

Running head: INTERACTIONS BETWEEN CLINICIANS AND VOICE HEARERS

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### **Summary of the MRP**

Research has shown that voice hearers wish to discuss their voices, but often feel ashamed of disclosing their voice-hearing experience. Interactions with clinicians can be destigmatising, but unhelpful responses may exacerbate stigma.

A systematic review of qualitative studies used a thematic synthesis to explore voice hearers' and clinicians' perspectives on helpful and unhelpful care. A large-scale mixed-methods study explored clinician attitudes to voice hearers and self-reported responses in interactions.

Clinicians in both parts of the MRP reported difficulties working with voice hearers, including fears and a risk focus, frustration with dominance of the medical paradigm and a lack of availability of other approaches and lacking knowledge of helpful techniques. In addition to these frustrations, research reported that patients thought that unavailable services and coercive or paternalistic practices undermined trust.

Voice hearers and clinicians described helpful approaches, including hopefulness, honesty, empathy, respect and common ground, validation, psychoeducation and normalising. Supervision and reflective practice, values-based work and creativity helped clinicians cope. Training, personal experience with voice hearers and psychosocial professional training were associated with less stigma.

Recommendations include expansion of the peer role, increased staff support and specific voice hearing training, especially for staff in biomedical professions or support worker roles.

**Author's declaration/ copyright statement**

The copyright of this thesis rests with the author. Information derived from it should be acknowledged and cited properly.

**Declaration of interests**

This thesis was sponsored by Canterbury Christ Church University. Data collection for the thesis received recruitment support from the NIHR Clinical Research Network and funding from the Economic and Social Research Council. The secondary supervisor for this thesis is the head of Sussex Voices Clinic, which provides CBT interventions for voice hearers and the author of this thesis worked on placement with the Voices Clinic from 2017-2018.



**Part A**

Voice hearers' and clinicians' views of the relational experience in their interactions

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Journal: Psychosis (please see Appendix D for author guidelines)

### **Abstract**

Research has found that voice hearers consider interpersonal relationships with clinicians to be important to their self-worth, personal recovery, experience of stigma and voice hearing experience. However, individuals with a psychosis diagnosis sometimes experience unhelpful or stigmatising responses from clinicians. This has been proposed to be due to biomedical approaches (Angermeyer et al., 2011), clinician burnout, compassion fatigue or dehumanisation following work stress.

This systematic review used a thematic synthesis with the aim of exploring similarities and differences in service users' and clinicians' perspectives on what constitutes, helps and hinders good care and the therapeutic relationship.

Clinicians and voice hearers both revealed struggles and fears because of the voices, and frustration with the dominance of the medical paradigm but a sense that other approaches were limited. Supervision, reflective practice, values-based work and creativity helped clinicians cope. Service users' coping strategies included social support, challenging and accepting voices. Service users valued clinician hopefulness, honesty, respect and common ground, whereas coercion, unavailable services, and paternalistic approaches undermined their trust. Cross-cultural differences had not been adequately described in the research.

Recommendations include increasing access to training in psychosocial approaches and increased staff support.

*Key words:* hallucinations, voice-hearing, qualitative, clinician, therapeutic relationship

## **Hearing Voices**

Voice hearing, otherwise known as experiencing auditory hallucinations, is an experience in which the voices have an identity, the person has a relationship and what they say is personally meaningful, and the experience has a compelling sense of reality and the experience has a significant impact on the person's life (Beavan, 2011). Prevalence estimates vary widely, ranging from 0.6% to 84%, depending on the population studied, definition used and methodology, with a median of 13.2% (Beavan et al., 2011). Ethnicity appears to play a role, with higher rates found among Caribbean adults (9.8%) than South Asian (2.3%) or 'Caucasian' (4%) individuals in the UK (Johns et al., 2002). Hearing voices is common amongst those with mental health difficulties (Johns et al., 2014; Upthegrove et al., 2015; van Os & Reininghaus, 2016), and is most commonly associated with a diagnosis of schizophrenia (Schneider, 1959), with around three quarters of those with a psychosis diagnosis report hearing voices (Bauer et al., 2011). There is growing evidence for the link between psychosocial factors, especially childhood adversity, and development of a psychosis diagnosis (Longden & Read, 2016)

### **The nature of voices and the nature of diagnosis.**

There are a wide range of individual, social, and cultural views regarding the development of voice hearing (Romme & Escher, 2000). Broadly, neuropsychological models propose that voice hearing is a misattribution of inner speech, whereas many psychological therapy models such as CBT focus on emotional and behavioural reactions to voice content (e.g. Hayward, Strauss, & Kingdon, 2018; Upthegrove, et al., 2015). Social constructionist models focus more on explanations and narratives relating to voice hearing in different historical and social contexts (Leudar & Thomas, 2000). Voice hearers describe developing a relationship with their voices, which often have a characterised identity, a compelling sense of reality and create a significant impact on the voice hearer's life (Beavan, 2011).

Voice hearing does not universally occur in the context of mental health difficulties. So-called 'healthy voice hearers' show similar brain activity, but on average experience less negative content, have more perceived control, have an earlier age of onset, are more likely to believe that the voices have an external origin and have less negative beliefs about voices (Baumeister et al., 2017). In defining the voice-hearing experience as a symptom of an illness, psychiatrists tend to rely on the functional impact that voices can have when making a diagnosis (American Psychiatric Association, 2013). In addition to failing to find a common cause or pathology relating to hearing voices or other psychosis diagnoses, there are further controversies about diagnostic approaches (Cuesta et al., 2009). This has led some to question whether it is meaningful or useful to frame unusual experiences such as voice-hearing as a symptom of a mental illness (Cooke, 2017).

Previous research has explored voice hearers' experiences and have found that the voices are meaningful in relation to life experiences such as trauma or experiencing emotions which are difficult to express (Beavan, 2011; Romme & Escher, 2000), and that voice hearers have found many ways of coping with the voices (Romme & Escher, 1993; 2000; 2006; Romme, Escher and Dillon, 2009).

Many voice hearers reported that they wished to discuss their experiences and that doing so had reduced their anxiety and helped them to cope (Romme & Escher, 1993). From this research, some techniques for clinicians were recommended. These included: understanding symptoms as partly a reaction to current circumstances, treating the voices as real experiences, relating them to the person's experience of life, acknowledging the person's real pain and trauma, and allowing the person to make choices in the therapeutic relationship to help them build a sense of power and control (Romme & Escher, 2000).

## **Stigma**

Around 9 out of 10 people diagnosed with schizophrenia report experiences of stigma and discrimination (Henderson et al., 2012), and stigma is a key concern for service users with a

psychosis diagnosis (Burke et al., 2016). Addressing stigma is one of the World Health Organisation's priorities for mental health in Europe (WHO, 2013). Staff working in healthcare settings have been found to hold some negative attitudes towards mental illness (Hansson et al., 2013; Rao et al., 2009; Ross & Goldner, 2009) which are comparable to the general public (de Jacq et al., 2016), and one in three service users reports having experienced stigma and discrimination from within mental health services (Rethink Mental Illness, 2017). Some of the most negative staff attitudes are directed to persons with a psychosis diagnosis such as schizophrenia (Hansson et al., 2013; Mittal et al., 2014). There has been a burgeoning body of research into clinicians' stigma amongst individuals diagnosed with a psychosis or schizophrenia diagnosis, with reviews finding that schizophrenia may be the most stigmatised diagnosis, and that biological causal beliefs were clearly associated with stigma (Kvaale et al., 2013; Valery & Prouteau, 2020).

A review of qualitative studies by Mestdagh and Hansen (2014) found that discriminatory or stigmatising behaviour is an ongoing issue in the relationship between clinicians and individuals diagnosed with schizophrenia receiving community mental health care. Exploring relational aspects of stigma encounters in daily life, they concluded that the diagnosis was accompanied by a reduction of social contacts, lack of support from their workplace and a sense that the diagnosis was accompanied by violence or unpredictability. Another theme was that of wanting to be taken seriously, but experiencing a paternalistic, overprotective approach from clinicians and those in their social circle. With clinicians, this included a lack of respect or adequate information about their diagnosis or treatment. Structural stigma was apparent in inadequate facilities focused on efficiency rather than good quality care. Patients worried about these stigmatising responses, so tended to conceal their diagnosis, symptoms and medication use and retract from social situations, sometimes compounding the external stigma they experienced (Mestdagh & Hansen, 2014).

Mestdagh and Hansen (2014) also found that participants did experience positive encounters in the mental health system and their social circles. Patients reported that they would

not have encountered one-way care without their diagnosis, and that support received from others helped them to build confidence and cope better with their symptoms.

Wood and colleagues (2015) reached different conclusions in a thematic synthesis of qualitative research exploring stigma in psychosis from a service-user perspective. They used a narrower sample including some different studies. They concluded that mental health services were only one of many societal systems which maintain stigma. Their analysis revealed eight sub-themes which could reduce or increase stigma, including communication, education, acceptance, kindness, and understanding.

A narrative literature review into the relationship between voice hearers' stigma and care seeking (Vilhauer, 2017) has found that stigma may prevent initial disclosure of voice-hearing. This review concurred with Mestdagh and Hansen's (2014) conclusions, finding that internalised stigma can decrease self-esteem, increase isolation, and may impact relationships with the voices which it has been theorised could increase distress.

Attitudes have previously been found to differ cross-culturally among the general public towards mental health difficulties (Seeman et al., 2016) and towards schizophrenia (Furnham & Wong, 2006). A review has found that culture affects the experience, label and understanding of 'hallucinations' among clinical and non-clinical populations (Larøi et al., 2014). Among mental health professionals, cross-cultural differences have also been found towards mental health difficulties (de Jacq et al., 2016), schizophrenia (Furnham et al., 2007; Richards et al., 2014) and 'auditory hallucinations' (Wahass & Kent, 1997).

### **Explanations for stigma**

Previous reviews have found that greater mental health literacy does not always appear to coincide with improved attitudes towards mental health difficulties (Schomerus et al., 2012). It is possible that clinicians faced with patients' trauma histories experience 'vicarious traumatisation' (Trippany et al., 2004), which may be associated with burnout or compassion fatigue (Newell & MacNeil, 2010). Conversely, some clinicians may have protected themselves from such emotional

exhaustion or burnout by distancing themselves from patients' suffering, using 'dehumanisation', and 'infrahumanisation' (Pavon & Vaes, 2017). The ensuing denial of humanness on an individual or group level, respectively, is linked to lack of empathy and understanding (Haslam & Loughnan, 2014), and has been correlated with stigma of mental illness such as fear, pity and social distance (Boysen et al., 2020).

Another factor may be that biomedical explanations seem to be linked to increased rejection and stigma towards schizophrenia (Angermeyer et al., 2011). More recent research corroborates these conclusions, finding that a bio-genetic (rather than a psychosocial) conceptualisation of schizophrenia was associated with dehumanising the person, and more favourable attitudes towards restraint methods (Pavon & Vaes, 2017).

Clinicians' stigmatising beliefs are hypothesised to result in discrimination (Corrigan et al., 2004), for example many individuals with schizophrenia report disadvantageous experiences when accessing healthcare (Corrigan et al., 2014; Harangozo et al., 2014; Sullivan et al., 2015). Disclosure of voice-hearing may be met with negative responses (Romme et al., 2009), which has been found to be associated with internalisation of the stigma, resulting in feelings of shame, an attempt to hide symptoms and a reluctance to seek help (Corrigan, 1998; Vilhauer, 2017; Thornicroft et al., 2007). This internalised stigma may prevent or impede individuals seeking or participating in treatment (Corrigan et al., 2014; Carrara & Ventura, 2018; Clement et al., 2015), and may worsen symptoms and reduce hope, self-esteem and empowerment (Livingston & Boyd, 2010).

To address these negative outcomes, there has been research into anti-stigma interventions for healthcare workers (Choi et al., 2016; Corrigan & Shapiro, 2010; Knaak et al., 2014; Thornicroft et al., 2016). At best, these interventions may increase empathy, understanding and patience (Chaffin & Adams, 2013). Enhanced empathy resulting from these interventions may also improve clinicians' wellbeing (Dal Santo et al., 2014). Although promising, the evidence for these approaches is variable, with small sample sizes, and poor study designs hampering firm conclusions of efficacy being drawn,

especially with regard to maintenance of initial gains (Gronholm et al., 2017; Thornicroft et al., 2016).

### **Changing views of hearing voices**

Traditional approaches to voice-hearing discouraged exploration of the experience; instead seeking to inform voice hearers that their voices are not real and re-focusing them toward a more objective reality (Leudar & Thomas, 2000), which risks invalidating their experiences (Geekie & Read, 2007) which may make them feel worse (Carson-Wong et al., 2018). The treatment focus was on reducing or removing the 'symptom' (Slade & Haddock, 1996).

More recently, research has demonstrated that antipsychotic medications can be associated with many adverse effects and may only help a minority of people (Morrison et al., 2012; Whitaker, 2016). A realisation that voice hearing is more usual in the general population than was previously assumed (Beavan et al., 2011; Baumeister et al., 2017) and that it is possible to live well whilst experiencing voices (Romme & Escher, 1993) has led some to focus instead on what can be done to help voice hearers cope with distressing voices using psychological approaches such as CBT (Hayward et al., 2018). Psychological interventions such as CBT and family therapy are recommended in national guidelines (NICE, 2014). However, individuals have limited access to these recommended therapies through standard services (Ince et al., 2015; Schizophrenia Commission, 2012).

With limited access to formal psychological therapies and with medications not helping a significant proportion of voice hearers, therapeutic relationships with others - such as staff members - become even more important (Gilburt et al., 2008). It is difficult to identify what aspects of stigma may be due to voice hearing as opposed to other aspects of voice hearers' lives such as accompanying symptoms, diagnosis, and effects of causative factors such as disrupted attachments. Nevertheless, this experience is important to explore in voice hearers because the voice hearing experience embodies a relationship between the voice hearer and the voices (Hayward et al., 2015),



and the responses of other people may either help or be detrimental in managing distressing voices. Interpersonal relationships can affect the voice hearing experience, and in particular links have been made between experiences of submission and hostility and voices' characteristics of omnipotence and malevolence (Carvalho et al., 2015); characteristics which have been associated with voice-related distress (Birchwood & Chadwick, 1997). Satisfactory relationships with service providers has been linked to a sense of respect, empowered decision making and sense of self-worth in service users (Clarke, 2014), whereas a systematic review has found that seeing oneself as of low social rank relative to others negatively influences relationships with and perception of voices (e.g. perceptions of the voices as omnipotent) and subsequent relationships with other people (Paulik, 2012). Social support in the early years of mental distress strongly predicts perceived stigmatisation (Mueller et al., 2006), and individuals with a psychosis diagnosis report that acceptance from others can reduce the negative impacts of stigma (Pyle & Morrison, 2014).

Previous research has concluded that mental health service users tend to be dissatisfied with an over-reliance on medicalisation and coercive practices, instead prioritising the therapeutic relationship, self-help groups, psychoeducation, and autonomy (Hopkins et al., 2009; Rydon, 2005). There is now an understanding that voices are meaningful, rather than merely a symptom of illness (Longden et al., 2012; Woods, 2013).

### **Previous research findings of helpful interactions**

A recent systematic review and qualitative metasynthesis suggested that practitioners who maintained a stance of curiosity about potential sources of distress would be perceived as more helpful by individuals experiencing first-episode psychosis (Griffiths et al., 2018). Staff hopefulness, and non-stigmatising approaches appear to be valued by service users (Schizophrenia Commission, 2012). Individuals diagnosed with schizophrenia view their recovery as having been supported by professionals who take the time to talk and make connections with the service users (Williams & Tufford, 2012).

A qualitative study revealed that service users with a diagnosis of schizophrenia perceived the interpersonal aspects of 'good care' to include enthusiasm, belief, positive feedback, concern, listening, truthfulness, dedication, kindness, acceptance and professionalism, advice and suggestions, encouragement to meet goals and promoting independence (Tunner & Salzer, 2006). A previous review found that service users who experienced relationships as positive, therapeutic, and facilitative appeared to have better outcomes (Hewitt & Coffey, 2005).

### **Rationale**

Reviews have concluded that there are very few studies focusing on service users' perspectives of stigma and discrimination (Thornicroft et al., 2016) or of what consumers see as constituting good care, contributing to recovery (Clarke, 2014). However, research suggests that service users' experience of the relationship with their clinicians appears to be important in terms of felt and internalised stigma (Mueller et al., 2006; Pyle & Morrison, 2014), a sense of hopefulness about recovery (Livingston & Boyd, 2010; Schizophrenia Commission, 2012), and a sense of power in their relationship with voices (Paulik, 2012).

In recent years several qualitative studies from different cultures have explored aspects of the relationship between voice-hearing service users and clinicians, including an exploration of stigma. As qualitative studies may focus on particular groups and have small sample sizes, their generalisability can be called into question. Furthermore, international studies may also be considered to have limited relevance to the UK context. The current review seeks to address this by exploring common threads and differences between the studies and between clinicians' and service users' perspectives.

## **Methodology**

### **Aims of the review**

This review explores the relational experience between staff and individuals who hear voices or have a psychosis diagnosis, from both perspectives. It also critically reviews the findings reported and the quality of the studies.

Exploring what happens in the interactions, this review aims to explore:

- Whether stigma plays a role;
- Whether evidence-based and psychological approaches are reported to be used or experienced. This may include whether they are offered formally, or as an underlying assumption behind other interactions;
- What are the common threads or differences between culturally disparate settings?

### **Search strategy**

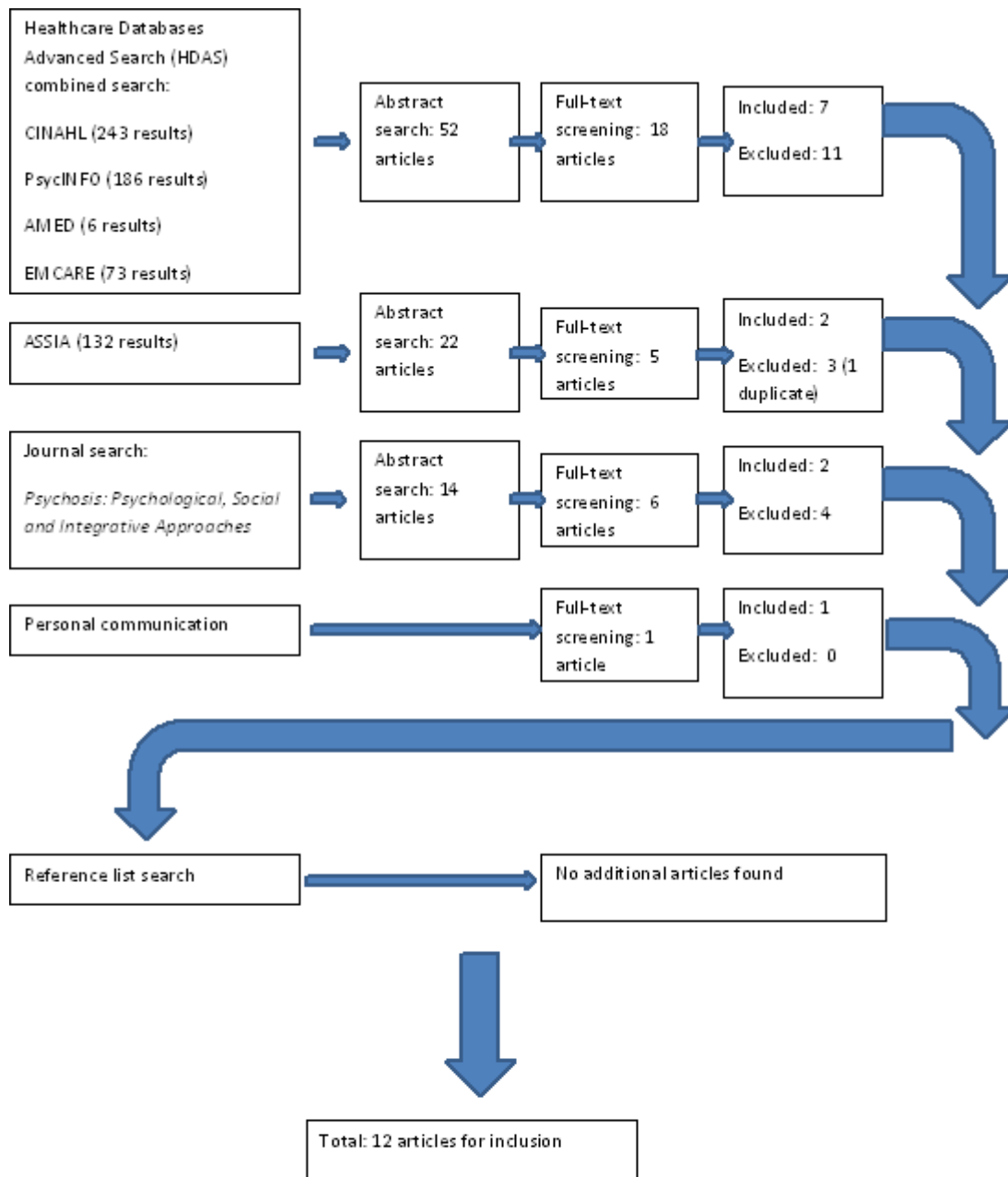
A systematic review was undertaken of the qualitative research exploring the interaction between clinicians and service users who hear voices or have a psychosis diagnosis. The search strategy is outlined below. Please see Appendix A for database search terms.

**Table 1: *Inclusion and exclusion criteria***


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Inclusion criteria:	<ul style="list-style-type: none"> <li>• Peer reviewed journal articles</li> <li>• Qualitative research</li> <li>• Descriptions of the interaction between staff members and individuals with a psychosis diagnosis or voice hearers, from the perspective of the individuals concerned.</li> </ul>
Exclusion criteria:	<ul style="list-style-type: none"> <li>• 'Grey literature': non peer-reviewed and government publications.</li> <li>• Non- English language articles</li> <li>• Articles where the interaction was not the focus.</li> <li>• Qualitative research where there are no human participants <i>per se</i>, e.g. discourse analysis of media sources.</li> <li>• Research where the interaction was interpreted by an independent individual, e.g. participant observation studies.</li> <li>• Articles focusing on family or carers rather than service users themselves.</li> <li>• Book chapters and book reviews.</li> <li>• Articles focusing on the voice-hearer's experience of hearing voices.</li> <li>• Articles focusing on physical health problems.</li> </ul>

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**Figure 1: PRISMA diagram of literature search process**

It must be noted that this literature search may not have been comprehensive, due to lack of clear descriptions of the methodology in the titles, abstract or keywords. This difficulty with qualitative research has been reported previously (Barroso et al., 2003).

Assuming no duplication between databases, the number of citations that met the search terms (640) and the number that met the criteria for inclusion in the review (12) gave a total yield of 1.875%.

### **Quality assessment**

Studies identified for inclusion were appraised using the Critical Appraisal Skills Programme (CASP) criteria (2018), which do not suggest a scoring system. For a list of identified strengths and weaknesses of each paper, please see Table 2.

