - Attachment theory (Bowlby, 1973)

Making Sense of Voices (MsV) and Experience Focussed Counselling (EFC), otherwise termed 'The Maastricht Approach'	Corstens, Escher & Romme (2008)	Maastricht, The Netherlands MsV piloted in Berkshire, UK; EFC piloted in North and Southwest Germany	- HVM guiding principles
Talking with Voices (TwV)	Longden et al. (2021)	Manchester, UK	As above + Psychology of Selves (Stone & Stone, 1989) + Dissociation model (Moskowitz, Read, Farrelly, Rudegeair, & Williams, 2009)
Compassion Focused Therapy for Psychosis (CFTp)	Heriot-Maitland, McCarthy-Jones, Longden & Gilbert (2019)	Various UK locations	- Extended cognitive model (Birchwood et al., 2004) - Social Rank Theory (Gilbert, 2000) - Attachment disruption pathway model (Pilton - et al., 2016) - Dissociation pathway model (Varese, Barkus & Bentall, 2012)

The table presents an overview of key theories referenced by each dialogical approach, together with the founders of each approach and where it originated. *Note.* 'Making sense of Voices' and 'Experienced Focussed Counselling' are also termed 'The Maastricht Approach' and represent clinical applications of the 'Maastricht Interview' developed by Romme & Escher (1999, 2008). *Theory has been specified according to explicit citations in the following literature: AT & VRT; Ward, Craig & Rus-Calafell, 2016; Relating Therapy; Hayward et al., 2013; Maastricht Approach; Romme & Escher, 2008; Talking with Voices; Corstens, May & Longden, 2011 & Longden, Moskowitz, Dorahy & Perona-Garcelán, 2018; CFTp; Heriot, Maitland, 2020.

A development of the cognitive model: moving from the intra- to interpersonal

Dialogical approaches stemming from traditional clinical and academic settings draw upon extensions of existing cognitive models which go beyond considering voices as an intra-psychic phenomenon to considering the interpersonal nature of the voice-hearing experience (Huckvale, Leff & Williams, 2013; Dellazizzo et al., 2020; Hayward et al., 2009; Heriot-Maitland, 2020). Early proponents of cognitive models of voice-hearing included Birchwood and Chadwick (1997) and Morrison (2001). These models propose that a person's beliefs about voices, together with the extent to which these beliefs are aligned with the social norms of the person's culture, play a central role in determining the extent to which the person is distressed by them (Birchwood & Chadwick, 1997; Morrison, 2001).

Later, Birchwood and colleagues (2000, 2004) proposed an extended cognitive model which incorporates Gilbert's (2000) social rank theory (Gilbert, 2000; Gilbert & Miles, 2000). Avatar Therapy, Relating Therapy and CFTp all reference Birchwood's theory. (Craig, Ward & Rus-Calafell, 2016; Hayward, Berry, McCarthy-Jones, Strauss & Thomas, 2013; Heriot-Maitland, 2020). It proposes that humans have evolved mechanisms for recognising dominant-subordinate interactions and therefore use strategies such as acts of submission and social spacing in order to protect ourselves against perceived threats (Gilbert, 2000). CFTp suggests that voice hearers may be especially attuned to using these defence mechanisms both within social relationships and with their voices, such that voices are often hostile and dominant and the person is fearful and submissive. (Heriot-Maitland, McCarthy-Jones, Longden & Gilbert, 2019).

Relating Therapy (Hayward et al. 2009) also applies Birtchnell's (1996) 'relating theory' to the voice-hearer relationship (Birtchnell 1996). Similarly to Gilbert' (2000) social rank theory, Birtchnell's

model draws parallels between social patterns of relating and the relationships which people have with their voices, focusing on two interpersonal dimensions of power and proximity (Hayward et al. 2011; Craig, Ward, & Rus-Calafell, 2016). The power dimension reflects Gilbert (2000) model's focus on dominant-subordinate interactions. In addition, Birtchnell's (1996) model considers the dimension of proximity, hypothesising that people who experience their voices as intrusive and who attempt to distance themselves from them are more likely find them distressing (Hayward et al. 2011; Craig, Ward, & Rus-Calafell, 2016).

Relating Therapy and CFTp also draw on attachment theory (Hayward, Overton, Dorey & Denney, 2009; Heriot-Maitland, 2020). Further to the social rank theory's focus on dominant-subordinate interactions, attachment theory provides a framework to consider how relationships are organised for caring and nurturing (Bowlby, 1973). According to the theory, human infants have an innate drive to seek closeness to a protective caregiver in order to feel safe and secure and to have their social and emotional needs met. This same motivational system is thought to be responsible for the bond that develops between adults in emotionally intimate relationships (Bowlby 1973). Patterns of insecure attachment have therefore been implicated in both the origins of voices and in the appraisal of the voice-hearing experience (E.g. Pilton et al., 2016). However, these proposals are still in their infancy and warrant empirical study (Heriot-Maitland, 2020).

Interpersonal trauma and dissociation

Dialogical approaches stemming from both the Hearing Voices Movement and CFTp (developed in collaboration with members of the Hearing Voices Network) highlight associations between traumatic life events, dissociation and voice-hearing (e.g. Romme & Escher, 2008; McCarthy-Jones, 2011). Avatar Therapy has also recently considered this as a therapeutic target (Ward et al., 2020). This may be in part a reflection of relative under-development of theory in this area prior to the development of Avatar Therapy(Pilton, Varese, Berry & Bucci, 2015) and debates in the literature concerning what might differentiate dissociative phenomena from trauma reactions observed among people with a 'Post Traumatic Stress Disorder' (PTSD) diagnosis (Peña-Salazar et al., 2016). This is somewhat less problematic for HVM-led approaches which have tended

to position themselves as transdiagnostic, given that adverse experiences are likely to be linked to voice-hearing per se rather than to a particular psychiatric diagnosis (Moskowitz & Corstens, 2007; Schnackenberg, Fleming, Walker & Martin, 2018).

Broadly, all dialogical approaches agree that voices can arrive in peoples' lives as part of a meaningful reaction to unresolved traumatic life events, and that voice content is relevant and should be engaged with (Longden Corstens, Escher & Romme, 2012; Thomas et al., 2014). HVM-led approaches and CFTp both draw on dissociation models (e.g. Moskowitz, Read, Farrelly, Rudegeair, & Williams, 2009 & Varese, Barkus & Bentall, 2012) which propose that voices represent dissociated or disowned parts of the self, or self-other relationships, that result from interpersonal trauma or related stressors (Corstens, Longden & May, 2012; Longden, Madill & Waterman, 2012). This framework has been referred to among various theoretical traditions concerned with the 'Psychology of Selves', including Jungian, Gestalt and Transactional Analysis and is upon which the TwV approach bases its methods (Corstens, Longden & May, 2012; Corstens, May & Longden, 2011Most recently, a theoretical model for voice-hearing as a dialogical experience has been proposed which compliments methods associated with the TwV approach (Perona-Garcelán, Pérez-Álvarez, García-Montes & Cangas, 2015).

Moreover, CFTp considers how the experience of shame and self-criticism as 'social rank threats' may play a role in maintaining or accentuating dissociative processes (Wood & Irons 2016). Likewise, CFTp bases its practice on the assumption that experiencing acts of caring and feelings of social safeness from others and within oneself has the potential to attenuate these processes (Heriot-Maitland, 2020).

HVM guiding principles

HVN-led approaches are guided by broader values which promote working with a person's own explanatory framework of voice-hearing and encourage people to develop ownership of their experiences through the use of peer support and collaboration (Corstens, Longden, McCarthy-Jones, Waddingham &Thomas, 2014). These guiding principles are summarised in table 2.

Table 2. Hearing Voices Network guiding principles

1. Hearing voices can be understood as a natural part of human experience
2. Diverse explanations are accepted for the origins of voices
3. Voice-hearers are encouraged to take ownership of their experiences and define it for themselves
4. Voice-hearing can be interpreted and understood in the context of life events and interpersonal narratives
5. A process of understanding and accepting one's voices may be more helpful for recovery than continual suppression and avoidance
6. Peer support and collaboration is empowering and beneficial for recovery

An overview of the Hearing Voices Network's guiding principles as referenced in (Corstens et al., 2014)

Summary of therapeutic aims

The therapeutic aims of each dialogical approach align with their theoretical underpinnings and are summarised in Table 3.

Broadly, all approaches emphasise acceptance and engagement with the voice-hearing experience as opposed to ignoring or eliminating voices. Likewise, all approaches consider that reducing negative attributions regarding the voice(s), for example perceived omnipotence or intention to do evil, will contribute towards hearers feeling less distressed by their voices.

All approaches have an overarching aim of bringing about positive change in hearer-voice relationships through the act of dialoguing with voices. This includes a consideration of ways to address a possible power imbalance in the relationship, where distressing voices are often perceived by the hearer as threatening, frightening, critical, or abusive. However, different approaches take slightly different approaches in relation to the power imbalance. Avatar Therapy, VRT and Relating

Therapy appear to support the hearer to increase power *over* voices by promoting assertive communication. In contrast, HVN-led approaches (MsV, EFC, TwV) and CFTp appear to support the hearer to establish more power *with* voices by promoting mutual understanding and peaceful ways of relating.

Table 3.

Main therapeutic aims of each of the dialogical approaches to helping people distressed by voices

Dialogical approach	Main aims
'Avatar Therapy' and 'Virtual Reality assisted Therapy' (VRT)	- to improve the hearer-voice relationship by helping the voice hearer gain more power and control through supporting the hearer to relate to voices in a more assertive manner.
'Relating Therapy'	- to improve the hearer-voice relationship by supporting the hearer to interact more closely with the voices and relate to voices in a more assertive manner.
'Making Sense of Voices' (MsV) and 'Experience Focussed Counselling' (EFC)	- to improve the hearer-voice relationship by supporting the hearer to begin to understand their voice-hearing experience, and develop a more peaceful relationship with voices.
Talking with Voices (TwV)	- As above but with dialoguing with voices being more central to the work. Dialoguing is used to support the voice hearer to distance themselves from the voices' emotional content by relating to the experience in a more compassionate, curious way and from the perspective that the voice(s) may reflect previous emotional conflicts that the hearer has faced in his/her lives.
Compassion Focused Therapy for Psychosis (CFTp)	- To improve the hearer-voice relationship by supporting both hearer and voices to increase feelings of social safeness and compassion and decrease perceptions of social rank threat.

The table summarises the therapeutic aims of each dialogical approach. All dialogical approaches share an overarching aim of improving hearer-voice relationships through the practice of dialoguing with voices. A key difference appears to be in the approach taken to the power imbalance in the relationship, whereby distressing voices are often experienced as threatening, frightening, critical, or abusive. Avatar Therapy, VRT and Relating Therapy appear to support the hearer to increase power *over* voices by promoting assertive communication whereas HVN-led approaches (MsV, EFC, TwV) and CFTp appear to support the hearer to establish more power *with* voices by promoting mutual understanding and peaceful ways of relating.

2. Similarities and differences in the practical application of dialogical approaches

Each approach has an associated protocol (see Table 4.) which includes an introduction to the approach and details of how dialogue work is introduced. The manuals for MsV and EFC (i.e. the Maastricht Interview), TwV and CFTp stress that therapy should be e process-driven and that the protocol should only be used as a guide.

Details of each intervention protocol are discussed below under the following subheadings: format and structure of sessions, facilitator training and supervision required, preparatory work for dialogue, nature and format of the dialogue, and endings. Table 5. provides an overview of these components.

Table 4.

Overview of intervention protocols

Avatar therapy	VRT	Relating therapy	MsV	EFC	TwV	CFTp
Introduction/ Pre-dialogue: Assessment of voices including verbatim content to use in the therapy**,** review and agree the focus of the dialogue, creation of avatar. **Active dialogue:** *Phase 1:* Exposure and Assertiveness- exposure to the avatar voicing verbatim content while the person is supported to respond assertively *Phase 2:* Relational, Developmental and Emotional Processes- formulation incorporating autobiographical context, meaning making, and experiences of trauma and powerlessness **Post-dialogue:** reflection on dialogue; a recording is provided.	**Introduction/ Pre-immersion:** Assessment of voices, creation of avatar for "most distressing voice", therapist determines therapy session objective with the patient at the start of each session. *Immersion:* Patient is immersed in the VR environment and encouraged to enter in a dialogue with their avatar animated in real time by the therapist. *Post-immersion:* Debrief, patient evaluation of the immersive experience. Sessions 2–4: targeted "emotional regulation and assertiveness" Session 5: targeted self-esteem.	**Phase 1-** Socialisation to Relating Theory and its implications for the inter-relating between hearer and voice, with focus on power and proximity dimensions. **Phase 2 –** Exploration of themes within the relational history of the hearer (with regard to voice and social relationships). **Phase 3-** Exploration and development of assertive approaches to relating (to the voice and socially), and experiential role plays to explore the motives of the voice (and other people) and practice relating in an assertive manner.	**Phase 1-** Engagement and a discussion of basic coping strategies that may help with distressing voices. **Phase 2-** assessment using the Maastricht Interview and development of 'the construct' (formulation) **Phase 3-** Development of a new voice-hearer led understanding of the voices, possibly in relation to life events and reconstruction of the relationship between the voice hearer and their voice(s) through the option of dialoguing.	Sequential use of EFC tools which include the Maastricht Interview, Report and Construct, alongside the development of HVM-suggested coping strategies, including voice dialogue.	**Phase 1-** (sessions 1-2) Engagement and psychosocial education. **Phase 2-** (sessions 3-7) Assessment and developing a construct (formulation), preparation for dialogue. **Phase 3-** (sessions 8-23) Dialogical work **Phase 4-** (sessions 24-26) Evaluation and consolidation.	**'Starting therapy'** **Level 1-** Establish safeness and connection **Level 2-**Psychoeducation: Learning about evolved brains, emotional systems, & multiple selves **Level 3-** Formulation **Level 4-** Building the compassionate self **Level 5-** Directing compassion to self, others, emotional parts, and voices. **'Ending therapy'**

Protocols described as mentioned in the academic literature: Avatar Therapy (Craig et al., 2015), VRT (Percie du Sert et al., 2018, adapted from Craig et al., 2015), Relating Therapy (Hayward et al., 2014), MsV (Steel et al., 2019) and EFC (Schnackenberg et al., 2017), as based on

the Maastricht Interview (Romme & Escher 2008), TwV (Longden et al., 2021a) and CFTp (Heriot-Maitland, 2020). *Note:* where published protocols were absent, details were located within case series studies and pilot RCTs (randomised controlled trials)

Table 5.
Overview of practical components of dialogical approaches for voice hearers and their voices

Practical detail	**Avatar therapy**	**VRT**	**Relating therapy**	**MsV**	**EFC**	**TWV**	**CFTp**
Number of sessions typically offered	6-9	9	16	20	30	26	26
Session frequency	weekly	weekly	weekly	~fortnightly	2/3 times per month	weekly	weekly
Average length of sessions	45- 60 minutes	45 minutes	60 minutes	Not specified	45- 60 minutes	60 minutes	60 minutes
Nature of dialogue with voice(s)	Indirect (digital simulation)	Indirect (digital simulation)	Indirect (role-play)	Direct	Direct	Direct	Direct
Amount of direct dialogue with voices	10-15 minutes of each session	Part of sessions, during immersion	During phase 3 (~sessions 9-16)	During phase 3, and elsewhere if useful	variable	Sessions 8-23	During level 5, although may happen earlier.
Dialoguing format	Voice hearer sits facing their avatar on a computer screen, therapist is in a separate room with a control panel which allows for them to speak as themselves and the avatar. Therapist views the interaction between	Voice hearer is immersed in a virtual reality environment using a head-mounted display. Display is of an avatar "seen from a first-person perspective standing in a dark room". Therapist sits physically separate from the voice hearer in a neighbouring room and has a control	Empty chair work, experiential role play between voice hearer, voice and the therapist.	Dialogue between voice hearer and voice is facilitated directly (voice hearer communicates what the voice says in real time) or indirectly (the voice hearer first listens to what the voice says then repeats it) by the facilitator. Emphasis is on this being conducted in an open and exploratory manner.			Details not specified.

	the voice hearer and avatar via a video link.	panel which allows for them to speak as themselves or as the avatar. Therapist views interaction via a video link.				
Therapist/ facilitator level of training	"Experienced clinicians skilled in psychological therapies" (typically psychologists or psychiatrists working with people with psychosis and related diagnoses). Group meets regularly for peer supervision.	Experienced clinician (Psychiatrist)	Mental health professionals (Psychologists, Nurse Consultant) trained by founder of approach	Mental health professionals (Clinical and Counselling Psychologists) who received training and regular supervision by MsV trainers.	Mental health professionals who had attended 6-day training programme in EFC and had regular supervision by an EFC trainer.	Clinical psychologist and developer of the intervention (10+ years' experience working with people with psychosis and related diagnoses and had received advanced CFT training)

The table provides an overview of the practical details of each approach under the following parameters: Number of sessions typically offered, session frequency, average length of sessions, whether the nature of the dialogue was direct (i.e. talking with a voice) or indirect (i.e. talking with a representation of a voice), amount of direct dialogue with voices, dialoguing format and the therapist/ facilitator level of training. *Note.* The table contents are a reflection of how approaches have been reported among treatment manuals and study protocols.

Format and structure of sessions

The number of sessions typically offered ranged from six to 30, with Avatar Therapy and VRT offering a shorter-term intervention of six to nine sessions, relating therapy offering 16 and HVM-led approaches and CFTp offering 20 to 30 sessions. Across all approaches, sessions were typically offered on a weekly basis and the length of each session ranged between 45 and 60 minutes.

The TwV approach protocol states that the therapy sessions in the pilot trial were conducted in the voice hearer's homes, unless otherwise requested, whereas Avatar Therapy, VRT and Relating Therapy take place within clinical settings.

Facilitator training and supervision

Avatar Therapy, Relating Therapy and the TwV approach required the therapist to be a qualified mental health professional who had a sufficient degree of experience with people who had a diagnosis of psychosis and had been trained by a person who had founded or had sufficient knowledge of the therapy (Craig et al., 2015; Percie du Sert et al., 2018; Longden et al., 2021a). For Avatar Therapy this included psychiatrists. VRT was delivered by a single psychiatrist who was 5 years qualified and had "treated over one thousand patients with major psychiatric disorders" (Percie du Sert et al., 2018). Details of additional training for the psychiatrist to deliver this type of intervention was not specified by the authors of the VRT study protocol (Freeman et al., 2019).

In CFTp, the developer of the manual delivered the CFTp sessions which were documented as a case series (Heriot-Maitland, 2020). The developer is a clinical psychologist with over 10 years of experience in working with people with a diagnosis of psychosis and had trained in CFT to an advanced level. Clinical applications of the Maastricht Interview (MsV; Steel et al., 2019 & EFC; Schnackenberg et al., 2017) were delivered by mental health professionals

who were working with voice-hearers in a clinical setting, although their level of experience or expertise was not specified. Access to regular supervision from a trained person during delivery of the intervention was emphasised in the protocols of Avatar Therapy and the TwV approach (Craig et al., 2015; Longden et al., 2021a).

Preparatory work for dialogue

Alongside building a formulation, Avatar Therapy and VRT make practical arrangements to prepare for the voice/hearer dialogue which involve creation of an avatar and familiarising the hearer with the digital equipment (Craig et al., 2015). The TwV approach and CFTp protocols specify that preparatory work is concentrated on supporting the hearer to develop self-care practices and coping or grounding skills to build a sense of safety and connection (Heriot-Maitland, 2020; Longden et al., 2021a).

Nature and format of the dialogue

The format of the dialoguing varies between protocols. The above table distinguishes 'direct' from ' 'indirect' dialogical approaches. The former involve direct dialoguing with voices whereas the latter involve dialoguing with an *external representation* of a voice. Indirect therapies include Avatar Therapy and VRT which involve dialoguing between the voice-hearer and a chosen persecutory voice which is created digitally as an "avatar" and controlled in real time by a therapist (Craig et al., 2015; Percie du Sert et al., 2018); and Relating Therapy, which involves dialoguing through experiential role plays where the voice hearer is encouraged to practice articulating assertive responses to typical voice utterances. The voice hearer or the therapist therefore enacts a persecutory voice (Hayward et al., 2014). In contrast, HVM-led approaches and CFTp involve direct dialogue with the voices carried out in one of two ways: 1) the hearer communicates what the voice says in real time to the facilitator, or 2) the hearer first listens to what the voice says then repeats it out loud to the facilitator.

The total amount of dialoguing varies between each protocol, with Avatar Therapy and VRT allocating a maximum of 15 minutes per 45- 60 minute session (i.e. 25% of overall intervention length) (Craig et al., 2015; Percie du Sert et al., 2018), Relating Therapy allocates approximately 6 sessions out of a total of 16 possible sessions for dialoguing (37.5% of overall intervention length) (Hayward et al., 2014), and the TwV approach allocates approximately 15 out of a total of 26 possible sessions for dialoguing (58% of overall intervention length) (Longden et al., 2021a). Amounts of dialoguing have not been explicitly defined within MsV, EFC and CFTp approaches.

Ending and reflections

Some protocols suggest how the work is best ended. Within Avatar Therapy and VRT, this takes the form of a debrief after each dialogue which gives an opportunity for the hearer to comment on the experience of dialoguing (Craig et al., 2015; Percie du Sert et al., 2018). In the final session, the hearer is also offered an audio-recording of the dialoguing from sessions to take with them, with the option of continuing what is referred to as a process of exposure, at home (Craig et al., 2015; Percie du Sert et al., 2018). The TwV approach makes use of an 'evaluation and consolidation' phase which includes a collaborative summary of what was achieved during the therapy and goals for the future; a handover session with an identified family member or healthcare worker to continue the work; and assistance to link the hearer with a local peer-support group if desired (Longden et al., 2021a). Other approaches may take a similar approach: however, this was not specified in the protocol.

Review of empirical evidence

The database search identified a total of 24 relevant empirical papers which had studied the use of dialoguing with voices. These corresponded to the main dialogical approaches previously listed in this review: Avatar Therapy, VRT, Relating Therapy, Clinical applications of the Maastricht Interview (EFC, MsV), The TwV approach and CFTp. Studies which referred to non-digital modifications of avatar therapies and approaches which studied the combined effects of a dialogical approach and CBT were also included. Study protocols were excluded from this part of the review. See Table 6. for an overview.

Each approachwas at a different stage of empirical development, which was reflected by the number and type of research papers available. Avatar Therapy was the most researched dialogical approach with 7 studies published to date, followed by Relating Therapy (n=5), Avatar Therapy modifications and EFC (n=3), VRT and MsV (n=2), and TwV and CFTp (n=1). Relating Therapy was the first of these to be studied empirically in 2009, followed by Avatar Therapy in 2013 and most recently CFTp and the TwV approach which had two papers published in 2020 and 2021, respectively; the first of which was part of a thesis and was awaiting publishing in a peer reviewed journal (Heriot-Maitland, 2020) . Both quantitative and qualitative data are available from the studies selected. These will be summarised below, along with a consideration of the methodology employed across studies.

Table 6. Overview of empirical study of dialogical approaches for voice hearers and their voices

Name of approach	Study design						Number of studies generated from search
	Case study	Case series	Pilot RCT	Pilot mixed method	RCT	Qualitative	
Avatar Therapy	Dellazizzo, et al., (2018b) Dellazizzo et al. (2018c)	Ward et al. (2020)	Leff et al. (2013)		Craig et al. (2018)	Beaudoin et al. (2021) Dellazizzo et al. (2018a)	7
Avatar therapy modifications	Cichocki et al. (2016) Stefaniak et al. (2017)		Stefaniak et al. (2019)				3
VRT			Percie du Sert et al. (2018)	Dellazizzo et al. (2020)			2
Relating Therapy	Paulik, Hayward, & Birchwood, (2013)	Hayward, Overton, Dorey & Denney (2009)	Hayward, Jones, Bogen-Johnston, Thomas & Strauss (2017)			Hayward, Bogen-Johnston & Deamer, (2018) Hayward& Fuller (2010)	5
EFC			Schnackenberg, Fleming & Martin (2017)			Schnackenberg, Fleming & Martin (2018) Schnackenberg, Fleming, Walker & Martin (2018)	3

Name of approach	Study design						Number of studies generated from search
	Case study	Case series	Pilot RCT	Pilot mixed method	RCT	Qualitative	
MsV		Steel et al. (2019)				Steel et al. (2020)	2
TWV			Longden et al. (2021)				1
Compassion for voices/ CFTp		Heriot-Maitland (2020)					1
							Total: 24

An overview of the number of empirical studies to date on dialogical approaches to voice hearing. The table summarises the 24 studies by design type.

Quantitative outcomes

12 out of the 24 studies selected measured quantitative outcomes. See table 7. for a summary.

Across the 12 studies, a total of 34 different outcome measures were used. This heterogeneity makes direct comparison across studies problematic, although this is to be expected given that different approaches have different conceptualisations of voice-hearing and different considerations of what might constitute key therapeutic benefits to measure.

Broadly, studies of Avatar Therapy, VRT and Relating Therapy emphasise measures of the emotional consequences of voice-hearing (i.e. voice-related distress and depression) and of observed power-differentials between the hearer and a persecutory voice. In this regard, these approaches have been reported to be helpful in reducing voice-related distress together with depression, and in increasing assertive communication of the voice hearer, as measured by the 'Psychotic Symptom Rating Scale' (PSYRATS; Haddock et al., 1999), the 'Calgary Depression Scale' (CDS; Addington, Addington & Maticka-Tyndale, 1993) or the 'Beck Depression Inventory' (BDI-11; Beck, Steer & Brown, 1996) and the 'Voice Power Differential Scale' (VPDS; Birchwood et al., 2000; 2004), respectively. As with reporting of antipsychotic trials, the use of these general measures risks masking possible the more specific effects, although factors such as quality of life and increased acceptance of voices have also been considered (e.g. the 'Quality of Life Enjoyment and Satisfaction Questionnaire', Q-LES-Q-SF; Stevanovic, 2011 & the 'Voices Acceptance and Action Scale', VAAS; Shawyer et al., 2007), with suggestions that VRT (Percie du Sert et al., 2018; Dellazizzo et al., 2020) and Avatar Therapy (Craig et al., 2018) have led to improvements in these areas. Avatar Therapy, VRT, MsV and TwV studies have used the 'Beliefs About Voices Questionnaire' (BAVQ-R; Strauss et al., 2018) which aims to capture voice hearer perceptions of voice malevolence, benevolence and omnipotence. Significant reductions were observed in overall beliefs about voices in the Avatar Therapy conditions compared with Treatment as Usual (Leff et al., 2013) and Supportive Counselling (Craig et al., 2018). This was also observed in the VRT proof of concept study when combined with CBT, although these effects

were not sustained at three month follow-up. Detailed quantitative findings have not yet been reported for the TwV approach (Longden et al., 2021b).

More specific measures have also been employed consistent with each approach. For example, The Relating Therapy RCT aimed to specifically capture a change in self-other relationships using the 'Person's Relating to Others Questionnaire' (PROQ3; Birtchnell, Hammond, Horn, De Jong & Kalaitzaki, 2013).) but the changes observed at 16 weeks and 36 weeks post intervention as measured by the PROQ3 total score were small (Cohen's *d*= 0.4; Hayward et al., 2018).

HVM-led and CFTp studies attempt quantitatively to capture other hallmarks of mental wellbeing and personal recovery using measures such as the Warwick--Edinburgh Mental Well--Being Scale (WEMWBS; Stewart-Brown et al., 2007) and the Questionnaire about the Process of Recovery (QP; Neil et al., 2014).Studies using these outcome measures suggest that these interventions can lead to clinically significant reductions in problematic dissociative experiences (Heriot-Maitland, 2020; Longden et al., 2021; Steel et al., 2018) and the CFTp case series suggests reductions in levels of shame and self-criticism over the course of the 26-week pilot intervention (Heriot-Maitland, 2020). However, the amount of quantitative evidence published to date regarding these approaches relatively small, with a focus being placed on their feasibility and acceptability in the first instance.

Crucially, developments can also be seen in the attempts of dialogical approaches to quantitatively capture changes in the dialogical characteristics of the relationship between the hearer and their voice/s, notably by the development of the 'Voice and You' questionnaire (VAY; Hayward, Denney, Vaughan & Fowler, 2008). In the Relating Therapy and TwV pilot RCTs (Hayward et al., 2017; Longden et al., 2021) suggest that these approaches can contribute to improvements in people's relationship with their voices. Yet, further study is required to avoid susceptibility to evaluation bias given that the VAY measure was created by the founders of Relating Therapy. Likewise, developers of the measure have previously advocated that conceptual clarification of this psychometric is needed (Hayward et al., 2008). One other measure which has attempted to capture changes in the hearer-voice relationship that has been used in the MsV's case series study (Steel et al., 2018), is the 'DAIMON' scale translated from Spanish (DAIMON-EV; Rosen et al., 2020). However, significant improvements

in interpersonal relating were not observed and replication is likely needed within a larger scale study. There also remains a need to further assess the predictive validity and sensitivity to change of this measure (Rosen et al., 2020).

Table 7.

Summary of the 12 studies of dialogical approaches for voice hearers and their voices which have used quantitative methodology

Approach	Quantitative study	Study design	Outcome measures used	Main findings
Avatar Therapy	Leff et al., 2013	Proof of concept pilot RCT	PSYRATS, BAVQ-R, CDS	Significant reduction in PSYRATS and BAVQ-R scores in Avatar Therapy group compared with TAU group. Abrupt cessation of AVHs in 3 patients, which remained at 3-month follow-up.
	Craig et al., 2018	RCT	PSYRATS, BAVQ-R, VAAS, VPDS, DASS-21, SAPS, SANS, MANSA, RSES	Significant reduction in PSYRATS total scores in avatar therapy condition compared to supportive counselling condition
Avatar Therapy modification	Stefaniak et al., 2019	Pilot study parallel groups	PSYRATS, VPDS	Lower PSYRATS and VPDS scores at time-point 1 compared to baseline. Effects sustained at 3-month follow up.
VRT	Percie du Sert et al., 2018	Pilot RCT	PSYRATS, PANSS, BDI-11, Q-LES-Q-SF	Significant improvements in AVH severity, depressive symptoms and quality of life in VRT condition compared to TAU. Results sustained at 3-month follow up.
	Dellazizzo et al., 2020	Proof of concept pilot RCT	PSYRATS, BAVQ-R, PANSS, BDI-11, Q-LES-Q-SF	Improvements observed for depressive symptoms and overall symptomatology of schizophrenia. Suggested as complimentary therapy to CBT.
Relating Therapy	Hayward et al., 2009	Case series	VAY, PSYRATS-AH, AHRS	Increased controllability reported by 3 participants, reductions in distress reported by 2 participants, reductions in negative voice relating reported in 4 participants.
	Paulik et al., 2013	Case study	PSYRATS, VPDS, DASS, RSES, SOFAS	Significant reductions across all measures between baseline and follow up, apart from VPDS.
	Hayward et al., 2017	Pilot RCT	PSYRATS, PROQ3, CHOICE, VAY, HADS at baseline, 16w and 26w	Significant reduction in AH distress in RT group compared with TAU, large effect size. Effect was

				maintained at follow-up. Medium-large effect sizes in favour of RT for improvements in negative relating with voices and others compared with TAU.
EFC	Schnackenberg et al., 2017	RCT	BPRS (Psychosis, Anxiety & Depression factors), PSYRATS	Clinically large treatment effects shown in the EFC group compared with the TAU group on both measures. Voice-hearers also felt more able to do first trauma disclosures in EFC group compared with TAU group.
MsV	Steel et al., 2018	Case series	PSYRATS, DAIMON, GAD7, PHQ9, DES-II, WEMWBS, SCS, BAVQ-R	Large effect sizes observed for SCS and BAVQ-R scores which warrants further study. Voice-related distress ratings not statistically significant between time points. Findings suspected to be limited by small sample size and reductions considered to still be clinically meaningful.
TwV	Longden et al., 2021	Pilot RCT	Primary: rates of referral, recruitment and retention, adherence to and completion of the intervention. Secondary: PANSS, BAVQ-R, VAY, DES-II, QPR, LSC-R	Target sample achieved. 37 participants out of 127 referrals declined to participate. Only baseline secondary outcomes available.
CFTp	Heriot-Maitland, 2020	Case series	PSYRATS, DAS-21, CORE, SocCS, OAS, SCS-SF, FSCSR, PBIQ-R, HRV, SSPS & DES-II	Significant improvements in outcome measures of depression, stress, wellbeing, voices and delusion were observed, the majority of which were maintained at 6-8 weeks follow-up. CFTp considered a feasible and acceptable intervention.

PSYRATS-AH/voices= Psychotic Symptom Rating Scale; **BAVQ-R**= Beliefs About Voices Questionnaire- Revised; **PANSS**= Positive And Negative Symptoms Scale; **VAAS**= The Voices Acceptance and Action Scale; **SAPS**= Simplified Acute Physiology Score; **SANS**= Scale for the Assessment of Negative Symptoms; **MANSA**= Manchester Short Assessment Of Quality of Life; **RSES**= Rosenberg's Self-Esteem Scale; **BDI**= Beck's Depression Inventory- version 2; **Q-LES-Q-SF**= The Quality of Life Enjoyment and Satisfaction Questionnaire; **BPRS**= Brief Psychiatric Rating Scale; **CDS**= Calgary Depression Scale; **VPDS**= Voice Power Differential Scale; **VAY**= the Voice And You; **LSCR**= Life Stressor Checklist – Revised**; AHRS**= Auditory Hallucinations Rating Scale; **DASS**= Depression and Anxiety Stress Scale; **SOFAS=** Social and Occupational Functional Assessment Scale; **PROQ3**= Person's Relating to Others Questionnaire version 3; **CHOICE**= CHoice of Outcome In Cbt for psychoses; **HADS**= Hospital Anxiety and Depression Scale; **PSRS**= The Perceived Stress Reactivity Scale; **DAIMON-EV**= A scale which measures the relationship with and between voices- English Version; **GAD-7**= Generalised Anxiety Disorder version 7; **PHQ-9**= Patient Health Questionnaire version 9, measures Depression; **DES-II**= Dissociative Experiences Scale version 2; **WEMWBS**= the Warwick--Edinburgh Mental Well--Being Scale; **QPR**= the Questionnaire about the Process of Recovery; **SCS**= Self-

Compassion Scale (and SCS-SF= short form); **CORE**= Clinical Outcomes in Routine Evaluation; **SocCS**= Social Comparison Scale; **FSCSR**= Forms of Self-Criticising/Attacking and Self-Reassuring Scale; **OAS**= Other as Shamer Scale; **PBIQ-R**= Personal Beliefs about Illness Questionnaire-Revised, **HRV**= Heart Rate Variability; **SSPS**= State Social Paranoia Scale. See Appendix B for further details of all studies. The table summaries studies which have used quantitative methodology. Information is summarised according to each dialogical approach, the study authors, study design, list of outcome measures and brief description of the main quantitative findings.

Themes from qualitative outcome studies

15 out of the 24 studies selected included qualitative outcomes. See Table 8. for a summary.

These comprised:

- seven qualitative studies which drew on themes from interview transcripts (Avatar Therapy; Beaudoin et al., 2021& Dellazizzo et al., 2018a, Relating therapy; Hayward & Fuller, 2010 & Hayward, Bogen-Johnston & Deamer 2018, EFC; Schnackenberg, Fleming & Martin, 2018 & Schnackenberg et al., 2018 & MsV; Steel et al., 2020),
- one systematic case review of 53 'therapy completers' (Avatar Therapy; Ward et al., 2020),
- five case reports, of which four were narrated by a clinician who had delivered the approach (Avatar Therapy; Dellazizzo et al., 2018c, Avatar Therapy modifications; Cichocki, Palka, Leff, & Cechnicki, 2016; Stefaniak, Sorokosz, Janicki & Wciórka, 2017, Relating Therapy; Paulik et al., 2013), and one included verbatim feedback from the voice-hearer (Avatar Therapy- Dellazizzo et al., 2018b), and
- two pilot RCTs which employed qualitative methodology (VRT; Dellazizzo et al., 2020 & TwV; Longden et al., 2021).

Qualitative studies yielded several themes related to the interpersonal processes at play among different hearer-voice relationships. These appeared to confirm explanatory models referenced earlier in this review in that the themes largely related to power and control (Avatar Therapy :Ward et al., 2020; Relating Therapy: Paulik et al., 2013 & MsV: Steel et al., 2020), changes observed with regard to emotional responses to voices (Avatar Therapy: Beaudoin et al., 2021; Dellazizzo et al., 2018a; Dellazizzo et al., 2018b; Dellazizzo et al., 2018c; Ward et al., 2020 and more recent study of Avatar Therapy suggesting that the development of compassion and work with loss and trauma could be therapeutic targets (Ward et al., 2020). Detailed qualitative summaries were not available for TwV and CFTp approaches at the time the search was conducted.

Acceptability and feasibility

Qualitative studies provided evidence to suggest the acceptability and feasibility of dialogical approaches, with variation in the generalisability of these findings. Acceptability was largely reported in case studies for Avatar Therapy (Dellazizzo et al., 2018b; Dellazizzo et al., 2018c), Avatar Therapy modifications (Cichocki et al., 2016; Stefanaik et al., 2017) and Relating Therapy (Paulik et al., 2013). However, generalisability of these findings are low given that these were case studies and reported as exceptional success stories. Nevertheless, these studies provide some insight into the potential acceptability among hearers who have experienced persecutory voices for a long time and have found more traditional forms of support unhelpful. Likewise, studies of the non-digital modification of Avatar Therapy require replication in a UK population but provide examples of how the approach could be made more feasible without the use of the advanced digital software ordinarily required.

Two papers reported on the acceptability of a dialogical approach being combined with Cognitive-based therapies. These studies were a single case study reporting the usefulness of Cognitive Therapy for Command Hallucinations (CTCH) combined with Relating Therapy (CBRT; Paulik et al., 2013 and a proof of concept study of Cognitive Behavioural Therapy combined with VRT (Dellazizzo et al., 2020). Authors of the CBRT case study report changes in patterns of relating, improved self-esteem and reductions in voice-related distress (Paulik et al., 2013). Likewise, the qualitative findings in the CBT and VRT proof of concept study suggest the two therapies being complimentary and (Dellazizzo et al., 2020). However, and taken together, both of these studies are very limited in terms of their generalisability, with further study required to investigate potential synergistic effects of dialogical approaches with other therapies.

Challenges of dialogical approaches

Challenges for voice-hearer and the therapist within the various approaches were also reported. For the voice-hearer, this was largely reported in terms of a level of unease about the prospect of dialoguing with voices (Relating Therapy; Paulik et al., 2013 & TwV Longden et al., 2021b).

However, this did not appear to significantly impact subsequent engagement with the approach (Paulik et al., 2013; Longden et al., 2021b). Ward and colleagues (2020) specifically identify challenges for therapists delivering Avatar Therapy, in terms of the equipment needed and also the need for sufficient knowledge and expertise, training and regular supervision. The case report by Cichocki et al. (2016) proposes a feasible modification of Avatar Therapy where a mask is used instead of a digital creation of an avatar. However, these findings are very limited and require replication with larger samples to determine whether non-digital adaptions of Avatar Therapy can be made whilst retaining the proposed therapeutic benefits.

Table 8.

Summary of the 15 studies of dialogical approaches to distressing voices which use qualitative methodology

Approach	Qualitative study	Study design	Outcome measures	Main qualitative findings
Avatar therapy	Beaudoin et al., 2021	Qualitative	Themes from interactions between voice-hearers and avatars	Confrontational techniques and building coping mechanisms (e.g. self-affirmation) appeared to be central to the therapeutic process.
	Dellazizzo et al., 2018a	Qualitative	Themes from interactions between voice-hearers and avatars	Emotional responses to the voices, beliefs about voices and schizophrenia, self-perceptions, coping mechanisms and aspirations appeared to be important therapeutic targets.
	Dellazizzo et al., 2018b	Case report	Clinician and peer verbal feedback	Intervention was very well received. The person's voices reduced by 80–90% and he was able to reduce his medication and gain employment. Researchers suggest that AT may be a promising intervention for voice hearers. Emphasis on the value of involving peers in therapy.
	Dellazizzo et al., 2018c	Case report	Clinician observation only	Morale of patient's family improved.
	Ward et al., 2020	Systematic case review	Detailed therapy notes and audio-recordings	10 therapeutic targets identified as important: power and control; self-esteem; maintenance; working toward internal attribution; identity; compassion toward the voice; experiential disengagement; working with grief; working with trauma; future focus. Engagement in dialogue was acceptable. Potential side effects: content can be challenging for voice-hearer and therapist; delivery challenges for therapist (e.g. switching between voice and therapist in real-time).
Avatar therapy modification	Cichocki et al., 2016	Case study	Clinician observation only	Therapeutic benefits observed. Patient's voices 'essentially ceased'. Result sustained at 1 year follow up.
	Stefaniak et al., 2017	Case study	Clinician observation only	Significant reduction in the frequency and intrusiveness of voices. Effects were sustained at 6-month follow-up.

VRT	Dellazizzo et al., 2020	Pilot RCT with qualitative interviews	Therapists' notes and patient interviews	Similarities found between CBT and VRT in that therapy helped patients better accept themselves and their voices while also learning to better manage their emotions. Therapy enabled patients to improve interpersonal relations with their voices and others. CBT and VRT considered complimentary approaches with CBT focusing on "questioning" and "comprehension" and VRT on "taking action" and "dialogue".
Relating therapy	Hayward & Fuller, 2010	Qualitative pilot	Semi-structured interview transcripts	Five themes identified: the process of engaging with the therapeutic model, the significance and impact of the therapist's approach to therapy, the process of developing a new relating style, challenges and obstacles to change, and how changed is described and defined by participants.
	Hayward et al., 2018	Qualitative	Semi-structured interview transcripts	Changes can be evident in both the hearer and the voice as a result of the voice hearer adopting a more assertive communication approach with the voice. These benefits can extend to communication the voice-hearer has with others.
	Paulik et al., 2013	Case study	Patient verbal feedback	Self-reported improvements in patient's relationship with voices and others. The therapy process was well received by the patient. Enabled patient to access a HVN group.
EFC	Schnackenberg et al., 2018a	Qualitative	Semi-structured interview transcripts	Themes identified: 'trauma-related', dealing with emotions, process of working with voices, intra- and interpersonal life, 'coping-related'.
	Schnackenberg et al., 2018b	Qualitative	Semi-structured interview transcripts	Themes identified: intervention applicability, impact of regular treatment before study, impact of EFC process, process of working with voices, impact of regular treatment during study, views on treatment or approach.
MsV	Steel et al., 2020	Qualitative	Interview transcripts	High satisfaction with the approach, positive outcomes appeared to relate to a better understanding of voice hearing experiences and a better sense of control over voices.
TWV	Longden et al., 2021	Pilot RCT with	Voice-hearer and staff verbal feedback about the acceptability and feasibility of the approach	37 participants out of 127 referrals declined to participate, most commonly due to 'lack of interest'. Level of unease with dialoguing

	qualitative interviews	with voices not judged by researchers as main reason for declining intervention. No indication of resistance from staff to refer to the trial.

HVN= Hearing Voices Network. See Appendix B. for further details of all studies. The table presents an overview of qualitative studies as listed by each approach, authors of the study, study design, list of outcome measures and a brief description of the main qualitative findings.

Discussion

Summary of the review

This first aim of this review was systematically to map the emerging literature on dialogical approaches to helping people distressed by voices, i.e. approaches which include the facilitation of dialogue between the hearer and their voices. The review suggested that such approaches can be divided into three types:

1. Approaches which stem from traditional academic and clinical settings, namely Avatar Therapy (Leff et al., 2014), Virtual Reality assisted Therapy (VRT; Percie du Sert et al., 2018), and Relating Therapy (RT; Hayward, Jones, Bogen-Johnston, Thomas, & Strauss, 2017)
2. Approaches which stem from the Hearing Voices Movement (HVM), namely 'Making sense of Voices' (MsV; Steel et al., 2020) (also known as 'Experienced Focused Counselling' [EFC; Schnackenberg et al., 2017]) and the 'Talking with Voices' approach (TwV; (Longden et al., 2021a) and
3. An approach which stems from both academic and clinical settings and the HVM: Compassion Focused Therapy for Psychosis' (CFTp; Heriot-Maitland, 2020).

The second aim of the review, given the diversification of therapeutic modalities in this area, was to provide a theoretical overview of each dialogical approach and also a detailed comparison of how these approaches are applied in practice. The third part of the review aimed to critically appraise the empirical evidence base to date with respect to how these approaches have been or could be helpful for voice hearers.