### **Data extraction and analysis**

Thematic synthesis of the data was carried out according to the stages recommended by Thomas and Harden (2008). Initial codes were recorded from the findings and the quotes in the articles. These were separated between the experiences of staff and service users. The codes were then grouped into descriptive themes. Finally, over-arching analytical themes were identified from the data, in particular paying attention to similarities and differences between clinicians' and service users' experiences. Some of these were immediately apparent from the data, for example opinions and discussions about medication use; whereas some required more interpretation by the author, such as identifying experiences of fear.

## **Results**

### **Overview of the selected papers**

The papers generated from the literature search focused on a diverse array of communication topics and approaches (for a summary of each paper please see Appendix B). All of the studies examined relatively small sample sizes in depth, which is a strength of qualitative research. Although many had limitations, none of these were significant enough to preclude their inclusion in the thematic analysis. Strengths and limitations of the studies can be viewed in Table 2.

**Table 2**

*Strengths and weaknesses of studies selected for analysis*

Study authors	Strengths of study	Weaknesses of study	Implications/ future research recommendations
(Amsalem et al., 2018)	Demonstrates how subtly pessimism and stigma can be transmitted, and how a recovery approach is not being used in initial crucial conversations. Incorporated families' responses.	No bracketing interviews mentioned, potential bias mentioned only briefly in the discussion. Very little information given on considerations of interviewers'/ investigators own role and biases (participants' response bias was referred to in the discussion, and the fact that one of the researchers was a staff member at the hospital where the research was undertaken). Limited demographic info provided. Difficult to generalise, as the results could have been specific to the way that these individuals were treated at that hospital.	Mental health providers' awareness of subtle stigmatising messages should be increased through workshops and professional training.
(Bogen-Johnston et al., 2019)	Information provided on reflexive positioning of the authors. Assessment of the quality and rigour of the analysis was also carried out.	Small sample of practitioners from one NHS service (EIP) in two settings. Limited demographic info provided. Themes and interpretations may be subject to personal preconceptions (although this was mitigated by exploring reflexive positioning).	Recruit practitioners from a broader range of EIP services and explore similarities and differences across services. Focus specifically on barriers and enablers for practitioners to support voice hearers. Explore the service user experience of receiving such support. Explore how practitioners can continue conversations about voices beyond psychological therapy.
(Bogen-Johnston et al., 2017)	Informative study on the factors influencing disclosure of voices. Relevant to service delivery and staff responses.	No discussion about the consideration given to the location of interviews (NHS vs. participant's home), nor to any	A need to explore and challenge barriers to disclosure. Strategies that focus on (1)



Study authors	Strengths of study	Weaknesses of study	facilitating	Implications/ future research recommendations
Bogen-Johnston et al. (2017) cont.		interactions between or influence of the interviewer on the participants. Limited demographic info provided.		hearers to disclose voices at onset and (2) encouraging positive responses from individuals who receive disclosure. Public education about initial symptoms of mental issues and the necessities of early intervention, so that families can facilitate pathways to care and to de-stigmatise. In order to de-stigmatise mental illness, a 'Headspace' model to be introduced, which offers support with a range of health and social care needs. Evaluating the training needs of GPs to address uncertainty around assessing for and discussing voices. Increased provision of training to deliver CBT for psychosis.
(Coffey & Hewitt, 2008)	Interviewing service users and the CMNHs they worked with allowed exploration of different perspectives on the same interactions, especially about professionals' responses to their symptoms.	No interview schedule provided. No information provided about how the researchers considered their own role, potential bias or influence in the study. Limited sample from one area of the UK leads to questions about generalisability. Limited demographic info provided. Focused interview approach may limit alternative avenues of investigation.		A need for mental health nurses to focus on the expressed needs of service users rather than biomedical edicts of psychiatry. Should involve exploration of the content and meaning of voices, with links to past and present experiences and the patient's interpretation. Service user inputs to nurse education.
(Coffey et al., 2004)	Mix of qualitative and quantitative methods aids triangulation of data.	No information about the researchers' own role in the study, including potential biases. Structured nature of		Further research aimed at establishing the influence of personal control upon attempts at coping with hearing voices

Study authors	Strengths of study	the interview schedule may have limited responses. Uncertain Weaknesses of study	may elicit areas in which CMHNS could help (for example supporting Implications/ future research recommendations
Coffey et al. (2004) cont.		generalisability due to small sample from one area of the UK. Limited demographic info provided.	development of personal control and efficacy). Support from other service users in similar circumstances. CMHNS to more flexibly respond to the needs of voice hearers and to explore their experience and meaning of the voices. Specific sample allows depth, and the implications could be (possibly more) relevant to other professions, which may have less provision made for supervision, training or workplace support.
Holtum et al. (2021)	Iterative process of thematic identification, using grounded theory. One strength was that participants were consulted on the model and amendments were made subsequently. The author was aware of her own potential bias. Difficulties were described respectfully.	No details of how the potential for participant distress was dealt with (for example, discussing distressing client experiences or their own difficulties). The impact of the researcher in the interviews was not addressed (e.g. social desirability effects). Limited demographic info provided.	The authors developed an educational programme based on the results of the study, to help nurses identify their preconceptions and work towards developing an equal footing with clients.
(Kakatura et al., 2010)	Provides the perspective from a very different culture, especially relevant given the health care policy differences (28.4 hospital beds per 10,000 people, compared with 7.7 in the US, 5.8 in the UK, and 3.9 in Australia; average hospital stays of 331.6 days). Interesting in that it explores the process of clinicians changing their views towards patients.	The fact that the study has been translated from Japanese may limit understanding of meanings. Small sample size limits generalisability even within Japan. However, it has face validity for generalisability to other countries and settings. No mention made of the researchers' own role in the research and potential biases. Limited demographic info provided.	Interviewer was a psychiatrist however there is no information on the researchers' potential bias in interpreting interviews. Nor about the Recommend improvements in service user involvement in decision-making bodies. Also spending time with patients beyond merely providing evidence-based
(Laugharne et al., 2011)	Exploring power. Rigorous analysis, ensuring saturation was reached and themes were agreed by four researchers.	Interviewer was a psychiatrist however there is no information on the researchers' potential bias in interpreting interviews. Nor about the	Recommend improvements in service user involvement in decision-making bodies. Also spending time with patients beyond merely providing evidence-based

Study authors	A range of service users were interviewed in two areas of the country. Strengths of study	impacts of power relationships in recruitment. Also, very little rationale Weaknesses of study	interventions to build trust and rapport. Greater provision of information to Implications/ future research recommendations
Laugharne et al. (2011) cont.		given for why they researched this topic. Self-selecting sample may have affected findings. Ethnicity provided but no reflection included on the effects of this on power.	patients to help them have more choice. Greater consideration to be given to patients' sense of implicit coercion in relation to involuntary detention. Research recommendations: focus on how patient experience can be improved through the provision of more information and different clinician behaviour.
(Loughland et al., 2015)	Research findings relevant to psychiatrists (it was published in a psychiatry journal). Produced findings from a relatively under-researched area.	Differences in length of time since diagnosis may mean that practices have changed in that time. Difficult to examine recruitment strategy due to this being detailed in another study. Limited demographic info provided.	Communication skills training for psychiatrists, bearing in mind the risk of stigmatising or labelling.
(McMullan et al., 2018)	Researcher conducted a reflexivity interview to consider how her own perspectives may influence data interpretation.	Limited generalisability due to small sample size from one hospital in the UK. The sample only focused on a sample of HSWs and MHNs in hospital. However, homogeneity is key in IPA methodology. Limited demographic info provided.	Greater emphasis on staff supervision and support. Training, alongside ongoing reflection and support around real-life practice.
(Saayman, 2018)	Provides a unique perspective of psychoanalytic therapists' perspectives working with individuals with experiences of psychosis, providing a different focus and language to describe their experiences. Sample being from South Africa provides information from a	Relatively small sample size of therapists in South Africa may limit generalisability, although some findings echo other studies' findings. It is unclear to what extent the findings are generalisable to the UK, as this is not a NICE-recommended therapeutic	Further investigation into somatic phenomena experienced by the patient and the therapist.

Study authors	Strengths of study	Weaknesses of study	Implications/ future research recommendations
Saayman (2018) cont.	setting with cultural differences from Europe or Australia.	approach for psychotic experiences. Many aspects of the study methodology were unclear; for example, in the results section it was unclear what was a summary of the theme emerging from the interviews, and what was from previous literature. Some of the language appears disrespectful, such as the use of 'madness', and negative language used about clients quoted from interviews.	
(Topor & Denhov, 2015)	Study has clear relevance to practice, detailing what clinicians can do to contribute to recovery. Has implications for what is typically thought of as good practice, such as 'maintaining boundaries'.	Data was used from a previous study, so some aspects of the study methodology were unclear, such as ethical consent (presumably these were described in one of the three previous publications). Swedish study may limit generalisability to the UK due to cultural and organisational differences, however the findings have face validity for being generalisable.	Implications for professional work, situating the service user in the context of their personal history and social situation, acknowledging their resources as well as their difficulties in life, and enabling staff members to have a more human relationship without this being seen as a risk factor.

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(White et al., 2019)	Considered data saturation. Researcher kept a reflective diary to ensure bias in interpretations was minimised. A recently published study, this provides information about nurses who have recently qualified, allowing an understanding about whether current training programmes affect their exploration of voice hearing.	Did not use a particular methodology, however the authors did provide a justification for this. Small study using a self-selecting sample. To preserve confidentiality many demographic characteristics were not reported.	Further investigation into nurses' preparation and support for working with voice hearers, and into putting their knowledge and skills into practice. Changes need to be made in the prevailing culture to enable newer colleagues to put their skills into practice, and for more experienced nurses can respond to evidence-based approaches.
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## Cross cultural aspects

Of the twelve articles, two were from Australia, one from Israel, one from Sweden, one from Japan, one from South Africa, and the remaining seven were from the UK. Although there were similarities for many of the papers, two stood out as having significantly different approaches.

The Japanese study by Kakatura and colleagues (2010) highlighted that the Japanese healthcare system has a significantly higher number of hospital beds and longer hospital stays than many other countries. This service context appeared to link with clinicians' expectations of clients needing to be protected and being unable to make decisions.

The South African study by Saayman (2018) was notable both in the fact that the participants were psychoanalysts, therefore from a different professional group from the other papers. The study was notable in the language used, which may appear disrespectful, for example: "madness", "creepy", and "it made my skin crawl". It was unclear to what extent this was due to cultural differences, or to the professional group not wishing to censor their genuine experiences (although another study with psychodynamically trained participants used much more respectful language; Holtum et al., 2021).

## Thematic summary

**Table 3**

*Themes identified in the analysis*

Key theme	Subthemes
1. Struggles, fears and managing difficulty	Struggles and fears Avoidance and control Values-led coping Service users: resistance, responsibility and revealing difficulties
2. Approaches to help with voices	"Medication is only one part of the treatment that should be given" Psychological approaches: swimming against the tide Other approaches: "Ignore, distract... doesn't work for everyone" Lacking confidence
3. Communication between clinicians and service users	Conversations about voices Communication and personal experience

#### 4. Building trust and connection

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### **Theme 1: Struggles, fears and managing difficulty**

#### ***Struggles and fears***

Working with voice hearers could be difficult for some clinicians, for example when the voices were present, “sometimes in the sessions she’d talk to them”, and working with stresses in clients’ past or present (Holtum et al., 2021). Clinicians described feeling shocked, disturbed, and potentially traumatised in response to witnessing voice hearers’ distressing experiences (McMullan et al., 2018). Symptoms of psychosis were seen as “alien, uncanny and way out there” (Saayman, 2018), and the unpredictable and sometimes unsafe and violent nature of the work meant that clinicians were confused (McMullan et al., 2018), scared (White et al., 2019) and “on tenterhooks” (McMullan et al., 2018). Clinicians described fears of being “sucked into something dangerous”, that boundaries were not maintained, and reality distorted (Saayman, 2018). They emphasised the physical impact of working in this environment as their own body shutting down, and a sense of “dead heaviness” (Saayman, 2018). Art therapists similarly struggled with their emotional responses to their work, saying “the whole thing was a struggle”.

Clinicians also described feeling guilt that they had “let them down” or “not been there enough” (McMullan et al., 2018), sometimes because of organisational pressure to see people short-term (Holtum et al., 2021).

#### ***Avoidance and control***

In response to fears and anxieties raised in clinicians, the need to “disidentify with such patients is very strong” (Saayman, 2018). Clinicians expressed difficulties overcoming their fear: “If I feel so scared [. . .] how am I supposed to be helping this person?” (White et al., 2019). The fear and not knowing what to do was associated with a sense of powerlessness (White et al., 2019). Some

clinicians avoided sharing accurate information with clients due to the fear that it could “antagonize people” and lead to assaults (Outram et al., 2014).

In response to consumers’ distress being perceived as out of the clinician’s control, some clinicians “focused on external control and talked about the use of force, or restraint to restore order”. A medical framework was sought by CMHNS to help them manage feelings of performance anxiety and self-doubt and make sense of voice-hearing experiences.

### ***Values-led coping***

Clinicians used their values and skills in positive ways to help them cope. Some clinicians managed their fear through a sense of duty and responsibility to protect the voice hearer, other service users, colleagues and themselves (McMullan et al., 2018). Art therapists described clients’ intense emotions as being channelled and processed through the art, and that therapy was often calming so that after some time “they’ll be much more able to talk ordinarily” (Holttum et al., 2021).

Some clinicians appeared to have more psychologically-informed ways of coping. One clinician described “needing to ground themselves on a daily basis” (Saayman, 2018). Reflective practice was used by some clinicians to help them make sense of voice hearing from a psychological perspective (McMullan et al., 2018), whereas art therapists reported art making, personal therapy and clinical supervision helped them to process emotions (Holttum et al., 2021).

### ***Service users: resistance, responsibility and revealing difficulties***

Fears of the voices and experiences were reflected by the experience of voice hearers, who tended to see the voices as malevolent and omnipotent. Their desire to gain personal control over the experience led to attempts to resist the voices (Coffey et al., 2004). Service users appeared to feel a responsibility for the effect that their experiences could have on others. They feared that disclosure of their voice hearing could “cause anguish to, or place a burden on others” (Bogen-



Johnston et al., 2017). Gradually, however, they would open up to those closest to them (Bogen-Johnston et al., 2017).

## **Theme 2: Approaches to help with voices**

### ***“Medication is only one part of the treatment that should be given”***

Both groups (service users and professionals) described medication as being the standard response to voice hearing and other experiences (Coffey et al., 2004; White et al., 2019), with PRN (as required) medication being the most usual way to address consumer distress (White et al., 2019). Service users sometimes accepted biomedical explanations, and sometimes refuted these constructions (Coffey & Hewitt, 2008).

Both service users and staff described frustration with the medical focus of interventions (Coffey et al., 2004; Coffey & Hewitt, 2008), “I think medication is only one part of the treatment that should be given” (service user; Coffey et al., 2004). Art therapists described a sense that the current provision isn’t adequate, and indeed may be traumatising for service users (Holttum et al., 2021). Service users talked about the limited effects of medication and the fact that staff responses were often limited to recommending medication or making an appointment with the consultant (Coffey & Hewitt, 2008). Clinicians described the lack of certainty relating to providing a diagnosis and an awareness that medication was not useful for all clients (Outram et al., 2014).

Psychiatrists were seen by service users as “more concerned with the illness than the person”, whereas case workers and psychologists were perceived as “taking the time” to get to know you. (Loughland et al., 2015). For those who wished to discuss medication, the flexibility of CMHNS to respond was considered helpful, rather than having to wait for an appointment with a consultant (Coffey & Hewitt, 2008).

### ***Psychological approaches: swimming against the tide***

It was notable that there was limited access to CBT, despite a desire expressed by voice hearers to learn more about it (Coffey & Hewitt, 2008). One mental health nurse who had been trained in CBT even doubted the rationale for a psychological model for voices and also his own competence to deliver voice-related therapy (Bogen-Johnston et al., 2019). Art therapists were proud of promoting a psychosocial approach, but were aware that this involved “swim[ming] against the tide” and expressed fears that “we can easily be cut from services” (Holttum et al., 2021). However, they expressed optimism that there was increasing awareness about the varied causes of mental distress, “I think it’s more of an awareness [...]. At the root cause of most mental distress is trauma [...] and that is changing rapidly, the thinking” (Holttum et al., 2021).

***Other approaches: “Ignore, distract... doesn’t work for everyone”***

Non-directive counselling, talking to and being with the consumer were considered by staff to be significant ways to reduce distress (Coffey et al., 2004; White et al., 2019). Consumers perceived this to be the only other intervention staff would use, other than medication, and saw this limited repertoire as posing a barrier to coping with voices (Coffey et al., 2004; Coffey & Hewitt, 2008).

Clinicians and service users both reported that clinicians used a range of other responses, including adopting a wait-and-see policy to assess change, increasing visits, asking clients to keep a diary, encouraging service users to use their own coping strategies, taking a normalising approach (Coffey et al., 2004; Coffey & Hewitt, 2008), diverting their attention away from the voices, reality testing and the use of earphones while listening to music (White et al., 2019). However, some doubted how successful these techniques were, “when I started even just a few years ago a lot of it was just ignore, distract... which doesn’t work. Or doesn’t work for everyone” (White et al., 2019). Clients themselves reported using a variety of coping strategies including social support, challenging voices or not letting them take control, and accepting the voices, “you can’t run away from something that’s happening... you’ve got to face up to it” (Coffey et al., 2004).

### ***Lacking confidence***

While some clinicians did feel confident working with voices, many lacked confidence to work with voices and other unusual experiences (Bogen-Johnston et al., 2019). Staff members described lacking skills (White et al., 2019), questioning their own capabilities and fearing that they might be exposed as incompetent workers, asking “what am I doing? What am I achieving here?” (McMullan et al., 2018). They described feelings of helplessness, not knowing what to say to reduce voice hearers’ distress (McMullan et al., 2018; White et al., 2019). Those who had received therapy training said that it had developed their “confidence to do a bit more”, but felt that they needed to gain experience, “muddle through” and “moderate your technique”, as well as being influenced by training by mental health system survivors and awareness of the Open Dialogue approach (Holttum et al., 2021; Seikkula et al., 2011). One clinician who had received training in working psychologically with voices described lacking confidence:

“I’d probably say that it’s something I don’t feel too skilled in and slightly fearful of (breathes in) I suppose I do have a slight fear of making them [the voices] worse for people”. (Nathan, Mental Health Nurse; quotation from (Bogen-Johnston et al., 2019).

Staff members’ reported lack of confidence in implementing psychological approaches was reported to be partly due to workplace culture presenting a barrier to this approach (White et al., 2019).

## **Theme 3: Communication between clinicians and service users**

### ***Conversations about voices***

Clinicians were generally supportive about the idea of talking about voices but saw limitations in their ability to offer this treatment (Coffey et al., 2004). In terms of opening up conversations, it was sometimes assumed that this would have already occurred, perhaps during the assessment process (Bogen-Johnston et al., 2019). Clinicians found that although many service users

were candid in disclosing voice hearing, some found it difficult to express their experiences (Bogen-Johnston et al., 2019).

CMHNs dismissed the possibility that voices had meaning located in past experiences with “astonishing assurance” (Coffey & Hewitt, 2008, p.1595), or feared that they might make things worse by opening up discussions about the content of people’s voices (McMullan et al., 2018; White et al., 2019).

Some clinicians described the importance of having a deeper conversation, “people who kind of want to engage in looking at kind of the meaning within those voices... I think for those who don't engage in that kind of work, I find that the kind of anxiety and fearfulness maintains itself more” (Bogen-Johnston et al., 2019). Clinicians recognised that there has been a shift in thinking towards discussing the content and meaning of voice and that to do so, they will have to overcome their own anxieties (Coffey & Hewitt, 2008).

Some clinicians appeared very aware of the potential for conveying hopelessness and stigma through a diagnosis. Some responded to this by trying to protect patients by avoiding giving a diagnosis (Outram et al., 2014). Some clinicians also described lack of insight as a barrier to open communication, whereas others felt that it was best to be open and honest, knowing that this can give the service user power and can enable them to access further information (Outram et al., 2014).

Whilst service users expressed a desire to discuss the content and meaning of their voices in more depth (Coffey & Hewitt, 2008), and that this improved their ability to cope, they experienced CMHNs as having very little direct engagement with the voice hearing (Coffey et al., 2004).

### ***Communication and personal experience***

Service users reported appreciating open communication, in which they were treated respectfully, provided with adequate information and with a sense of empathy and hope (Loughland et al., 2015). However, in one study service users reported having the impression that their lived experience was not relevant and that the doctors knew what was right for them. The authors

concluded that this message had been internalised, so that they felt their opinions were not worthwhile, “Whatever I think, they (the treating psychiatrists) are the professionals. Not me. I believe everything they said, I don’t have a choice.” They reported sometimes receiving the impression that their diagnosis meant they had no hope for recovery (Amsalem et al., 2018).

Clinicians’ personal disclosures, when used without burdening the service user with the professional’s problems, were seen as helpful by service users in two studies (Laugharne et al., 2011; Topor & Denhov, 2015); for example, sharing a common experience or interest which helped the service user to know that they were seen as more than just their illness (Topor & Denhov, 2015). Conveying a sense of getting something for themselves (e.g. enjoyment) from the relationship and going beyond usual expectations of clinicians in that setting helped service users to feel valued (Topor & Denhov, 2015). Having developed a strong therapeutic relationship with the clinician opened up communication (Loughland et al., 2015).

#### **Theme 4: Building trust and connection**

Trust was reported from both sides to be important in the interaction, with reciprocity being important (Laugharne et al., 2011). Art therapists saw their main task as finding a way of building a relationship, connecting, being there for the client as a consistent listening figure, to allow them to share experiences that needed attention such as trauma and to consider alternative perspectives (Holtum et al., 2021). They also focused on supporting clients’ personhood and their goals and agency. However, therapy did not always run smoothly and some clients did disengage, which therapists sought to learn from (Holtum et al., 2021). From some clinicians’ perspective, trust, respect and a sense of equal footing were earned by demonstrating abilities to cope with daily life and not always to accept suggestions for support (Kakatura et al., 2010). This helped clinicians to re-evaluate their own preconceptions about the client’s abilities and support the client’s wills and wishes (Kakatura et al., 2010).

Clinicians often reported feeling close and connected with voice hearers (McMullan et al., 2018), and an awareness that this helped consumers share their vulnerabilities such as voice-hearing experiences (Bogen-Johnston et al., 2019; White et al., 2019). Conversely, some clinicians had felt disconnected and rejected, kept “at arm’s length”, with voices or other unusual experiences seen as a barrier to connection (McMullan et al., 2018; Saayman, 2018). One clinician reported that having taken part in a hearing voices simulation had helped him to better understand and develop rapport with clients (White et al., 2019).

Service users described several factors which helped build their trust in clinicians, including professional expertise, a caring and kind attitude, continuity of care, reliability, honesty and delivering promises, listening to the patient, and positivity about the future (Laugharne et al., 2011).

Service users also reported several factors which undermined their sense of trust in services. Some of these were related to organisational factors, such as a history and threat of coercion (e.g. compulsory detention), perceived neglect when unwell (“there’s no one to help me manage”) and high staff turnover (Laugharne et al., 2011). Relying only on a medical model of care also undermined trust, “Their knowledge is restrictive, it’s created a sense of reality for them and their society which is only partial truth.” (Laugharne et al., 2011). Some service users felt that they were not trusted to have the insight or capabilities to be informed about or discuss their condition. This led to them feeling patronised and not treated with respect (Amsalem et al., 2018).

## **Discussion**

This review aimed to explore whether stigma, evidence-based and psychological approaches were evident in the relational experience between staff and individuals who hear voices. It also aimed to explore similarities between culturally disparate settings. Key themes elicited from the studies were: fears and managing anxieties, approaches to help with voices, communication between clinicians and service users, and building trust and connection.

## Stigma

A key aspect of stigmatising beliefs was revealed in clinicians' sense of fear, danger and powerlessness working with voice hearers. They described the unpredictable or violent nature of the work and feeling overwhelmed by their empathic engagement with clients' voice hearing or traumatic experiences. Themes of lack of control, ongoing struggle and sometimes feeling overwhelmed echo previous findings of voice hearers' experiences of relationships with their voices (Tully et al., 2017). Clinicians' perspectives may be understood in the light of the reality of violence and aggression experienced by many NHS staff (NHS, 2021), and a situation where "too many... wards have become frightening places where the overwhelmed nurses are unable to provide basic care and support" (Schizophrenia Commission, 2012, p. 4).

Disruption to clinicians' basic needs for safety and control may contribute to vicarious traumatisation (Trippany et al., 2004). The fears of "being sucked into something dangerous" and feelings of "dead heaviness" that Saayman (2018) reported may be representative of the exhaustion and negativity associated with burnout (Maslach et al., 2001; World Health Organisation, 2019). Previous research has found high rates of burnout among mental health staff (Jenkins & Elliott, 2004) and turnover amongst staff is high (Rethink Mental Illness, 2017). Recent figures have shown a 12.63% reduction in mental health nurses since 2010 (NHS Confederation, 2017).

It is possible that in response to fears and anxieties, dehumanising and coercive practices are elicited, such as such as "the use of force, or restraint to restore order" (White et al., 2019). Some clinicians described holding on to biomedical or external control approaches to provide them with a sense of security (McMullan et al., 2018; White et al., 2019). This adherence to rules and procedures as a way of managing anxiety is reminiscent of Lyth's findings from over 60 years ago (Lyth, 1960). Crawford and colleagues (2002) have noted that CMHNs may resist incorporating evidence-based practice as a means of retaining control over their working lives. This resistance to change was also described by Lyth (1960) as a social defence against anxieties. Although it would be hoped that

approaches change over time, the experience of newly qualified mental health nurses was that the prevailing culture prevented them from implementing some of the psychological approaches they had been taught (White et al., 2019).

As adverse psychosocial experiences and interpersonal relationships have been linked to aversive voice hearing experiences (Beavan et al., 2011; Romme & Escher, 2006) and in particular hostility and coercive behaviours from others linking to malevolent and omnipotent voices (Carvalho et al., 2015), these responses are of concern. However, it was encouraging that many clinicians and voice hearers reported positive encounters, for example helping voice hearers to cope better, echoing previous findings by Mestdagh and Hansen (2014). A clinician focus on developing positive relationships, self-help groups, providing psychoeducation and promoting autonomy would be preferred by service users (Hopkins et al., 2009; Rydon, 2005), may help reduce experienced stigma (Clarke, 2014) and may even reverse some of the harm previously enacted.

### **Biomedical approaches**

The prioritisation of the medical model over other approaches was a source of frustration for many clinicians and service users (Coffey et al., 2004; Coffey & Hewitt, 2008; Holttum et al., 2021; Outram et al., 2014; White et al., 2019), echoing previous findings (Hopkins et al., 2009; Rydon, 2005). Some within the psychiatry profession were identified as dehumanising, “more concerned with the illness than the person” (Loughland et al., 2015) and paternalistic, for example attempting to protect patients from their diagnosis (Outram et al., 2014). This echoes previous research which has found dissatisfaction with purely medical approaches (Hopkins et al., 2009; Rydon, 2005), but may also represent aspects of burnout, which a meta-analysis has concluded is high amongst this professional group (Rotstein et al., 2019).

Some service users may respond to these approaches by adopting perspectives that others may see them as dangerous or that they did not have a right to say what was right for them (Amsalem et al., 2018). This ‘self-stigma’ corresponds with Mestdagh and Hansen’s (2014) findings



that service users' responses to others' stigma sometimes compounded the isolation associated with the diagnosis and symptoms, and may hinder recovery (Vass et al., 2017).

### **Psychosocial approaches**

There was a notable lack of confidence and perceived lack of organisational support for clinicians offering psychological interventions. Further, clinicians described a lack of confidence in abilities to talk about and work with voices. It is encouraging that training and consolidation in subsequent experience seemed to help some (Holttum et al., 2021; White et al., 2019). Clinicians described being reluctant to open up conversations about voices for fear of making things worse. This suggests that they lacked skills and information about the benefits of discussing the meaning and content of voices and were unaware of the fact that service users may desire these conversations. Using a tool to guide conversations about voices, such as the Maastricht Interview (Romme & Escher, 2000) or the Auditory Hallucinations Interview Guide (Trygstad et al., 2015) may help clinicians to feel more comfortable about these conversations which can also guide subsequent interventions (Trygstad et al., 2015).

There was a mismatch between clinicians' and service users' perspectives about the range of psychosocial approaches offered to help patients cope with voices. While clinicians described a range of interventions (Coffey & Hewitt, 2008; White et al., 2019), service users viewed non-directive counselling as the only non-medical intervention that clinicians used (Coffey & Hewitt, 2008) and experienced clinicians as rarely engaging with the voice hearing experience (Coffey et al., 2004). Service users had developed their own coping strategies for dealing with voices (Coffey et al., 2004) which echoed those found in previous research of voice hearers' coping strategies (Romme et al., 2009).

Service users appreciated open communication, feeling valued (Loughland et al., 2015), and getting to know clinicians (Laugharne et al., 2011; Topor & Denhov, 2015), approaches which have previously been found to support recovery (Williams & Tufford, 2012). Clinicians also described

valuing the close relationships developed with service users when they were able to overcome barriers to connection (McMullan et al., 2018; Saayman, 2018). Destigmatising approaches such as these may help service users to share their voice hearing experiences (Bogen-Johnston et al., 2017) and reduce the sense of isolation associated with diagnosis, symptoms and accompanying stigma, and helping them to build confidence, as previously reported by Mestdagh and Hansen (2014). It was encouraging that clinicians expressed a desire to destigmatise their practice, for example developing relationships on a more equal footing (Kakatura et al., 2010), as positive relationships have been linked with better outcomes (Hewitt & Coffey, 2005).

### **Cross-cultural differences**

The study by Kakatura and colleagues (2010) was the only one which described the care context in cultural terms, and only Laugharne and colleagues (2011) detailed ethnicity. This review did not identify any notable cultural differences between 'westernised' countries (UK, Australia, Israel and Sweden), possibly due to the globalisation of mental health care practice. (White, 2013) White (2013) has opined that this homogenisation of mental health care may not be beneficial, especially if it entails an increasing medicalisation of mental health difficulties and a disregard for cultural factors.

Some studies may not have detailed demographic characteristics to maintain confidentiality, as Coffey and Hewitt (2008) suggest. It is also possible that this was not highlighted be due to an assumption amongst the researchers that cultural or ethnic differences did not play a factor. This was unexpected, as one of the strengths of qualitative research is the appreciation of the importance of context and the social constructionist stance (Roller & Lavrakas, 2015). Previous research has found different attitudes between societies (de Jacq et al., 2016; Richards et al., 2014; Seeman et al., 2016; Wahass & Kent, 1997) and within multi-racial societies (Furnham & Wong, 2006; Furnham et al., 2007). Further, the intersectionality of mental health with other marginalising characteristics of patients (or clinicians) may have an impact on the power differential between

these groups (Cleary et al., 2014; Rosenfield, 2012). Therefore, this apparent lack of consideration represents an omission.

### **Limitations of the review**

The findings from this review provides a useful starting point to understand the relational experiences from the perspectives of both clinicians and service users. However, as there were relatively few studies found, some conclusions, such as cross-cultural differences, were based on small and specific samples.

The present review presents an artificial distinction between clinicians and service users/voice hearers, whereas clinicians frequently have lived experience of mental health difficulties (in2gr8mentalhealth, 2021), and the role of peer workers is expanding (NHS, 2019). Nevertheless, it may be that individuals with dual roles also face similar challenges depending on the role they are inhabiting at that time.

The present review did not consult or collaborate with experts-by-experience which was a regrettable oversight. Given that seeing oneself as a low rank to others has been associated with negative aspects of voice hearing (Paulik, 2012), social inclusion such as involving voice hearers in research may help to boost their self-esteem and support recovery (Berry et al., 2010). Further, it would have enriched the work by providing alternative perspectives (Minogue et al., 2005).

As the themes in the present review were identified manually, it is possible that researcher bias affected the findings. This was minimised by having oversight by a second researcher (SH), but nevertheless using computer software, in line with previous research (Mestdagh & Hansen, 2014; Thomas & Harden, 2008) may have further minimised any bias.

### **Service implications**

Service users provided many examples of factors which helped them to build trust in clinicians and services, which included a caring, kind and empathic attitude, respect, honesty, hopefulness, listening and providing adequate information to inform them of their condition,

echoing previous review findings relating to stigma (Mestdagh & Hansen, 2014; Wood et al., 2015). Stigmatising practices such as coercion and exclusively relying on the medical model to explain their experiences, along with a high staff turnover served to undermine trust (Laugharne et al., 2011).

In this review, service users appeared to be in the role of passive recipients of care and support from clinicians, with little power over their treatment. Providing treatment options, for example psychological therapy to address early trauma experiences or develop coping strategies, may help individuals to gain a sense of power and control (Romme and Escher, 2000).

If clinicians are reaching a stage of compassion fatigue or burnout, it is difficult for them to maintain more positive approaches. Organisations may help clinicians to provide a good service by supporting coping strategies, including values-based working, grounding, personal therapy, reflective practice and clinical supervision. Both clinicians and clients seemed to benefit from emotional expression in another medium (art), so encouraging creativity may also help. Supporting clients to build upon existing coping strategies may be helpful (Hayward et al., 2018; Romme & Escher, 2000).

It was encouraging to find that one clinician reported that an anti-stigma intervention – a voice-hearing simulation – had enabled him to better understand and build rapport with clients (White et al., 2019). Training one person at a time in a psychological approach appeared to leave clinicians lacking confidence; it may be that building a culture in which clinicians support each other to think reflectively about psychological responses to voice hearing could be helpful, as suggested by Holttum and colleagues (2021).

The findings of the current review would suggest that clinicians gain positive feelings from building trust and connection with service users, which may prove protective against burnout. Adequate staffing and high levels of support from colleagues may also be protective against burnout (Jenkins & Elliott, 2004). Ensuring adequate facilities focused on good quality care would reduce the structural stigma this group suffers from (Mestdagh & Hansen, 2014).

### **Suggestions for further research**

The bulk of the studies featured in this review pertained to clinicians' perspectives. In exploring differences in the viewpoints of both clinicians and service users, Coffey and Hewitt (2008) provided a useful insight into the limitations of exploring only one perspective, especially when exploring relational issues. More research incorporating both perspectives would allow more exploration of differing opinions.

A limitation of many of the studies was a lack of consideration of demographics such as ethnicity and sexuality. There was no apparent consideration of how this 'intersectionality' (Seng et al., 2012) may have impacted on relationships between patients and staff. Further research would benefit by taking these factors into consideration, and there remains a gap in the literature specifically exploring these factors amongst voice hearers.

The small sample sizes and specific nature of the groups studied provided depth. Larger-scale, mixed methods research would allow exploration of some of the themes identified within this review in more detail.

## **Conclusion**

This review provided an exploration into the similarities and differences between voice hearers' and clinicians' viewpoints on what takes place in their interactions. Stigmatising beliefs seemed to arise in conjunction with clinicians' fears, uncertainty and lack of confidence in many aspects of their work. They described frustration with the medical approach but struggled to provide psychological interventions and other approaches in a culture which was not supportive of this. Service users did not always recognise the techniques clinicians were trying to use, feeling that the medical approach was paramount and that voices were not explored. They had developed coping strategies including social support, challenging voices, not letting them take control and accepting the voices (Coffey et al., 2004). Voice hearer described lacking power in their relationships, especially with psychiatrists, but appreciated positive communication with clinicians on an even footing. Both groups described building positive therapeutic relationships as satisfying.

There is a need for more research exploring these perspectives, and into understanding the impact of marginalising identities on interactions between patients and staff. Further research into influences on clinicians' stigmatising responses is also recommended.

Clinicians may help service users' recovery by being more explicit about the interventions they are offering to clients, developing upon existing coping strategies and working co-operatively with them to empower them to manage symptoms, rather than turning to coercive treatment approaches.

Providing training for working constructively with voices, especially early in clinicians' careers, alongside supportive practices including may help them to avoid stigmatising or reaching burnout.



## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D.C.: American Psychiatric Association.  
<https://doi.org/https://doi.org/10.1176/appi.books.9780890425596>
- Amsalem, D., Hasson-Ohayon, I., Gothelf, D., & Roe, D. (2018). Subtle ways of stigmatisation among professionals: The subjective experience of consumers and their family members. *Psychiatric Rehabilitation Journal, 41*(3), 163-168.  
<https://doi.org/http://dx.doi.org/10.1037/prj0000310>
- Angermeyer, M., Holzinger, A., Carta, M., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: A systematic review of population studies. *The British Journal of Psychiatry, 199*, 367-372. <https://doi.org/10.1192/bjp.bp.110.085563>
- Barroso, J., Gollop, C., Sandelowski, M., Meynell, J. P., & Collins, L. (2003). The challenges of searching for and retrieving qualitative studies. *Western Journal of Nursing Research, 25*(2), 153-178.
- Bauer, S., Schanda, H., Karakula, H., Olajossy-Hilkesberger, L., Rudaleviciene, P., Okribelashvili, N., . . . Stompe, T. (2011). Culture and the prevalence of hallucinations in schizophrenia. *Comprehensive Psychiatry, 52*, 319-325. <https://doi.org/10.1016/j.comppsy.2010.06.008>
- Baumeister, D., Sedgwick, O., Howes, O., & Peters, E. (2017). Auditory verbal hallucinations and continuum models of psychosis: A systematic review of the healthy voice-hearer literature. *Clinical Psychology Review, 51*, 125-141.  
<https://doi.org/http://dx.doi.org/10.1016/j.cpr.2016.10.010>
- 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.



- Berry, C., Gerry, L., Hayward, M., & Chandler, R. (2010). Expectations and illusions: A position paper on the relationship between mental health practitioners and social exclusion. *Journal of Psychiatric and Mental Health Nursing*, 17, 411-421. <https://doi.org/10.1111/j.1365-2850.2009.01538.x>
- Birchwood, M., & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine*, 27(6), 1345–1353. <https://doi.org/10.1017/S0033291797005552>
- Bogen-Johnston, L., de Visser, R., Strauss, C., Berry, K., & Hayward, M. (2017). "That little doorway where I could suddenly start shouting out": Barriers and enablers to the disclosure of distressing voices. *Journal of Health Psychology*, 1-11. <https://doi.org/10.1177/1359105317745965>
- Bogen-Johnston, L., de Visser, R., Strauss, C., Berry, K., & Hayward, M. (2017). "That little doorway where I could suddenly start shouting out": Barriers and enablers to the disclosure of distressing voices. *Journal of Health Psychology*, 1-11. <https://doi.org/10.1177/1359105317745965>
- Bogen-Johnston, L., deVisser, R., Strauss, C., & Hayward, M. (2019). A qualitative study exploring how Practitioners within Early Intervention in Psychosis Services engage with Service Users' experiences of voice hearing? *Journal of Psychiatric and Mental Health Nursing*, 27(5), 607-615. <https://doi.org/https://doi.org/10.1111/jpm.12612>
- Boysen, G., Isaacs, R., Tretter, L., & Markowski, S. (2020). Evidence for blatant dehumanization of mental illness and its relation to stigma. *The Journal of Social Psychology*, 160(3), 346-356. <https://doi.org/https://doi.org/10.1080/00224545.2019.1671301>
- Burke, E., Wood, L., Zabel, E., Clark, A., & Morrison, A. (2016). Experiences of stigma in psychosis: A qualitative analysis of service users' perspectives. *Psychosis*, 8(2), 130-142. <https://doi.org/http://dx.doi.org/10.1080/17522439.2015.1115541>

- Carrara, B., & Ventura, C. (2018). Self-stigma, mentally ill persons and health services: An integrative review. *Archives of Psychiatric Nursing, 32*, 317-324.  
<https://doi.org/http://dx.doi.org/10.1016/j.apnu.2017.11.001>
- Carson-Wong, A., Hughes, C., & Shireen, R. (2018). The effect of therapist use of validation strategies on change in client emotion in individual DBT treatment sessions. *Personality Disorders: Theory, research and treatment, 9*(2), 165-171.  
<https://doi.org/https://doi.org/10.1037/per0000229>
- Carvalho, C., Motta, C., Pinto-Gouveia, J., & Peixoto, E. (2015). Hallucinatory activity in schizophrenia: The relationship with childhood memories, submissive behaviour, social comparison and depression. *World Academy of Science, Engineering and Technology, 9*(5), 401-409. <https://doi.org/http://hdl.handle.net/10400.3/3991>
- Chaffin, A., & Adams, C. (2013). Creating empathy through use of a hearing voices simulation. *Clinical Simulation in Nursing, 9*, e293-e304. <https://doi.org/10.1016/j.ecns.2012.04.004>
- Choi, H., Hwang, B., Kim, S., Ko, H., Kim, S., & Kim, C. (2016). Clinical education in psychiatric mental health nursing: Overcoming current challenges. *Nurse Education Today, 39*, 109-115.  
<https://doi.org/http://dx.doi.org/10.1016/j.nedt.2016.01.021>
- Clarke, L. (2014). Mental health nursing: What difference does it make? *Journal of Psychiatric and Mental Health Nursing, 21*, 558-563.
- Cleary, M., Horsfall, J., & Escott, P. (2014). Marginalization and associated concepts and processes in relation to mental health/illness. *Issues in Mental Health Nursing, 35*, 224-225.  
<https://doi.org/https://doi.org/10.3109/01612840.2014.883792>
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., . . . Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*, 11-27. <https://doi.org/10.1017/S0033291714000129>

- Coffey, M., & Hewitt, J. (2008). 'You don't talk about the voices': Voice hearers and community mental health nurses talk about responding to voice hearing experiences. *Journal of Clinical Nursing, 17*, 1591-1600. <https://doi.org/10.1111/j.1365-2702.2007.02185.x>
- Coffey, M., Higgon, J., & Kinnear, J. (2004). 'Therapy as well as the tablets': An exploratory study of service users' views of community mental health nurses' (CMHNs) responses to hearing voices. *Journal of Psychiatric and Mental Health Nursing, 435-444*.
- Cooke, A. (2017). *Understanding psychosis and schizophrenia: Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help*. London: British Psychological Society Division of Clinical Psychology.
- Corrigan, P. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice, 5*, 201-222.
- Corrigan, P., & Shapiro, J. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30*, 907-922.  
<https://doi.org/10.1016/j.cpr.2010.06.004>
- Corrigan, P., Druss, B., & Perlick, D. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*(2), 37-70.  
<https://doi.org/10.1177/1529100614531398>
- Corrigan, P., Markowitz, F., & Watson, A. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*(3), 481-491.
- Corrigan, P., Mittal, D., Reaves, C., Haynes, T., Han, X., Morris, S., & Sullivan, G. (2014). Mental health stigma and primary health care decisions. *Psychiatry Research, 218*, 35-38.  
<https://doi.org/10.1016/j.psychres.2014.04.028>
- Crawford, P., Brown, B., Anthony, P., & Hicks, C. (2002). Reluctant empiricists: community mental health nurses and the art of evidenced based praxis. *Health and Social Care in the Community, 10*, 287-298.

- Critical Appraisal Skills Programme. (2018). *CASP qualitative checklist*. Retrieved October 14, 2019, from Critical Appraisal Skills Programme: <https://casp-uk.net/casp-tools-checklists/>
- Cuesta, M., Basterra, V., Sanchez-Torres, A., & Peralta, V. (2009). Controversies surrounding the diagnosis of schizophrenia and other psychoses. *Expert Review of Neurotherapeutics*, 9(10). <https://doi.org/https://doi.org/10.1586/ern.09.102>
- Dal Santo, L., Pohl, S., Saiani, L., & Battistelli, A. (2014). Empathy in the emotional interactions with patients. Is it positive for nurses too? *Journal of Nursing Education and Practice*, 4(2). <https://doi.org/http://dx.doi.org/10.5430/jnep.v4n2p74>
- de Jacq, K., Norful, A., & Larson, E. (2016). The variability of nursing attitudes towards mental illness: An integrative review. *Archives of Psychiatric Nursing*, 30, 788-796.
- Furnham, A., & Wong, L. (2006). A cross-cultural comparison of British and Chinese beliefs about the causes, behaviour manifestations and treatment of schizophrenia. *Psychiatry Research*, 151(1-2), 123-138. <https://doi.org/https://doi.org/10.1016/j.psychres.2006.03.023>
- Furnham, A., Raja, N., & Khan, U. (2007). A cross-cultural comparison of British and Pakistani medical students' understanding of schizophrenia. *Psychiatry Research*, 159, 308-319. <https://doi.org/doi:10.1016/j.psychres.2007.08.019>
- Geekie, J., & Read, J. (2007). Fragmentation, invalidation and spirituality: Personal experiences of psychosis – ethical, research and clinical implications. In J. Gleeson, E. Killackey, & H. Krstev, *Psychotherapies for the psychoses: Theoretical, cultural and clinical integration* (pp. 17-29). London: Routledge.
- Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8(1). <https://doi.org/doi:10.1186/1472-6963-8-92>

- Griffiths, R., Mansell, W., Edge, D., & Tai, T. (2018). Sources of distress in first-episode psychosis: A systematic review and qualitative metasynthesis. *Qualitative Health Research*, 1-17.  
<https://doi.org/10.1177/1049732318790544>
- Gronholm, P., Henderson, C., Deb, T., & Thornicroft, G. (2017). Interventions to reduce discrimination and stigma: The state of the art. *Social Psychiatry and Psychiatric Epidemiology*, 52(3), 249-258. <https://doi.org/10.1007/s00127-017-1341-9>
- Hansson, L., Jormfeldt, H., Svedberg, P., & Svensson, B. (2013). Mental health professionals' attitudes towards people with mental illness: Do they differ from attitudes held by people with mental illness? *International Journal of Social Psychiatry*, 59(1), 48-54.  
<https://doi.org/http://dx.doi.org/10.1177/0020764011423176>
- Harangozo, J., Reneses, B., Brohan, E., Sebes, J., Csukly, G., Lopez-Ibor, J., . . . Thornicroft, G. (2014). Stigma and discrimination against people with schizophrenia related to medical services. *International Journal of Social Psychiatry*, 60(4), 359-366.  
<https://doi.org/10.1177/0020764013490263>
- Haslam, N., & Loughnan, S. (2014). Dehumanization and infrahumanization. *Annual Review of Psychology*, 65, 399-423. <https://doi.org/https://doi.org/10.1146/annurev-psych-010213-115045>
- Hayward, M., Awenat, Y., McCarthy Jones, S., Paulik, G., & Berry, K. (2015). Beyond beliefs: A qualitative study of people's opinions about their changing relations with their voices. *Psychosis*, 7(2), 97-107. <https://doi.org/10.1080/17522439.2014.926388>
- Hayward, M., Strauss, C., & Kingdon, D. (2018). *Overcoming distressing voices*. London: Robinson.
- Hayward, M., Strauss, C., & Kingdon, D. (2018). *Overcoming distressing voices*. London: Robinson.
- Henderson, C., Corker, E., Lewis-Holmes, E., Hamilton, S., Flach, C., Rose, D., . . . Thornicroft, G. (2012). England's Time to Change antistigma campaign: One-year outcomes of service user-rated experiences of discrimination. *Psychiatric Services*, 63(5), 451-457.

- Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing*, 52(5), 561-570.  
<https://doi.org/10.1111/j.1365-2648.2005.03623.x>
- Holtum, S., Wright, T., & Wood, C. (2021). Art therapy with people diagnosed with psychosis: Therapists' experiences of their work and the journey to their current practice. *International Journal of Art Therapy*. <https://doi.org/10.1080/17454832.2021.1893370>
- Hopkins, J., Loeb, S., & Fick, D. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: A literature review. *Journal of Psychiatric and Mental Health Nursing*, 16, 927-937. <https://doi.org/10.1111/j.1365-2850.2009.01501.x>
- in2gr8mentalhealth. (2021, July 01). *Welcome to in2gr8mentalhealth Ltd*. Retrieved from <https://www.in2gr8mentalhealth.com/>
- Ince, P., Haddock, G., & Tai, S. (2015). A systematic review of the implementation of recommended psychological interventions for schizophrenia: Rates, barriers, and improvement strategies. *Psychology and Psychotherapy: Theory, Research and Practice*, 89(3).  
<https://doi.org/10.1111/papt.12084>
- Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: Nurses in acute mental health settings. *Journal of Advanced Nursing*, 48(6), 622-631.
- Johns, L., Kompus, K., Connell, M., Humpston, C., Lincoln, T., Longden, E., . . . Fernyhough, C. (2014). Auditory verbal hallucinations in persons with and without a need for care. *Schizophrenia Bulletin*, 40(Suppl\_4), S255-S264.
- Johns, L., Nazroo, J., & Bebbington, P. (2002). Occurrence of auditory hallucinations in a community sample and ethnic variations. *British Journal of Psychiatry*, 180, 172-178.
- Kakatura, N., Yamamoto-Mitani, N., & Ishigaki, K. (2010). Home-visit nurses' attitudes for providing effective assistance to clients with schizophrenia. *International Journal of Mental Health Nursing*, 19, 102-109. <https://doi.org/10.1111/j.1447-0349.2009.00641.x>

- Knaak, S., Modgill, G., & Patten, S. (2014). Key ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. *The Canadian Journal of Psychiatry, 59*(Supplement 1).
- Kvaale, E., Haslam, N., & Gottdiener, W. (2013). The 'side effects' of medicalization: A meta-analytic review of how biogenic explanations affect stigma. *Clinical Psychology Review, 33*, 782-794.
- Larøi, F., Luhrmann, T., Bell, V., Christian, W., Deshpande, S., Fernyhough, C., . . . Woods, A. (2014). Culture and hallucinations: Overview and future directions. *Schizophrenia Bulletin, 40*(suppl. no. 4), S213-S220. <https://doi.org/doi:10.1093/schbul/sbu012>
- Laugharne, R., Priebe, S., McCabe, R., Garland, N., & Clifford, D. (2011). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry, 58*(5), 496-506. <https://doi.org/10.1177/0020764011408658>
- Leudar, I., & Thomas, P. (2000). *Voices of reason, voices of insanity: Studies of verbal hallucinations*. Philadelphia: Routledge.
- Livingston, J., & Boyd, J. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine, 71*, 2150-2161. <https://doi.org/10.1016/j.socscimed.2010.09.030>
- Longden, E., & Read, J. (2016). Social adversity in the etiology of psychosis: A review of the evidence. *American Journal of Psychotherapy, 70*(1), 5-33. Retrieved from <https://www.ingentaconnect.com/contentone/afap/ajp/2016/00000070/00000001/art00002>
- Longden, E., Madill, A., & Waterman, M. (2012). Dissociation, trauma and the role of lived experience: Toward a new conceptualisation of voice hearing. *Psychological Bulletin, 138*(1), 28-76.
- Loughland, C., Cheng, K., Harris, G., Kelly, B., Cohen, M., Sandhu, H., . . . Outram, S. (2015). Communication of a schizophrenia diagnosis: A qualitative study of patients' perspectives.

*International Journal of Social Psychiatry*, 61(8), 729-734.

<https://doi.org/10.1177/0020764015576814>

Lyth, I. (1960). Social systems as a defense against anxiety. *Human Relations*, 13, 95-121.

Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annual Review of Psychology*, 52, 397-422.

McMullan, E., Gupta, A., & Collins, S. (2018). Experiences of mental health nursing staff working with voice hearers in an acute setting: An interpretive phenomenological approach. *Journal of Psychiatric and Mental Health Nursing*, 25, 157-166. <https://doi.org/10.1111/jpm.12448#>

Mestdagh, A., & Hansen, B. (2014). Stigma in patients with schizophrenia receiving community mental health care: A review of qualitative studies. *Social Psychiatry and Psychiatric Epidemiology*, 49, 79-87. <https://doi.org/https://doi.org/10.1007/s00127-013-0729-4>

Minogue, V., Boness, J., Brown, A., & Girdlestone, J. (2005). The impact of service user involvement in research. *International Journal of Health Care Quality Assurance*, 18(2), 103-112. <https://doi.org/https://doi.org/10.1108/09526860510588133>

Mittal, D., Sherman, M., Han, X., Reaves, C., Morris, S., Corrigan, P., . . . Sullivan, G. (2014). Healthcare providers' attitudes towards persons with schizophrenia. *Psychiatric Rehabilitation Journal*, 37(4), 297-303. <https://doi.org/10.1037/prj0000095>

Morrison, A., Hutton, P., Shiers, D., & Turkington, D. (2012). Antipsychotics: Is it time to introduce patient choice? *The British Journal of Psychiatry*, 201, 83-84. <https://doi.org/10.1192/bjp.bp.112.112110>

Mueller, B., Nordt, C., Lauber, C., Ruesch, P., Meyer, P., & Roessler, W. (2006). Social support modifies perceived stigmatization in the first years of mental illness: A longitudinal approach. *Social Science & Medicine*, 62, 39-49. <https://doi.org/10.1016/j.socscimed.2005.05.014>



- Newell, J., & MacNeil, G. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best Practices in Mental Health, 2*, 57-68. Retrieved from <https://www.ingentaconnect.com/content/follmer/bpmh/2010/00000006/00000002/art00006>
- NHS. (2019, July). *NHS mental health implementation plan 2019/20 - 2023/24*. Retrieved from <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>
- NHS. (2021, March). *National results*. Retrieved from NHS Staff Survey: <https://www.nhsstaffsurveys.com/results/national-results/>
- NHS Confederation. (2017, July). *Key statistics on the NHS*. Retrieved from NHS Confederation: <https://www.nhsconfed.org/publications/key-statistics-nhs>
- NICE. (2014). *Psychosis and schizophrenia in adults: Prevention and management*. London: National Institute for Health and Care Excellence.
- Outram, S., Harris, G., Kelly, B., Cohen, M., Sandhu, H., Vamos, M., . . . Loughland, C. (2014). Communicating a schizophrenia diagnosis to patients and families: A qualitative study of mental health clinicians. *Psychiatric Services, 65*(4), 551-554. <https://doi.org/10.1176/appi.ps.201300202>
- Paulik, G. (2012). The role of social schema in the experience of auditory hallucinations: A systematic review and a proposal for the inclusion of social schema in a cognitive behavioural model of voice hearing. *Clinical Psychology and Psychotherapy, 19*, 459-472. <https://doi.org/10.1002/cpp.768>
- Pavon, G., & Vaes, J. (2017). Bio-genetic vs. psycho-environmental conceptions of schizophrenia and their role in perceiving patients in human terms. *Psychosis, 9*(3), 245-253. <https://doi.org/http://dx.doi.org/10.1080/17522439.2017.1311359>

- Pyle, M., & Morrison, A. (2014). "It's just a very taboo and secretive kind of thing": Making sense of living with stigma and discrimination from accounts of people with psychosis. *Psychosis*, 6(3), 195-205. <https://doi.org/http://dx.doi.org/10.1080/17522439.2013.834458>
- Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, 16, 279-284.
- Rethink Mental Illness. (2017). *The Schizophrenia Commission progress report: Five years on*. Rethink Mental Illness.
- Richards, M., Hori, H., Sartorius, N., & Kunugi, H. (2014). Cross-cultural comparisons of attitudes toward schizophrenia amongst the general population and physicians: A series of web-based surveys in Japan and the United States. *Psychiatry Research*, 215(2), 300-307. <https://doi.org/https://doi.org/10.1016/j.psychres.2013.12.012>
- Roller, M., & Lavrakas, P. (2015). *Applied qualitative research design: A total quality framework*. New York: Guilford Press.
- Romme, M., & Escher, S. (1993). *Accepting voices*. London: MIND Publications.
- Romme, M., & Escher, S. (2000). *Making sense of voices: A guide for mental health professionals working with voice hearers*. London: Mind Publications.
- Romme, M., & Escher, S. (2006). Trauma and hearing voices. In W. Larkin, & T. Morrison, *Trauma and psychosis: New directions for theory and therapy*. Hove, East Sussex: Routledge.
- Romme, M., Escher, S., & Dillon, J. (2009). *Living with voices: 50 stories of recovery*. Ross-on-Wye: PCCS Books Ltd.
- Rosenfield, S. (2012). Triple jeopardy? Mental health at the intersection of gender, race, and class. *Social Science & Medicine*, 74(11), 1791-1801. <https://doi.org/https://doi.org/10.1016/j.socscimed.2011.11.010>

- Ross, C., & Goldner, E. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*, 558-567.
- Rotstein, S., Hudaib, A., Facey, A., & Kulkarni, J. (2019). Psychiatrist burnout: a meta-analysis of Maslach Burnout Inventory means . *Australasian Psychiatry, 27*(3), 249-254.  
<https://doi.org/https://doi.org/10.1177/1039856219833800>
- Rydon, S. (2005). The attitudes, knowledge and skills needed in mental health nurses: The perspective of users of mental health services. *International Journal of Mental Health Nursing, 14*(2), 78-87. <https://doi.org/https://doi.org/10.1111/j.1440-0979.2005.00363.x>
- Saayman, N. (2018). Psychoanalytic psychotherapists' experiences of disturbance in response to working with psychosis. *Psychosis, 10*(4), 329-339.  
<https://doi.org/https://doi.org/10.1080/17522439.2018.1534879>
- Schizophrenia Commission. (2012). *The abandoned illness: A report from the Schizophrenia Commission*. London.
- Schneider, K. (1959). *Clinical Psychopathology* (5th ed.). (M. W. Hamilton, Trans.) Grune & Stratton.
- Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P., Grabe, H., Carta, M., & Angermeyer, M. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 125*, 440-452. <https://doi.org/10.1111/j.1600-0447.2012.01826.x>
- Seeman, N., Ting, S., Brown, A., & Ing, A. (2016). World survey of mental illness stigma. *Journal of Affective Disorders, 190*, 115-121.  
<https://doi.org/http://dx.doi.org/10.1016/j.jad.2015.10.011>
- Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The comprehensive open-dialogue approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced

community care. *Psychosis*, 3(3), 192-204.

<https://doi.org/https://doi.org/10.1080/17522439.2011.595819>

Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Meldrum, C. D. (2012). Arginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science & Medicine*, 75(12), 2437-2445.

<https://doi.org/https://doi.org/10.1016/j.socscimed.2012.09.023>

Slade, P., & Haddock, G. (1996). A historical overview of psychological treatments for psychotic symptoms. In G. Haddock, & P. Slade (Eds.), *Cognitive-behavioural interventions with psychotic disorders* (pp. 28-42). London: Routledge.

Sullivan, G., Mittal, D., Reaves, C., Haynes, T., Han, X., Mukherjee, S., . . . Corrigan, P. (2015).

Influence of schizophrenia diagnosis on providers' practice decisions. *Journal of Clinical Psychiatry*, 76, 1068-1074.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative systematic reviews. *BMC Medical Research Methodology*, 8, 45. <https://doi.org/10.1186/1471-2288-8-45>

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., . . . Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, 387, 1123-1132. [https://doi.org/10.1016/S0140-6736\(15\)00298-6](https://doi.org/10.1016/S0140-6736(15)00298-6)

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Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry*, 19, 113-122.

<https://doi.org/http://dx.doi.org/10.1080/09540260701278937>

Topor, A., & Denhov, A. (2015). Going beyond: Users' experiences of helping professionals.

*Psychosis*, 7(3), 228-236. <https://doi.org/http://dx.doi.org/10.1080/17522439.2014.956784>

- Trippany, R., Kress, V., & Wilcoxon, S. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82*, 31-37. <https://doi.org/https://doi.org/10.1002/j.1556-6678.2004.tb00283.x>
- Trygstad, L., Buccheri, R., Buffum, M., Ju, D., & Dowling, G. (2015). Auditory Hallucinations Interview Guide: Promoting recovery with an interactive assessment tool. *Journal of Psychosocial Nursing and Mental Health Services, 53*(1).  
<https://doi.org/https://doi.org/10.3928/02793695-20141203-01>
- Tully, S., Wells, A., & Morrison, A. (2017). 'You've got your own demons that you've got to fight every day': A qualitative exploration of how people respond to the experience of psychosis. *Psychology and Psychotherapy, 90*(4), 550-566. <https://doi.org/10.1111/papt.12124>
- Tunmer, T., & Salzer, M. (2006). Consumer perspectives on quality of care in the treatment of schizophrenia. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 674-681. <https://doi.org/10.1007/s10488-006-0050-6>
- Upthegrove, R., Broome, M., Caldwell, K., Ives, J., Oyebode, F., & Wood, S. (2015). Understanding auditory verbal hallucinations: A systematic review of current evidence. *Acta Psychiatrica Scandinavica, 133*(5). <https://doi.org/https://doi.org/10.1111/acps.12531>
- Valery, K., & Prouteau, A. (2020). Schizophrenia stigma in mental health professionals and associated factors: A systematic review. *Psychiatry research, 113068*.  
<https://doi.org/http://dx.doi.org/10.1016/j.psychres.2020.113068>
- van Os, J., & Reininghaus, U. (2016). Psychosis as a transdiagnostic and extended phenotype in the general population. *World Psychiatry, 15*, 118-124. <https://doi.org/10.1002/wps.20310>
- Vass, V., Sitko, K., West, S., & Bentall, R. (2017). How stigma gets under the skin: The role of stigma, self-stigma, and self-esteem in subjective recovery from psychosis. *Psychosis, 9*(3), 235-244.  
<https://doi.org/https://doi.org/10.1080/17522439.2017.1300184>

- Vilhauer, R. (2017). Stigma and need for care in individuals who hear voices. *International Journal of Social Psychiatry*, 63(1), 5-13. <https://doi.org/10.1177/0020764016675888>
- Wahass, S., & Kent, G. (1997). A cross-cultural study of the attitudes of mental health professionals towards auditory hallucinations. *International Journal of Social Psychology*, 43(3), 184-192.
- Whitaker, R. (2016, July). *The case against antipsychotics*. Retrieved from Mad in America: <https://www.madinamerica.com/2016/07/the-case-against-antipsychotics/>
- White, M., Stein-Parbury, J., Orr, F., & Dawson, A. (2019). Working with consumers who hear voices: The experience of early career nurses in mental health services in Australia. *International Journal of Mental Health Nursing*, 28, 605-615. <https://doi.org/10.1111/inm.12566>
- White, R. (2013). The globalisation of mental illness. *The Psychologist*, 26(3), 182-185. Retrieved from <https://psycnet.apa.org/record/2013-07807-001>
- WHO. (2013). *The European mental health action plan*. Copenhagen: World Health Organisation.
- Williams, C., & Tufford, L. (2012). Professional competencies for promoting recovery in mental illness. *Psychiatry*, 75(2), 190-201.
- Wood, L., Burke, E., Byrne, R., Pyle, M., Chapman, N., & A., M. (2015). Stigma in psychosis: A thematic synthesis of current qualitative evidence. *Psychosis*, 7(2), 152-165. <https://doi.org/http://dx.doi.org/10.1080/17522439.2014.926561>
- Woods, A. (2013). The voice-hearer. *Journal of Mental Health*, 22(3), 263-270. <https://doi.org/10.3109/09638237.2013.799267>
- World Health Organisation. (2019, May 28). *Burn-out an "occupational phenomenon": International Classification of Diseases*. Retrieved from <https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases>



### Appendix A: Search terms

Database (date searched)	Specialism	Search terms	Number of results (titles screened)
CINAHL (10.08.2019)	Nursing and allied health professions	Thesaurus: Attitude to mental illness OR stigma AND Hallucinations AND Medical staff AND Qualitative studies	243
		String: (attitudes OR perceptions OR opinions OR thoughts OR feelings OR beliefs OR stigma* OR discriminat* OR respon*).ti,ab AND (hearing voices OR auditory hallucinations OR voice-hear* OR voice hear* OR AVH OR hallucination* OR psychosis OR psychotic OR schizophreni*).ti,ab AND (clinician OR psychologist OR personnel OR physician OR psychiatrist OR therapist OR counsellor OR counselor OR psychotherapist OR trainee OR staff OR nurse OR student OR social worker).ti,ab AND Ethnograph* OR discourse OR ethnomethodol* OR narrative* OR "GROUNDED THEORY"/ OR PHENOMENOLOGICAL OR "CASE STUDY"/ OR thematic OR "MIXED METHOD"/ OR qualitative	
PsycINFO (10.08.2019)	Psychology and allied fields	Thesaurus: Mental illness (attitudes toward) AND Auditory hallucinations AND Mental health personnel OR occupational therapists OR psychiatric nurses OR psychiatrists AND Mixed methods research OR qualitative methods	310
		String:	



		<p>(attitudes OR perceptions OR opinions OR thoughts OR feelings OR beliefs OR stigma* OR discriminat* OR respon*).ti,ab</p> <p>AND</p> <p>(hearing voices OR auditory hallucinations OR voice-hear* OR voice hear* OR AVH OR hallucination* OR psychosis OR psychotic OR schizophreni*).ti,ab</p> <p>AND</p> <p>(clinician OR psychologist OR personnel OR physician OR psychiatrist OR therapist OR counsellor OR counselor OR psychotherapist OR trainee OR staff OR nurs* OR student OR social worker).ti,ab</p> <p>AND</p> <p>Ethnograph* OR discourse OR ethnomethodol* OR narrative* OR "GROUNDED THEORY"/ OR PHENOMENOLOGICAL OR "CASE STUDY"/ OR thematic OR "MIXED METHOD"/ OR qualitative</p>	
EMCARE (10.08.2019)	Nursing and allied health professions	<p>Thesaurus:</p> <p>Attitude to mental illness OR stigma</p> <p>AND</p> <p>Auditory hallucination</p> <p>AND</p> <p>Medical personnel</p> <p>AND</p> <p>Qualitative studies OR qualitative research OR qualitative study</p>	73
		<p>String:</p> <p>(attitudes OR perceptions OR opinions OR thoughts OR feelings OR beliefs OR stigma* OR discriminat* OR respon*).ti,ab</p> <p>AND</p> <p>(clinician OR psychologist OR personnel OR physician OR psychiatrist OR therapist OR counsellor OR counselor OR psychotherapist OR trainee OR staff OR nurse OR student OR social worker).ti,ab</p> <p>AND</p> <p>(hearing voices OR auditory hallucinations OR voice-hear* OR voice hear* OR AVH OR hallucination* OR psychosis OR psychotic OR schizophreni*).ti,ab</p> <p>AND</p> <p>Ethnograph* OR discourse OR ethnomethodol* OR narrative* OR "GROUNDED THEORY"/ OR PHENOMENOLOGICAL OR "CASE STUDY"/ OR thematic OR "MIXED METHOD"/ OR qualitative</p>	
AMED (10.08.2019)	Allied health professions,	<p>Thesaurus:</p> <p>Attitude of health personnel OR prejudice</p>	6

	complimentary medicine	AND Hallucinations AND Health personnel AND Interviews	
		String: (attitudes OR perceptions OR opinions OR thoughts OR feelings OR beliefs OR stigma* OR discriminat* OR respon*).ti,ab AND (hearing voices OR auditory hallucinations OR voice-hear* OR voice hear* OR AVH OR hallucination* OR psychosis OR psychotic OR schizophreni*).ti,ab AND (clinician OR psychologist OR personnel OR physician OR psychiatrist OR therapist OR counsellor OR counselor OR psychotherapist OR trainee OR staff OR nurse OR student OR social worker).ti,ab AND Ethnograph* OR discourse OR ethnomethodol* OR narrative* OR "GROUNDED THEORY"/ OR PHENOMENOLOGICAL OR "CASE STUDY"/ OR thematic OR "MIXED METHOD"/ OR qualitative	
ASSIA (19.10.2019)	Health and social care journals from a broadly social scientific perspective	(Ethnograph* OR discourse OR ethnomethodol* OR narrative* OR "GROUNDED THEORY" OR PHENOMENOLOGICAL OR "CASE STUDY" OR thematic OR "MIXED METHOD" OR qualitative) AND (ab(attitudes OR perceptions OR opinions OR thoughts OR feelings OR beliefs OR stigma* OR discriminat* OR respon*) AND ab(hearing voices OR auditory hallucinations OR voice-hear* OR voice hear* OR AVH OR hallucination* OR psychosis OR psychotic OR schizophreni*)) AND ab(clinician OR psychologist OR personnel OR physician OR psychiatrist OR therapist OR counsellor OR counselor OR psychotherapist OR trainee OR staff OR nurs* OR student OR social worker) AND stype.exact("Scholarly Journals"))	197
Journal: Psychosis: Psychological, Social and Integrative Approaches (19.10.2019)	Publications focused on the psychological treatments of psychosis and the psycho-social causes of psychosis.	All articles searched from Volume 1 (January 2009) to Volume 11 (June 2019)	489