The main findings were as follows:

Theoretical contributions

Dialogical approaches have been part of a recent theoretical development in which voice hearing is considered not so much as an intra-psychic phenomenon as an interpersonal one. Voices are

conceptualised as other people (or representations of other people), beings, or parts of the self with whom the person has a relationship. These approaches draw upon extended cognitive models which take account of interpersonal factors such as social rank threat and the role of power and proximity, both in the hearer-voice relationship and in self-other relationships more generally. Voices are seen as often representing dissociated or disowned parts of the self, or self-other relationships, that result from interpersonal trauma or related stressors. This is most explicit in the newer approaches of Talking with Voices and Compassion Focused Therapy for psychosis. The TwV approach primarily draws upon psychoanalytic frames of reference to understand interpersonal aspects of the self. However, broader values of the HVM also stress the need to respect and draw on the hearer's own explanatory framework.

These ideas are reflected in the main therapeutic aims of each approach. Approaches can broadly be divided into two in this regard: dialogical approaches which prioritise the development of assertive communication from the hearer to the voice and others (Avatar Therapy, VRT, Relating Therapy) and dialogical approaches which emphasise developing understanding and more peaceful and empathic ways of relating between the hearer and voice (MsV, EFC, TwV and CFTp).

Practical application

Intervention protocols were available for all approaches, with HVM-led approaches and CFTp aiming to be more individualised and therefore using protocols more loosely, as a guide. Details of each protocol were reviewed in terms of the interventions' overall format and structure along with the specific contribution of dialoguing. The total number of sessions offered varied considerably with Avatar Therapies and VRT, Relating Therapy, HVM-led approaches and CFTp representing shorter-term, medium term and longer-term interventions, respectively. The amount of time allocated to dialoguing in each session also varied between approaches, with the TwV approach allocating the most time (58%), followed by Relating Therapy (37.5%) and Avatar Therapy and VRT (25%). The emphasis placed on preparation for, and debriefing after the dialogue work also varied between approaches. Avatar Therapy and VRT adopted a more pragmatic focus, perhaps representative of their brevity: TwV and CFTp allocated more time preparing for the dialogue with the use of safety-building

exercises first . Opportunities for evaluation and consolidation were explicitly mentioned in Avatar Therapy and TwV protocols.

Appraisal of the evidence base

The dialogical approaches identified in this review were at varying stages of empirical development, with Avatar Therapy being the most researched, followed by Relating Therapy, The Maastricht Approach, VRT, TwV and CFTp respectively. This perhaps reflects Avatar Therapy and Relating Therapy's closer alignment with Cognitive Behavioural Therapy for Psychosis (CBTp), the therapy currently recommended people who hear voices who have a psychosis diagnosis (NICE 2014). Further, both VRT and Relating Therapy are suggested to have synergistic benefits with cognitive therapies, although these findings are yet to be replicated beyond a proof of concept and case study (Dellazizzo et al., 2020; Paulik et al., 2013).

TwV and CFTp were the newest of the dialogical approaches and, for the first time, offer manualised protocols for supporting *direct* dialoguing with voice hearers and their voices that, from preliminary findings, are considered feasible to be delivered by a trained mental health professional within clinical services. However, further results from a randomised controlled trial of the TvW approach are yet to be published (Longden et al., 2021a) and CFTp awaits evaluation beyond its initial case series study (Heriot-Maitland, 2020).

In terms of methodology, across the body of research there appeared to be a general trend towards moving away from traditional efficacy studies analogous to drug trials which focus on symptom frequency and severity, towards outcome research which focuses on voice-related distress and quality of the hearer-voice relationship. However, measures which aimed to capture the quality of the hearer-voice relationship, particularly the dialogical aspects; require further development. Likewise, there was also a move towards process research aiming to better understand the psychological mechanisms of each approach: however studies were very preliminary.

Limitations

The methodological quality of the reviewed papers was examined by taking into consideration the types of study design, sample sizes and outcome measures used. However, a formal quality assessment tool was not used in this review. This seemed appropriate given the study aims to provide a broad overview of the theory, practical application and evidence base of dialogical approaches to helping people who hear distressing voices to date, and is standard for scoping reviews (Peters et al., 2020). However, it should be noted that the quality of individual studies varied considerably in terms of their implementation. This therefore requires further consideration as the evidence base develops to the stage where a systematic review would be useful.

Another limitation is that the review only included literature that was available in English. Given that the dialogical approaches associated with the Hearing Voices Movement have been delivered across different countries, and Avatar Therapy modifications are being developed in Poland; it likely that this review excludes other important findings which could yield further insights about the application of dialogical approaches in this area.

Lastly, and as mentioned in the introduction, the position of the author was that voice-hearing is a meaningful experience to be explored. This undoubtedly informed the methods by which the review was conducted, the choice of language used and the way that individual publications have been summarised and interpreted.

Conclusion and Implications

The development of dialogical approaches reflects an important shift in conceptualisation of voice-hearing from traditional medical or psychological understandings, which view the phenomenon as indicating neurological or cognitive dysfunction, to one which sees it as an essentially interpersonal phenomenon often linked to past relationships or trauma. Yet, the review demonstrates that empirical study of dialogical approaches to helping people who hear distressing voices is still in its infancy.

The review identified differences among the methods of dialogical approaches which seemed to relate to different therapeutic aims which focused on developing assertiveness (Avatar Therapy, VRT,

Relating Therapy) versus developing understanding (Maastricht Approach, TwV, CFTp). Further comparisons of these approaches are needed in order to identify how these approaches differ in ways that would enable better tailoring of approaches to be available to people who hear voices in services. This includes research which places further focus on studying potential therapeutic targets of each dialogical approach, including how each approach might target voice-related distress, trauma and aspects of personal recovery.

Likewise, future research will need to continue to develop and consistently use valid measurements of the proposed therapeutic targets. Specific to dialoguing, this demands the development of measures which better capture changes in the interpersonal processes and dialogical characteristics of the hearer-voice relationship. For example, wider implementation of the 'Voice and You' (VAY; Hayward et al., 2008) measure and further study of the 'DAIMON' (Rosen et al., 2020) in a UK population.

Finally, there is a need to further consider how dialogical approaches could be implemented in services as well as to consider what the main barriers are which might prevent successful implementation. This is especially relevant given the questioned practical feasibility of Avatar Therapy and VRT approaches which use specialist digital equipment, and questions remaining how services could be transformed to allow for adoption of the Hearing Voices Movement ethos.

References

Adams, J., Hillier-Brown, F. C., Moore, H. J., Lake, A. A., Araujo-Soares, V., White, M., et al. (2016). Searching and synthesising 'grey literature' and 'grey information' in public health: Critical reflections on three case studies. *Systematic Reviews, 5*(1), 1-11. https://doi.org/10.1186/s13643-016-0337-y

Addington, D., Addington, J., & Maticka-Tyndale, E. (1993). Assessing depression in schizophrenia: The calgary depression scale. *The British Journal of Psychiatry, 163*(S22), 39-44. https://doi.org/10.1192/S0007125000292581

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Beaudoin, M., Potvin, S., Machalani, A., Dellazizzo, L., Bourguignon, L., Phraxayavong, K., et al. (2021). The therapeutic processes of avatar therapy: A content analysis of the dialogue between treatment resistant patients with schizophrenia and their avatar. *Clinical Psychology & Psychotherapy,* 28 (3), 500-518. https://doi.org/ 10.1002/cpp.2556

Beavan, V. (2011). Towards a definition of "hearing voices": A phenomenological approach. *Psychosis, 3*(1), 63-73. https://doi.org/10.1080/17522431003615622

Beavan, V., Read, J., & Cartwright, C. (2011). The prevalence of voice-hearers in the general population: A literature review. *Journal of Mental Health, 20*(3), 281-292. https://doi.org/10.3109/09638237.2011.562262

Beck, A. T., & Rector, N. A. (2003). A cognitive model of hallucinations. *Cognitive Therapy and Research, 27*(1), 19-52. https://doi.org/10.1023/A:1022534613005

Beck, A. T., Steer, R. A., & Brown, G. (1996). Beck depression inventory–II. *Psychological Assessment,* 67(3), 588-597. https://doi.org/10.1207/s15327752jpa6703_13

Bell, V., Raballo, A., & Larøi, F. (2010). Assessment of hallucinations. (pp. 377-397). New York, NY, US: Oxford University Press. https://doi.org/10.1093/med/9780199548590.003.0019

Birchwood, M., Dunn, G., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., et al. (2018). The COMMAND trial of cognitive therapy to prevent harmful compliance with command hallucinations: Predictors of outcome and mediators of change. *Psychological Medicine, 48*(12), 1966-1974. https://doi.org/10.1017/S0033291717003488

Birchwood, M., Gilbert, P., Gilbert, J., Trower, P., Meaden, A., Hay, J., et al. (2004). Interpersonal and role-related schema influence the relationship with the dominant voice in schizophrenia: A comparison of three models. *Psychological Medicine, 34*(8), 1571. https://doi.org/ 10.1017/S0033291704002636

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: Subordination and entrapment by voices and significant others. *Psychological Medicine, 30*(2), 337-344. https://doi.org/10.1017/S0033291799001828

Birtchnell, J. (1996). *How humans relate: A new interpersonal theory.* Psychology Press.

Birtchnell, J. (2002). Psychotherapy and the interpersonal octagon. *Psychology and Psychotherapy: Theory, Research and Practice, 75*(3), 349-363. https://doi.org/10.1348/147608302320365235

Birtchnell, J., Hammond, S., Horn, E., De Jong, C., & Kalaitzaki, A. (2013). A cross-national comparison of a shorter version of the person's relating to others questionnaire. *Clinical Psychology & Psychotherapy, 20*(1), 36-48. https://doi.org/10.1002/cpp.789

Bowlby, J. (1973). *Attachment and loss: Separation* (vol. 2). Basic Books.

Cichocki, L., Palka, J., Leff, J., & Cechnicki, A. (2016). The use of masks in the treatment of patients with chronic auditory hallucinations. *Psychoterapia, 1*, 17-28. http://www.psychoterapiaptp.pl/uploads/PT_1_2016/ENGver17Cichocki_Psychoterapia_1_2016.pdf

Corstens, D., Escher, S., & Romme, M. (2008). Accepting and working with voices: The maastricht approach. *Psychosis, trauma and dissociation: Evolving perspectives on severe psychopathology*, 381-396. https://doi.org/10.1002/9781118585948.ch24

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis*, *4*(2), 95-104. https://doi.org/10.1080/17522439.2011.571705

Corstens, D., May, R., & Longden, E. (2011, January 26). *Talking with voices*. Rufus May: Holistic approaches to mental health. https://rufusmay.com/2011/01/26/talking-with-voices/

Corstens, D., May, R. & Longden, E. (2011). Talking with voices. In M. Romme & S. Escher (Eds.), *Psychosis as a personal crisis*. Routledge.

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*(Suppl_4), S285-S294. https://doi.org/10.1093/schbul/sbu007

Craig, T., Ward, T., & Rus-Calafell, M. (2016). Psychological therapies for voice hearing: An overview. *Brief Interventions for Psychosis: A Clinical Compendium*, 41.

Craig, T. K., Rus-Calafell, M., Ward, T., Fornells-Ambrojo, M., McCrone, P., Emsley, R., et al. (2015). The effects of an audio visual assisted therapy aid for refractory auditory hallucinations (AVATAR therapy): Study protocol for a randomised controlled trial. *Trials, 16*(1), 1-9. https://doi.org/10.1186/s13063-015-0888-6

Craig, T. K., Rus-Calafell, M., Ward, T., Leff, J. P., Huckvale, M., Howarth, E., et al. (2018). AVATAR therapy for auditory verbal hallucinations in people with psychosis: A single-blind, randomised controlled trial. *The Lancet Psychiatry, 5*(1), 31-40. https://doi.org/10.1016/S2215-0366(17)30427-3

Dellazizzo, L., Percie du Sert, O., Phraxayavong, K., Potvin, S., O'Connor, K., & Dumais, A. (2018a). Exploration of the dialogue components in avatar therapy for schizophrenia patients with

refractory auditory hallucinations: A content analysis. *Clinical Psychology & Psychotherapy, 25*(6), 878-885. https://doi.org/10.1016/j.schres.2018.02.031

Dellazizzo, L., Percie du Sert, O., Potvin, S., Breton, R., Pelletier, J., Renaud, P., et al. (2018b). Avatar therapy for persistent auditory verbal hallucinations: A case report of a peer research assistant on his path toward recovery. *Psychosis, 10*(3), 213-219. https://doi.org/10.1080/17522439.2018.1499799

Dellazizzo, L., Potvin, S., Phraxayavong, K., & Dumais, A. (2020). Exploring the benefits of virtual reality-assisted therapy following cognitive-behavioral therapy for auditory hallucinations in patients with treatment-resistant schizophrenia: A proof of concept. *Journal of Clinical Medicine, 9*(10), 3169. https://doi.org/10.3390/jcm9103169

Dellazizzo, L., Potvin, S., Phraxayavong, K., Lalonde, P., & Dumais, A. (2018c). Avatar therapy for persistent auditory verbal hallucinations in an ultra-resistant schizophrenia patient: A case report. *Frontiers in Psychiatry, 9*, 131. https://doi.org/10.3389/fpsyt.2018.00131

Finlay, L., & Gough, B. (2008). *Reflexivity: A practical guide for researchers in health and social sciences* John Wiley & Sons.

Freeman, D., Yu, L., Kabir, T., Martin, J., Craven, M., Leal, J., et al. (2019). Automated virtual reality (VR) cognitive therapy for patients with psychosis: Study protocol for a single-blind parallel group randomised controlled trial (gameChange). *BMJ Open*, 9(8), e031606. http://dx.doi.org/10.1136/bmjopen-2019-031606

Gilbert, P. (2000). The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 7*(3), 174-189. https://doi.org/10.1002/1099-0879(200007)7:3<174::AID-CPP236>3.0.CO;2-U

Gilbert, P., & Miles, J. N. (2000). Sensitivity to social put-down: It's relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and Individual Differences, 29*(4), 757-774. https://doi.org/10.1016/S0191-8869(99)00230-5

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*(4), 879-889. https://doi.org/10.1017/S0033291799008661

Hayward, M., Berry, K., McCarthy-Jones, S., Strauss, C., & Thomas, N. (2013). Beyond the omnipotence of voices: Further developing a relational approach to auditory hallucinations. psychosis: Psychological. *Social and Integrative Approaches, 6*, 1-11. https://doi.org/10.1080/17522439.2013.839735

Hayward, M., Berry, K., & Ashton, A. (2011). Applying interpersonal theories to the understanding of and therapy for auditory hallucinations: A review of the literature and directions for further research. *Clinical Psychology Review, 31*(8), 1313-1323. https://doi.org/10.1016/j.cpr.2011.09.001

Hayward, M., Bogen-Johnston, L., & Deamer, F. (2018). Relating therapy for distressing voices: Who, or what, is changing? *Psychosis, 10*(2), 132-141. https://doi.org/10.1080/17522439.2018.1469037

Hayward, M., Jones, A., Bogen-Johnston, L., Thomas, N., & Strauss, C. (2017). Relating therapy for distressing auditory hallucinations: A pilot randomized controlled trial. *Schizophrenia Research, 183*, 137-142. https://doi.org/10.1016/j.schres.2016.11.019

Hayward, M., Overton, J., Dorey, T., & Denney, J. (2009). Relating therapy for people who hear voices: A case series. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 16*(3), 216-227. https://doi.org/10.1002/cpp.615

Hayward, M., Strauss, C., & Bogen-Johnston, L. (2014). Relating therapy for voices (the R2V study): Study protocol for a pilot randomized controlled trial. *Trials, 15*(1), 1-5. https://doi.org/10.1186/1745-6215-15-325

Heriot-Maitland, C. (2011). Exploring the compatibility of biomedical and psychological approaches to treating psychosis. *Psychosis, 3*(2), 133-140. https://doi.org/10.1080/17522439.2010.518320

Heriot-Maitland, C., McCarthy-Jones, S., Longden, E., & Gilbert, P. (2019). Compassion focused approaches to working with distressing voices. *Frontiers in Psychology, 10*, 152. https://doi.org/10.3389/fpsyg.2019.00152

Heriot-Maitland, C. (2020). *Social influences on dissociative processes in psychosis.* (PhD). King's College London, Retrieved from https://kclpure.kcl.ac.uk/portal/files/130519645/2020_Heriot_Maitland_Charles_1276898_ethesis.pdf

Higgs, R. N. (2020). Reconceptualizing psychosis: The hearing voices movement and social approaches to health. *Health and Human Rights, 22*(1), 133. PMID: 32669795; PMCID: PMC7348419.

Holt, L., & Tickle, A. (2014). Exploring the experience of hearing voices from a first person perspective: A meta-ethnographic synthesis. *Psychology and Psychotherapy: Theory, Research and Practice, 87*(3), 278-297. https://doi.org/10.1111/papt.12017

Huckvale, M., Leff, J., & Williams, G. (2013). Avatar therapy: An audio-visual dialogue system for treating auditory hallucinations. Paper presented at the *Interspeech*, pp. 392-396. https://www.isca-speech.org/archive_v0/archive_papers/interspeech_2013/i13_0392.pdf

INTERVOICE (2021). *World Map*. https://maps.google.co.uk/maps/ms?msa=0&msid=206854668906561198640.0004d62ee0abdfd28256e&dg=feature

Iudici, A., Quarato, M., & Neri, J. (2019). The phenomenon of “Hearing voices”: Not just psychotic Hallucinations—A psychological literature review and a reflection on clinical and social health. *Community Mental Health Journal, 55*(5), 811-818. https://doi.org/10.1007/s10597-018-0359-0

James, A. (2001). *Raising Our Voices: An Account of the Hearing Voices Movement*. Gloucester: Handsell Publishing.

Johnstone, L., & Dallos, R. (2013). *Formulation in psychology and psychotherapy: Making sense of people's problems* Routledge.

KCL. (2015). *Compassion for Voices: 1st month report* (dated 27 March 2015). Retrieved from https://www.kcl.ac.uk/archive/cultural/-culturalinstitute/showcase/current/kei/compassionforvoices/compassion-for-voicesreport1.pdf

Larøi, F., & Woodward, T. S. (2007). Hallucinations from a cognitive perspective. *Harvard Review of Psychiatry*, 15(3), 109-117. https://doi.org/ 10.1080/10673220701401993

Leff, J., Williams, G., Huckvale, M., Arbuthnot, M., & Leff, A. P. (2014). Avatar therapy for persecutory auditory hallucinations: What is it and how does it work? *Psychosis, 6*(2), 166-176. https://doi.org/10.1080/17522439.2013.773457

Longden, E., Corstens, D., Escher, S., & Romme, M. (2012). Voice hearing in a biographical context: A model for formulating the relationship between voices and life history. *Psychosis, 4*(3), 224-234. https://doi.org/10.1080/17522439.2011.596566

Longden, E., Corstens, D., Morrison, A. P., Larkin, A., Murphy, E., Holden, N., et al. (2021a). A treatment protocol to guide the delivery of dialogical engagement with auditory hallucinations: Experience from the talking with voices pilot trial. *Psychology and Psychotherapy: Theory, Research and Practice.* https://doi.org/10.1111/papt.12331

Longden, E., Corstens, D., Pyle, M., Emsley, R., Peters, S., Chauhan, N., et al. (2021b). Engaging dialogically with auditory hallucinations: Design, rationale and baseline sample characteristics of

the talking with voices pilot trial. *Psychosis,*1-12. https://doi.org/10.1080/17522439.2021.1884740

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*(1), 28. https://doi.org/10.1037/a0025995

Longden, E., Moskowitz, A., Dorahy, M.J. & Perona-Garcelán, S. (2018). Auditory Verbal Hallucinations: Prevalence, Phenomenology, and the Dissociation Hypothesis. In A. Moskowitz, M. J. Dorahy & I. Schäfer (2nd Ed.) *Psychosis, Trauma and Dissociation: Evolving Perspectives on Severe Psychopathology* (pp. 207-222). John Wiley & Sons Ltd.

McCarthy-Jones, S. (2011). Voices from the storm: A critical review of quantitative studies of auditory verbal hallucinations and childhood sexual abuse. *Clinical Psychology Review, 31*(6), 983-992. https://doi.org/10.1016/j.cpr.2011.05.004

McCarthy-Jones, S. (2012). *Hearing voices: The histories, causes and meanings of auditory verbal hallucinations*. New York, NY, US: Cambridge University Press. https://doi.org/10.1017/CBO9781139017534

McCarthy-Jones, S., Waegeli, A., & Watkins, J. (2013). Spirituality and hearing voices: Considering the relation. *Psychosis: Psychological, Social and Integrative Approaches, 5*(3), 247-258. https://doi.org/10.1080/17522439.2013.831945

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*(3), 257. https://doi.org/ 10.1017/S1352465801003010

Moskowitz, A., Read, J., Farrelly, S., Rudegeair, T., Williams, O., Dell, P., et al. (2009). In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 521–533). Routledge/Taylor & Francis Group.

National Institute for Health and Care Excellence. (2014*). Psychosis and schizophrenia in adults: prevention and management* [NICE Clinical Guideline No. 178]. https://www.nice.org.uk/guidance/cg178

Paulik, G., Hayward, M., & Birchwood, M. (2013). Cognitive behavioural relating therapy (CBRT) for voice hearers: A case study. *Behavioural and Cognitive Psychotherapy, 41*(5), 626-631. https://doi.org/10.1017/S1352465812001014

Peña-Salazar, C., Nebot, F. A., Alvarez, M. J., Fontseré, H. M., Coll-Negre, M., Roura-Poch, P., et al. (2016). Do concepts of childhood trauma and dissociation provide an epistemological linkage between schizophrenia and PTSD? *Nervenheilkunde, 35*(04), 242-251. https://doi.org/ 10.1055/s-0037-1616371

Percie du Sert, O. P., Potvin, S., Lipp, O., Dellazizzo, L., Laurelli, M., Breton, R., et al. (2018). Virtual reality therapy for refractory auditory verbal hallucinations in schizophrenia: A pilot clinical trial. *Schizophrenia Research, 197*, 176-181. https://doi.org/10.1016/j.schres.2018.02.031

Pérez-Álvarez, M., García-Montes, J. M., Perona-Garcelán, S., & Vallina-Fernández, O. (2008). Changing relationship with voices: New therapeutic perspectives for treating hallucinations. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 15*(2), 75-85. https://doi.org/10.1002/cpp.563

Perona-Garcelan, S., Perez-Alvarez, M., Garcia-Montes, J. M., & Cangas, A. J. (2015). Auditory verbal hallucinations as dialogical experiences. *Journal of Constructivist Psychology, 28*(3), 264-280. https://doi.org/10.1080/10720537.2014.938847

Peters, M. D., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., et al. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis, 18*(10), 2119-2126. https://doi.org/10.11124/JBIES-20-00167

Pilton, M., Bucci, S., McManus, J., Hayward, M., Emsley, R., & Berry, K. (2016). Does insecure attachment mediate the relationship between trauma and voice-hearing in psychosis? *Psychiatry Research, 246*, 776-782. https://doi.org/10.1016/j.psychres.2016.10.050

Pilton, M., Varese, F., Berry, K., & Bucci, S. (2015). The relationship between dissociation and voices: A systematic literature review and meta-analysis. *Clinical Psychology Review, 40*, 138-155. https://doi.org/10.1016/j.cpr.2015.06.004

Romme, M.A.J., & Escher, A.D.M.A.C. (1999). *Werken met stemmenhoorders. Maastricht: Vakgroep sociale psychiatrie*, Universiteit Maastricht.

Rosen, C., Chase, K. A., Perona-Garcelán, S., Marvin, R. W., & Sharma, R. P. (2020). The psychometric properties of the DAIMON scale, a translation from spanish to english: An instrument to measure the relationship with and between voices. *Psychosis, 12*(1), 45-56. https://doi.org/10.1080/17522439.2019.1652843

Schnackenberg, J. K., Fleming, M., & Martin, C. R. (2018a). Experience focussed counselling with voice hearers as a trauma-sensitive approach. results of a qualitative thematic enquiry. *Community Mental Health Journal, 54*(7), 997-1007. https://doi.org/10.1007/s10597-018-0294-0

Schnackenberg, J., Fleming, M., & Martin, C. R. (2017). A randomised controlled pilot study of experience focused counselling with voice hearers. *Psychosis, 9*(1), 12-24. https://doi.org/10.1080/17522439.2016.1185452

Schnackenberg, J., Fleming, M., Walker, H., & Martin, C. R. (2018b). Experience focussed counselling with voice hearers: Towards a trans-diagnostic key to understanding past and current Distress—A thematic enquiry. *Community Mental Health Journal, 54*(7), 1071-1081. https://doi.org/10.1007/s10597-018-0280-6

Shawyer, F., Ratcliff, K., Mackinnon, A., Farhall, J., Hayes, S. C., & Copolov, D. (2007). The voices acceptance and action scale (VAAS): Pilot data. *Journal of Clinical Psychology, 63*(6), 593-606.

Steel, C., Schnackenberg, J., Perry, H., Longden, E., Greenfield, E., & Corstens, D. (2019). Making sense of voices: A case series. *Psychosis, 11*(1), 3-15. https://doi.org/10.1002/jclp.20366

Steel, C., Schnackenberg, J., Travers, Z., Longden, E., Greenfield, E., Meredith, L., et al. (2020). Voice hearers' experiences of the making sense of voices approach in an NHS setting. *Psychosis, 12*(2), 106-114. https://doi.org/10.1080/17522439.2019.1707859

Stefaniak, I., Sorokosz, K., Janicki, A., & Wciórka, J. (2017). Use of an avatar in cognitive-behavioural therapy of a person who is chronically experiencing negative auditory hallucinations–case study. *Advances in Psychiatry and Neurology/Postępy Psychiatrii i Neurologii, 26*(4), 275-289. https://doi.org/10.5114/ppn.2017.71340

Stefaniak, I., Sorokosz, K., Janicki, A., & Wciórka, J. (2019). Therapy based on avatar-therapist synergy for patients with chronic auditory hallucinations: A pilot study. *Schizophrenia Research, 211*, 115-117. https://doi.org/10.1016/j.schres.2019.05.036

Stone, H., & Stone, S. (1989). *Embracing our selves: The voice dialogue manual.* New World Library.

Strauss, C., Hugdahl, K., Waters, F., Hayward, M., Bless, J. J., Falkenberg, L. E., et al. (2018). The beliefs about voices Questionnaire–Revised: A factor structure from 450 participants. *Psychiatry Research, 259*, 95-103. https://doi.org/10.1016/j.psychres.2017.09.089

Styron, T., Utter, L., & Davidson, L. (2017). The hearing voices network: Initial lessons and future directions for mental health professionals and systems of care. *Psychiatric Quarterly, 88*(4), 769-785. https://doi.org/10.1007/s11126-017-9491-1

Thomas, N., Hayward, M., Peters, E., Van Der Gaag, M., Bentall, R. P., Jenner, J., et al. (2014). Psychological therapies for auditory hallucinations (voices): Current status and key directions for future research. *Schizophrenia Bulletin, 40*(Suppl_4), S202-S212. https://doi.org/10.1093/schbul/sbu037

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., et al. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. *Annuals of Internal Medicine, 169*(7), 467-473. https://doi.org/10.7326/M18-0850

Varese, F., Barkus, E., & Bentall, R. P. (2012). Dissociation mediates the relationship between childhood trauma and hallucination-proneness. *Psychological Medicine*, 42(5), 1025-1036. https://doi.org/10.1017/S0033291711001826

Ward, T., Craig, T. & Rus-Calafell, M. (2016). AVATAR Therapy for Refractory Auditory Hallucinations. In B. Pradhan, N. Pinninti & S. Rathod (Eds.), *Brief Interventions in Psychosis.* Springer Nature. https://doi.org/10.1007/978-3-319-30521-9_4

Ward, T., Rus-Calafell, M., Ramadhan, Z., Soumelidou, O., Fornells-Ambrojo, M., Garety, P., et al. (2020). AVATAR therapy for distressing voices: A comprehensive account of therapeutic targets. *Schizophrenia Bulletin, 46*(5), 1038-1044. https://doi.org/10.1093/schbul/sbaa061

Wood, L., & Irons, C. (2016). Exploring the associations between social rank and external shame with experiences of psychosis. *Behavioural and Cognitive Psychotherapy*, *44*(5), 527. https://doi.org/10.1017/S1352465815000570

TITLE PAGE OF PART B

Section B

"It allowed us to let our pain out"

A qualitative study exploring the experience of the 'Talking with Voices' approach: Perspectives from voice hearers and their voices.

Word Count: 7992

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

May 2021

SALOMONS INSTITUTE

CANTERBURY CHRIST CHURCH

Abstract

The 'Talking with Voices' (TwV) approach is a novel, formulation-driven approach which is based on an understanding of voice-hearing as essentially relational phenomenon, often linked to trauma. Therapy involves facilitation of dialogical engagement between hearers and their voices. There are as yet few outcome studies. The current study explored experiences of the TwV approach from the perspectives of voice hearers and also of their voices. Ten semi-structured qualitative interviews were subjected to Interpretative Phenomenological Analysis. Participants' experiences appeared to relate to four main themes: 1) Voice dialogue is a powerful enabler of change; 2) A safe base is key; 3) Life circumstances and medicalised services can be barriers to change, and; 4) Good relationships, approach towards underlying ideas, and flexibility are key facilitators of change. The findings provide support for the acceptability and value of dialogical approaches for helping people who hear distressing voices. The study proposes that voices can also share valuable insights and their perspectives should be valued in future evaluation.

Keywords: talking with voices, dialogical approaches, voice-hearing, qualitative research methods

Introduction

The experience of hearing voices ('auditory hallucinations') has typically been seen in the UK and other western medical contexts as a symptom of mental illness such as psychosis or schizophrenia (American Psychiatric Association, 2013). Over the past 30 years, psychological understandings which emphasise the need for voices to be understood and engaged with have become increasingly accepted within services (Johnstone & Dallos, 2006). Kingdon, Turkington, Garety and Morrison were among the first pioneers to propose talking therapy for psychosis (Garety et al., 2001; Kingdon & Turkington, 1994; Morrison, 2001) by developing 'Cognitive Behavioural Therapy for Psychosis' (CBTp) from Beck's (1979) original cognitive model. This has since enabled the development of a robust evidence base and has paved the way for the development of other therapeutic approaches in this area (Thomas et al., 2014).

Outside of services, the work of the peer-led Hearing Voices Movement has been hugely influential in promoting alternative approaches to understanding and managing distressing voices since its founding in the Netherlands in the late 1980s. Part of its contribution has been to highlight that many voice hearers have endured significant trauma (Corstens et al., 2014; Romme & Escher, 2006). Specifically, Romme and Escher (2000) provide an explanatory model for voice-hearing which suggests that voices often 'arrive' in people's lives as part of a meaningful reaction to unresolved traumatic life events. Engagement with voices is therefore actively encouraged to explore voice content, develop meaning from the experience and understand voice motives (Romme & Escher, 2000). These frameworks of understanding which centre the experiences of voice-hearers have also brought to the fore a common view among voice-hearers themselves, that voices are people, beings, or parts of the self with

whom the hearer has a relationship (McCarthy-Jones, 2012; Chin et al., 2009). This conceptualisation of the voice as a relational "other" has stimulated the development of a group of therapeutic approaches that focus on the interpersonal aspects of voice-hearing and in which a therapist or other trained person facilitates dialogue between the voice-hearer and voice(s). There are a number of such dialogical approaches, and these vary in terms of their theoretical emphases and practical application. They can be broadly clustered into two overlapping strands: one stemming from traditional academic and clinical settings which consists of: 'Avatar Therapy' (AT; Leff et al., 2014), 'Virtual Reality assisted Therapy' (VRT; Percie du Sert et al., 2018), and 'Relating Therapy' (RT; Hayward et al., 2017); and one stemming from the Hearing Voices Movement (HVM) which include the 'Making sense of Voices' (MsV; Steel et al., 2020) approach or 'Experienced Focused Counselling' (EFC; Schnackenberg et al., 2017) and the 'Talking with Voices' (TwV; Longden et al., 2021a) approach. Lastly, 'Compassion Focused Therapy for Psychosis' ('CFTp'; Heriot-Maitland, 2020), otherwise termed 'Compassion for Voices' (KCL, 2015), appears to offer a fusion of these two strands (Heriot-Maitland et al., 2019).

Both Avatar therapies and Relating Therapy focus on the voice-hearer developing assertive communication with a persecutory voice. In AT (e.g. Leff et al., 2014) and VRT (e.g. Percie du Sert et al., 2018) the voice is created as an avatar, whereas in RT (e.g. Hayward et al., 2017) it is enacted by the voice-hearer or therapist through role-play exercises. Conversely, CFTp and HVM-led approaches focus on helping the voice-hearer to develop a more peaceful relationship with a persecutory voice. The therapist adopts a position of enquiry about the meanings behind critical voice communication, models compassion, and with the person's permission facilitates direct dialogue with the voice (CFTp: Heriot-Maitland, 2020; EFC: Schnackenberg et al., 2017; MsV; Steel et al., 2020; TwV: Longden et al., 2021). The various dialogical approaches are each at a different stage of theoretical and empirical

development, with the TwV approach being one of the newest approaches to be developed into a manualised protocol and systematically evaluated.

The method of dialoguing used in the Talking with Voices (TwV) approach is distinct in that it is predominantly derived from various theoretical traditions concerned with the psychology of self, including Jungian, Gestalt and Transactional Analysis (Stone & Stone, 1989). Specifically, voices are construed as a "dynamic embodiment of social, emotional and interpersonal influences which are often experienced as subjectively real states of consciousness that are disconnected from a person's sense of self" (Dorahy & Palmer, 2015). Further, the approach positions these 'disconnected' or 'dissociated' parts as dialogical (i.e. parts that can be conversed with and relate to each other) and therefore provides an explanatory framework for the use of verbal engagement with voices as a possible way to decrease conflict and promote more peaceful and empathic ways of relating between a person's selves (Longden et al., 2021). Use of dialogical engagement with voices has become well established within the Hearing Voices Movement across the UK and worldwide (Corstens et al., 2014; Thomas, 2014). This includes use of the 'Maastricht Interview' which is a tool developed by pioneers of the HVM to assist voice hearers in developing an understanding of voices within the context of their lives; and dialoguing with voices is often encouraged to facilitate this process (Romme & Escher, 2000). By contrast, approaches which promote dialogical engagement with voices in clinical services are as yet relatively uncommon.

To date, empirical investigations of HVM-led dialogical approaches are limited to a case series (n = 15; Steel et al., 2019), a small randomised control trial (n = 12; Schnackenberg et al., 2017) and three qualitative studies (n= 25, Schnackenberg et al., 2018a; n=25, Schnackenberg et al., 2018b & n= 12, Steel et al., 2020) which present findings on clinical

applications of the Maastricht Interview; and a pilot trial of the TwV approach (n= 50, Longden et al., 2021). Broadly, results across studies to date provide preliminary evidence for the acceptability and feasibility of approaches which promote psychotherapeutic dialogues between voice hearers and their voices. Longden and colleagues (2021) operationalise the TwV approach by means of the following four-phase protocol: 1) engagement and psychosocial education, 2) assessment, formulation and preparing for dialogue, 3) dialogical work, and 4) evaluation and consolidation. Dialogical work is undertaken for the majority of sessions offered (15 out of 26). Likewise, there are attempts to capture other potential therapeutic targets such as problematic dissociative experiences and broader aspects of recovery (Longden et al., 2021).

Taking these initial findings, there remains a need to further understand the processes by which dialoguing might lead a person to become more or less distressed by voices, as well as consideration of how this approach may lead to other benefits such as providing a framework to work through loss and trauma, and promotion of p broader aspects of recovery (Longden et al., 2021b). Likewise, research to date has largely privileged the perspective of the therapist or facilitator, with less focus on the experiences of the voice hearer. The current study aims to redress this imbalance by exploring the perspectives not only of voice hearers but of their partners in dialogue, namely the voices themselves. Seeking voices' perspective is consistent with the assumption of the TwV approach that voices may represent different parts of the self, whose experiences are likely to diverge. In this regard, the current study will seek to explore experiences of the TwV approach from the perspectives of voice hearers and also of their voices. In doing so, it attempts to answer the following research questions:

1. How do voice-hearers and their voices experience the TwV approach?

2. What do voice-hearers and their voices perceive has changed in their relationship, as a result of the TwV approach?
3. What do voice-hearers and their voices perceive has changed elsewhere in the hearer's life, as a result of the TwV approach?
4. What factors do voice hearers and their voices think might have helped or hindered the described changes?

Method

Theoretical Framework

This study takes a social constructionist epistemological perspective which focusses on locating understandings about human behaviour and experience within social, historical, and political contexts (Burr, 2015). The study also takes a critical psychology perspective and therefore seeks to challenge the assumptions, ideologies and methodologies of mainstream psychology (Prilleltensky et al., 2013). Among the 'psy' professions, voices are commonly pathologised and seen as symptoms of mental illness (Cooke & Kinderman, 2018). The current study conversely adopts a position that hearing voices is not always pathological, can often be understood within a person's life context, and does not necessarily require a clinical label. The study employed 'double hermeneutics' (Smith et. al., 2012) whereby the first author attempted to understand the participants, who in turn sought to make sense of their own experiences. A guideline outlined by Sandelowski (2000) was followed to ensure that the experiences reported were as closely aligned to the viewpoint of the participants as possible.

Design

A qualitative approach using Interpretative Phenomenological Analysis (IPA, Smith et al., 2012) was employed to gain an in-depth understanding of voice-hearers and voices' subjective experiences by focusing on personal meaning-making.

Participants and sampling

10 voice-hearers aged between 18 and 65 who reported to have heard voices for at least 12 months and had experienced the TwV approach within the previous 5 years were recruited to the study via homogeneous purposive sampling (Smith et al., 2012). All prospective participants who contacted the researcher met the inclusion criteria (See Table 9. for further details). Upon recruitment, 10 voices chose to participate in the interview alongside their hearers. The sample size was in keeping with ranges reported for IPA studies (Brocki & Wearden, 2006) of health-related topics, and allowed for sufficiently rich narratives to be explored (Smith, 2004). Diagnosis was not recorded in line with the values of the Hearing Voices Network who typically reframe traditional biomedical understandings of voice-hearing (Corstens et al., 2014).

Table 9. Participant inclusion criteria

• Aged between 18 and 65
• Do not suffer from any organic condition with which voice-hearing may be associated e.g. dementia
• Do not have a significant history or current use of illicit drugs or alcohol which may affect ability to participate fully in the interview

- Reporting a history of distressing voices
- Reporting having heard voices for at least 12 months
- Have experience of the TwV approach currently or within the past 5 years
- Are willing to talk about their experience of voice dialogue
- Are able to consent to participate in a fully informed way
- Are not currently acutely distressed or in crisis

Demographic (Table 10.) and relevant background details were collected via two questionnaires (Appendix C.) which were given to participants after the interview and were returned via email or post. A total of six people were accessing a Hearing Voices Group (HVG) at the time of study. Experience of voice dialoguing ranged from two to 31 sessions. Four people were still engaging in sessions at the time of study. Participants had either received TvW sessions by being referred to a clinician trained in the approach in services or by undertaking sessions with a facilitator of a Hearing Voices Group. (see Appendix D. for further details about HVG membership and voice dialogue sessions). Availability of demographic details for voices varied across participants and these have not been included in the report to protect anonymity, although some broad characteristics have been referred to in the results section.

Table 10. Demographic details of participants

Demographic parameters	Categories (N)
Gender	Male: 5 Female: 4 Non-binary: 1
Age	18 years -24 years: 1 25 years- 34 years: 2 25 years- 44 years: 4 45 years - 54 years: 1 55 years or over: 2
Ethnicity	White British: 8 White Welsh: 1 White European: 1
Highest Educational Qualification	GCSE or equivalent: 6 BSc: 1 MSc: 2 Prefer not to say: 1
Relationship status	Single: 4 Separated: 1 Married: 4 Co-living with partner: 1
Housing status	Living with parents: 1 Private renting: 5 Renting from housing association: 1 Supported living: 1 Homeowner: 1 Prefer not to say: 1
Employment status	Student: 1 Disabled/ not able to work: 6 Self-employed: 1 Part-time employed: 1 Full-time employed: 1

Procedure

Participants were recruited via a project website (‘km7341.wixsite.com/voicedialoguestudy’) which was developed and published by the researcher. The researcher also shared details about the project at an online peer-led, UK-based Hearing Voices Network group facilitated by one of the research supervisors (RM). Prospective participants were invited to ask questions about the study in the HVN group, via the website or email before consenting to

take part. Those interested were then sent a study information sheet (Appendix E.) and consent form (Appendix F.), before arranging an interview slot. All participants were reimbursed for time and expenses with a £20 Amazon voucher. Participants were invited to opt-in to receive further communication about the study, which as a minimum would include a summary of findings via email.

Interview

A semi-structured interview was used to elicit participants' experiences of the TWV approach The interview schedule (Appendix G.) was developed by the first author and informed by the most recent revision of the Maastricht Hearing Voices Questionnaire (Escher et al., 2010). This questionnaire provides a framework for asking both voice-hearers and voices about their experiences, including asking about voice characteristics and aspects of the hearer-voice relationship. The researcher's two supervisors and one expert-by-experience from the university's service user and carer advisory group (SAGE) were also consulted and edits were made to the schedule in response to feedback.

The researcher conducted nine interviews using videoconferencing and one via telephone (based on participant preferences) between June and September 2020. Interviews lasted between 72 and 95 minutes. This allowed enough time to fully explore each participant's experiences.

Data Analysis

Interviews were audio-recorded, transcribed verbatim (see Appendix H. for excerpt) and analysed using Interpretative Phenomenological Analysis (Smith et al., 2012). All comments which highlighted participants' experiential and phenomenological understanding of the Talking with Voices approach were marked on the transcripts. The transcripts were then

continually referred back to in order to develop subordinate themes. Superordinate themes were defined by merging the subordinate themes and were illustrated with quotes from participants who were all assigned pseudonyms. To increase validity, themes were cross-checked with the researcher's lead supervisor.

Comparison with the COREQ checklist (Tong et al., 2007) indicated adherence to qualitative research guidelines.

Ethical considerations

The study was approved by the Canterbury Christ Church University Salomons Institute Ethics Panel (Appendix I). The British Psychological Society's (2018) Code of Ethics and Conduct was followed throughout. Precautions regarding evoking undue distress were given close consideration, given the nature of the conversations to be had in the interviews and the need to provide safe ways for the hearer's voices to participate, given that this had not been undertaken in a research study of this kind to date.

Participants were given opportunity to make a self-care plan before and after the interview. Time was set aside during and after the interview to take a break and talk about activities which helped people relax and look after themselves. The possibility of opting out of particular questions was also emphasised. A full debrief was provided to all participants at the end of each interview: this included asking both voice-hearers and voices how they had found the interview. A follow-up phone call or email was also offered.

All information collected throughout the study was kept strictly confidential and handled in accordance with General Data Protection Regulation (GDPR) procedures and the Data Protection Act (2018). See Appendix J. for further details.

Results

Overview

Details of voice hearers and their voices who participated in the study is provided in Table 11.

From the ten interviews, four superordinate themes were derived in relation to hearers' and their voices' experiences of the dialogue method: *Voice dialogue is a powerful enabler of change; A safe base is key; Life circumstances and medicalised services can be barriers to change, and; Good relationships, approach towards underlying ideas and flexibility are key facilitators to change.* Together with the 15 subordinate themes, these are summarised in Table _ and discussed below. The number of participants who referred to each subordinate theme have been reported, however due to the need for brevity, only a sample of quotes have been included. Voices' views were relayed in the third person by voice hearers, but voice comments have been written in first person in attempt to centre their experiences alongside the hearers'. Likewise, voices have collectively been referred to as 'voices' for clarity, although many participants preferred referring to their voices as people.

Table 11.

Voice hearers and voices interviewed

Pseudonym	**Experience of voice-hearing**	**Voice input in interview?**	**Voice Pseudonym**
Angela	Started hearing voices later in life after a traumatic incident.	Yes	Father Jones
Paul	Started hearing voices as a child following a traumatic brain injury.	No- voices did not wish to participate	
Erin	Has always heard voices: more appeared later in life, usually during times of stress.	Yes	Sylvester & Monica
Dan	Has heard voices for as long as he can remember but voices became more distressing and grew in number following traumatic events in his life.	No- Dan did not feel it was safe	
Jackie	Has heard voices all of her life	Yes	Maribel, 'the angry voices'
Natalie	Has heard voices all of her life	No- Natalie did not feel it was safe	
Steph	Has heard voices all of her life	Yes	'The voices'
Mike	Has heard voices on and off since he was a child. Often coincided with traumatic events.	No- no voices at time of study	
Steve	Started hearing voices during school exams. Became "full on" following the breakdown of his marriage later in life.	Yes	Victor

Chris	Started hearing voices in a limited way when he was 18. Worsened following a traumatic event when he was 19.	No – Chris did not feel it was safe

Note: some voices preferred to refer to themselves collectively and therefore were not explicitly named.