### Appendix B: Main features of the selected papers

Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
(Amsalem et al., 2018)	Retrospective case design. Individual interviews with people treated at a large general hospital, diagnosed with schizophrenia or schizoaffective disorder. Family members also interviewed.	Mean age 26.5 years; 12 male, 4 female; Mean interval between receiving the diagnosis and interview was 16 months (S.D. $\pm$ 10.17 months, range 2 weeks – 3 years). Country: Israel	<p>Subtle ways of stigmatization among professionals: The subjective experience of consumers and their family members. (N.B. The themes reported here are from the responses of the consumers rather than the family members, as that is outside the scope of the current review).</p> <p>1: Lived experience is not relevant</p> <ul style="list-style-type: none"> <li>• Told the doctors knew what is right for [them].</li> <li>• This message was internalised, feeling [they had] no relevant information to offer.</li> </ul> <p>2: People diagnosed with a psychosis-related disorder have no hope for recovery</p> <ul style="list-style-type: none"> <li>• “She [the psychiatrist] told me that it will never go away”.</li> <li>• “The doctors said that schizophrenia is for life”.</li> </ul> <p>3: Sharing and discussing professional knowledge is not necessary</p> <ul style="list-style-type: none"> <li>• The belief that consumers and their families are not able to understand their condition and that they are automatically assumed to lack insight.</li> <li>• It appears that the perspective of the health care staff is that informing the consumer is useless, that the consumer is not worthy of talking to, and that a discussion about their condition with him/her would be beyond his or her comprehension.</li> <li>• Described feelings of inferiority, not being treated with respect, “they were patronizing me”.</li> </ul>
(Bogen-Johnston et al., 2019)	Practitioners from Early Intervention in Psychosis services.	A range of training, some trained therapists and others with no formal training. Country: UK	<p>Nine themes generated from the analysis, four of which were presented in this paper:</p> <p>1: Starting a conversation about voices</p> <ul style="list-style-type: none"> <li>• Mixed views about how conversations were initiated. Some presumed this would have naturally occurred or would occur through the standardised assessment process</li> <li>• Many service users were candid about disclosure of voices, but some clinicians found that clients found it difficult to express their experiences.</li> <li>• Prior engagement with non-EIP services could limit conversations about voices, and practitioners had to build trust with service users to support their pathway to disclosure.</li> </ul>

Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
			<p>2: Continuing the conversation about voices: 3 sub-themes</p> <p>2a: Voices are not always the main concern</p> <ul style="list-style-type: none"> <li>• Non-psychologists did view voices as a prevalent symptom, a typical cause for initial referral to EIP. Psychologists believed that voices were not the primary concern or even a typical symptom. This may lead to conversations about voices being curtailed.</li> </ul> <p>2b: Importance of having a deeper conversation</p> <ul style="list-style-type: none"> <li>• A deeper conversation helped hearers gain a sense of agency over the voices, normalised the experiences in a safe relationship, rendered the voices less frightening and distressing, and something that could be spoken about.</li> <li>• Practitioners described needing to be flexible based on whether the service user wanted to make sense of hearing voices or forget their experiences.</li> </ul> <p>2c: Confidence to work with voices</p> <ul style="list-style-type: none"> <li>• Some felt more confident working with voices than other symptoms such as unusual beliefs; others lacked confidence despite training to work with voices.</li> </ul>
(Bogen-Johnston et al., 2017)	<p>Semi-structured interviews.</p> <p>Included: participants who had been hearing voices for at least 3 months, working with Early Intervention in Psychosis teams in Sussex (n=17) and Manchester (n=3).</p> <p>Exclusions: possible organic cause for voices</p>	<p>Service users. 12 men and 8 women aged 19-35 years. Voice duration ranged from less than 1 to 21 years.</p> <p>Country: UK</p>	<p>Barriers and enablers to the disclosure of hearing voices.</p> <p>1: Effect of disclosure on the self</p> <p>1a: What problem?</p> <ul style="list-style-type: none"> <li>• A process whereby the presence of voices had to be acknowledged.</li> <li>• "I'd been [...] trying to ignore it for so long and I just didn't think I could do that anymore [...] I struggled with it for quite a long time before I actually admitted that there was a problem.</li> <li>• Remaining silent and existing within a dysfunctional relationship with voices was preferable to disclosing and risk losing them.</li> </ul> <p>1b: I feel too ashamed</p> <ul style="list-style-type: none"> <li>• Coping with the embarrassment of being a voice hearer and identifying as someone who has mental health issues.</li> <li>• The self-stigmatization of identifying as "crazy" meant that hearing voices was an embarrassing experience best concealed.</li> <li>• For other participants, awareness of ... stigmatization prompted them to challenge unhelpful common beliefs and to begin a process of enquiry of finding opportunities to talk about voices</li> </ul>

Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
			<p>1c: Reaching desperation</p> <ul style="list-style-type: none"> <li>• In many cases, seeking help was not initiated until it became necessary and voices could no longer be endured alone.</li> </ul> <p>2: Effect of disclosure on others</p> <p>2a: Concerns about others</p> <ul style="list-style-type: none"> <li>• Some participants worried that disclosure of voices would cause anguish to, and place a burden on, significant others in their lives.</li> <li>• Most participants disclosed their voices to significant others such as parents or partners, but only after a period of time.</li> </ul> <p>2b: How will they respond?</p> <ul style="list-style-type: none"> <li>• Other people's experiences, understanding, and attitudes toward mental health issues functioned to either discourage or encourage participants' willingness to reveal and discuss their voices.</li> </ul> <p>3: Help-seeking</p> <p>When they reached the point of wanting help from others, hearers needed to have someone to talk to.</p>
(Coffey & Hewitt, 2008)	Purposive sample of 20 UK voice hearers and the community mental health nurses (CMHNs) they worked with.	20 CMHNs and 20 service users who hear voices. Service users: 10 female, 10 male; mean age 43 years (range 22-68); mean number of years hearing voices 12.8 (range 2-48)	<p>1: Facilitators to coping with voices</p> <p>1a: Professional strategies</p> <p>Medication</p> <ul style="list-style-type: none"> <li>• Flexibility of CMHN is helpful.</li> </ul> <p>Discussion of voices</p> <ul style="list-style-type: none"> <li>• CMHNS should discuss the content and meaning of their voices with them.</li> </ul> <p>Coping skills</p> <ul style="list-style-type: none"> <li>• CMHNs reinforcing reality, "normalness" or "reality checking".</li> </ul> <p>1b: Personal strategies</p> <ul style="list-style-type: none"> <li>• Accessing and benefiting from social support networks.</li> <li>• Discussing and comparing voice-hearing experiences with other service users.</li> </ul>

		years), diagnosis: schizophrenia (15), psychotic episode (2),	<ul style="list-style-type: none"> <li>Attempt to gain personal control over voices by challenging them, but this may not always work.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
(Coffey & Hewitt, 2008) cont.		bipolar disorder (1), uncertain (2). CMHNs: 11 female, 9 male; mean years in nursing 18; years in current post 10-31 (mean 7); mean numbers on caseload who hear voices 17 (range 1-40).	<p>2: Barriers to coping with voices</p> <ul style="list-style-type: none"> <li>Limited effects of medication</li> <li>CMHNs' responses limited to recommending medication, make an appointment with the consultant or non-directive counselling.</li> <li>Limited access/ experience to CBT despite desire to learn more.</li> <li>Sometimes speaking with other voice hearers can raise anxieties.</li> </ul> <p>3: Attributions about voices</p> <ul style="list-style-type: none"> <li>Acceptance of biomedical constructions of mental illness, although some refuted these constructions.</li> <li>Voices can be seen as omnipotent which could lead to them being seen as God or a Demon. Sometimes seen as a consequence or retribution for previous life events.</li> </ul>
(Coffey et al., 2004)	Purposive sample from caseloads of 34 CMHNs in South Wales. Clients who had been experiencing auditory hallucinations for at least 12 months, age 18-70. Heterogeneous sample, selected to include those	22 service users interviewed: 12 male and 10 female (data subsequently excluded from 2 males due to concerns about their mental health). Hearing voices for 18 months – 48 years (mean 12.8 years). All heard	<p>Two thematic threads from interviews about CMHNs responses to voice-hearing experiences.</p> <p>1: Professional help</p> <p>1a: Service users' responses</p> <ul style="list-style-type: none"> <li>CMHNs had little direct engagement with the voice hearing.</li> <li>Described benefits of nurses discussing the content of voices</li> <li>Discussion of voices should occur in the context of a therapeutic relationship with the nurse.</li> </ul> <p>1b: CMHNs' responses</p> <ul style="list-style-type: none"> <li>Supportive about the idea of talking about voices but saw limitations in their ability to offer this treatment.</li> <li>Frustration with the [medical] focus of interventions</li> </ul> <p>2: Discussing meaning of voices</p> <p>2a: Voice hearers' responses</p> <ul style="list-style-type: none"> <li>A helpful intervention and reported that this was one way of improving coping.</li> </ul>

	who had heard voices for over 10 years and with a range of experiences.	voices. Reported Diagnoses: schizophrenia-type illness (15),	2b: CMHNS' responses <ul style="list-style-type: none"> <li>Dismissed the possibility that voices had meaning located in past experiences, with "astonishing assurance".</li> <li>Shift in thinking towards discussing content and meaning of voices and recognised that they will have to overcome their own anxieties.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
Coffey et al., 2004 (cont.)	Exclusion: currently in hospital, currently unwell or on caseload of one author.	psychotic episodes (2), bipolar disorder (1), uncertain (2). Country: UK	3: Responses to an increase in voices 3a: Voice hearers' responses <ul style="list-style-type: none"> <li>Voice hearers universally responded that an increase in medication was the standard help offered.</li> <li>In most cases, the only other intervention identified was non-directive counselling.</li> <li>Two respondents reported that their nurses reviewed their coping strategies.</li> </ul> 3b: CMHNS' responses <ul style="list-style-type: none"> <li>Adopting a wait-and-see policy.</li> <li>A normalising rationale to the experience of voices.</li> </ul> 4: CMHNS' responses to voice hearers reporting a change in their voices (most frequent responses first). <ul style="list-style-type: none"> <li>Assessment of what the change is.</li> <li>Refer to psychiatrist.</li> <li>Increase medication.</li> <li>Increase visits.</li> <li>Ask them to keep a diary.</li> <li>Encourage to use own coping strategies.</li> <li>Non-directive counselling.</li> <li>Monitoring for change.</li> <li>Collaborate with the service user.</li> </ul> 5: Personal help Included using social support networks, self-help initiatives and establishing control over the voice-hearing experience (this theme is not covered in detail in this review as it is not the focus of the review).

<p>Holttum et al. (2021)</p>	<p>Grounded theory. Theoretical sampling used for a range of settings and levels of experience. Interviews audio recorded, transcribed and open coded alongside further interviewing so emerging themes could be expanded. Then focused codes were grouped together and diagrammed.</p>	<p>18 UK based art therapists, working in the NHS. 1-20 years' experience; 13 participants had more than 15 years' experience. 7 male and 11 female. A range of settings.</p>	<p>Swimming against the tide</p> <ul style="list-style-type: none"> <li>• Art therapists valuing a position as outsiders</li> <li>• Recognition of precariousness</li> <li>• Promoting a psychosocial approach to psychosis.</li> </ul> <p>Training as challenge and resilience/ not good enough</p> <ul style="list-style-type: none"> <li>• Developing confidence, expanding practice working with psychosis.</li> <li>• Training being insufficient, further experience needed.</li> </ul> <p>What the client brings</p> <ul style="list-style-type: none"> <li>• Severe difficulties, e.g. with voices, stresses in past and present or the mental health system itself.</li> </ul> <p>Therapist struggle</p> <ul style="list-style-type: none"> <li>• Difficult emotions in response to the work, with clients and the organisational context.</li> <li>• Used art making, personal therapy and clinical supervision.</li> </ul> <p>Got to moderate your technique</p> <ul style="list-style-type: none"> <li>• 'muddling through', moving away from a too-rigid approach.</li> <li>• Influenced by training by mental health system survivors and the Open Dialogue approach.</li> </ul> <p>Just gotta find a way of relating</p> <ul style="list-style-type: none"> <li>• Main task as finding a way of building a relationship with the client, a belief in a therapeutic aim, and adapting therapy to take possible trauma into account.</li> </ul> <p>Client connects</p> <ul style="list-style-type: none"> <li>• Connecting may be with the art materials or with the therapist directly. This helped the client to tell their story.</li> <li>• Clients expressed high emotion, but art could be calming or enjoyable.</li> <li>• Clients could express negative emotions to the art.</li> <li>• Therapists learnt from their mistakes, e.g. "I don't think I was gentle enough with it".</li> </ul> <p>Client develops</p> <ul style="list-style-type: none"> <li>• Developing new coping or perspectives helped clients to move towards greater agency.</li> <li>• Could address difficult things, e.g. trauma.</li> </ul> <p>Supporting the client's journey</p> <ul style="list-style-type: none"> <li>• Supporting personhood, helping clients to understand their difficulties, supporting clients' goals and agency.</li> </ul>
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			<p>Client goes on a course.  Client is stuck/disengages</p> <ul style="list-style-type: none"> <li>• Sometimes therapy ended without apparent benefit.</li> <li>• Sometimes consistency helped the client to build trust and consider alternative perspectives.</li> </ul> <p>Client still has difficulties.  Being there for the client</p> <ul style="list-style-type: none"> <li>• Persistence, consistency, avoiding mistakes, re-inviting clients into therapy.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
Holttum et al., 2021 (cont.)			<p>Work supporting/ clash of needs</p> <ul style="list-style-type: none"> <li>• Team working or other professionals could be supportive of therapist and client.</li> <li>• Organisational practices could be unhelpful, e.g. prioritising medication over a more holistic view of the person.</li> </ul> <p>Tide turning in the right way/ things stuck/ getting worse</p> <ul style="list-style-type: none"> <li>• Recognition of some positive changes in society and institutions, e.g. recognition that trauma is “at the root cause of most mental distress”.</li> <li>• Some pessimism about inadequate or poor treatment in the mental health system.</li> </ul>
(Kakatura et al., 2010)	Methodology/ Inclusion criteria: a) experience in providing care for clients with schizophrenia and b) having one or more clients who have not been hospitalised for more than 2 years.	Sample description () 7 home-visit nurses; age group from 30s – 60s; number of years working as a nurse: 8-44. Country: Japan	<p>Community nurses’ process of acquiring positive attitudes towards clients with schizophrenia.</p> <p>1: Encountering unexpected client behaviours.  1a: Client has much higher skills for daily life than I expected.  1b: Client understands his or her own surroundings much more than I had expected.  1c: Client turns down my suggestions.</p> <p>2: Becoming aware of one’s own problematic care.  2a: I was not paying enough attention to the client’s will and wishes.  2b: I was underestimating the client’s skills for daily life.  2c: I was underestimating the client’s understanding.  2d: I was prejudiced about the client’s violent behaviours.</p> <p>3: Having equal footing with the client  3a: Now I can talk to the client more honestly and without being overly sensitive.  3b: Now I can sense the client’s will and wishes that had long been oppressed.  3c: Now I can believe in the client’s innate ability.</p>

			3d: Now I can respect and support the client's will and wishes. 3e: Now I am more reflective of my own view of the client.
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
(Laugharne et al., 2011)	Cornwall: individuals on a register of enhanced care programme with mental health services were approached alphabetically, then when 9 participants had been recruited who were disproportionately male over 50, females and those under 50 were selectively recruited.	Cornwall sample: 16 service users who had suffered with a psychotic illness; 8 male and 8 female; all white; age range 38-62 (median 51); length of illness 5-41 years (median 25 years). London sample: 6 patients with a history of psychotic illness attending a day hospital; 2 male and 4 female; 2 White British, 1 African, 2 Black British, 1 Asian; age range 21-40;	Themes enhancing or undermining clients' sense of trust, choice and power (most commonly expressed listed first, with number of interviewees in brackets). 1: Trust 1a: Enhance <ul style="list-style-type: none"> <li>• Reciprocity of trust – depends on the patient as well as the clinician (11)</li> <li>• Patient valuing professional expertise (11)</li> <li>• Caring/kind attitude of the clinician (10)</li> <li>• Continuity of care (10)</li> <li>• Reliability/regularity of clinician (10)</li> <li>• Clinician delivering promises (8)</li> <li>• Clinician listening to the patient (6)</li> <li>• Personal disclosure by clinician (4)</li> <li>• Clinician positive about the future (3)</li> <li>• Honesty (2)</li> </ul> 1b: Undermine <ul style="list-style-type: none"> <li>• Perceived neglect when unwell (9)</li> </ul> History of coercion and perceived threat of coercion (8) <ul style="list-style-type: none"> <li>• Nature of illness itself (7)</li> <li>• Relying only on scientific knowledge (2)</li> </ul> 2: Choice 2a: Enhance <ul style="list-style-type: none"> <li>• Patient experience/knowledge of illness (5)</li> </ul>

		length of illness 3 weeks-21 years (median 4 years). Country: UK	<ul style="list-style-type: none"> <li>• Time with staff (2)</li> <li>• More than medication on offer (2)</li> </ul> <p>2b: Undermine</p> <ul style="list-style-type: none"> <li>• Choice not considered by patients (8)</li> <li>• Nature of illness itself (8)</li> <li>• Lack of information especially in early stages of illness (6)</li> <li>• History of coercion and perceived threat of coercion (6)</li> <li>• Lack of confidence after illness (4)</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
Laugharne et al. (2011) cont.			<p>3. Power</p> <p>3a: Enhance</p> <ul style="list-style-type: none"> <li>• Patients feel clinicians use powers of compulsory detention legitimately (14)</li> <li>• Patient knowledge and information increases their power (5)</li> <li>• Patient sharing responsibility with clinician (3)</li> <li>• Clinician sharing responsibility of compulsory detention with other professionals and carers (overcoming confidentiality) (2)</li> </ul> <p>3b: Undermine</p> <ul style="list-style-type: none"> <li>• Perceived neglect when unwell (10)</li> <li>• Nature of illness itself (7)</li> <li>• History of coercion and perceived threat of coercion (5)</li> <li>• Other patients abusing power (3)</li> </ul> <p>Clinicians straying into areas they should not (3)</p>
(Loughland et al., 2015)	Individuals with a diagnosis of schizophrenia. Recruited through community mental health services and the	14 service users, aged 33-65; 9 female, 5 male. Country: Australia	<p>1: The importance of communicating a schizophrenia diagnosis.</p> <ul style="list-style-type: none"> <li>• The majority of participants believed it was beneficial to receive a diagnosis.</li> </ul> <p>2: Dissatisfaction with communication</p> <ul style="list-style-type: none"> <li>• Poor communication skills, including a lack of rapport and empathy, affected the patient's trust in the clinician.</li> </ul>

	Australian Schizophrenia Research Bank Exclusion criteria: individuals with co-morbid drug and alcohol addiction, brain injury or IQ <70.		<ul style="list-style-type: none"> <li>• Patients contrasted the communication styles of case workers and psychologists with that of psychiatrists – the latter perceived as “more concerned with the illness than the person”, and the former with “taking the time” to get to know you.</li> <li>• Difficulties establishing rapport due to high turnover of clinical staff.</li> </ul> <p>3: Good communication</p> <ul style="list-style-type: none"> <li>• Doctors who treated them respectively, communicated well and provided adequate information.</li> <li>• Caseworker with good communication skills, ability to build rapport, educate patients and provide a sense of hope.</li> <li>• Explaining schizophrenia in understandable terms, adapted to the individual.</li> <li>• Conveying a sense of empathy.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
Loughland et al. (2015) cont.			<p>4: Difficulty obtaining information about schizophrenia</p> <ul style="list-style-type: none"> <li>• Paucity of information about the nature and meaning of schizophrenia, which resulted in increased anxiety about their illness.</li> <li>• Accurate, realistic information given provided hope when working towards recovery.</li> <li>• Poor communication about medication and possible side effects resulted in poorer outcomes.</li> <li>• The roles of different mental health staff within treating teams were also poorly communicated and few participants expressed an awareness of their rights.</li> <li>• Patients who felt sufficiently informed were more confident to discuss treatment options.</li> </ul>
(McMullan et al., 2018)	Methodology/ Inclusion criteria  Recruitment took place within an acute mental health hospital in England,	Sample description ()  8 clinicians; 3 mental health nurses and 8 healthcare support workers;	Experiences of mental health nursing staff working with voice hearers in an acute setting. 1: “It’s quite scary really, not unlike a horror movie”. <ul style="list-style-type: none"> <li>• Described feeling shocked and disturbed in response to witnessing voice hearers’ distress.</li> <li>• Potential vicarious trauma.</li> <li>• A prevailing sense of worry about working in an unpredictable, unsafe and confusing environment, which leads them to question their own capabilities. Participants described feeling confused.</li> </ul>