Table 12. Summary of superordinate and subordinate themes

Superordinate themes	Subordinate themes
Voice dialogue is a powerful enabler of change	- Started a conversation between us - Helps discover the meaning and purpose of the voices - Gives us a tool for healing past trauma - Enables us to get along better - Helps relationships elsewhere in life
A safe base is key	- Dialoguing is difficult - It can take time to build trust in the process - The timing has to be right
Life circumstances and medicalised services can be barriers to change	- It can be difficult having these ideas accepted and understood in services - You sometimes need to stop dialoguing when life gets in the way - The approach is often not available
Good relationships, approach towards underlying ideas and flexibility are key facilitators of change	- Qualities of the facilitator are key - You need support around you - The underlying ideas are key but need to be held lightly, with humility - Flexibility is key

Voice dialogue is a powerful enabler of change

The first superordinate theme concerns the changes that people and their voices reported as a result of engaging in facilitated dialogue with their voices. These were summarised into five subordinate themes: 1) Voice Dialogue started a conversation between us; 2) Voice Dialogue helps discover meaning and purpose of the voices; 3) Voice Dialogue gives us a tool for healing past trauma; 4) Voice Dialogue enables us to get along better; and 5) Voice Dialogue helps relationships elsewhere in life (see Table 12. for overview).

1. Started a conversation between us

Four people suggested that the TwV approach had enabled them to have two-way communication with voices for the first time:

Angela:	*"I ignored the voices before. I was frightened [and] I didn't know what else to do. I find that I can communicate with them and have a conversation with them now."*
Natalie:	*"[Outside of the dialogue sessions] It's always been a one-way conversation. When voices told me to do something, there wasn't this second thought like "Should I really go through with this?", "Are they really telling me the truth to do this?" It was always "I need to find a way to do it". It wasn't a choice, it was a "How can I do it to make them shut up?"*
Chris:	*"I didn't have a discussion with my voices before voice dialogue, they talked at me."*

These people also described that the approach enabled them to continue to dialogue with their voices themselves outside of sessions:

Angela:	*"After I'd named them… I was dialoguing with them myself. They're easier to talk with, and I have times of the day now where I sit and listen to both, and do things they like to do, like watching things on telly."*
Steph:	*"Since starting the [voice dialogue] sessions with [name of facilitator], I have been trying to practice with doing it myself. It's not as good as when [facilitator] does it with me, but practice makes perfect."*

2. Helps discover meaning and purpose of the voices

Four people commented that the approach had enabled them to discover the meaning and purpose of the voices. For some this felt revolutionary:

Angela:	*"I didn't understand it. Now I understand it as a reaction to trauma… I got through that, so that means I've got strength."*
Dan:	*"It was really astonishing… that there really were parts of me…which I subsequently came to call dissociative parts of me, that relate to things in my life that I had little or no awareness of until I started doing the dialoguing."*
Jackie:	*"I knew I had voices but I didn't know why …. And through voice dialoguing, it was like putting a light switch on. It was like 'Ah, this*

	explains that and that explains that… I felt that I wasn't perhaps as insane as I used to think."

Two voices shared their opinions on what this process had been like for them:

Jackie's angry voices:	*"It felt like at long last that someone wanted to listen to our pain because we were hurting. Even Jackie didn't know about this [before the dialoguing]. It was like a manuscript that's been in a dark cupboard and someone flashes a torch onto it".*
Steve's voice Victor:	*"[Steve and I] were always getting into angry fall-outs. I used to tell him to smash people's faces in [when he was being taken advantage of] because I wanted Steve to stick up for himself more. He knows this now".*

3. Gives us a tool for healing past trauma

Five people, and one person's voices, shared how valuable they had found the voice dialogue method for working through past trauma. They all highlighted how this had been both a difficult and liberating process, with timing and a focus on safety being paramount:

Erin:	*"Voice dialogue can be useful if people have some level of dissociation or trauma… voices will be able to support this process as they can often remember things that the person cannot."*

Jackie:	*"[Some voices] are stuck in a time warp; they're stuck in the time I was abused. They've had to hold a lot of pain for me".* On the process of dialoguing: *"I remembered snapshots of the conversations* [between the facilitator and voices], *a bit like flashback type things, but some of it was just closed to me until afterwards when* [the facilitator] *went through what they had said, if I wanted him to. And so I learnt about why they were so angry. Because they took a lot of the abuse."*
Jackie's voices:	*"Voice dialoguing allowed us to let our pain out."*
Mike:	*"I dialogued with the voice who [had previously] told me that there were cameras everywhere, [and] the voice came out as a child who was frightened of this man [who threatened me]. It was a very beautiful experience."*
Dan:	*"[The persecutory voice] turned out to be a defensive part that was defending a younger part inside by copying or imitating somebody who had hurt me in childhood… the more this part dropped its mask of the perpetrator, the more the child emerged kind of emboldened."*

4. Enables us to get along better

Having two-way conversations and discovering the meaning and purpose of the voices had enabled people and voices to develop more empathic and peaceful ways of relating to each other. For some people, this had involved making small changes over time. Voice hearers

commented that witnessing voices mature and evolve in response to hearers choosing to relate to them differently, had been both striking and heartening.

Dan:	*"[I developed] a relationship with the child part that emerged… It was a bit like looking after a real child. This child part asked to do child-like things like be read a story, or go to a park or to eat ice cream, things like that… the more I established (this) relationship, basically by ministering to its childlike needs, the more this part grew up."*
Steve:	*"I started treating them as individual people rather than something that I just didn't want in my life… and I no longer see them as enemies and there are two or three of the voices that are quite helpful in my life."*
Angela:	*"After [dialoguing] I listened to [Father Jones] more, and I talk to him more, and say 'Can you tell me in a nicer way what you want me to do?'. So he tells me to stick up for myself now. Rather than goading me."*

Likewise, two voices commented on their experiences of the hearer relating to them differently:

Steph's voices	*"It is better now that Steph talks to us and no longer ignores us. We don't want people to think that we're bad. We have important roles."*
Angela's voice Father Jones	*"It was so frustrating when Angela was ignoring us…when Angela asked me about being called Father Jones, I told her I loved it and it's stuck ever since."*

Moreover, four people described how voices had become extremely helpful to them as a result of dialoguing, and had become sources of strength for them in their lives:

Jackie:	*"Maribel is the extravert in me. I wear colourful clothes now, which for me is a good thing because it's more of my extravert personality trying to come out."*
Steph:	*"I've always found it really hard to fit in places, and the voices have helped make me fit in if that make sense. They tell me what to say sometimes [in social situations]."*

5. Helps relationships elsewhere in life

Aside from better hearer-voice relationships, four people provided examples of how engagement with the approach had positively impacted other relationships.

Angela:	*"Doing the dialoguing has helped bring [me and my daughter] closer together. She tells me she's got her mum back."*
Mike:	*"I just sat down and I told [my wife]…She didn't know what to say, but she was just so loving to me, and just so generous in her kind of humility in not knowing what to do but being overwhelmed by it. We just talked for an hour… it just felt like this really heavy thing was just taken off me. I didn't have to carry it around with me anymore."*

A safe base is key

The second superordinate theme reflects the need articulated by both voice hearers and voices to create a safe base from which to approach dialogue work. This has been divided into three subordinate themes: *1) Dialoguing is difficult, 2) It can take time to build trust in the process, and 3) The timing has to be right.*

1. Dialoguing is difficult

Five voice hearers and two voices shared that they had initially felt very uneasy about the prospect of facilitated dialoguing. The hearers' decision to give permission for someone else to talk to their voices had been a very anxious one. Two had worried that it might not be safe to let the voices engage with somebody else, leading them to delay using this approach.

Erin:	*"Even though I worked on talking with the voices myself, I had a lot of anxiety about letting somebody else talk to them."*
	"Voices often hold energy or characteristics that we judge quite harshly in our society, so it's really difficult to talk about. And it's even more difficult to give voice to it in a voice dialogue… I was worried that [the voices] would say things I didn't want to feel responsible for because I knew how counter-cultural and how harshly judged it would be."
Angela:	*"I felt quite uncomfortable about even naming my voices at [first]."*
Paul:	*"The [voices] don't like me interacting with anyone about them."*

Likewise, voices themselves expressed mixed opinions about using the approach. Often they had discouraged voice hearers from engaging with it as a self- protective strategy:

Erin's voice, Sylvester:	*"It was a very fragile time, and I remember how involved and excited Erin was and I was glad that she became more cautious because it was like surfing, it was like being on a wave and going with it in the beginning, and she was really immersed in it… Erin was lucky that [the facilitators] were trustworthy people and that it was kept safe, and she had some skills already to keep herself safe. [If that wasn't so], she could have been taken advantage of."*
Steph's voices:	*"We told Steph not to tell anyone because it wasn't safe, [plus we thought] it's not going to work anyway so there's no point in trying."*

Some voices expressed concerns that dialoguing would mean the end of them:

Steph's voices:	*"We thought that voice dialoguing might get rid of us, but [the facilitator] told Steph that they're not trying to do that, they're just trying to understand us."*
Jackie's angry voices:	*"We are concerned that if [the approach] stopped us from being angry, we would die"*

One person's voice had welcomed the prospect of facilitated dialoguing:

Erin's voice, Monica:	*"I [remember thinking] it might be a really exciting experience and I was sort of frustrated with some of the other voices who put a block on it at the time. Erin could have got more out of it… I don't think she made the most of it."*

Another person reflected that conflicting messages from voices about entering into dialogue work are common:

Steve:	*"I think it depends on the level of pain that they're in. I think the more pain a voice is in, the harder it is to get it on board and communicate with it."*

2. It can take time to build trust in the process

Six people shared difficult past experiences with services which included not feeling heard and staff being dismissive or fearful when they had shared experiences of voice-hearing. People described how these experiences had subsequently led them to be mistrustful or sceptical of voice dialoguing ideas when they were first introduced to them.

Paul:	*"I never wanted to tell anyone what was happening to me after [bad experience with services]. I didn't want to engage in any types of services."*
Erin:	*"I sort of thought, is this just another way to try and get me to accept and be compliant? I thought that I might get tricked or something."*

3. The timing has to be right

Five people spoke about the importance of being in relatively stable place in their life before pursuing dialoguing work. This was largely based on recognition that pursuing this type of work required a significant amount of personal and emotional investment, and therefore could not be undertaken during a time of stress or crisis:

Dan:	*"I was in a state after having a breakdown and I just needed to become stable in a very basic sense. First by getting some sort of income… and finding a place to live…. I spent a couple of years just doing that [before starting dialoguing]."*
Chris:	*"There's no way I could've done [voice dialoguing] in crisis… There are more immediate things you need to do…"* Later: "*I felt safer. If you don't feel safe you can't open up, and it feels like your voices won't let you because they don't feel safe."*
Steve:	*"Dialoguing is hard work… very emotional and you seem to burn a lot of energy."*

Life circumstances and medicalised services can be barriers to change

The third superordinate theme relates to factors which people saw as possible barriers to change. There appeared to be three subordinate themes: *1) It can be difficult having these ideas accepted and understood in services, 2) you sometimes need to stop dialoguing when life gets in the way,* and *3) the approach is not always available when you need it.*

1. ***It can be difficult having these ideas accepted and understood in services***

By and large, both people and voices felt that they had not been listened to in services, and that (with some notable exceptions) services had imposed a medicalised view and treatments.

Erin:	*"There was a lot of tension between me and services about what I thought was going on and what they thought was going on, and we clashed around it. They thought the problem was hearing the voices. And I thought I had very different problems that need addressing, but they wouldn't address it unless the hearing voices was addressed first."*
Mike:	*"I had lots of experiences [that felt] coercive and oppressive…[apart from] one registrar who made me cups of tea and sat and talked to me like a normal human."*

Three people stated that it was important to them for others to understand that voices were people who had needs and feelings too. They emphasised the need for people at least to acknowledge their reality. One person used the analogy of acknowledging that someone's mother was important to them.

Similarly, two people contrasted their experiences of attempting to adopt a TwV approach within services with their experiences outside, noting that in services they feared negative consequences for being honest:

Natalie:	*"They [HVGs inside and outside of services] have been vastly different. The first one, you had support from the hospital. It was very ordered. You went round one by one. If one person was speaking you couldn't speak and it was very scheduled. [Outside of services], it was very loosely scheduled. You didn't have to be so careful with what you said."*

Chris:	In services: *"You don't know how [staff] will react and so people have to censor what they say". "I was hospitalised the moment I said about people being able to read my mind and read my thoughts.* Support group outside of services: "*I could just say whatever I felt and it wasn't ever a problem and everyone else could do the same."*

2. You sometimes need to stop dialoguing when life gets in the way

Echoing what they had said about the need to prepare for dialogue work, people recalled having found dialoguing unhelpful and possibly harmful at times of crisis or of significant change in their lives which demanded a lot of emotional resources.

In addition, three people described negative views from friends, family and society more generally which prevented them from dialoguing more freely with voices in their daily lives:

Chris:	*"I mentioned the depression [and] intrusive thoughts …rather than voices because I wasn't comfortable about saying that I was hearing voices. Even my ex-partner, I didn't tell her I heard voices."*
Jackie:	*"I've learnt over the years to keep [the voices] to myself rather than to be open to people outside about it. Because you get a lot of trouble… People think you're mad."*

One person provided a contrasting experience of living in a therapeutic community where talking with voices was an accepted norm in daily life:

Mike:	*"There was 8 of us living in a semi-detached house. It was absolutely beautiful you know, and I would say that it was there where I became un-mad.…We just lived in madness which turns out wasn't terribly mad."*

3. The approach is often not available

Most people, and most voices, highlighted the general lack of availability of the TwV approach and wished that it was available more widely:

Jackie:	*"I've done a couple of CBT groups recently, and I've asked and asked to do voice dialoguing again, because I found it so useful. But no one does it in [place name]. Which is a pity because it helped me such a lot."*
Dan: (Describing friend who first facilitated dialogue between him and his voices)	*"[It] is quite a rare thing to find somebody who knows what to say and how to say it, and this wasn't some magic knack that she had. She had actually read some very good professional literature on trauma, dissociation, voice hearing and on voice dialoguing."*

Good relationships, approach towards underlying ideas, and flexibility are key facilitators of change

The final superordinate theme relates to factors which people and their voices felt facilitated change within the dialoguing process. These were grouped into four subordinate themes: *1) Qualities of the facilitator are key; 2) You need support around you; 3) The underlying ideas are key but need to be held lightly, with humility, and; 4) Flexibility is key.*

1. Qualities of the facilitator are key

Five people and one voice referred to personal qualities of the facilitator which they considered essential. These included being open, non-judgemental, trustworthy, and courageous.

Paul:	*"Having someone you can trust is a big part of it. [My facilitator] takes the time to understand and see what you want to talk about. He doesn't push you. When someone tries to understand, it's easier to open up."*
Erin:	*"There was a real emphasis on safety and choice… [the facilitator] acknowledged the reality of [the voices]…Even towards things that are very strange and unfamiliar, [the facilitator] was just persistently non-judgmental and open minded… He didn't take sides, he wasn't about me against the voices, or helping me tell off the voices for being evil or nasty or*

	critical or ruining my life …he was curious and compassionate. It just helped me reconnect with feeling curious about what was going on, and not just dismiss it and ignore it and be angry about it."
Erin's voice Monica:	*"I think it's also about [facilitators] possessing courage. I would really love people to have the courage to engage with me.*
Steve:	*"You've got be very open minded and not easily offended because I think people's voice hearing experiences can be quite full on."*
Chris:	*"Perhaps the biggest thing is the honesty. When he doesn't know something, he'll just tell you…and that helps in engender a trust."*

People said that voices would resist a facilitator who did not embody those qualities, because they would feel unsafe. In other words:

Chris:	"If you don't feel safe, the voices won't feel safe"

2. You need support around you

Seven people referred to the availability of good community support as being a significant enabler of recovery. This included support from hearing voices groups, professionals, friends and family.

Angela:	*"It affected me in a great way. I started socialising and going out. My confidence grew…I'd go out sometimes with members of the [HVG] for something to eat as a group which was nice and that gave me my life back."*
Steve:	*"I think the peer support that you get helps you make friends with people as well, as a lot of us mad people don't have that many friends."*
Chris:	*"I attended the group before trying individual voice dialogue. I found this a very safe and supportive space. [It gave] me social support and a social structure…Before I had the group, I didn't talk to anyone."*

3. The underlying ideas are key but need to be held lightly, with humility

Two people highlighted the importance of the ideas behind the TwV approach as well as the practice itself:

Steve:	*"I got on board with the [idea that my voices] are parts of me from the past who dealt with difficult situations. [As a result] my experience was easier probably."*
Erin:	*"I was very influenced by the original voice dialogue from Hal and Sidra Stone, using it to get to know parts of self, and … become more*

	compassionate and understanding to that's what's going on…I immersed myself in it…and I keep coming back to the voice dialogue ideas. I find them supportive in my personal life, in my relationship with myself and approaching things with an attempt to relate and dialogue with it; not just to talk at it."

One person expressed feeling uncomfortable with the idea of seeing themselves as 'parts'. He shared his own interpretations and stressed the importance of spiritual understandings being acknowledged and worked with:

Mike:	*"I do think the voices are meaningful messages and messengers…. But I suppose there's a bit of me… that doesn't feel comfortable to say, "this part of you is split off and is being represented out here". It's just not been my experience…"* *"I think dialoguing in the UK is looking through a white lens. We have to be more creative than the rigid structures of models."*

4. Flexibility is key

Five people described additional adaptations that had helped them to both engage and persist with dialoguing. These included building in other skills from other therapeutic modalities, using a Hearing Voices Group as graded introduction and dialoguing with voices in a group setting.

Steph:	*"We've been doing some compassion-based therapy but moved to the dialogue work a little bit after that. It's been really good."*
	"...using grounding techniques helps stop them from spiralling."
Steve:	*"Talking about the method of voice dialoguing in the [HVG] first was a nice opening."*
Erin:	*"I found it a lot easier demonstrating voice dialogue to an audience than doing it one-to-one with the therapist so for me there's something about the communal approach."*

Discussion

This section is divided into five parts. The first is a summary of the main findings, outlined in relation to the research questions and existing theoretical and empirical literature. The second discusses the study's limitations. The third makes recommendations for future research. The fourth outlines implications for clinical practice. Finally, overall conclusions are drawn.

Summary of findings

The current study aimed to provide a qualitative insight into voice hearers' and their voices' experiences of the Talking with Voices approach, given that systematic study of this approach is still in its infancy (Longden et al., 2021a). Correspondingly, it attempted to understand how the approach may have brought about change in the hearer-voice relationship and elsewhere in hearers' lives, and to better understand any factors which may have both helped or hindered these changes. The findings have therefore been presented under the following subheadings: Experience of the Talking with Voices approach, Changes brought about by dialoguing, and Barriers to and facilitators of change:

Experience of the Talking with Voices approach

In line with corresponding literature, the study findings confirm that at least for some, voices are experienced as beings, people or parts of self with whom the hearer has a relationship (McCarthy-Jones, 2012; Chin et al., 2009). Correspondingly, it supports personal accounts and preliminary empirical evidence suggesting that supporting dialogical engagement with voices can be a meaningful and productive endeavour (Corstens et al., 2012; Longden et al., 2021a).

The qualitative findings suggest that the TwV approach was broadly acceptable to all voice hearers and their voices who participated in the study, and led to positive changes which in

some cases appeared transformative. Five (half) of the voice hearers interviewed had initially experienced unease, shared by their voices, at the prospect of someone else dialoguing with the voices, which is consistent with existing findings from clinical use of the Maastricht approach (Steel et al., 2020). However, they had overcome this through peer support and through reassuring the voices that the aim was to understand them rather than to get rid of them. One voice hearer described an adverse experience whereby dialoguing had left her feeling overwhelmed in the short-term as it had unearthed previous trauma, but she had been supported through this by a family member. This participant highlighted the need for support after dialoguing work. Relatedly, voice hearers also stressed that the process of dialoguing requires significant emotional investment, so recommended avoiding it at times of crisis or emotional challenge. Other considerations included the need to build up trust in potential helpers again after negative experience of services, and the value for some of peer-led hearing voices groups as a helpful introduction.

Participants' experiences also seemed to highlight the power of the ideas behind the TwV approach, beyond implementation of its techniques. This seemed to align with broader values of the Hearing Voices Movement which emphasise that diverse explanations of voice-hearing are accepted for the origins of voices, and seeking to accept and understand them may be most beneficial for recovery (Corstens et al., 2014). Likewise, the study findings report that voices themselves expressed a need to be accepted and understood within both the hearer-voice relationships, in services, and elsewhere in the hearers' lives.

Changes brought about by dialoguing

Both voice hearers and voices described experiencing significant changes as a result of the TwV approach. Many voice hearers felt that the approach had enabled them to:

- Change the way they communicated with their voices, including initiating their own dialogues
- Discover the meaning and purpose of the voices
- Find more peaceful and empathic ways of relating to voices
- Work through trauma.
- Improve other relationships in their lives.

These findings have some similarities with other dialogical approaches, which have also been found to change the nature of communication between hearers and voices (e.g. Leff et al., 2014, Hayward et al., 2017 & Percie du Sert et al., 2018) and to enable improved relationships with others (e.g. Hayward et al., 2017). However, the TwV approach appears to differ in the way it accomplishes these changes i.e. by placing focus on understanding voices as opposed to exerting power over them. In this regard, the study results suggest that the intended aims of the TwV approach and HVM-led approaches more broadly to promote dialogical engagement with voices as a way to explore and develop meaning from the experience and understand voice motives are appropriate and helpful.

Likewise, these findings support the suggestion that voices often reflect threatening or overwhelming events in a hearer's life (Dorahy & Palmer, 2015; Romme and Escher, 2000). Engaging in dialoguing might therefore provide a means to work through trauma and, in particular, to address dissociated emotions or parts of the self (Longden et al., 2021; Schackenberg et al., 2017; Steel et al., 2020).

Barriers to, and facilitators of change

Both voice hearers and voices also highlighted factors which they felt had either facilitated or prevented change through the process of dialoguing which were summarised as follows:

Barriers to change

- It can be difficult having TwV approach ideas accepted in services,
- life circumstances may not always be conducive to being able to dialogue with voices, and
- the approach is often not available to access.

Facilitators of change

- Qualities of the facilitator are key,
- you need support around you to pursue dialoguing,
- the underlying ideas are key but need to be held lightly, and,
- flexibility with regard to the delivery of the approach is key.

These experiences seem consistent with existing assumptions about the perceived helpfulness of juxtaposed ideas about voices in services whereby psychological approaches are often contradictory to medical approaches, yet they exist alongside each other and represent recommended practice in services (Heriot-Maitland, 2011; NICE, 2014).