	<p>participants were self-selecting; those who responded to advertising throughout the hospital.</p>	<p>years working in an acute setting ranged from 1-10 years. Country: UK</p>	<ul style="list-style-type: none"> <li>• Feeling anxiety about whether they were able to do the job, fearing that they might be exposed as incompetent workers.</li> <li>• By opening up discussions about the content of people’s voices, they feared that they might make things worse.</li> <li>• Feelings of helplessness, as they did not know what to do or say to lessen the voice hearers’ distress.</li> </ul> <p>2: “I can only influence what’s in front of me”.</p> <ul style="list-style-type: none"> <li>• Struggling to exercise control: feeling powerless and having a sense of being controlled by an authoritative and powerful system to feeling powerful, learning to negotiate power, finding ways to take control and influence people’s lives.</li> <li>• Feeling trapped and helpless, compounded by the hierarchy of the professional groups, with HSWs feeling unable to influence decision-making.</li> <li>• When powerful, participants reported experiencing a good feeling inside and a sense of confidence and competency.</li> <li>• Felt frustrated, either at the stagnation/revolving door, or that the work they can do with voice hearers is not recognised or valued by others.</li> </ul> <p>3: “Just chipping away”.</p> <ul style="list-style-type: none"> <li>• To manage feelings of performance anxiety and self-doubt, they all sought a framework/model to help them make sense of voice-hearing experiences, which included a medical/biological model.</li> <li>• Also drew on a trauma model and spoke about the importance of attending reflective practice groups to help them understand the voice hearer’s experiences.</li> <li>• The reality of the distress and the unpredictable nature of the work meant that they remained “on tenterhooks”. Participants managed this through a sense of duty and responsibility to protect the voice hearer, other service users, colleagues and themselves.</li> <li>• Feeling guilty when they thought they had “let them down” or “not been there enough”.</li> <li>• All participants experienced times of feeling close and connected in their relationships with voice hearers. However, some had felt disconnected and rejected; “at arm’s length”, with voices often seen as a barrier to connection.</li> </ul>
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(Saayman, 2018)	<p>Inductive analytic approach described - Braun &amp; Clarke thematic analysis.</p> <p>Convenience sample of individuals from professional network and through the professional body.</p>	<p>8 psychoanalytically trained psychologists. Country: South Africa.</p>	<p>Psychoanalytic psychotherapists' experiences of disturbance in response to working with psychosis.</p> <p>1: The therapist's experience of madness</p> <ul style="list-style-type: none"> <li>• Working with psychosis produces anxieties for therapists (petrifies them) and the need to disidentify with such patients is very strong.</li> <li>• 'Psychotic' phenomena are experienced as alien, uncanny and way out there.</li> </ul> <p>1a: When thinking fails.</p> <ul style="list-style-type: none"> <li>• When deeply defended against... reality, the patient does not welcome thinking that could lead to an experience of reality, and this has an impact on the therapist.</li> <li>• Participants described the anti-thinking nature of the 'psychotic space' and feeling that metaphorically one can be sucked into something dangerous.</li> </ul> <p>1b: Difficult close encounters.</p> <ul style="list-style-type: none"> <li>• Participants described powerful experiences of their patients getting too close to them.</li> <li>• A sense of being invaded.</li> <li>• The experience of their own body shutting down as a result of their close proximity to madness.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
Saayman (2018) cont.	<p>Inclusion criteria included the following: registration with the Health Professions Council of South Africa as a clinical, counselling or educational psychologist; Training in a psychoanalytic</p>		<p>1c: Breakdown in the therapist's experience of reality.</p> <ul style="list-style-type: none"> <li>• The therapist's experience is influenced by an engagement with the patient's relationship and response to consensual reality.</li> <li>• Being pulled into psychotic perception and needing to ground themselves on a daily basis.</li> </ul> <p>1d: Failing to differentiate between self and other.</p> <ul style="list-style-type: none"> <li>• A breakdown in the psychotic individual's capacity to distinguish between themselves and others, and the psychotherapist's experience of this dynamic further informs the experience of madness.</li> </ul> <p>One participant notes how terrifying it was to become engaged in a manner in which... his reality became distorted.</p> <p>2: The role of the body</p> <p>2a: A dead space, a tired space.</p> <ul style="list-style-type: none"> <li>• The patient benefits from the therapist's ability to think about and navigate difficult affects and experiences.</li> </ul>

	<p>approach to psychotherapy; and experience of having worked for at least 5 years with psychotic phenomena or conditions within clinical practice.</p>		<ul style="list-style-type: none"> <li>• What is emphasised... is the feeling of physical heaviness (dead heaviness) associated with carrying something primitive and unsymbolised.</li> <li>• The work required in the process of therapy with ‘psychotic patients’ is enormously taxing.</li> </ul> <p>2b: Primal hunger.</p> <ul style="list-style-type: none"> <li>• The idea of metabolising, specifically on the therapist’s ability [to] receive the patient’s projections and contain them, think them through and offer them back to the patient in a meaningful, manageable and potentially transformative manner.</li> <li>• One participant related his experience of fear to that of a terrified infant. Another participant described trying to “trap what I am feeling inside whether it be hunger or fatigue” in response to “reality [becoming] more porous”. “I notice that I get hungry when things start to make sense again”.</li> </ul>
(Topor & Denhov, 2015)	<p>Grounded theory. The inclusion criteria: had been or was currently being treated in psychiatry for one or more of the diagnoses psychosis, including schizophrenia, personality disorder and bipolar disorder, and that he/she fulfilled</p>	<p>58 service users; 29 female and 29 male; ages ranged from 18 to over 61; diagnoses: psychosis 41, personality disorder 9, bi-polar disorder 8; selected with the aim of achieving maximum heterogeneity within the SMI spectrum and diversity of length</p>	<p>Going beyond: Users’ experiences of helping professionals.</p> <p>1: Challenging the rationality of the institutions.</p> <p>1a: Special treatment.</p> <ul style="list-style-type: none"> <li>• The professional gives a particular user something over and above what the user has learned to expect as a reasonable and possible form of intervention.</li> </ul> <p>1b: Everyday actions.</p> <ul style="list-style-type: none"> <li>• It is the very ordinariness of these actions, occurring in an institutional setting, that was given a special meaning by the users.</li> </ul> <p>1c: Emotionally charged:</p> <ul style="list-style-type: none"> <li>• Rule infringement... is spontaneous... most of the described helpful actions reflect an emotional quality.</li> </ul> <p>2: Restoring the professional as a person.</p> <ul style="list-style-type: none"> <li>• Helpful professionals were expected to listen to the user’s stories without burdening the user with the professional’s own problems. At the same time, users described helpful professionals as open to making personal disclosures.</li> </ul> <p>2a: The professional’s own needs and desires.</p>

	Warner's (2004) criteria pertaining to social and total recovery.	of contact with psychiatry. Country: Sweden	<ul style="list-style-type: none"> <li>• Sharing a common experience or interest that [is to do] with the patient's experiences and competence outside the sphere of mental illness.</li> <li>• The professional took the initiative to go beyond his/her formal role, [and appeared to desire] the contact.</li> </ul> <p>2b: Has seen something in the user... beyond a diagnosis.</p> <ul style="list-style-type: none"> <li>• The user is no longer reduced to a one-dimensional patient role.</li> </ul> <p>2c: Reciprocity.</p> <ul style="list-style-type: none"> <li>• The professional gets something for him/herself from the relationship with the user, it brings about a change in how the user relates to the professional and the surrounding world.</li> </ul> <p>2d: Taking a risk.</p> <ul style="list-style-type: none"> <li>• Professionals who go beyond the institution's rules run a risk if they are found out. They can be accused of being overly involved in the user and failing to maintain professional distance.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
Topor & Denhov, 2015 (cont.)			<p>3: Restoring the patient as a person.</p> <p>3a: To be chosen.</p> <ul style="list-style-type: none"> <li>• Conveys to the user that... he is accepted as a complex person behind the 'illness'.</li> </ul> <p>3b: To be appreciated.</p> <ul style="list-style-type: none"> <li>• "I felt he was someone who had a special liking for me"</li> </ul> <p>3c: To be given, and have, value</p> <ul style="list-style-type: none"> <li>• Such an experience was of great importance for persons whose social relationships consisted mainly of a one-sided dependency on others for support; relationships that are perhaps necessary, but which nevertheless may reinforce the feeling of being without value.</li> </ul> <p>4: "Almost like a friend"</p> <p>Many users characterised helpful professionals in this way. It is not a question of having replaced a professional relationship with an ordinary friendship.</p>
(White et al., 2019)	Thematic analysis using a general	9 early career nurses in	Working with consumers who hear voices: The experience of early career nurses in mental health services in Australia.



	<p>inductive thematic approach.</p> <p>Purposive selection strategy following individuals having contacted via information sheets being distributed in 2 public health services in NSW, Australia. Services selected to represent a range of mental health services.</p>	<p>Australia; having worked as registered nurses from 1-5 years. No additional demographics provided to ensure confidentiality. Country: Australia</p>	<p>1: Responding to consumers who hear voices.</p> <p>1a:</p> <ul style="list-style-type: none"> <li>Administering medication: "I think the medication is... the goal".</li> <li>Reducing distress associated with the voices: "She was just... too frightened".</li> <li>Offering PRN medication was the most common response to reducing consumer distress.</li> <li>Talking to the consumer, or being with the consumer, was also a way to reduce distress.</li> <li>Other techniques including diverting the consumer's attention away from the voices and reality testing, the use of earphones while listening to music.</li> <li>However another participant noted that these techniques were not particularly successful.</li> <li>The relationship between consumer distress and the perceived power and control of the voices was very aptly described by one participant illustrating the feeling of helplessness to reduce the distress that was expressed by many participants</li> </ul> <p>1b: Reducing risk and promoting safety: 'If I feel so scared [. . .] how am I supposed to be helping this person?'</p> <ul style="list-style-type: none"> <li>Distress and agitation [among clients] engendered anxiety and fear as participants had experienced violence in the workplace.</li> <li>Expressions of personal fear and not knowing what to do were also commonly reported accompanied by a sense of powerlessness.</li> <li>When consumer distress was perceived as being out of their control, participants focused on external control and talked about the use of force, or restraint to restore order.</li> </ul> <p>1c: Building rapport and a relationship: 'If somebody has a good rapport with you, [. . .] they're much more willing to share their vulnerabilities'</p> <ul style="list-style-type: none"> <li>When unable to gain a consumer's trust, one participant described observing them to determine whether they were hearing voices.</li> <li>Participating in a hearing voices simulation had helped to better develop rapport.</li> </ul>
Study authors	Methodology/ Inclusion criteria	Sample description	Main findings/ themes (verbatim from study as far as possible)
White et al., 2019 (cont.)	Inclusion criteria: an early career		2: Developing knowledge and skills: "we have to do a lot of training ourselves".

	<p>Registered Nurse, employed in a mental healthcare service, and within the last three months had cared for a consumer who hears voices.</p>	<ul style="list-style-type: none"> <li>• Participants described a mixture of admiration and disappointment in their more experienced colleagues.</li> <li>• None of the participants felt they currently had enough knowledge and skills.</li> <li>• Lack of structure for learning on their job.</li> </ul> <p>3: Viewing the role of the mental health nurse “There’s not a clear understanding”.</p> <ul style="list-style-type: none"> <li>• View that there is no difference between caring for consumers who hear voices and caring for all consumers.</li> <li>• Perceived lack of ability to help or awareness that they could help.</li> </ul> <p>4: the impact of the practice context “Won’t be doing those therapeutic interventions”.</p> <p>Inpatient work was less highly regarded and perceived as unskilled by some of the participants, while community work was not only seen as skilled but also as a role that belonged to the advanced practice nurse.</p>
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### Appendix C: Strengths, limitations and implications of each study

Study authors	Strengths of study	Weaknesses of study	Implications/ future research recommendations
(Amsalem et al., 2018)	Demonstrates how subtly pessimism and stigma can be transmitted, and how a recovery approach is not being used in initial crucial conversations. Good that they incorporated families' responses.	No bracketing interviews mentioned, potential bias mentioned only briefly in the discussion. Very little information given on considerations of interviewers'/ investigators own role and biases (participants' response bias was referred to in the discussion, and the fact that one of the researchers was a staff member at the hospital where the research was undertaken). Difficult to generalise, as the results could have been specific to the way that these individuals were treated at that hospital.	Mental health providers' awareness of subtle stigmatising messages should be increased through workshops and professional training.
(Bogen-Johnston et al., 2019)	Information provided on reflexive positioning of the authors. Assessment of the quality and rigour of the analysis was also carried out.	Small sample of practitioners from one NHS service (EIP) in two settings. Themes and interpretations may be subject to personal preconceptions (although this was mitigated by exploring reflexive positioning)	Recruit practitioners from a broader range of EIP services and explore similarities and differences across services. Focus specifically on barriers and enablers for practitioners to support voice hearers. Explore the service user experience of receiving such support. Explore how practitioners can continue conversations about voices beyond psychological therapy.

(Bogen-Johnston et al., 2017)	Informative study on the factors influencing disclosure of voices. Has relevance to service delivery and staff responses.	No discussion about the consideration given to the location of interviews (NHS vs. participant's home), nor to any interactions between or influence of the interviewer on the participants.	A need to explore and challenge barriers to disclosure. Strategies that focus on (1) facilitating hearers to disclose voices at onset and (2) encouraging positive responses from individuals who receive disclosure. Public education about initial symptoms of mental issues and the necessities of early intervention, so that families can facilitate pathways to care and to de-stigmatise. In order to de-stigmatise mental illness, a 'Headspace' model to be introduced, which offers support with a range of health and social care needs. Evaluating the training needs of GPs to address uncertainty around assessing for and discussing voices. Increased provision of training to deliver CBT for psychosis.
(Coffey & Hewitt, 'You don't talk about the voices': Voice hearers and community mental health nurses talk about responding to voice hearing experiences, 2008)	Interviewing service users and the CMNHs they worked with allowed exploration of different perspectives on the same interactions, especially about professionals' responses to their symptoms.	No interview schedule provided. No information provided about how the researchers considered their own role, potential bias or influence in the study. Limited sample from one area of the UK leads to questions about generalisability. Focused interview approach may limit alternative avenues of investigation.	A need for mental health nurses to focus on the expressed needs of service users rather than biomedical edicts of psychiatry. Should involve exploration of the content and meaning of voices, with links to past and present experiences and the patient's interpretation. Service user inputs to nurse education.

<p>(Coffey et al., 'Therapy as well as the tablets': An exploratory study of service users' views of community mental health nurses' (CMHNs) responses to hearing voices, 2004)</p>	<p>Mix of qualitative and quantitative methods aids triangulation of data.</p>	<p>No information about the researchers' own role in the study, including potential biases. Structured nature of the interview schedule may have limited responses. Uncertain generalisability due to small sample from one area of the UK.</p>	<p>Further research aimed at establishing the influence of personal control upon attempts at coping with hearing voices may elicit areas in which CMHNs could help (for example supporting development of personal control and efficacy). Support from other service users in similar circumstances. CMHNs to more flexibly respond to the needs of voice hearers and to explore their experience and meaning of the voices.</p>
<p>Holttum et al. (2021)</p>	<p>Iterative process of thematic identification, using grounded theory. One strength was that participants were consulted on the model and amendments were made subsequently. The author was aware of her own potential bias. Difficulties were described respectfully.</p>	<p>No details of how the potential for participant distress was dealt with (for example, discussing distressing client experiences or their own difficulties). Also the impact of the researcher in the interviews was not addressed (e.g. social desirability effects).</p>	<p>Specific sample allows depth, and the implications could be (possibly more) relevant to other professions, which may have less provision made for supervision, training or workplace support.</p>
<p>(Kakatura et al., 2010)</p>	<p>Provides the perspective from a very different culture, especially relevant given the health care policy differences (28.4 hospital beds per 10,000 people, compared with 7.7 in the US, 5.8 in the UK, and 3.9 in Australia; average hospital stays of 331.6 days). Interesting in that it explores the process of clinicians changing</p>	<p>The fact that the study has been translated from Japanese may limit understanding of meanings. Small sample size limits generalisability even within Japan. However, it has face validity for generalisability to other countries and settings. No mention made of the researchers' own role</p>	<p>The authors developed an educational programme based on the results of the study, to help nurses identify their preconceptions and work towards developing an equal footing with clients.</p>

	their views towards patients.	in the research and potential biases.	
(Laugharne et al., 2011)	Interesting topic. Rigorous analysis, ensuring saturation was reached and themes were agreed by four researchers. A range of service users were interviewed in two areas of the country.	Interviewer was a psychiatrist however there is no information on the researchers' potential bias in interpreting interviews. Nor about the impacts of power relationships in recruitment. Also, very little rationale given for why they researched this topic. Self-selecting sample may have affected findings.	Recommend improvements in service user involvement in decision-making bodies. Also spending time with patients beyond merely providing evidence-based interventions to build trust and rapport. Greater provision of information to patients to help them have more choice. Greater consideration to be given to patients's sense of implicit coercion in relation to involuntary detention. Research recommendations: focus on how patient experience can be improved through the provision of more information and different clinician behaviour.
(Loughland et al., 2015)	Research findings relevant to psychiatrists (it was published in a psychiatry journal). Produced findings from a relatively under-researched area.	Differences in length of time since diagnosis may mean that practices have changed in that time. Difficult to examine recruitment strategy due to this being detailed in another study.	Communication skills training for psychiatrists, bearing in mind the risk of stigmatising or labelling.
(McMullan et al., 2018)	Researcher conducted a reflexivity interview to consider how her own perspectives may influence data interpretation.	Limited generalisability due to small sample size from one hospital in the UK. The sample only focused on a sample of HSWs and MHNs in hospital. However, homogeneity is key in IPA methodology.	Greater emphasis on staff supervision and support. Training, alongside ongoing reflection and support around real-life practice.
(Saayman, 2018)	Provides a unique perspective of	Relatively small sample size of	Further investigation into somatic phenomena

	<p>psychoanalytic therapists' perspectives working with individuals with psychotic experiences, providing a different focus and language to describe their experiences.</p>	<p>therapists in South Africa may limit generalisability, although the findings echo other studies' findings. It is also unclear to what extent the findings are generalisable to the UK, as this is not a NICE-recommended therapeutic approach for psychotic experiences. Many aspects of the study methodology were unclear; for example, in the results section it was unclear what was a summary of the theme emerging from the interviews, and what was from previous literature. Some of the language appears disrespectful, such as the use of 'madness', and negative language used about clients quoted from interviews.</p>	<p>experienced by the patient and the therapist.</p>
<p>(Topor &amp; Denhov, 2015)</p>	<p>Interesting study about what clinicians can do to contribute to recovery. Has implications for what is typically thought of as good practice, such as 'maintaining boundaries'.</p>	<p>Data was used from a previous study, so some aspects of the study methodology were unclear, such as ethical consent (presumably these were described in one of the three previous publications). Swedish study may limit generalisability to the UK, however the findings have face validity for being generalisable.</p>	<p>Implications for professional work, situating the service user in the context of their personal history and social situation, acknowledging their resources as well as their difficulties in life, and enabling staff members to have a more human relationship without this being seen as a risk factor.</p>
<p>(White et al., 2019)</p>	<p>Considered data saturation.</p>	<p>Did not use a particular</p>	<p>Further investigation into nurses' preparation</p>

	<p>Researcher kept a reflective diary to ensure bias in interpretations was minimised. A recently published study, this provides information about nurses who have recently qualified, allowing an understanding about whether current training programmes affect their exploration of voice hearing.</p>	<p>methodology, however, the authors did provide a justification for this. Small study using a self-selecting sample. To preserve confidentiality many demographic characteristics were not reported.</p>	<p>and support for working with voice hearers and putting their knowledge and skills into practice. Changes need to be made in the prevailing culture to enable newer colleagues to put their skills into practice, and for more experienced nurses can respond to evidence-based approaches.</p>
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## **Appendix D: Author guidelines for publication in Psychosis journal**

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the [Uniform Requirements for Manuscripts Submitted to Biomedical Journals](#), prepared by the International Committee of Medical Journal Editors (ICMJE).

### Structure

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**Part B**

How training, stereotypes and stigma may lead to discriminatory behaviours when working  
with voice hearers.

Word count: 7999 (8156 after corrections)

Journal: Psychosis (please see Appendix I for author guidelines)

### **Abstract**

Clinicians working with voice hearers traditionally aimed to shut down or remove the voices. In recent years, research has revealed voice hearers desire to and benefit from talking about the voices. Clinicians' attitudes may present one barrier to exploring voices. It has been theorised that training and experiences lead to stigmatising attitudes, which translate to behaviours. Research has also found that biomedical perspectives increase stigma. This study used a mixed-methods approach to explore these factors in a large sample of NHS staff.

Findings provided partial support for the hypotheses. Clinicians in more psychosocial professions, or with specific voices training or personal experience of voices or voice hearers tended to have lower stigma, and to describe more exploratory and psychosocial interactions with voice hearers. Hospital-based support workers and psychiatrists had higher stigma and low levels of training.

Clinicians predominantly described providing reassurance and encouraging distraction, both approaches which may be unhelpful. Many also described developing validating, empathic therapeutic relationships and more helpful techniques such as psychoeducation, hopefulness, normalising, and exploring voices.

The results support the expansion of the peer worker role. There is a need for additional training, especially for hospital-based support workers and psychiatrists.

*Key words:* Clinicians, stigma, attitudes, hallucinations, voice-hearing, Maastricht

Auditory verbal hallucinations (AVH) are defined as sounds (often voices) experienced in the absence of an appropriate stimulus, experienced in a conscious state and not caused by organic or state-dependent circumstances such as substance use (Beck & Rector, 2003). They often have a compelling sense of reality (McCarthy-Jones, 2012; McCarthy-Jones et al., 2015). A systematic review and meta-analysis estimates mean lifetime prevalence in the adult general population to be 5.8% (Maijer et al., 2018). Although it is often distressing, many voice hearers do not need care or support (Baumeister et al., 2017; de Leede-Smith & Barkus, 2013) and around half of voice hearers report hearing a positive or useful voice at some point (Jenner et al., 2008).

### ***A note on terminology***

The term 'patient' has been used when appropriate in this text. Whilst a medical term, this has been found to be preferred by the majority of UK mental health service users (Dickens & Picchioni, 2012; Simmons et al., 2018). It is acknowledged that there are different views on terminology, and the reader is directed to Slade (2009) for a further exploration.

### **Voice hearing**

In a mental health context, voice hearing is predominantly associated with a psychosis diagnosis such as schizophrenia (APA, 2013; Bauer et al., 2011), and has been most commonly researched in this context. It is also experienced as part of a range of other diagnoses (Paulik et al., 2018; Kingdon et al., 2010; Moskowitz et al., 2017). Childhood trauma may contribute to negative content of voices (Romme & Escher, 2006; Scott et al.,

2020), and there are suggestions that voice hearing may be a dissociative phenomenon related to traumatic experiences (Moskoitz & Corstens, 2007).

The aim in treating voices, especially in Westernised countries, previously tended to be to reduce or remove the voices and discouraged exploration of the experience (Slade & Haddock, 1996; Corstens et al., 2008). Fears were expressed that exploring voices might worsen symptoms of psychosis (Smith, 2007). Developments in theoretical understanding and psychological interventions have since advanced the concept that voices are meaningful, rather than merely a symptom of illness (Klapheck et al., 2014; Longden et al., 2012; Romme & Escher, 2006) and that accepting the voice hearing experience and understanding it in relation to one's life experiences may be helpful for recovery (Corstens et al., 2014; Romme & Escher, 2000).

The Maastricht Approach to working with voices is a framework developed to guide exploration of the voice hearing experience. It covers a range of topics, exploring the experience, relationship between the voices and the VH, relating the voices to past experiences, impact on daily life and coping strategies (Corstens et al., 2008). This may help develop formulations and guide treatment. CBT approaches advocate discussing the voices, with the aim of helping the person to develop coping strategies to reduce the power and control the voices have and to develop a more positive relationship with the voices (Hayward et al., 2018).

Qualitative research into voice hearers' perspectives has highlighted a desire to discuss the meaning of these experiences (Coffey & Hewitt, 2008; Griffiths et al., 2018), but that they perceive clinicians as not engaging with the experience (Coffey & Hewitt, 2008; Coffey et al., 2004). Those who cope better are more likely to have talked about voices and

feel they have more supportive, positive and understanding relationships with others (Hayward et al., 2015; Hewitt & Coffey, 2005; Romme & Escher, 2000; Romme et al., 2009). As part of their recovery, voice hearers report needing support to develop a normalised attitude to voices (i.e. as a normal response to their life experiences (Kilbride et al., 2013), acceptance (Hayward et al., 2015) and engagement with the meaning of the experience, alongside (at times of despair) harnessing resources such as medication to survive the experience (de Jager et al., 2016). Quantitative research corroborates this, concluding that discussing experiences helps people with a psychosis diagnosis to make sense of their experiences (Klapheck et al., 2014) and that using multiple coping strategies helps them to succeed academically and occupationally (Cohen et al., 2017). Negative appraisals of the voices has been linked to need for care in voice hearers, whereas the use of emotional coping skills appears to help (de Leede-Smith & Barkus, 2013). It therefore appears important that voice hearers feel able to share and discuss their experiences, and that clinicians are responsive, able to convey a normalising view of voices, flexible and able to support the development and use of coping strategies when disclosures are made.

### **Stigma**

According to Vilhauer (2017), stigma is one of the main barriers to talking about voice hearing experiences. Stigma may lead to hopelessness and social exclusion, thereby affecting recovery (Alyahya et al., 2020). A survey amongst the general population has revealed stigma toward schizophrenia is linked to emotions of fear and stereotypes of unpredictability, incompetence and dangerousness (Thonon & Larøi, 2017). Clinicians prefer more social distance (de Jacq et al., 2020; Hansson et al., 2013; Stuber et al., 2014), believe

that people with schizophrenia could be dangerous (Giandinoto et al., 2018; Mannarini et al., 2020), and lack hope for recovery (Vistorte et al., 2018).

Despite attempts to reduce stigma in the general public (e.g. Evans-Lacko et al., 2014), clinicians continue to hold negative attitudes towards mental illness (de Jacq et al., 2020) and schizophrenia (Valery & Prouteau, 2020). Clinician factors such as fear of being assaulted, low personal accomplishment and cautiousness personality traits have been linked with higher stigma (Zaninotto et al., 2018). More experience in the mental health field, higher education level and having been diagnosed with a mental health difficulty have been associated with lower mental health stigma amongst clinicians (Stuber et al., 2014). Anti-stigma interventions do show some promise in reducing stigma around voice hearing (Reddyhough et al., 2020).

The reaction of others may influence appraisals of the voices. For example, establishing an attitude of disapproval or rejection toward the voices, which a systematic review has concluded can worsen voice-related distress (Mawson, et al., 2010). Whereas developing an understanding and constructive relationship with voices can be very helpful (Faccio et al., 2013; Hayward et al., 2015).

### **Stigma models**

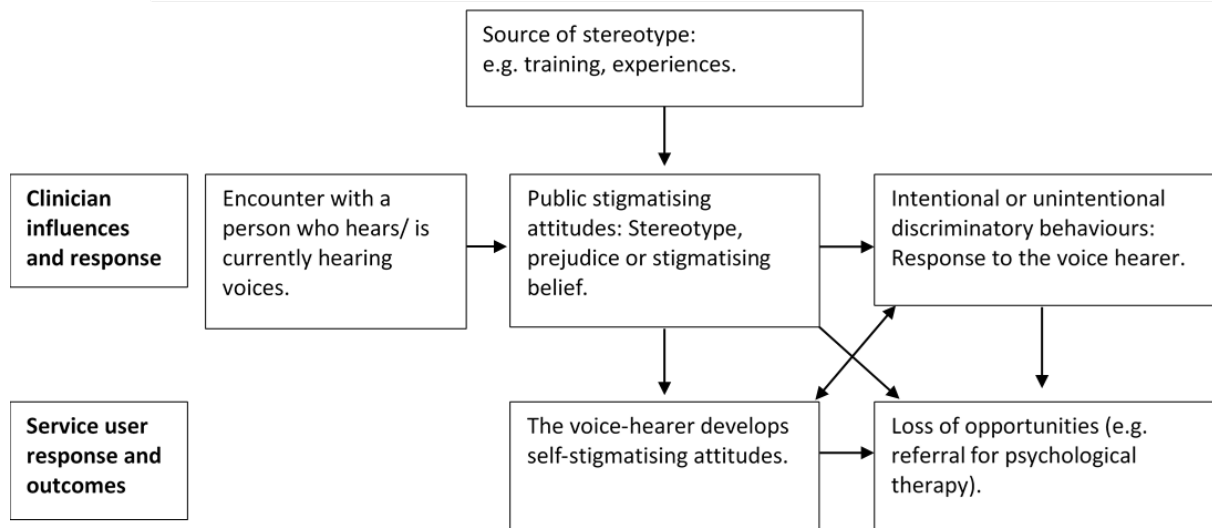
The social-cognitive model of stigma (Corrigan, 2002; Corrigan, Markowitz, & Watson, 2004) suggests that signals (for example, diagnoses or experiences such as voice hearing) cue certain attitudes or stereotypes which have been learnt. These stigmatising beliefs are hypothesised to bring about discriminatory behaviours (see figure 1), to result in the patient self-stigmatising, and result in loss of opportunities for the patient.



Building on this, Thornicroft, Brohan, Kassam and Holmes (2008) proposed that stigma can be seen in terms of lack of knowledge, attitudes, and behaviour (discrimination). They recommended that interventions to reduce stigma include direct social contact and advertising to improve knowledge among the general public.

**Figure 1**

**Figure 1**  
Applying Corrigan, Markowitz and Watson's (2004) social cognitive model to the interaction between a clinician and a voice-hearer.



### ***Source of stereotypes: training and experiences***

Amongst clinicians, sources of stereotypes may include personal or work experiences, or the orientation of training. There is mixed evidence whether increased contact between clinicians and patients is associated with lower mental illness stigma (Henderson et al., 2014; Mittal et al., 2016). Allport's contact theory (Allport, 1954; Hewstone & Swart, 2011) would propose that quality of contact, involving common goals, equal status or rewarding interactions may be necessary to reduce mental health stigma (for reviews relating to mental health, see Corrigan & Shapiro, 2010; Jorm et al., 2012). A meta-

analysis has found that both education and contact reduce stigma when used in anti-stigma interventions (Corrigan et al., 2012).

Staff treating patients with a psychosis diagnosis or working in inpatient settings have been found to hold the most negative attitudes (Hansson et al., 2013; Valery & Prouteau, 2020). This corresponds with the quality of the contact being crucial, since contact with people at their most unwell and/or who may pose a risk to themselves or others may affect staff attitudes negatively. Because individuals are discharged from services when they recover, clinicians have most contact with acutely unwell patients, which can lead to pessimism about treatment and recovery (Ross & Goldner, 2009; Vistorte et al., 2018).

Personal rather than professional contact may reduce negative attitudes (Arbanas et al., 2019; Henderson et al., 2014). Indeed, research has found that personal familiarity is linked to increased knowledge, improved attitudes and less intended social distance in the general public (Henderson et al., 2016) and reduced explicit stigma amongst medical trainees and psychiatrists (Sandhu et al., 2019).

Although there is a paucity of research into the effects of peer workers on stigma, a literature review has concluded that they can benefit services in a number of ways, such as driving cultural change (Gillard & Holley, 2018). Lived experience has been found to be associated with reduced stigma (Harris et al., 2016), and there is emerging evidence that supporting disclosure of lived experience of mental health difficulties may reduce stigma in organisations (Harris I. et al., 2019).

Professionals' orientation of training and causal explanations of mental health difficulties may also affect their attitudes. For example, primary care clinicians and

psychiatrists express more negative attitudes towards mental illness than mental health nurses or psychologists, which the authors concluded was due to the medical orientation of their training leading to a focus on dysfunction rather than strengths (Smith et al., 2017).

A biomedical view of schizophrenia as “an illness just like any other” (Larkings & Brown, 2018, p. 928) has been promoted as a strategy to reduce blame and stigma (e.g. National Alliance on Mental Illness, n.d.). However, a meta-analysis has found that whilst biogenetic explanations of schizophrenia have been found to reduce blame, they were associated with greater perceptions of dangerousness and pessimism about recovery (Kvaale et al., 2013). Systematic reviews have concluded that biological beliefs were associated with higher stigma or negative attitudes amongst both patients and mental health professionals towards mental distress and schizophrenia (Larkings & Brown, 2018; Schomerus et al., 2012; Valery & Prouteau, 2020). There is a wide body of evidence reporting that a biological understanding of mental illness is associated with aspects of stigma including pessimism for recovery, desire for increased social distance and perceived dangerousness (Angermeyer et al., 2011; Dietrich et al., 2004; 2013; Kvaale et al., 2013; Magliano et al., 2017). A systematic review (Carter et al., 2018) concluded that most individuals with a psychosis diagnosis had psychosocial explanations for their experiences, and that those with biological causal beliefs had worse internalised stigma, and were less likely to consider that they could have some control over their experiences. The authors suggested that contact with mental health services influences patients’ beliefs in a biomedical direction.

A recent systematic review revealed that biomedical approaches toward treatment and recovery prevail among mental health staff working with people with psychosis (Morera

et al., 2017). These beliefs may reduce clinicians' likelihood of discussing voice-hearing or referring for psychological therapies, with a corresponding increased focus on medication and risk (Berry & Haddock, 2008; Carter et al., 2017; Larkings & Brown, 2018; Magliano et al., 2017; McMullan et al., 2018; Singh et al., 2003). A bio-genetic conceptualisation of schizophrenia has been found to be associated with dehumanising the patient and more favourable attitudes towards restraint (Pavon & Vaes, 2017). Interestingly, the authors found that attribution of symptoms to genetic causes was associated with higher professional satisfaction and lower rates of burnout (Pavon & Vaes, 2017). Patients who have learnt a biomedical causal model from clinicians have been found to be more willing to take medication, but to have much lower perceived personal control over their symptoms (Lüllmann et al., 2011). They have described dissatisfaction with over-medicalising approaches (Hopkins et al., 2009; Rydon, 2005).

***Unintentional or intentional discriminatory behaviours: response to the voice hearer***

With regard to the current study, intentional or unintentional discrimination may take the form of not receiving the care which is recommended in national guidelines, which includes psychological therapies and addressing social issues (NICE, 2014). Waddingham (2019) suggests this may be due to a lack of funding, availability of services, clinician training, clinician awareness about how best to care for voice hearers, or all of these.

A qualitative study (Coffey & Hewitt, 2008) found that nurses perceived that they had engaged patients about their voices, however voice hearers saw their care as emphasising a medical paradigm. Nurses in that study expressed anxiety and uncertainty about the value of discussing voices in greater depth (Coffey & Hewitt, 2008). A recent study found that clinicians reported reservations about prioritising medication, but lacked

confidence using psychosocial interventions with voice hearers (McCluskey & deVries, 2020). Clinicians' confidence may be affected by factors such as lack of time or training and anxieties about appearing incompetent or worsening symptoms, causing them to turn to medical explanations and structured tools to gain a sense of control (McMullan, Gupta, & Collins, 2018). Unwillingness to discuss voices, alongside biomedical causal explanations, may present a barrier to accessing psychological treatments, which are rarely accessed by individuals with diagnoses of psychotic disorders (Carter et al., 2017; Magliano et al., 2020; Schizophrenia Commission, 2012). Providers of psychological therapies have described pressures to offer fewer sessions and a sense that they "can easily be cut from services" (Holttum et al., 2021, p. 4). Coercive, invalidating or hostile responses from clinicians may replicate earlier damaging relationships, which have been found to be associated with voices' malevolence and omnipotence (Carvalho et al., 2015); features which are associated with distress (Birchwood & Chadwick, 1997). Pity may be associated with patients' increased depression, hopelessness, and decreased empowerment and self-esteem (Fominaya et al., 2016).

It has been suggested that the use of biomedical labelling and pharmaceutical treatments is in itself stigmatising (Thatchuk, 2011). Research has revealed that service users feel stigmatised when coercive (Sapey, 2013), disrespectful (Harangozo et al., 2014) or paternalistic (Mestdagh & Hansen, 2014) approaches are used. It has also been suggested that antipsychotic medications do more harm than good (Whitaker, 2016). Thornicroft and colleagues (2018) proposed that psychiatrists can reduce discrimination in their encounters by referring for psychological therapy and promoting realistic optimism about recovery.

### **Therapeutic alliance**

Recent reviews have concluded that whilst stigma is one of the most frequently reported barriers to recovery, a positive therapeutic alliance can be one of the greatest enablers of recovery from a psychosis diagnosis (Alyahya et al., 2020), and is predictive of improved functioning and engagement with treatments (Browne et al., 2019). The therapeutic relationship is reported to be one of the key tools clinicians use in their care of people who hear voices (McCluskey & deVries, 2020). A synthesis of qualitative evidence has found that stigma can be overcome through acceptance, kindness, communication and understanding (Wood et al., 2015), and a sense of acceptance may increase patients' feelings of hope and belonging (Işık & Ergün, 2019). A recent systematic review has found that alliance predicts symptomatic outcomes of psychosis, and therapists' genuineness, trustworthiness and empathy were associated with better client-rated alliances (Shattock et al., 2018). The therapeutic relationship with clinicians may provide an attachment figure to help voice hearers heal and recover from childhood trauma (Berry et al., 2020; Bucci et al., 2020).

### **National guidance**

National guidance for NHS staff (NICE, 2011) recommends care being offered in an "atmosphere of hope and optimism", and building "supportive, empathic... relationships as an essential part of care" (p.7). It recommends that stigma and discrimination should be taken into consideration, and that in addressing this, professionals should be competent in assessment skills and explaining mental distress from "a range of cultural, ethnic, religious or other diverse backgrounds" (p.9). NICE guidance also recommends (in addition to medication) that psychological, family and arts therapies, social and occupational interventions are offered to everyone with a diagnosis of schizophrenia (NICE, 2014). The

early intervention in psychosis framework recommends low stigma interventions, encouraging help-seeking and engagement, and therapeutic optimism (IRIS, 2012).

### **The present study**

The present study explored responses to voice hearers, based on the presented adaptation of Corrigan and colleagues' (2004) model (Figure 2). Whilst biomedical explanations have been found to be associated with certain aspects of stigma (e.g. Kvaale et al., 2013), whether these two factors translate to behaviours remains less clear. The present study sought to explore whether previously found links between training and experiences, stigma and attitudes and behaviours were apparent in a large, nationally representative sample of NHS mental health staff working with voice hearers.

If similar processes are taking place to those previously described in smaller-scale studies and in mental health more generally, this may potentially suggest a need for training to provide services which reflect previous findings about what voice hearers want from clinicians, such as facilitating greater understanding of their voices, or for anti-stigma training. Additionally, if links are found between personal experience and reduced stigma or less discriminatory behaviours, this may support the expansion of the peer worker role (NHS, 2019) or support for clinicians to share their lived experience.

Although qualitative research suggests that patients perceive that clinicians rarely explore the voice hearing experience (Coffey et al., 2004; Coffey & Hewitt, 2008), larger-scale research on clinician-patient interactions is lacking. A qualitative element in the present study allowed examination of the extent to which encounters are described as exploratory and use psychosocial approaches, along with inductive identification of themes

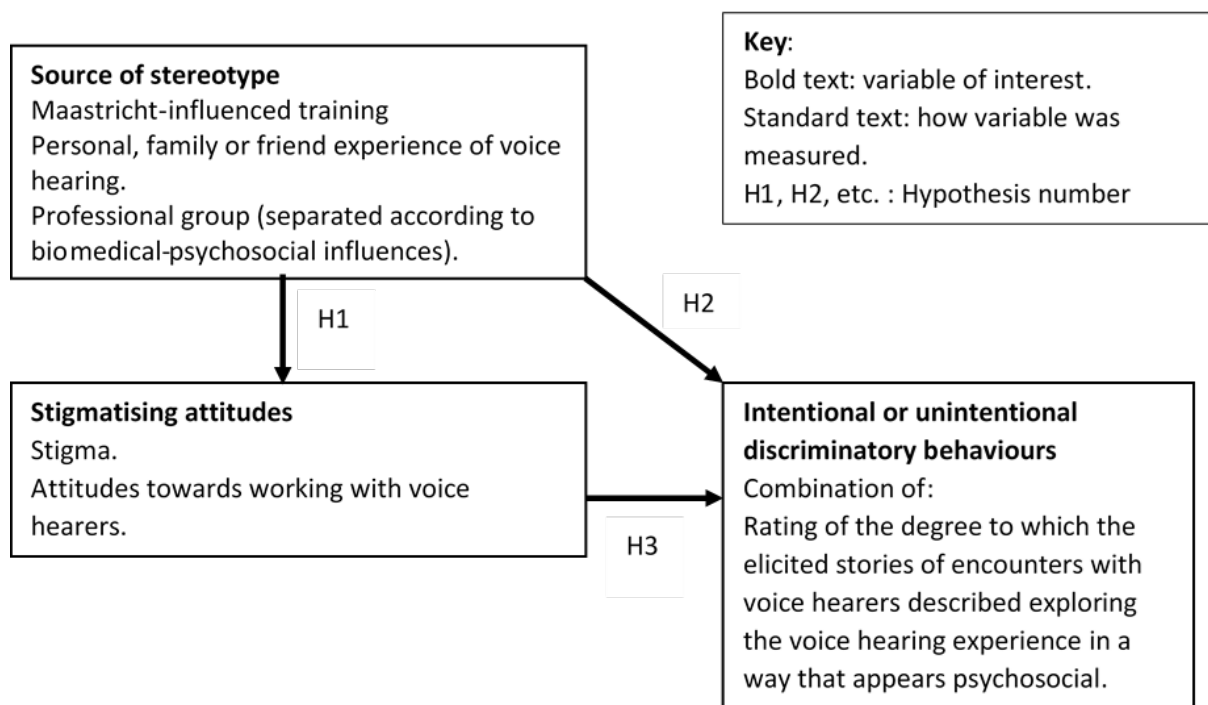
from the data which may have been missed by standardised outcome measures. This additional contextual information could help in understanding quantitative findings.

By exploring whether evidence-based practice is taking place, and whether clinicians are responding to ways in which patients have indicated that they would prefer, the project supports the NHS values of aspiring to the highest standards of excellence and professionalism and prioritising patients' needs.

## Figure 2

### Figure 2

*Model used in the current study*



### **Hypotheses and aims**

Hypothesis 1a: Participants who have received Maastricht-informed training and/or personal experience will have less stigmatising attitudes.



Hypothesis 1b: Professions with more psychosocial training and experience will have less stigmatising attitudes.

Hypothesis 2a: Participants who have received Maastricht-informed training and/or personal experience will have interactions rated as more exploratory and psychosocial.

Hypothesis 2b: Professions with more psychosocial training and experience will have interactions rated as more exploratory and psychosocial.

Hypothesis 3: Less stigmatising attitudes will be associated with more exploratory and psychosocial-rated encounter descriptions.

### ***Qualitative aims***

Qualitative aims: Exploring what clinicians' intentions and actions were, and what themes were apparent in descriptions of encounters with voice hearers.

## Method

### Design

This study was a predominantly quantitative mixed-methods, between-groups cross-sectional study (represented as 'QUAN + qual' in Palinkas et al., 2011). It featured a battery of self-report questionnaires and a qualitative question in which participants described a recent interaction with a voice hearer. It was an elaborative design, which allowed for triangulation, combining the breadth of a quantitative approach with deeper understanding of the manner in which services are being delivered. Both enabled comparison with previous research. Both inductive and theoretical thematic analysis were used, based on the research questions (Braun & Clarke, 2006). Variables used in the analysis are listed in Table 1.

**Table 1: Variables used in analysis**

Hypothesis number	Independent variables	Dependent variables
1a	Training: having received Maastricht-informed training. Personal experience: self, family or friends having experienced voices.	Stigma (AQ-9) <sup>1</sup> Attitudes and beliefs about working with voice hearers (AAPPQ) <sup>2</sup>
1b	Professional group (nurses, psychiatrists, psychosocial professions, hospital-based HCSWs, community-based HCSWs).	Stigma (AQ-9) Attitudes and beliefs about working with voice hearers (AAPPQ)
2a	Training: having received Maastricht-informed training. Personal experience: self, family or friends having experienced voices.	Exploratory/ psychosocial rating: Rating of the degree to which the elicited stories of encounters with voice hearers described exploring the voice hearing experience multiplied by a rating of whether the encounter was described as predominantly psychosocial (as opposed to biomedical). <sup>3</sup>
2b	Professional group (nurses, psychiatrists, psychosocial professions, hospital-based HCSWs, community-based HCSWs).	Exploratory/ psychosocial rating: Rating of the degree to which the elicited stories of encounters with voice hearers described exploring the voice hearing experience multiplied by a rating of whether the encounter was described as predominantly psychosocial (as opposed to biomedical).
3	Professional group (nurses, psychiatrists, psychosocial professions, hospital-based HCSWs, community-based HCSWs).	Stigma (AQ-9) Attitudes and beliefs about working with voice hearers (AAPPQ)
Research question		
1	Themes featuring in qualitative data (inductive)	

Notes. <sup>1</sup> AQ-9 (Corrigan et al., 2014). <sup>2</sup> AAPPQ (McLeod et al., 2002). <sup>3</sup> See text for detailed

description of analysis.

**Procedure**

The study received ethical approval from the Salomons Ethics Panel (Appendix A) the Health Research Authority (Reference: 048 HAY/ IRAS ID: 257355,) and IRAS (Appendix B).

Data for the present study was gathered alongside another study, which also explored data from clinicians working with under 18s. The survey included items not used for the present study, relating to the theory of planned behaviour (please see Appendix C for the full survey, indicating questions not used).

**Recruitment**

Clinicians were invited to participate through the research department of their NHS Trust or Clinical Research Network, and through advertisement materials. Participants gave informed consent to voluntarily participate in the anonymous study as the first page of the online survey; those who declined were not given the option to continue with the self-report questionnaires. Average survey completion time was 37 minutes.

**Participants**

Inclusion criteria for the present study was NHS clinicians who work in mental health services with adult voice hearers (aged 19 years and over) who consented and completed demographic questions ( $N = 1018$ ).

An *a-priori* sample size analysis gave a minimum sample size of 960, for a 5 group, between-groups analysis with a 2-tailed hypothesis, with the alpha level at .01. For regression with 9 predictors, the minimum sample size was 127 (Free statistics calculators, 2018). For the Kruskal-Wallis test, the minimum sample size was 5 per group.