Qualities of the facilitator highlighted, which include modelling curious and compassionate, but courageous dialogue compliment existing findings for the approach to be delivered in collaboration with people and voices, away from an 'expert-led' framework (Corstens et al., 2019; Steel et al., 2020).

Limitations

For feasibility reasons, participants were recruited largely through a peer-led, UK HVN group with whom the researcher's supervisor had direct connections. This could have resulted in an overrepresentation of people and voices who found the TwV approach helpful. Although participants did describe circumstances where they felt the approach might not be helpful, future studies could usefully use theoretical sampling to include people who had found the approach was less helpful.

Similarly, the study adopted a social constructionist epistemological perspective in relation to the voice-hearing experience and related dialogical ideas. This aligned with the researcher's own position with regard to conceptualising voice-hearing as a meaningful experience to be explored and understood. This was also the standpoint of the researcher's supervisors. Although guidelines (Sandelowski, 2000) were used to ensure close reporting of participant perspectives, the positions of the researcher and supervisors are likely to have influenced how the interviews developed, and how the results were subsequently analysed.

Due to the nature of study of this kind, generalisability of the findings is compromised in favour of reporting richer descriptions of participants' experiences within a smaller sample size. That said, generalisability will have been further compromised given that all of the sample were white British, Welsh or European. This is important to note given that non-western cultures tend to be more open to the idea of voice-hearing as a spiritual or religious phenomenon (McCarthy-Jones et al., 2013).

Future research

The above limitation relates to a requirement of future research to ascertain the acceptability of the approach among people from a range of different cultural backgrounds McCarthy-Jones et al., 2013). Although the TwV approach is underpinned by the Hearing Voices Movement principles to accept and promote working with all explanations of voices; its wider implementation among people who share these different conceptualisations is yet to be systematically tested.

Further study is also needed in order to refine the TwV approach in terms of further understanding its distinct active ingredients and similarities with other dialogical approaches to helping people who hear distressing voices. This will serve to inform ideas around which

therapeutic approach might benefit any given individual, as well as to further understand when the approach may be less helpful.

The current study also speaks to the value of centring the experiences of voice hearers in order to gain further insights into how the TwV might work and provides an example of how perspectives from voices can be gathered to yield additional insights about this process. Researchers should therefore seek to prioritise and forge collaborative relationships with voice-hearers, and with permission, voices; to facilitate their active involvement in the design and conduct of future research.

Clinical implications

The study findings provide preliminary evidence to suggest that the TwV approach can create positive change for people, and should be further investigated for use in services. This includes highlighting the potential of the TwV approach as a means to work through past trauma. It also appears to offer a method to develop compassion and *understanding with* voices in contrast to other clinically applied dialogical approaches which promote developing *assertiveness over* voices.

Correspondingly, the study highlights the potential challenges of implementing such an approach within current medically led treatment culture whereby different conceptualisations of voice-hearing might not always been understood or accepted. In this regard, there is a need to consider how this approach and related HVM-led approaches can be implemented in services in a way that is not co-opted by services, is less 'expert-led' and retains the HVM ethos. This would therefore demand workers to adopt an attitude of epistemological and aetiological humility by holding all frameworks of understanding lightly so as not to impose ideas about what the voice-hearing experience might mean to whom.

Conclusion

The current study aimed to provide qualitative insight into the Talking with Voices approach; a novel approach which promotes dialogical engagement with voices, from the perspectives of both voice hearers and their voices. The study findings suggest that the TwV approach can be a powerful enabler of change for some people with respect to improving hearer-voice and self-other relationships, discovering meaning and purpose of the voices, and presenting itself as a potential tool for healing past trauma. Future research is needed to develop understandings of how this approach might work, along with further consideration of its compatibility for sustained use in clinical services.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

British Psychological Society. (2018). *Code of Ethics and Conduct (2018).* https://bps.org.uk/newsand-policy/bps-code-ethics-and-conduct

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*(1), 87-108. https://doi.org/10.1080/14768320500230185

Burr, V. (2015). *Social constructionism.* Routledge.

Chin, J. T., Hayward, M., & Drinnan, A. (2009). Relating to voices: Exploring the relevance of this concept to people who hear voices. *Psychology and Psychotherapy: Theory, Research and Practice, 82*(1), 1-17. https://doi.org/10.1348/147608308X320116

Cooke, A., & Kinderman, P. (2018). But what about real mental illnesses?" alternatives to the disease model approach to "Schizophrenia. *Journal of Humanistic Psychology, 58*(1), 47-71. https://doi.org/10.1177/0022167817745621

Corstens, D., Longden, E., & May, R. (2012). No title. *Talking with Voices: Exploring what is Expressed by the Voices People Hear.Psychosis: Psychological, Social and Integrative Approaches, 4 (2), 95–104*. https://doi.org/10.1080/17522439.2011.571705

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*(Suppl_4), S285-S294. https://doi.org/10.1093/schbul/sbu007

Dorahy, M. J., & Palmer, R. (2015). Auditory hallucinations in chronic trauma disorders: Phenomenology and psychological mechanisms. In *Comprehensive Guide to Post-Traumatic Stress Disorder.* Switzerland: Springer. https://doi.org/10.1007/978-3-319-08613-2_45-1

Escher, S. , Hage, P. , Romme, M. , & Pennings, M. (2010). Voice hearing: A questionnaire. Measurement instrument. Retrieved from http://www.hearingvoices.org.nz/index.php/helpful-pamphlets-and-information-sheets/59-the-maastricht-interview

Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychol Med*, *31*(2), 189-195. https://doi.org/ 10.1017/S0033291701003312

Hayward, M., Jones, A., Bogen-Johnston, L., Thomas, N., & Strauss, C. (2017). Relating therapy for distressing auditory hallucinations: A pilot randomized controlled trial. *Schizophrenia Research, 183*, 137-142. https://doi.org/10.1016/j.schres.2016.11.019

Heriot-Maitland, C. (2011). Exploring the compatibility of biomedical and psychological approaches to treating psychosis. *Psychosis, 3*(2), 133-140. https://doi.org/10.1080/17522439.2010.518320

Heriot-Maitland, C., McCarthy-Jones, S., Longden, E., & Gilbert, P. (2019). Compassion focused approaches to working with distressing voices. *Frontiers in Psychology, 10*, 152. https://doi.org/10.3389/fpsyg.2019.00152

Johnstone, L., & Dallos, R. (2013). *Formulation in psychology and psychotherapy: Making sense of people's problems.* Routledge.

Kingdon, D., Turkington, D., & John, C. (1994). Cognitive behaviour therapy of schizophrenia: The amenability of delusions and hallucinations to reasoning. *The British Journal of Psychiatry, 164*(5), 581-587. https://doi.org/ 10.1192/bjp.164.5.581

Leff, J., Williams, G., Huckvale, M., Arbuthnot, M., & Leff, A. P. (2014). Avatar therapy for persecutory auditory hallucinations: What is it and how does it work? *Psychosis, 6*(2), 166-176. https://doi.org/10.1080/17522439.2013.773457

Longden, E., Corstens, D., Morrison, A. P., Larkin, A., Murphy, E., Holden, N., et al. (2021a). A treatment protocol to guide the delivery of dialogical engagement with auditory hallucinations: Experience from the talking with voices pilot trial. *Psychology and Psychotherapy: Theory, Research and Practice.* https://doi.org/10.1111/papt.12331

Longden, E., Corstens, D., Pyle, M., Emsley, R., Peters, S., Chauhan, N., et al. (2021b). Engaging dialogically with auditory hallucinations: Design, rationale and baseline sample characteristics of the talking with voices pilot trial. *Psychosis,* , 1-12. https://doi.org/10.1080/17522439.2021.1884740

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

McCarthy-Jones, S., Waegeli, A., & Watkins, J. (2013). Spirituality and hearing voices: Considering the relation. *Psychosis, 5*(3), 247-258. https://doi.org/10.1080/17522439.2013.831945

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*(3), 257. https://doi.org/ 10.1017/S1352465801003010

National Institute for Health and Care Excellence. (2014*). Psychosis and schizophrenia in adults: prevention and management* [NICE Clinical Guideline No. 178]. https://www.nice.org.uk/guidance/cg178

Percie du Sert, O. P., Potvin, S., Lipp, O., Dellazizzo, L., Laurelli, M., Breton, R., et al. (2018). Virtual reality therapy for refractory auditory verbal hallucinations in schizophrenia: A pilot clinical trial. *Schizophrenia Research, 197,* 176-181. https://doi.org/10.1016/j.schres.2018.02.031

Prilleltensky, I., & Stead, G. B. (2013). Critical psychology, well-being, and. *The Oxford Handbook of the Psychology of Working,* Oxford University Press.

Romme, M., & Escher, S. (2000). *Making sense of voices: A guide for mental health professionals working with voice-hearers.(includes interview supplement).* Mind Publications.

Romme, M., & Escher, S. (2006). Trauma and hearing voices. In W. Larkin & A. P. Morrison. *Trauma and Psychosis* (1st Ed, pp.162-191). Routledge.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334-340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Schnackenberg, J. K., Fleming, M., & Martin, C. R. (2018a). Experience focussed counselling with voice hearers as a trauma-sensitive approach. results of a qualitative thematic enquiry. *Community Mental Health Journal, 54*(7), 997-1007. https://doi.org/10.1007/s10597-018-0294-0

Schnackenberg, J., Fleming, M., & Martin, C. R. (2017). A randomised controlled pilot study of experience focused counselling with voice hearers. *Psychosis, 9*(1), 12-24. https://doi.org/10.1080/17522439.2016.1185452

Schnackenberg, J., Fleming, M., Walker, H., & Martin, C. R. (2018b). Experience focussed counselling with voice hearers: Towards a trans-diagnostic key to understanding past and current Distress—A thematic enquiry. *Community Mental Health Journal, 54*(7), 1071-1081. https://doi.org/10.1007/s10597-018-0280-6

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54. https://doi.org/ 10.1191/1478088704qp004oa

Smith, J. A., & Shinebourne, P. (2012). Interpretative phenomenological analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology* (Vol. 2). *Research designs: Quantitative, qualitative,*

neuropsychological, and biological (pp. 73–82). American Psychological Association. https://doi.org/10.1037/13620-005

Steel, C., Schnackenberg, J., Perry, H., Longden, E., Greenfield, E., & Corstens, D. (2019). Making sense of voices: A case series. *Psychosis, 11*(1), 3-15. https://doi.org/10.1080/17522439.2018.1559874

Steel, C., Schnackenberg, J., Travers, Z., Longden, E., Greenfield, E., Meredith, L., et al. (2020). Voice hearers' experiences of the making sense of voices approach in an NHS setting. *Psychosis, 12*(2), 106-114. https://doi.org/10.1080/17522439.2019.1707859

Stone, H., & Stone, S. (1989). *Embracing our selves: The voice dialogue manual*. New World Library.

Thomas, N., Hayward, M., Peters, E., Van Der Gaag, M., Bentall, R. P., Jenner, J., et al. (2014). Psychological therapies for auditory hallucinations (voices): Current status and key directions for future research. *Schizophrenia Bulletin, 40*(Suppl_4), S202-S212. https://doi.org/10.1093/schbul/sbu037

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349-357. https://doi.org/10.1093/intqhc/mzm042

Section C: Appendices

Appendix A.: *Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist*

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	
TITLE			
Title	1	Identify the report as a scoping review.	✓
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	✓
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	✓
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	✓
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	✓
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	✓
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	✓
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	✓
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	✓
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	✓
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	✓
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	✓
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	
RESULTS			

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	✓
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	✓
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	✓
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	✓
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	✓
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	✓
Limitations	20	Discuss the limitations of the scoping review process.	✓
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	✓
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	N/A

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.
* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.
† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).
‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.
§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

Appendix B. *Summary of study characteristics from quantitative and qualitative studies*

No.	Therapeutic Approach	Authors, year	Design	Sample	Aims	Outcome Measures	Analysis	Main Findings
1.	Avatar Therapy	Beaudon et al., 2021	Qualitative	18 patients with 'treatment resistant schizophrenia'	To investigate the therapy's therapeutic processes	Themes from discourses between voice-hearers and avatars	Content analysis	Assertiveness, emotional responses to the voices and prevention strategies suggested to be central to the therapeutic process
2.	Avatar Therapy modification	Cichocki et al., 2016	Case study	A 28-year-old man with 'chronic AVHs'	To describe the utility of a modification of AT with the use of a mask	Clinician observation only	N/A	Therapeutic benefits observed. Patient's voices 'essentially ceased'. Result sustained at 1 year follow up
3.	Avatar Therapy	Craig et al., 2018	RCT	150 people with a diagnosis of schizophrenia or affective disorder who heard persistent, troubling voices for ≥12 months despite medication'	To investigate the effectiveness of avatar therapy on AVHs compared with supportive counselling	PSYRATS-AH, BAVQ-R, VAAS, VPDS, DASS-21, SAPS, SANS, MANSA, RSES.	Linear mixed-effects model. Assessment at baseline,12 & 24 weeks.	Significant reduction in PSYRATS-AH total score in avatar therapy condition compared to supportive counselling condition
4.	Avatar Therapy	Dellazizzo et al., 2018a	Qualitative	12 voice hearers	To explore the main themes emerging from the therapy	Themes from discourses between voice-hearers and avatars	Content analysis	Emotional responses to the voices, beliefs about voices and schizophrenia, self-perceptions, coping mechanisms and aspirations hypothesised as potential therapeutic targets
5.	Avatar Therapy	Dellazizzo et al., 2018b	Case report, with emphasis	A man in his early 50s who heard voices for 30 years. Participant in Percie	To acquire peer knowledge and critique of AT following participation in the pilot RCT	Clinician description of the case, first person account of the	N/A	Intervention was very well received. The person's voices reduced by 80–90% and he was able to reduce his medication and gain

No.	Therapeutic Approach	Authors, year	Design	Sample	Aims	Outcome Measures	Analysis	Main Findings
			on peer contribution	du Sert et al., 2018 pilot RCT		therapeutic experience		employment. Researchers suggest AT may be a promising intervention for voice hearers.
6.	Avatar Therapy	Dellazizzo et al., 2018c	Case report	A man in early 30s who had heard voices for 20 years, 'ultra-resistant' to treatment	To demonstrate potential acceptability of AT for 'treatment-resistant' patients	Clinician observation only	N/A	Clinical improvement of 'positive symptoms and depressive symptoms' observed. Morale of patient's family also improved
7.	CBT + Virtual Reality Assisted Therapy (VRT)	Dellazizzo et al., 2020	Proof-of - concept study	10 participants with 'treatment-resistant schizophrenia' who heard distressing voices	To detail the benefits of combining CBT for voices followed by VRT as part of a trial comparing the efficacy of VRT to CBT	PSYRATS-AH, BAVQ-R, PANSS, BDI-11, Q-LES-Q-SF, therapists' notes and patient interviews	Linear mixed-effects model,	Improvements observed for depressive symptoms and overall symptomatology of schizophrenia. Suggested as complimentary therapy to CBT. Similarities found between CBT and VRT in that therapy helped patients better accept themselves and their voices while also learning to better manage their emotions. Therapy enabled patients to improve interpersonal relations with their voices and others. CBT and VRT considered complimentary approaches with CBT focusing on "questioning" and "comprehension" and VRT on "taking action" and "dialogue"
8.	Avatar Therapy	Leff et al., 2013	Proof-of-concept study, randomised, single blind, partial crossover trial	27 patients who were hearing distressing voices	To verify the effectiveness of AT compared with Treatment as Usual (TAU)	PSYRATS-AH, BAVQ-R, CDS	Descriptive statistics, T-test	Significant reduction in PSYRATS and BAVQ-R scores in AT group compared with TAU group. Abrupt cessation of AVHs in 3 patients, which remained at 3-month follow-up.

No.	Therapeutic Approach	Authors, year	Design	Sample	Aims	Outcome Measures	Analysis	Main Findings
9.	Virtual Reality Assisted Therapy (VRT)	Percie du Sert et al., 2018	Pilot randomized, partial cross-over trial	19 patients with 'refractory AVHs'	To compare the effectiveness of VRT based on AT with Treatment as Usual (TAU)	PSYRATS-AH, PANSS, BDI-11, Q-LES-Q-SF	Linear mixed-effects model	Significant improvements in AVH severity, depressive symptoms and quality of life in VRT condition compared to TAU. Results sustained at 3-month follow up.
10.	Avatar Therapy modification	Stefaniak et al., 2017	Case study	A 40 year old man with 'chronic negative AVNs' lasting 7 years	To present the most important features of the therapy for the patient	Clinician observation only	N/A	Significant reduction in the frequency and intrusiveness of voices. Effects were sustained at 6-month follow-up.
11.	Avatar Therapy modification	Stefaniak et al., 2019	Pilot study, parallel groups	23 'treatment-resistant' patients with 'chronic AVNs'	To verify the effectiveness of the proposed short-term therapy based on an interaction between the therapist and the avatar.	PSYRATS-AH, VPDS	Descriptive statistics, Shapiro-Wilk test, T-Test, Wilcoxon Signed Rank test.	Lower PSYRATS-AH and VPDS scores at time-point 1 compared to baseline. Effects sustained at 3 month follow up.
12.	Avatar Therapy	Ward et al., 2020	Systematic case review	53 'therapy completers'	To present the therapeutic targets, acceptability and potential side-effects of avatar therapy	Detailed therapy notes and audio-recordings	Systematic review process using two raters	10 therapeutic targets identified: power and control, self-esteem, maintenance, working toward internal attribution, identity, compassion toward the voice, experiential disengagement, working with grief, working with trauma, future focus. Engagement in dialogue was acceptable. Potential side effects: content can be challenging for voice-hearer and therapist, delivery challenges.
13.	Relating Therapy	Hayward et al., 2009	Case series	5 voice-hearers from community mental health services with a schizophrenia or	To explore the development and value of the approach	VAY, PSYRATS-AH, AHRS	Descriptive statistics only	Increased controllability reported by 3 participants, reductions in distress reported by 2 participants, reductions in negative voice relating reported in 4 participants.

No.	Therapeutic Approach	Authors, year	Design	Sample	Aims	Outcome Measures	Analysis	Main Findings
				affective disorder diagnosis				
14.	Relating Therapy	Hayward & Fuller 2010 *(based on Fuller, 2006)*	Qualitative pilot	10 participants: 3 therapists, 3 voice hearers who received RT, 2 relatives, and 2 referrers	To explore the experience and usefulness of a pilot of RT	Semi-structured interview transcripts	IPA	Five themes identified: the process of engaging with the therapeutic model, the significance and impact of the therapist's approach to therapy, the process of developing a new relating style, challenges and obstacles to change, and how changed is described and defined by participants.
15.	Cognitive Behavioural Relating Therapy (CBRT)	Paulik et al., 2013	Case study	Woman in late 30s who heard voices and received a diagnosis of schizophrenia aged 26	To demonstrate the application of CBRT through a case study	PSYRATS-AH, VPDS, DASS, RSES, SOFAS, patient verbal feedback	Descriptive statistics only	Significant reductions across all measures between baseline and follow up, apart from VPDS. Self-reported improvements in patient's relationship with voices and others and reductions in voice-related distress. The therapy process was well received by the patient. Enabled patient to access a HVN group.
16.	Relating Therapy	Hayward et al., 2017	Pilot RCT, parallel groups	29 people who had heard distressing voices for >1.	To verify the effectiveness of RT compared with TAU	PSYRATS-AH, PROQ3, CHOICE, VAY, HADS at baseline, 16w and 26w	Descriptive statistics, change scores, Cohen's d standardised effect sizes	Significant reduction in AH distress in RT group compared with TAU, large effect size. Effect was maintained at follow-up. Medium-large effect sizes in favour of RT for improvements in negative relating with voices and others compared with TAU.
17.	Relating Therapy	Hayward et al., 2018	Qualitative	9 people who heard distressing voices	To explore voice-hearers experiences of RT	Semi-structured interview transcripts	Thematic Analysis	Changes can be evident in the hearer and the voice as a result of the voice hearer adopting a more assertive communication approach with the voice. These benefits can extent to communication the voice-hearer has with others.

No.	Therapeutic Approach	Authors, year	Design	Sample	Aims	Outcome Measures	Analysis	Main Findings
18.	Experience Focused Counselling (EFC)	Schnackenberg et al., 2017	RCT	12 voice-hearers	To evaluate EFC as a novel approach	BPRS (Psychosis, Anxiety & Depression factors), PSYRATS-voices	Descriptive statistics, paired t-test, ANOVA. Assessment at baseline, 3m, 6m and 44 weeks.	Clinically large treatment effects shown in the EFC group compared with the TAU group. Voice-hearers also felt more able to do first trauma disclosures in EFC group compared with TAU group.
19.	Experience Focused Counselling (EFC)	Schnackenberg et al., 2018a	Qualitative	25 voice-hearers and mental health professionals	To explore whether EFC could be experienced as trauma-sensitive compared to TAU	Semi-structured interview transcripts	Thematic Analysis	Themes identified: 'trauma-related', dealing with emotions, process of working with voices, intra- and interpersonal life, 'coping-related'.
20.	Experience Focused Counselling (EFC)	Schnackenberg et al., 2018b	Qualitative	25 voice-hearers and mental health professionals	To explore whether EFC is of value and has transdiagnostic application	Semi-structured interview transcripts	Thematic Analysis	Themes identified: intervention applicability, impact of regular treatment before study, impact of EFC process, process of working with voices, impact of regular treatment during study, views on treatment or approach.
21.	Making Sense of Voices (MsV)	Steel et al., 2018	Case series	15	To evaluate outcomes of the MsV approach with a focus on dialoguing techniques	PSYRATS-voices, DAIMON, GAD7, PHQ9, DES, WEMWBS, SCS, BAVQ-R SCS	Linear mixed-models	Large effect sizes observed for SCS and BAVQ-R scores which warrants further study. Voice-related distress ratings not statistically significant between time points. Findings suspected to be limited by small sample size and reductions considered to still be clinically meaningful.
22.	Making Sense of Voices (MsV)	Steel et al., 2020	Qualitative	12	To report on voice-hearers experiences of the MsV approach	Interview transcripts	Thematic Analysis	High satisfaction with the approach, positive outcomes appeared to relate to a better understanding of voice hearing experiences and a better sense of control over voices.

No.	Therapeutic Approach	Authors, year	Design	Sample	Aims	Outcome Measures	Analysis	Main Findings
23.	Talking With Voices	Longden et al., 2021	Pilot RCT	50 voice-hearers in contact with secondary mental heath care services	To assess the feasibility and acceptability of the dialogical intervention to ameliorate voice-related distress in an NHS setting`	Primary: rates of referral, recruitment and retention, adherence to and completion of the intervention. Acceptability. Secondary: PANSS, BAVQ-R, VAY, DES-II, QPR, LSC-R, Voice-hearer and staff verbal feedback.	Descriptive statistics, point estimates and 95% confidence intervals, sample size calculation for future trial, thematic analysis.	Target sample achieved, 37 participants out of 127 referrals declined to participate most commonly due to 'lack of interest'. Level of unease with dialoguing with voices not judged by researchers as main reason for declining intervention. No indication of resistance from staff to refer to the trial using this intervention. Only baseline secondary outcomes available.
24.	Compassion Focused Therapy for Psychosis (CFTp)	Heriot-Maitland (2020)	Case series	8 voice-hearers under the care of a community mental health team	To develop and test the acceptability of an individual CFT for distressing experiences in psychosis (CFTp).	PSYRATS-AH, DAS-21, CORE, SocCS, OAS, SCS-SF, FSCSR, PBIQ-R, HRV, SSPS & DES-II	Reliable Change Index and Tau-u statistic at single-case level and Wilcoxon Signed Rank Test and Tau-u statistic at group level,	Significant improvements in outcome measures of depression, stress, wellbeing, voices and delusion were observed, the majority of which were maintained at 6-8 weeks follow-up. CFTp considered a feasible and acceptable intervention.

PSYRATS-AH= Psychotic Symptom Rating Scale- Auditory hallucinations section; **BAVQ-R**= Beliefs About Voices Questionnaire- Revised; **PANSS**= Positive And Negative Symptoms Scale; **VAAS**= The voices acceptance and action scale; **SAPS**= Simplified Acute Physiology Score; **SANS**= Scale for the Assessment of Negative Symptoms; **MANSA**= Manchester Short Assessment Of Quality of Life; **RSES**= Rosenberg's Self-Esteem Scale; **BDI**= Beck's Depression Inventory- version 2; **Q-LES-Q-SF**= The Quality of Life Enjoyment and Satisfaction Questionnaire; **BPRS**= Brief Psychiatric Rating Scale; **CDS**= Calgary Depression Scale; **VPDS**= Voice Power Differential Scale; **VAY**= the Voice And You; **LSCR**= Life Stressor Checklist – Revised**; AHRS**=

Auditory Hallucinations Rating Scale; **DASS**= Depression and Anxiety Stress Scale; **SOFAS=** Social and Occupational Functional Assessment Scale; **PROQ3**= Person's Relating to Others Questionnaire version 3; **CHOICE**= CHoice of Outcome In Cbt for psychoses; **HADS**= Hospital Anxiety and Depression Scale; **PSRS**= The Perceived Stress Reactivity Scale; **DAIMON**= A scale which measures the relationship with and between voices; **GAD-7**= Generalised Anxiety Disorder version 7; **PHQ-9**= Patient Health Questionnaire version 9, measures Depression; **DES-II**= Dissociative Experiences Scale version 2; **WEMWBS**= The Warwick--Edinburgh Mental Well--Being Scale; **QPR**= The Questionnaire about the Process of Recovery; **SCS**= Self-Compassion Scale (and SCS-SF= short form); **CORE**= Clinical Outcomes in Routine Evaluation; **SocCS**= Social Comparison Scale; **FSCSR**= Forms of Self-Criticising/Attacking and Self-Reassuring Scale; **OAS**= Other as Shamer Scale; **PBIQ-R**= Personal Beliefs about Illness Questionnaire-Revised, **HRV**= Heart Rate Variability; **SSPS**= State Social Paranoia Scale .

Appendix C. *Questionnaires used to collect demographic information and background details*

Participant ID number: …….

Date: …….

QUESTIONNAIRE [Demographic Information]

Please *tick* the appropriate box:

1. Gender
   - ☐Male
   - ☐Female
   - ☐Non-binary/ third gender
   - ☐Prefer to self-describe: …….
   - ☐Prefer not to say

2. Age Group
   - ☐18- 24
   - ☐25- 34
   - ☐35- 44
   - ☐45- 54
   - ☐55 or over

3. Ethnicity

Choose ***one*** section from A to E, then tick ***one*** box which best describes your ethnic group or background

White
- ☐English/ Welsh/ Scottish/ Northern Irish/ British
- ☐Irish
- ☐Gipsy or Irish traveller
- ☐Any other white background. Write below:

  …….

Asian/ Asian British
- ☐Indian
- ☐Pakistani
- ☐Bangladeshi
- ☐Chinese
- ☐Any other Asian background. Write below:

  …….

Black/ African/ Caribbean/ Black British

☐African
☐Caribbean
☐Any other African/ Caribbean background. Write below:

……

Mixed/ multiple ethnic groups

☐White and Black Caribbean
☐White and Black African
☐White and Asian
☐Any other mixed/ multiple ethnic groups. Write below:

……

Other ethnic group

☐Arab
☐Any other ethnic group. Write below:

……

Prefer not to say

☐

4. What is your highest school qualification?

☐Less than school diploma
☐School diploma/ O-level/ GCSE/ GCE or equivalent
☐Bachelor's degree
☐Master's degree
☐Doctorate degree
☐Other. Write below:

……
☐Prefer not to say

5. Relationship status

☐Married
☐Divorced
☐Widowed
☐Separated
☐Single
☐Other. Please write below:

……
☐Prefer not to say

6. Housing status

☐Renting from Housing Association
☐Renting from Council
☐Private renting
☐Home owner
☐Other. Write below:

……

☐Prefer not to say

7. Employment status

☐Full-time employment
☐Part-time employment
☐Self-employed
☐Unemployed
☐Student
☐Retired
☐Disabled, not able to work
☐Other. Write below:

……..

☐Prefer not to say

QUESTIONNAIRE [Additional Information]

1. Are you currently attending a Hearing Voices Group (HVG)? (if no, skip to Q3)

   ……

2. How long have you been attending this group?

   ……

3. Have you attended any (other) HVGs in the past? If so, please state total time involved.

   ……

4. When did you start receiving the voice dialogue method? *(Please indicate rough time period if difficult to remember)*

   ……

5. How would you describe the relationship you had with your Voice Dialogue Facilitator?

   Very poor☐ Poor☐ OK☐ Good☐ Excellent☐

6. Roughly, how many sessions of voice dialogue did you receive?

   ……

7. How often did you attend these sessions?

……

8. Are you still receiving sessions? If not, please indicate when you finished.

……

Thank you

This is the end of the questionnaire.

Appendix D. *Background details about HVG membership and voice dialogue sessions*

Question number	Question	Answer
1a.	**Current HVG member?**	Yes: 6 No: 4
1b.	**If yes, how long attending?**	2 months: 1 4 years: 3 7 years: 2
2a.	**Attended any other HVGs?**	Yes: 7 No: 3
2b.	**If yes, total time attending**	Range: 2 years- 7 years and 6 months
3.	**When started receiving voice dialogue method?**	2006: 1 2014: 1 2015: 1 2018: 1 2019: 4 2020: 2
4.	**Described relationship of voice dialogue facilitator**	Good: 1 Excellent: 9
5.	**Total voice dialogue sessions received**	1 session: 1 2- 5 sessions: 3 6- 10 sessions: 3 11- 20 sessions: 2 Over 30 sessions: 1 (31)
6.	**Frequency of sessions attended**	Almost daily: 1 Weekly: 3 Fortnightly: 1 Monthly: 1 Ad hoc: 3 N/A: 1
7a.	**Still receiving sessions at time of interview?**	Yes: 4 No: 6
7b.	**If no, when stopped?**	2016: 1 2019: 4 2020: 1

Appendix E. *Study Information Sheet*

PROJECT INFORMATION SHEET

Project Title: The Voice Dialogue Method for distressing voices. Exploring perspectives from voice hearers and voices

Hi! Thanks for showing an interest in my project. My name is Kerry Middleton and I am a Trainee Clinical Psychologist from Salomons Applied Institute of Psychology (Canterbury Christ Church University). I am conducting this research as part of my Doctoral Dissertation with the support of my supervisors, Anne Cooke (Clinical Psychologist and Principle lecturer at Canterbury Christchurch University) and Rufus May (Clinical Psychologist).

This information sheet provides an overview of the project, including what it would look like if you were to get involved. If you have any questions, please don't hesitate to get in touch via email: Km734@canterbury.ac.uk

Background to the Project

The experience of hearing voices is relatively common, with 3-10% of the population hearing a voice or voices at some point within their lifetime. At the moment, mental health services are developing their knowledge of approaches to voice hearing that move beyond considering the experience of hearing voices as a symptom of illness. Exploring a person's relationship with their voices through direct dialogue (Voice Dialogue) has been an approach which has existed for some time within peer support settings but there is currently little research on people's experiences of this approach.

Project Aims

The current project is interested in finding out about different people's experiences of the voice dialogue method, both from the perspectives of people with lived experience of voice hearing and their voice(s).

Why have I been invited?

You have been invited as you have lived experience of voice hearing and have recent experience of the voice dialogue method. You also might have attended or have some association with the Hearing Voices Network group in Bradford.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will the project involve?

The project will be a single video interview, lasting up to 90 minutes. The main part of the interview will involve asking questions about your experiences of the voice dialogue method. If you have a voice or voices who are willing and feel safe to share their views on this too, this would be welcomed.

There will also be an optional survey to complete at the end of the interview. This survey will be asking for some demographic information about yourself and some more detail about your experience of the voice dialogue method (e.g. the length and frequency of sessions you received).

At the end, there will be an opportunity for a debrief, which will involve checking how you and your voices found the interview, whether you would like to ask any further questions, and to check how you would like to be updated on the project, if at all, going forward.

Who is responsible for the data collected in this study?

I (Kerry) will hold responsibility for the data collection within the study. To make sure that I can fully and accurately represent the information you share, I will ask for the interview to be audio-recorded and the audio files will be stored on a password protected USB for use by myself only. All information which is collected from or about you during the course of the research will be kept strictly confidential. Data will be handled and held securely in accordance with General Data Protection Regulation (GDPR) procedures and the Data Protection Act (2018). Data will be retained for use in future studies for up to 10 years in line with recommendations by the Medical Research Council. Only authorised persons such as researchers, sponsors, regulatory authorities and Research and Development Audit (for monitoring of the quality of research) will have access to view the data during this time. After this time, the data will be disposed of in a safe and unrecoverable manner. Any identifiable information you give during the interview will be removed when the results are written up and published so that you cannot be recognised.

Limits of confidentiality

The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else.

What are the risks involved in this study?

Risks associated with participating in the study are low. We acknowledge that talking about your experiences of voice hearing and the voice dialogue method could be mildly distressing.

What are the benefits for taking part in this study?

Taking part in the study will enable us to develop a better understanding of how the voice dialogue method helps people, and possibly how it could be improved. It is also possible that this research might lead to more people being offered voice dialogue in future, including within mainstream services.

You will receive a £20 amazon voucher as a thank you for your time.

What are my rights as a participant?

Taking part in the study is voluntary. You are not obliged to answer any questions asked during the interview. You may choose not to take part. If you do take part you can withdraw any time without needing to explain why. You also have right to check the accuracy of data held about yourself and correct any errors.

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

If you choose to withdraw from the study, we would like to use the data collected up to your withdrawal, but this will be up to you. If you do not wish for any data to be stored, we will remove this data accordingly.

Concerns and 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 address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me [Kerry Middleton] and I will get back to you as soon as possible.

If you wish to speak to the university's supervisory lead on the project, Anne Cooke, they can be contacted via email: Anne.cooke@canterbury.ac.uk.

If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology: fergal.jones@canterbury.ac.uk

What will happen to the results of the research study?

The results will be reported in an academic journal which should be available through open access. It is expected that the first results will be published about two years after the study finishes recruiting.

If you decide to take part, then we will keep you up-to-date on progress with the study. All identifiable information about yourself will be removed in the final write up

which I submit to the university and before publication. We ask that we can include anonymised quotes from your interview in the published report with your consent.

Who is sponsoring and funding the research?

The research is being sponsored by Canterbury Christ Church University.

Who has reviewed the study?

This project has been reviewed and approved by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University, One Meadow Road, Tunbridge Wells, Kent TN1 2YG

For more information

If you have any further questions about this study, please contact:

Kerry Middleton
Email: Kerry.j.middleton734@canterbury.ac.uk

Anne Cooke
Email: anne.cooke@canterbury.ac.uk

Thank you for reading!

Appendix F. *Study consent form*

Salomons Centre for Applied Psychology

CONSENT FORM

Project title: The Voice Dialogue Method for Distressing Voices. Exploring perspectives from voice hearers and their voices.

Researcher: Kerry Middleton
Supervisors: Rufus May, Anne Cooke

☐ I confirm that I have read and understand the information sheet dated 10/06/2020 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ I am aware that any personally identifiable information I disclose during the interview will be kept confidential

☐ I understand that taking part is entirely voluntary and that I can withdraw my consent at any time without giving a reason

☐ I am aware that anonymous data collected will be stored securely, safely and in accordance with General Data Protection Regulation (GDPR) procedures and the Data Protection Act (2018)

☐ I am aware that I am not obliged to answer any question, but that I do so at my own free will

☐ I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings

☐ I agree for my anonymous data to be used in further research studies

☐ I am aware that I have the right to review and give feedback on the transcript of my interview once it has been completed

☐ I agree to have the interview audio-recorded

☐ I agree to take part in the above study.

X _____

Participant

_____ _____

Researcher's Signature Date

Appendix G. *Interview Schedule*

Interview schedule- Discussion guides. Version 4 27/11/2019

DISCUSSION GUIDE 1: VOICE HEARERS & VOICE(S)

Warm-up:

- The main part of this interview will be asking about your experience of voice hearing and voice dialoguing, but first, perhaps it would be useful for me to say a bit more about myself and the research
- *[Introduce self- training background, reasons for interests in voice hearing experience, connection with Hearing Voices Network]* My name is Kerry and I'm currently training to be a Clinical Psychologist at Canterbury Christchurch University. I have been interested for some time in the experience of voice hearing, from supporting a relative in the past who hears voices, to working with voice hearers who have accessed mental health services in previous work roles and making connections with the Hearing Voices Network.
- *[Explain research rationale]* In this study the aim is to develop a better understanding of how the voice dialogue method helps people, and how it could be improved. It is possible that this research might lead to more people being offered voice dialogue in the future, including within mainstream services.
- I want to acknowledge that when asking questions about certain interventions, people might feel compelled to say what was good about the approach and how it was helpful. I would say that I'm more interested in finding out about your own individual experience. So, when I ask questions, I'm asking you to bring what feels important to you.
- Are there any questions you would like to ask me having said that?
- *[provide with travel expenses and get participant to initial to confirm that this has been received; complete consent form here if this hasn't been done already]*

Main discussion:

- *[Explain semi-structured format of interview and that it will involve asking some questions about the hearer's experience of voice hearing and the voice dialogue method].* So, just to recap on the format of this interview. It will be semi-structured. By that I mean that I will ask a few questions but it is up to you how you might want to steer it. For example, some questions might feel more relevant and so we might want to explore those a bit more. The questions will be around your experience of voice hearing and the voice dialogue method. I appreciate that talking about these topics can potentially feel quite difficult or bring up strong emotions. One thing to emphasise is that you are not obliged to answer any of my questions and we can take breaks at any time. What can be useful to think about is how you might look after yourself in this, both during the session, and if anything comes up for you once the interview has ended. Would you like to think more about this? [*include action plan of what to do if participant becomes distressed in the session; offer direct follow up with myself and/ or supervisor within specified time frame if needed]* . Thank you for talking this through with me.

- *[Explain that as well as interviewing the voice hearer, there is an option to also interview their voice/ one of their voices for the second half of the interview].* Finally, as well as asking yourself about your experience of voice hearing, there is also an opportunity within the second part of the interview to invite your voice or voices to answer some similar questions. It seems important to provide this opportunity given that some voices will want to be heard. Related to this, it might be worthy to note that this interview has been developed jointly with people with lived experienced of voice hearing, and their voices.
- *[Offer alternatives for voice participation e.g. for participant to submit written answers from voice(s) after the interview]*

Initial topic guides for VOICE HEARER:

1. *How the voice hearer came to be involved in the Hearing Voices Network*
2. *How the voice hearer came to receive the voice dialogue method*

Questions/ guides about voice hearing for VOICE HEARER

1. Do you have a voice who would be willing to participate in this interview?
2. Are there any other voices who might like to be heard?
3. If YES: *[Explain that would like to ask a few questions about the voice- offer option of voice hearer to read out the questions to the voice and report back aloud/ in writing, or the interviewer to ask the questions directly addressing the voice(s) and voice hearer to feedback.].* Great. There are different ways in which we could do this. One way is for yourself to ask the questions to your voice(s) and to report back to me out loud or in writing, or I could speak to your voice(s) directly and you could feedback, again, either aloud or in writing. Which method would you and your voice(s) prefer?

4. [*Ask permission for voice's name, when they came into voice hearer's life, some general characteristics. Thank the voice for participation and explain that they will be asked some questions later in the interview.]* Hello. Thank you very much for joining in the session. Could I ask what your name is? And, if you can remember, when did you come into [voice hearer]'s life? Is there anything else you would like me to know about yourself to help me get to know you? Thanks for sharing. I'm going to ask a few questions to [voice hearer] now, and if you feel comfortable, I will ask some similar questions to you a bit later on. Would this be okay?

5. *[Ask about voice hearer's experience of voice hearing in relation to themselves]*. Coming back to you [voice hearer's name]; how do you make sense of [voice(s)' name(s)] coming into your life?

Questions/ guides about the voice dialogue method for VOICE HEARER

1) *[Invite the voice hearer to say a bit about their life and how voice(s) became a part of it. Invite voice hearer to story this how they like].* Could you tell be a bit about your life and how your voice(s) came a part of it?
2) *[Ask about their experience of the voice dialogue method- how they think it works, what is different about it, what are the key elements, initial thoughts and after having gone through it]. And you attended some voice dialogue sessions? What's your sense of how this approach works? What do you think is different about it? What do you think are the key elements of it?*

Could you tell me about your experience of it? Did you have any initial thoughts going into it? What was it like when you started? How has it been since?

a. *[*prompt: ask about relationship with voices before and after, co-occurring life factors which may have contributed to change. Gain an idea of short and longer-term changes]*

3) *[Invite voice hearer to add anything else they feel might be relevant to add].* Is there anything we haven't talked about that you feel would be relevant to add?

With permission, I'd now like to talk to the voice. Again, would *[insert voice's name]* prefer me to directly ask them or would they prefer for you to ask the questions?

<u>Questions/ guides about the voice dialogue method for the VOICE(S)</u> *[*ask to each voice if more than one]*

1. *[Invite voice to share their story of how they came into the voice hearer's life]*
4) *[Ask about their experience of the voice dialogue method- how they think it works, what is different about it, what are the key elements, initial thoughts and after having gone through it].* And you attended some voice dialogue sessions? What's your sense of how this approach works? What do you think is different about it? What do you think are the key elements of it? Could you tell me about your experience of it? Did you have any initial thoughts going into it? What was it like when you started? How has it been since?
2.
    a. *[*prompt: ask about relationship with voice hearer before and after, co-occurring life factors which may have contributed to change. Gain an idea of short and longer-term changes]*
3. *[Gain voice(s) understanding of how and why they may have entered voice hearer's life]*. Could you tell me what you think about how and why you might have come into [voice hearer's name]'s life?
4. *[Invite voice(s)to add anything else they feel might be relevant to add].* Is there anything we haven't talked about that you feel would be relevant to add?

[Explain that this is the end of the set interview questions and thank both voice hearer and voice(s) for their time in answering the questions.]

Lastly, I have a couple of questionnaires. These are optional and I'll explain the rationale for including each of them.

[Provide with demographic information questionnaire]

In research, it's important to get a diversity of perspective from people from a range of different backgrounds. To ensure that I've covered enough information about yourself in this regard, I'd appreciate if you could fill out a demographic questionnaire. Again, you do not have to answer each question if you do not wish.

Demographic questions, with 'prefer not to say' option for each:

9. Age range
10. Sex
11. Ethnicity
12. Relationship status
13. Housing status
14. Education background
15. Employment status

[Provide with 'additional information' questionnaire]

This questionnaire asks a bit more about your current experience of the Hearing Voices Group and the sessions of voice dialogue you had or are having. Providing this information might help us understand more about when and what might be helpful. Again, you don't have to answer any of the questions if you do not wish.

'Additional information' questions:

16. How long have you been attending the Bradford Hearing Voices Group (HVG)?
17. Have you attended any other HVGs? If so, please state total time involved
18. When did you start receiving the voice dialogue method? (Please indicate rough time period if difficult to remember)
19. Roughly, how many sessions of voice dialogue did you receive?
20. How often did you attend these sessions?
21. Are you still receiving sessions? If not, please indicate when you finished.

Thank you. This is the end of the interview. We now have some time to talk through how you (and voice(s)) are doing and next steps.

DEBRIEF questions

1) How did you find it? Are you feeling okay? [*also check for voice(s)]*
2) Would you like to ask me any questions?
3) How would you like to be updated on the project (if at all)?

[recap post-interview self-care and follow-up plan if required]

Appendix H. *Transcript Excerpts (fully anonymised)*

Excerpt 1:

Me: are you able to speak to something from your own experience of that in terms of having you know someone model something that felt really powerful or helped you in some way. It sounds like you are that person for people in your work. I wondered whether that came from you experiencing it yourself.

ERIN: I know how I was struck by how [voice facilitator], those first couple of meetings we had and I was struck by how curious he was and how compassionate he was, not just towards me but towards the voices as well which I was not doing and it really resonated within me. It was something very..it sort of aligned itself with the values I already had about being understanding and caring Even towards things that are very strange and unfamiliar towards us and he was just persistently non-judgmental and open minded. no matter what I talked about or how I described it. He didn't take sides you know he wasn't about me against the voices or helping me tell off the voices for being evil or nasty or critical or ruining my life or you know…it's very easy to take those positions but he just didn't take those positions, he was curious and compassionate. It just helped me reconnect with feeling curious about what was going on and not just dismiss it and ignore it and be angry about it and it shifted very quickly it was a very quick shift for me and the initial I remember it being quite overwhelming and painful because I initially did feel very shamed. I think that's a real barrier to this work is the shame we can feel about how we've been. So, you know, when we change I've seen it when I've been doing training with some mental health professionals and they're really struck by stories about how people have suffered in the mental health system during treatment but they can't make the shift to think that they've done any of that, that they have hurt anyone, they just can't make the shift because it's too painful, it's too shameful to think that "oh, when I was engaging with that person, I might have actually caused harm, even though that wasn't my intention I may have actually caused harm and I created more problems". So I remember that for myself, that sort of like "oh my god, this is really embarrassing" and thinking like that at that point probably for about 15 years I've been really frustrated with the voices and I hadn't done anything much to improve my relationship with them or being curious about them. I'd been very self-obsessed and very rational about everything. Yeah, so it was a painful process. Those first couple of months sort of thinking "OK", not how can I change the voices but "what can I do differently? What is my responsibility in this?" and really working on that. I needed a lot of support and being reminded and having it role modelled was really important for me to see that you can persist with this. Sometimes I failed, sometimes it was fine, unfair, demanding but I kept building that sense of curiosity and respect and thinking, you know, the voices wouldn't know that I needed modelling. I needed somebody else to model it for me. And then what I thought was "well, maybe the voices need me to model to them. Maybe they don't know what to do differently because nobody has shown them so I need to be the person to show them". So that was my main inspiration was this idea that I could be a role model for the voices. They helped me with my sense of connection to my values.

Me: Just going back to…if it's ok to sit with it..going back to the feeling of shame..you drawing those parallels makes you appreciate that it's probably a very common experience. And in terms of that shame, was that kind of like a moment of realisation of being quite harmful to voices.

ERIN: and to myself.

Me: Yeah

ERIN: Oh yeah, definitely. And feeling quite stupid as well like I should have known better. And I should have done better. So I can get quite upset with myself for it and I had to put it in the context of what was going on at that time…I was responding in the way I was responding because…yeah maybe I knew better…but the context of my life was as it was and I didn't have the support to do things differently really either. It's hard to change something quite fundamental in you.

Me: yeah

ERIN: you know, it's hard because it's quite deep and quite primary and automatic as well.

Me: Hmm. And those feelings as they kind of showed up. You said in terms of contextualising some of that felt helpful. Was there something about the approach that helped that?
ERIN: just the openness. Such an open approach. You know the lack of judgement of things that we normally would see as taboo or evil, you know that culturally voices often hold energy or characteristics that we judge quite harshly in our society so it's really difficult to talk about and it's even more difficult to give voice to it in a voice dialogue. You know, that was another reason why I wouldn't let people talk to the voices I hear because I was worried that they would say things I didn't want to feel responsible for because I knew how counter-cultural and how harshly judged it would be. So, you know, things around sexuality…I guess political stuff…just you know
Me: something about voices speaking the unspoken
ERIN: yeah, and how threatening that is to who you want to see yourself as. Because I think that's quite a common thing. You really don't recognise what the voice is talking about. It feels so strange to you that you don't want to see it as part of yourself. And the openness in the approach (hearing voices approach and voice dialogue) the values, is really about that all of this is part of us, however uncomfortable and ugly it is, we can't just pretend that it's the paedophiles and the rapists and the colonists. It's not just out there. We're part of this web of these things. And that's hard. But the openness in the approach helps soften some of that anxiety around it I think.
Me: and was that kind of like.. er..a process of discovery as you were going through the approach or was that an expectation that you had going into it
ERIN: No, it was like that feeling of it resonating deeper in me but I had this sort of socialised cultural layers of judgement and critical thinking that I sort of had to re-calibrate a bit about how I approached things and I still really struggle. I'm a really strong perfectionist. I'm very discerning about a lot of things and therefore easy for me to get into critical, judgemental thinking and being open and curious is a constant work and process. Even though it feels like quite deep and important and primary to my values, it's still something I have to work really hard on to do. I do look for- the HV approach, the voice dialogue method- I do look for methods that help me on that because it is a work in progress, it's a constant learning process.
Me: It's lifelong
ERIN: Yeah. And I think partly because of the culture we live in. and because we clash with people all the time. But yeah, the emphasis on relating and taking responsibility for how we relate is key to a lot of the things I love. And I keep coming back to the voice dialogue ideas. I find them supportive in my personal life with my partner in conflict situations, in my relationship with myself and approaching things with an attempt to relate and dialogue with it. And not just to talk at it.
Me: [introduce break]
Me: up to you where you want to steer it. Was there anything else that you wanted to bring?
ERIN: something that I've remembered is experiencing or witnessing voice dialogue, which is another sort of, not everybody who has done voice dialogue has witnessed it but I know with the training in voice dialogue you witness it often. I know the way XXX does it in the group sometimes other members of the group are there to support it. Like I said, I quite like that communal approach where there's more accountability and there's less of a sort of therapy lid but it can also be quite challenging to witness as people sitting around. I've had some quite insulting and disrespectful responses to it but also people getting really freaked out by it but there's something about letting a voice talk, you know, some people associate it with spiritism or clairvoyance and there's a lot of fear around it as well, around voices taking over and yeah..so I wondered about, it might be interesting to hear if people witnessed dialogue before they tried it themselves, how they found that. You know, seeing that happen. How is that when you see it happen.
Me: Yeah. Interesting, And it sounds like for you, sometimes a difficult experience?

ERIN: I've always found it quite a privilege for watch when people do voice dialogue, I've always felt quite humbled by the experience but the other way around, being on the receiving end of people's responses..you know, you need to be prepared for that. And it's just interesting what it provokes in people because that's how I see it…there's something about it that's quite challenging to our ideas of the psyche and what's safe and what's not. So yeah, people can get quite uncomfortable.

Me: and just to check my understanding of how it works maybe if it's done in a group setting like that. If you are a witness, are you kind of discouraged from talking as the person being spoken to and the voices and the facilitator or are you invited to contribute?

ERIN: that depends on the situation, it's contextual, so it depends on how, so for me personally when I've done it, I'm always open to let people other participants ask me questions to ask the voices so involve everybody in it but it really depends on the facilitator's confidence about that. It also depends on how comfortable the person feels with the facilitator, their voices and the people around them. You can also get it so that the facilitator talks to the person and talks to the voices and you're just in the audience quiet and sometimes you can get a different dynamic as well. yeah there is somebody in Australia who has sort of developed a more reflective practice or approach to it where you have a couple of people and they invite you to engage as well

Me: one to jot down and have a look myself. Thanks for sharing. Cool. Soo. Have we got any voices that might like to show up?

ERIN: all the 4 I mentioned earlier are up for having their say. .So I would probably start with one and see. We don't need to do all 4. But they're all willing anyway. There's a bit of negotiation. I think it would be good to speak to Sylvester but I need to negotiate so that we make sure that we make time to speak to another one who is more keen but I think it would be good to speak to both of them.

Me: Ok, great. And how would you like me to do it? Would you like me to talk to you and then you ask them?

ERIN: Yeah, that's fine.

Me: cool. So it might feel very similar unless you think there's another question that might be useful yeah whatever they want to contribute I guess. Going back generally in terms of how they experienced the voice dialogue session and it might be again I'm not sure when they kind of came into your life but it might be going back to that point where you've been in services and then you'd started with this approach or you started talking with Jan and maybe their experiences of it at that time.

ERIN: so I put that to Sylvester and he talks about the first thing he mentioned was that it was a very fragile time he remembers how involved and excited I was and glad that I became more cautious because it was like surfing it was like being on a wave and going with it in the beginning and I was really immersed in it so he's highlighting more the fragility of those first months and how vulnerable I actually was you know. So his take on it was that I was lucky that these were trustworthy people and that it was kept safe and I had some skills already to keep myself safe. And he's right, it was very exciting and it was very it was like taking the lid off you know I just I remember those first sessions with [voice facilitator] I will talk with him I would meet up with him once a week and I would talk with him for half an hour. I was so excited about the whole thing is was almost like a spiritual experience so yeah I could have I could have crashed massively or somebody could have taken advantage of that if you could've been keen to. So that's interesting that he's highlighting that.

Me: hmm. And I'm wondering at that time if he wanted to put the brakes on

ERIN: yeah. Can you say that again?

Me: it sounds like he was wanting to maybe put the brakes on things during that period of excitement recognising that things felt fragile but at the same time now being glad that it was a process that you went through and you were unharmed in that as well.

ERIN: yeah. He's just acknowledging that it's an element of luck I all of that. You know, when you throw your trust in something, you are to some extent out of control and there is an

element of luck in who you meet and how things are done. Yeah. Sorry. I'm just checking if there's anything else. Yeah, he's said, and that being said, he thinks I've ended up a bit too cautious around the actual voice dialogue. He's glad I got into it eventually. He says I am quite cautious and I don't use it very often, as I said in my personal life. And he thinks that it's not as precious as I sometimes make it out to be.

Me: Can I ask any more on that? In terms of his stance…I'm getting the vibe that it's an ok approach but we might not save the world with it

ERIN: so he says that his experience of me is that I take it quite seriously. I think that it can talk on the deep things and can really mess with someone's psyche if you're not careful but he says it could just be a way of getting information and also a way to have fun. That there are other sides to it than this deep psychoanalytical side. It's not so singular. So he'd like me to be a bit more carefree around it maybe in my personal life. He appreciates the way I used it for training and he says that it's a shame that it mainly happens there. He thinks it could be a resource for all sorts of things.

Me: yeah almost like there can be a lightness to it.

ERIN: Yeah

Me: it doesn't need to be deep and serious all the time…would he like to say anything else? it could be about the approach or something more generally

ERIN: he thinks it should be taught in schools. Yeah, just the voice dialogue ideas. The idea that you can relate to things that might not be visible you relate to different parts of ourselves and be more flexible about our identity and other people's identity so we don't get so locked up in "I'm like this and I need to be like this". And also, make it more of a communal responsibility for it to be OK to hear voices.

Me: nice. Can you thank him very much for bringing that. Looking at the time, I know there was someone else who you said was very keen.

Excerpt 2:

Me: can I ask so where things are at for you now in terms of talking with voices? Whether that's something that is going on regularly for you now?

DAN: I mean yeah the course of my recovery has been a two steps forward one step back kind of thing. A couple of years ago I did a lot of dialoguing and it was very productive indeed and I was actually amazed about what I found out about what the hell was going on inside me just by doing the dialoguing. But unfortunately, about one year later, I ended up having another breakdown which by the way it didn't have to do with the dialoguing, it had to do with other stuff. I ended up getting hospitalised, sectioned for a while. Fortunately it was only 2 or 3 weeks but after that in a way I felt that I had been set back to square one and I had to work to come in stable all over again, and for the past couple of years I have been focused on that, trying to keep myself on a kind of even keel and as a result you know questions about doing sort of complex working dialoguing have been put on the back burner a bit.

Me: yeah of course, managing different priorities.

DAN: yeah hm definitely and over the past year or so I've been volunteering at mind and now I've been taken on as a member of staff and so a lot of my mental resources, if you like, are invested in at the moment and there's not an awful lot left over by the end of the day so speak to invest in other things. What I'm hoping is that as I become more used to walking at Mind, I will then have a more stable base to re-engage with therapy and with voice dialoguing and so on yeah and I think that's [how it will be].

Me: I think that's a really important point that you raised about, yeah I took that as something about voice dialoguing being quite intense work with the potential to bring up stuff you were previously unaware or unassuming of, so when things happen that

force to exist more in survival mode, there's a need to then step back from that little bit and just dip in and out of it when you feel ready.

DAN: no I think that is dead right. I think when you are in survival mode you can't really do it. When you are in that mode, it's usually because other things are running your life or other things come up and need to be sorted out first. I mean in the HV group at Mind, I don't advise people to start dialoguing unless they've got a stable and secure life generally. If they've got problems with benefits or they've got shitty housing or problems with the landlord or other serious relationship issues then I would work on sorting out those things first. When they get sorted out so they got the stable basis, that's when to [offer] / consider starting voice dialoguing.

Me: [info about structure of interview: a structure to it it really is an invitation to say anything and everything you know where ever comes up]. Is there anything you would like to say more about?

DAN: Perhaps it would be useful to say bit more about the content of the dialoguing and the development that took place during that maybe.

Me: yeah sure if you don't mind spending the time on that.

DAN: no no it's fine it's probably the most important bit to be honest in my opinion. Then I did the dialoguing 2 years ago and the good friend of mine helped me to get it going in terms of talking to my voices… and we did that by me conveying to her what the voice was saying and then her she used to respond to it. And at first, the main voice that I had is like the my voice probably most people have, certainly people who got complex childhood trauma. It seemed to be an abusive adult, an adult voice that was saying not very nice things to me you know critical negative blaming things. again that's the voice that all the people I work with have. And ofcourse at first, I didn't really know how to engage with that voice. All I'd really been doing up until that point was writing some stuff down in [Europe] you know. I'd just been coping with it in the way that most people do you get some education and support. I'd just been ignoring it, trying to distract myself but my friend she read some stuff on what that voice may be and it was very useful indeed. She read it in the work of a [European language] trauma therapist and theorist and when it comes to this voice he used the metaphor of somebody wearing a mask. He said when you hear a voice saying all this horrible stuff, insulting you blaming you for stuff. He says you have to imagine that is like a child wearing a dragon mask or the mask of a monster and that turned out to be exactly right. You know ofcourse another way of putting it is to say that this was like a persecutor part that is engaged in defence of typically of a child part, at least one child part. This is exactly what it turned out to be for me. So when my friend turned to talk to this voice, she made the assumption which was absolutely crucial to getting the dialoguing that this part was…no matter what this part said no matter how seemingly awful… it was actually there to protect me or a younger part inside, so it had a defence function. And it was on the basis of that assumption that she was able to begin a dialogue and it naturally turned out to be it was a defensive part that was defending a younger part inside by copying or imitating on mimic somebody who had hurt me in childhood.

Appendix I: Ethics Approval letter and response to approval in principle from which an email confirmation was received.

Canterbury Christ Church University

Salomons Institute for Applied Psychology

Kerry Middleton
Trainee Clinical Psychologist
Canterbury Christ Church University

20 December 2019
Direct line 01227 927094
E-mail margie.callanan@canterbury.ac.uk
Our Ref V:\075\Ethics\2019-20

Dear Kerry,

Voice Dialoguing for Distressing Voices. Exploring perspectives from voice hearers and their voices.

Outcome: Approval in Principle

The panel would like to offer approval in principle. Please address the following in a letter to the Chair with Claire Fullalove (claire.fullalove@canterbury.ac.uk) copied in; once these are satisfactorily addressed then approval can be given. Any revised research documents should be included with the letter.

1. Section Eleven: the panel do not recommend making follow calls or emails unless part of the research process as this goes outside the remit of the researcher's role with the participant. Consider and review please.
2. Project Information Sheet:
   a. It is usually useful to introduce the researcher more fully (trainee, doctorate research and so on) as well as the supervisors and their credentials. Consider and review please.
   b. Consider replacing jargonistic words ('semi-structured interview') with more straight-forward language.
   c. On page 3: be clear about up to what point withdrawal is possible.
3. Interview Schedule: it would be useful for the panel to have the rationale for the researcher making a disclosure about own family experience in the interview. The panel are wondering about participants who may not want to reveal distressing elements to the researcher, given that it might resonate and be distressing to her. It places the researcher in a position in relation to the experiences that is less objective, in the participants' perceptions potentially. Please consider and feed back to the panel.

Yours sincerely,

Professor Margie Callanan
Chair of the Salomons Ethics Panel

Cc Anne Cooke

School of Psychology, Politics and Sociology
Faculty of Social and Applied Sciences

Canterbury Christ Church University
1 Meadow Road Tunbridge Wells Kent TN1 2YG (UK)
Tel +44 (0)1227 927168
www.canterbury.ac.uk

Professor Rama Thirunamachandran, Vice-Chancellor and Principal

Monday 3rd February 2020

Dear Margie,

Re. Project: Voice Dialoguing for Distressing Voices. Exploring perspectives from voice hearers and their voices. Outcome: Approval in Principle

Thank you for your comments on the above project. I have since made the suggested changes and have listed these in relation to each of your comments below:

1. **Section Eleven: the panel do not recommend making follow up calls or emails unless part of the research process as this goes outside the remit of the researcher's role with the participant. Consider and review please.**
   S11 Procedures to minimise distress: *A follow-up phone call or email is also offered by the lead researcher should this be needed.*

   Response: I will not offer this to participants. Full section now reads: It has been described in the information sheet and interview schedule that talking about experiences of voice dialogue and related events may be mildly distressing for participants. Within the interview, participants are invited to think about a self-care plan during and after the interview. Options such as taking regular breaks and emphasis on opting out of interview questions has also been made to minimise any potential harm to participants. All participants shall receive a debrief at the end of interviews. The project supervisor, Anne Cooke, has also offered to talk to any distressed participant to help them access appropriate support should the above arrangements be insufficient.

2. **Project Information Sheet:**
   a. **It is usually useful to introduce the researcher more fully (trainee, doctorate research and so on) as well as the supervisors and their credentials. Consider and review please.**

   Response: I have included a section at the beginning of the information sheet which reads:
   Hi! Thanks for showing an interest in my project.
   My name is Kerry Middleton and I am a trainee clinical psychologist from Salomons Applied Institute of Psychology (Canterbury Christ Church University). I am conducting this research as part of my Doctoral Dissertation with the support of my supervisors, Anne Cooke (Clinical Psychologist and Principle lecturer at Canterbury Christchurch University) and Rufus May (Clinical Psychologist, Bradford NHS Trust). This information sheet provides an overview of the project, including what it would look like if you were to get involved. If you have any questions, please don't hesitate to get in touch via email: Kerry.j.middleton734@canterbury.ac.uk
   I've also included a photo of myself.

   b. **Consider replacing jargonistic words ('semi-structured interview') with more straight-forward language.**

   Response:
   'Semi-structured interview' – ''semi-structured' removed
   'Demographic information' replaced with- background information e.g. age, gender
   'perceptions' replaced with 'experiences' and 'views'
   'medicalised framework' replaced with 'symptom of illness'
   'factors' removed
   'peer-reviewed' replaced with 'academic'

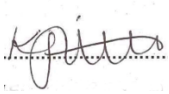
   c. **On page 3: be clear about up to what point withdrawal is possible.**

   Response: I have specified an end date estimated to be towards the end of the recruitment period: 31st July 2020.

3. **Interview Schedule: it would be useful for the panel to have the rationale for the researcher making a disclosure about own family experience in the interview. The panel are wondering about participants who may not want to reveal distressing elements to the researcher, given that it might resonate and be distressing to her. It places the researcher in a position in relation to the experiences that is less objective, in the participants' perceptions potentially. Please consider and feed back to the panel.**

   Response: Advice was provided to share more about my own interests in/ reasons for pursuing the project but I understand how this information might impact on what participants choose to share. I have therefore edited the paragraph so that it reads as follows: I have been interested for some time in the experience of voice hearing, from supporting a relative in the past who hears voices, to working with voice hearers who have accessed mental health services in previous work roles and making connections with the Hearing Voices Network.

Yours sincerely,



Kerry Middleton
Trainee Clinical Psychologist

Salomons Institute for Applied Psychology
Canterbury Christ Church University
Lucy Fildes Building | 1 Meadow Road |Tunbridge Wells | Kent |TN1 2YG
Tel: 01227 927166

Appendix J: *Details of data handling, as submitted in the ethics application*.

All information which is collected throughout the study will be kept strictly confidential. All data (signed consent forms, contact details, audio-recordings and transcripts) will be handled and held securely in accordance with General Data Protection Regulation (GDPR) procedures and the Data Protection Act (2018). Data will be retained for use in future studies for up to 10 years in line with recommendations by the Medical Research Council. Only authorised persons such as researchers, sponsors, regulatory authorities and Research and Development Audit will have access to view the data during this time. After this time, the data will be disposed of in a safe and unrecoverable manner. All potentially identifiable material will be removed from the research report. Each audio-recording of the interviews will be given a numerical identifier rather than the name of the participant and the transcriptions will be anonymised and pseudonyms used in the write up. Audio-recordings will be saved directly onto an encrypted storage device. The transcription and analysis of the interviews will be conducted by the lead researcher (first author) only.

Appendix K: *Research Diary:*

I approached by supervisor, Anne Cooke, in the beginning stages of this project with an interest in wanting to pursue some qualitative work which considered approaches to supporting people with distressing voices that I didn't see happening in mainstream services. Fortunately for me, Anne was in contact with Rufus May, so the decision to think about ways to systematically study the 'voice dialogue method' for voices or 'Talking with Voices' approach which he uses in his practice, started from there.

I've been interested in other therapeutic approaches for voice-hearing for some time, having completed a Masters and work placement in 'Early intervention in Psychosis' at King's College London shortly prior to starting DClinPsy training. I've also grown up with family and friends who hear voices, and became involved in the work of the Hearing Voices Movement, attending their Hearing Voices Group facilitator training in London around 5 years ago and brought voice dialoguing ideas into practice myself as an Assistant. I've loved these ideas and found it a shame that I subsequently didn't come across them as much in my training.

Appendix L: *Dissemination/End of Study Letter for Salomons Institute Ethics Panel, NHS Ethics and/or NHS R & D*

Monday 26th April 2021

Dear Salomon's Ethics Committee

Re. Project: Voice Dialoguing for Distressing Voices. Exploring perspectives from voice hearers and their voices.

I am writing to send a short summary of findings and details of dissemination regarding the above study.

The study's abstract is as follows:

The 'Talking with Voices' (TwV) approach is a novel, formulation-driven approach which is based on an understanding of voice-hearing as essentially relational phenomenon, often linked to trauma. Therapy involves facilitation of dialogical engagement between hearers and their voices. There are as yet few outcome studies. The current study explored experiences of the TwV approach from the perspectives of voice hearers and also of their voices. Ten semi-structured qualitative interviews were subjected to Interpretative Phenomenological Analysis. Participants' experiences appeared to relate to four main themes: 1) Voice dialogue is a powerful enabler of change; 2) A safe base is key; 3) Life circumstances and medicalised services can be barriers to change, and; 4) Good relationships, approach towards underlying ideas, and flexibility are key facilitators of change. The findings provide support for the acceptability and value of dialogical approaches for helping people who hear distressing voices. The study proposes that voices can also share valuable insights and their perspectives should be valued in future evaluation.

I plan to share a summary of findings to all participants who requested ongoing communication about the study via email. We also hope to publish the findings in the peer reviewed journal 'Psychosis' and provide a short presentation submission of the findings to this upcoming online conference on 'Transdiagnostic Approaches to Mental Health' on 23-24 September 2021.

Kind regards,

Kerry

Kerry Middleton
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology
Canterbury Christ Church University
Lucy Fildes Building | 1 Meadow Road |Tunbridge Wells | Kent |TN1 2YG
Tel: 01227 927166