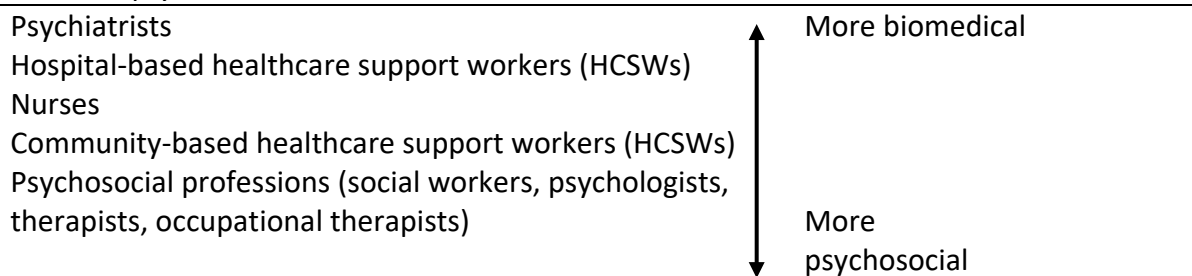
**Materials**

### ***Demographic and sampling characteristics***

In addition to demographic information, participants were asked to provide a range of details about their profession, work setting, experience with voice hearers and, additional training on voice hearing and whether they or someone close to them had heard voices. Where more than one profession was selected, the highest paid, most senior or most patient-facing profession was selected for analysis (for examples, see Appendix D).

Professions were divided into groups according to whether their training and experiences could be considered to be more psychosocial or biomedical (for details, see Figure 3 and Appendix E). Respondents who were not mental health clinicians were excluded from analysis (classified as ‘other’ in results section; N = 136). HCSWs were divided between those who work in the community or hospital because their knowledge stems predominantly from experience.

**Figure 3:** *Professional groups – degree to which training and experience were considered to be bio-psychosocial.*



### ***Attitudes towards working with voice hearers***

An adapted and modified 35-item version of the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ; Mcleod et al., 2002) was used to assess attitudes and

beliefs about working with voice hearers. Items were scored using a 7-point Likert scale, with higher scores indicating more positive attitudes or beliefs.

The original questionnaire had five subscales, which made up two composite scales. The composite scales were reported in the present study due to high correlations frequently found between subscales (Gorman & Cartwright, 1991). A subscale on empathy was also included, following previous research (Berry & Greenwood, 2016; Mcleod et al., 2002), as it may play a key component in the therapeutic relationship (Berry & Greenwood, 2016; Poyato & Nogueira, 2021).

Composite scales showed good reliability (Table 2).

**Table 2:** *AAPPQ composite scales – internal consistency reliability check for the present study*

Composite scale	Description and example	Reliability ( $\alpha$ )
Role security	Clinicians' perceptions of the adequacy of their knowledge and skills and knowledge working with voice hearers and the degree to which they feel it is appropriate to work with voice hearers. "I feel I have a clear idea of my responsibilities in helping service users who hear distressing voices".	0.878
Therapeutic commitment	Clinicians' motivation or willingness to engage voice hearers in treatment, the extent to which they find this work personally and professionally rewarding, and how satisfied they feel with their work. "I am interested in the nature of distressing voice-hearing in service users and the responses that can be made to it".	0.883
Empathy	The degree to which clinicians can mentally identify with voice hearers and see the world as they do. "I find it hard to imagine what it might be like for service users to hear distressing voices" (reverse-scored).	0.696

### ***Stigma towards voice hearers***

The 9-item version of the Attribution Questionnaire (AQ-9; Corrigan, 2012) addresses key stereotypes about people with mental illness. Internal consistency and test-

retest reliability have been found to be .71 and .87, respectively among mental health practitioners (Corrigan et al., 2014). Although construct validity has been found to be poor in some studies, (Rus et al., 2019), it is brief and could be adapted to reflect attitudes to voice hearers. Items consist of nine statements on a Likert scale, e.g. "I would feel pity for Sam" (1 = *not at all*; 9 = *very much*). The vignette was adapted to include a voice hearer with a gender neutral name ('Sam'), to prevent bias due to gender differences found between different diagnoses (Ochoa et al., 2012; Sansone & Sansone, 2011). A question asking what diagnosis the clinicians identified from the vignette allowed exploration of which diagnosis stigma related to. Scores from individual questions were reported, so internal reliability was not carried out.

### **Qualitative data**

Respondents were asked to recount a recent encounter with a voice hearer. In the absence of the ability to observe interactions, this question was included to allow exploration of self-reported behaviours. Prompt questions encouraged breadth of behavioural descriptions, developed following discussion with S.H. (Table 3).

**Table 3:** *Qualitative encounter prompt questions*

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How did you become aware that this person was hearing voices?
Where were you, and what were you doing at the time?
What did you think about the voices?
What did you do or say?
What did you hope or expect the outcome of your words or actions would be?
What was the outcome?
Is there anything else you would like to say about this encounter?

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Thematic analysis was informed by Braun & Clarke (2006). For the theoretical analysis, coding schemes were devised for whether the behaviour described in the encounters appeared predominantly biomedical or psychosocial, and the degree to which

the descriptions suggested an exploratory interaction (Table 4). These were refined and 20% were independently coded by S.H. to check and refine code clarity. These were scored separately as there was a conceptual difference between psychosocial and exploratory.

**Table 4:** *Examples of encounter descriptions and coding*

Exploratory	
Rating	Example quote
1. Definitely did not ask about voices	"I did not further assess as had already spoken to psychiatrist and psychologist. Did not want service user to have to keep repeating themselves talking about their voices"
2. Appeared to ask about voices but unclear to what extent	"explored what the person was experiencing and how it was impacting upon them."
3. Asked but not in depth (described 1-2 questions)	"Asked about nature and content of the voices"
4. Definitely exploratory (described 3 or more questions)	"I assessed the number of voices heard (one or more), asked if the patient could identify those voices as people he knew, asked what the voices said, asked if the voices gave him commands and whether he acted according to the voices, asked if the voices were aggressive in nature or asked him to harm himself or other people."
5. Client declined to talk (removed from analysis) <sup>a</sup>	"I asked once about what she was hearing, but she clearly did not want to talk about it or even admit she was hearing anything I couldn't, so I let the subject drop."
Rating	Example quote
1. Predominantly biomedical	"Reassurance the patient was being listened to. Diagnostic questions to aid with medication planning [...] Patient prescribed antipsychotic medication and arranged for review".
2. Mixed, neutral or ambiguous response	"Gave reassurance and offered them a chance to speak with the psychiatrist about the voices in case the medication is not working well. Also gave advice on distraction and relaxation techniques to reduce distress."
3. Psychosocial response	"I asked for more information and tried to build a picture of the voices, their patterns, triggers, emotional and behavioural consequences and links with other difficulties in this individuals' life."
Combined ratings	
1. Biomedical, not exploratory	"Do not let those voices interrupt your thoughts of well being. Try to ignore them and concentrate on your progress along with PRN Lorazepam."
4. Biomedical, highly exploratory	"That they were most likely intrusive thoughts due to their EUPD diagnosis [...] Asked about what they hear from the voices, are they positive or negative, do they challenge the



3. Psychosocial, not exploratory	voices, are they able to ignore them, what was their understanding of them, are they ever more quiet or more present [...]To get more information for the assessment.” “I spent much time with service user. I assisted showering and hair washing when she was in the good place. I tried to distract and calm her when she was not.”
12. Psychosocial, highly exploratory	“I explained that voice hearing is common in the general population, and that people can live their lives with voices. I expressed that I was happy she felt able to speak to friends, and was glad they were understanding. I asked whether they experienced voices of good and bad quality, whether the voices were familiar, what meaning those voices might have, the extent of their distress, and whether they would be happy if the reduction in bad voices also reduced the good voices.”

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*Note.* <sup>a</sup> Interactions where the voice hearer declined to talk about their voices were removed from the analysis as it was deemed that this was not dependent upon the clinician’s willingness to ask.

Cohen's  $\kappa$  was run to determine inter-rater reliability with a sample scored by a service user representative who is not a voice hearer but has a diagnosis of schizophrenia and experience of using various mental health services ( $N = 25$ ). There was very good agreement for psychosocial-biomedical ratings,  $\kappa = .937$ , 95% CI [.817, 1.057],  $p < .001$ . There was good agreement for exploratory ratings,  $\kappa = .670$ , 95% CI [.443, .897],  $p < .001$ .

Inductive analysis was used to explore what clinicians described doing and their reflections about their actions. This was carried out by reading all stories and identifying themes between the stories to identify, analyse and report patterns in the data (Braun & Clarke, 2006). Then all stories were re-read to count how many encounters they featured in. In order to ensure data were not missed, key words relating to the theme were identified from descriptions within in this theme, and all records were searched electronically. For example, for the core theme fear, the following related words were searched for: “scare”,

“anxi”, “intimidat”, “nervous”, “worr”, “violen”, “panic”, “risk”. Dependent on the context, stories subsequently identified were also added to the theme.

### **Stakeholder involvement**

The Psychosis Theme experts by experience steering group was consulted in the early stages of the proposal, in order to refine research questions.

In order to inform the discussion, findings were discussed with a representative from the Salomons SAGE experts by experience group who hears voices and a Nursing lecturer based at a local university (redacted to maintain confidentiality). Please see Appendix F for full notes from these meetings.

### **Researcher bias**

The author (JB) used a bracketing interview with a peer and ongoing reflection with the aim of minimising researcher bias. She has worked in mental health for 14 years, and has had personal experience of mental illness, as well as caring for a family member with a diagnosis of schizophrenia. She has had predominantly positive experiences with services with provision of psychosocial intervention and where a personal recovery ethos has been prioritised. More negative personal and professional experiences have been due to a predominant medical model and inadequate service provision (termed ‘perceived neglect’ by Laugharne et al., 2011, p.499). As this may have led to preconceived ideas about how she approached the research questions, she attempted to understand the motivations of clinicians without bias. This included rating qualitative data without looking at what professional group the respondent fell into, and ensuring that she discussed any areas which may have been biased openly with her supervisor. Reading the qualitative data helped her

to understand that clinicians had good intentions, even if this did not translate into using best practice, and what the reasons for that might be.

## Results

### Demographics and sample characteristics

Participants' demographics were comparable to NHS England (NHS Digital, 2021; NHS Employers, 2019). They covered a range of locations, work settings and professions. Only 9.6% of Hospital-based HCSWs had received voices-specific training, compared with 23.7% of nurses and 26.9% of psychosocial professions. Psychiatrists were least likely to have had personal experience with voices or voice hearers (18.9%), compared with 32.4% of community-based HCSWs. Excepting pity, stigma scores were mostly low, and mean attitudes suggested broadly positive attitudes. Over half (54.1%) of respondents considered the voice-hearer vignette to represent a psychosis or schizophrenia diagnosis.

**Table 5:** *Sample characteristics (n = 1018)*

	N (N missing)	M	Range	SD
Age	999 (19)	40.52 <sup>a</sup>	18-99 <sup>b</sup>	11.77
Years in current profession	1001 (17)	11.17	0-49	10.52
Number of years working in mental health	997 (21)	12.86	0-49	10.25
Number of years working with voice hearers	996 (22)	1.28	0-4	.74

*Notes.* <sup>a</sup> NHS average is 43 (NHS Employers, 2019). <sup>b</sup> Excluding two outliers reporting age

98 and 99, the maximum age was 72.

**Table 6: Gender**

	N	Percent	NHS England % a
Female	711	69.8	77
Male	288	28.3	23
Identify as another term	4	0.4	
Prefer not to say	15	1.5	
Missing responses	0	0.0	
Total	1018	100.0	

Note. <sup>a</sup> NHS staff percentages (NHS Digital, 2021).

**Table 7: Nationality and ethnicity**

	N	%	NHS England groupings	NHS England % a
<b>Nationality<sup>b</sup></b>				
British	853	83.4		
'Old EU' <sup>c</sup>	63	6.3		
'New EU' <sup>d</sup>	18	1.8		
Asian	25	2.4		
African	25	2.4		
'Somewhere else' (other nationality)	16	1.6		
Missing data	23	2.2		
<b>Ethnicity<sup>b</sup></b>				
White British	732	71.9	White	77.9
White other	116	11.4		
Asian/Asian British	53	5.2	Asian	10.7
Chinese/ Chinese British	2	0.2	Chinese	0.6
Black/ African/ Caribbean/ Black British	49	4.8	Black	6.5
Mixed ethnicity	28	2.8	Mixed	1.9
Other ethnic group	14	1.4	Other	2.6
Prefer not to say/ missing	24	2.4		
Total	1018	100		

Notes. <sup>a</sup> NHS staff percentages (NHS Digital, 2021). <sup>b</sup> Multiple choice options, with free

text for 'other'. <sup>c</sup> 'Old EU': Austrian, Belgian, Danish, Dutch, Finnish, French, German,

Greek, Irish, Italian, Luxembourger, Portuguese, Spanish, Swedish. <sup>d</sup> 'New EU': Bulgarian,

Croatian, Cypriot, Czech, Estonian, Hungarian, Latvian, Lithuanian, Maltese, Polish,

Romanian, Slovakian, Slovenian.

**Table 8: Participants' NHS Trust**

	N	%
Sussex Partnership NHS Foundation Trust	90	8.8
Southern Health NHS Foundation Trust	27	2.7
Nottinghamshire Healthcare NHS Foundation Trust	29	2.8
Lincolnshire Partnership NHS Foundation Trust	45	4.4
Kent and Medway NHS and Social Care Partnership Trust	64	6.3
South West Yorkshire Partnership NHS Foundation Trust	23	2.3
Berkshire Healthcare NHS Foundation Trust	54	5.3
Oxford Health NHS Foundation Trust	50	4.9
Somerset Partnership NHS Foundation Trust	38	3.7
Cornwall Partnership NHS Foundation Trust	49	4.8
West London Mental Health NHS Trust	48	4.7
Humber NHS Foundation Trust	35	3.4
Essex Partnership University NHS Foundation Trust	96	9.4
Northumberland, Tyne and Wear NHS Foundation Trust	14	1.4
Surrey and Borders Partnership NHS Foundation Trust	29	2.8
Pennine Care NHS Foundation Trust	10	1.0
Norfolk and Suffolk NHS Foundation Trust	5	0.5
Greater Manchester Mental Health NHS Foundation Trust	29	2.8
Central and North West London NHS Foundation Trust	54	5.3
Camden and Islington NHS Foundation Trust	87	8.5
Cambridgeshire and Peterborough NHS Foundation Trust	109	10.7
Hertfordshire Partnership University NHS Foundation Trust	33	3.2
Total	1018	

**Table 9: Mental health service context**

Team	N	Percent
Community mental health team (CMHT)	456	44.8
Inpatient services	267	26.2
Specialist service	176	17.3
Primary care/ Increasing access to psychological therapies (IAPT)	21	2.1
##Other	98	9.6
Missing data	0	0.0
Total	1023	100

**Table 10: Main profession <sup>a</sup>**

Profession			Grouped professions					
	N	%	N	%				
CBT therapist	20	2.0	Psychosocial professions	324	31.8			
Counsellor	4	0.4						
Art therapist	8	0.8						
Psychotherapist	13	1.3						
Psychological wellbeing practitioner	10	1.0						
Counselling psychologist	13	1.3						
Clinical psychologist	73	7.2						
Assistant psychologist	51	5.0						
Trainee clinical psychologist	20	2.0						
Social worker	51	5.0						
Occupational therapist	55	5.4						
Peer worker	6	0.6						
Mental health nurse	194	19.1				Nurse	334	32.8
Senior mental health nurse	122	12.0						
Nursing trainee	18	1.8						
Psychiatrist	112	11.0	Psychiatrist	112	11.0			
Support worker/ healthcare assistant (healthcare support workers; HCSWs)	112	11.0						
			Inpatient-based HCSWs	52	5.2			
			Community-based HCSWs	38	3.7			
			Other HCSWs (specialist services or 'other' team)	22	2.0			
Student	25	2.5	Other	136	13.4			
Research staff	22	2.2						
Admin	6	0.6						
Other	68	6.7						
Missing data	15	1.5						
Total	1018							

*Note.* <sup>a</sup> Clinicians were invited to select all that applied. Where more than one profession was selected, the most patient-facing or highest-status profession was selected (assuming, for example, that some had undergone additional professional training). For further details of this process, please see Appendix D.

**Table 11:** *Additional training for working with voice hearers*<sup>a</sup>

	N	%
Maastricht approach	23	2.3
Hearing Voices Network	147	14.4
Voice Collective	13	1.3
Working to recovery (Ron Coleman & Karen Taylor)	35	3.4
Sussex Voices Clinic	23	2.3
The Hearing Voices: Refugees and Asylum Seekers project training (by Mind in Camden)	5	0.5
Behind the Label training (by Rachel Waddingham) <sup>b</sup>	14	1.4
Open Dialogue Approach training	80	7.9
Has received any additional voices training (excluding 'other')	243	23.9
Other (free text)	313	30.7
Voice hearing training – 'Other' (themes derived from free text) <sup>c</sup>		
Part of professional training (nursing, clinical psychology, psychiatry)	78	7.7
In team/ trust	56	5.5
CBT/ third wave therapy training	42	4.1
Conferences/ workshops/ seminars	34	3.3
Discussion/ supervision	14	1.4
Reading	13	1.3
Thorn course (psychosocial interventions and family work)	12	1.2
Psychodynamic/ family therapy/ narrative therapy training	10	1.0
Restraint/breakaway	2	0.2
Other training – e.g. led by charity groups	22	2.2
Other – not specified	41	4.0

*Notes.* <sup>a</sup> Participants were invited to select any that applied – percentages given are based

on the number of individuals who selected each training out of the total of 1018

respondents. <sup>b</sup> Rachel Waddingham is an expert by experience. <sup>c</sup> This is provided for the

reader's information, however 'other' training was not included in analysis due to

uncertainty of the quality or nature of the training (e.g. breakaway training).



**Table 12:** *Additional voices training by professional group (N = 1001<sup>a</sup>)<sup>b</sup>*

Profession	Received additional training N	% low to high	No additional training N	%
Hospital-based HCSWs	5	9.6	47	90.4
Psychiatrists	18	16.1	94	83.9
Community-based HCSWs	9	23.7	29	76.3
Psychosocial professions	87	26.9	237	73.1
Nurses	95	28.4	239	71.6
Other	29	20.6	112	79.4
Total	243	24.3	758	75.7

*Note.* <sup>a</sup> Responses were available for 1001 participants; data for 17 were

missing. <sup>b</sup> Due to unknown quality of training, 'other' training was excluded

from analysis.

**Table 13:** *Professional groups' personal experience of voices, "Have you, or someone close to you (such as a relative or friend), heard voices?" (N = 1002<sup>a</sup>)*

	Yes - N	Yes - %	No - N	No - %
Psychiatrists	21	18.9	90	81.1
Hospital-based HCSWs	12	24.0	38	76.0
Nurses	85	26.1	241	73.9
Psychosocial professions	97	30.6	220	69.4
Community-based HCSWs	12	32.4	25	67.6
Other	93	33.1	46	66.9
Total	284	28.3	718	71.7

*Note.* <sup>a</sup> Responses were available for 1002 participants; data for 16 were missing.

**Table 14: Stigma – sample characteristics**

	N	Minimum	Maximum	Mean	Std. Deviation
AQ-9 <sup>a</sup>					
AQ-9, Q1 Pity	810	1	9	4.66	2.475
AQ-9, Q2 Dangerousness	807	1	9	2.49	1.547
AQ-9, Q3 Fear	807	1	9	1.85	1.354
AQ-9, Q4 Blame	807	1	9	1.27	0.815
AQ-9, Q5 Segregation	807	1	9	1.69	1.241
AQ-9, Q6 Anger	806	1	9	1.18	0.826
AQ-9, Q7 Help	806	1	9	2.37	2.420
AQ-9, Q8 Avoidance	805	1	9	1.27	0.849
AQ-9, Q9 Coercion	804	1	9	2.71	1.788
AQ-9, total score	804	9	81	19.47	7.659
AAPPQ – subscales <sup>b</sup>					
AAPPQ: Adequacy	832	1	7	4.93	1.172
AAPPQ: Legitimacy	834	2	7	5.33	0.942
AAPPQ: Motivation	834	1.2	7	5.64	0.918
AAPPQ: Work satisfaction	832	2.2	7	5.63	0.867
AAPPQ: Self-esteem	834	2	7	5.33	0.835
AAPPQ – composite subscales <sup>c</sup>					
AAPPQ: role security	832	1.00	7.00	5.06	0.959
AAPPQ: therapeutic commitment	834	2.47	7.00	5.52	0.787
AAPPQ: empathy	832	1.00	7.00	4.28	0.616

Notes. <sup>a</sup> AQ-9 scores range from 1-9 with higher scores indicating higher stigma. <sup>b</sup>

These subscales were not used- as reported in the method section, however

descriptive statistics are reported here for the purposes of comparison with

previous research. <sup>c</sup> AAPPQ scores range from 1-7, with higher scores indicating

more positive attitudes.

**Table 15: Predicted diagnosis from AQ-9 vignette <sup>a</sup>**

Predicted diagnosis	N	%	Valid %
Schizophrenia	232	22.8	31.1
Psychosis	172	16.9	23.0
Borderline personality disorder/ emotionally unstable personality disorder	12	1.2	1.6
Other <sup>b</sup>	21	2.1	2.8
Multiple diagnoses listed	121	11.9	16.2
Symptom based/ don't like diagnosis	68	6.7	9.1
Prefer not to say (based on limited information)	121	11.9	16.2
Missing data	271	26.6	
Total	1018		

Notes. <sup>a</sup> Free-text response. <sup>b</sup> e.g. schizoaffective disorder, bipolar disorder, depression.

**Table 16: Were voices explored in the interaction described?**

	Frequency	Valid %	Rating
Not explored.	115	17.2	1
Appeared to have asked but unclear to what extent.	225	33.6	2
1-2 questions asked.	216	32.3	3
3 or more questions asked.	113	16.9	4
Total rated	669	100.0	
Missing	349		

Note. Please see Appendix G for rating schedule. 14 encounters in which the patient declined were excluded from analysis. Exploratory and psychosocial ratings were combined to form a rating out of 12. Please see Methodology section for details.

**Table 17:** *Was the focus of the interaction predominantly psychosocial or biomedical?*

	N	Valid %	Rating
Psychosocial	235	34.4	1
Neutral/ mixed	331	48.4	2
Biomedical	118	17.3	3
Total rated	684		
Missing	334		

*Note.* Please see Appendix G for rating schedule. Exploratory and psychosocial ratings

were combined to form a rating out of 12; please see Methodology section for details.

### **Hypothesis testing**

For clarity, only significant results are presented below. For full results, please see Appendix F.

***Hypothesis 1a: Participants who have received Maastricht-informed training and/or personal experience will have less stigmatising attitudes.***

#### **Training in supporting voice hearers**

Participants selected any specific training they had attended from a list provided (please see Table 10 for the full list). Due to outliers, a nonparametric test was used to compare differences between groups in stigma, attitudes and exploration.

**Table 18:** *Training in supporting voice hearers and stigma – Kruskal-Wallis test*

	Yes - Mdn	Yes – M	No – Mdn	No – M	U	z	Asymptotic sig. (p) <sup>b</sup>
<b>AQ-9</b>							
Pity <sup>a</sup>	5	4.44	5	4.73	58480.5	-1.364	.173
Dangerousness <sup>a</sup>	2	2.37	2	2.53	56883.0	-1.868	.062
Fear <sup>a</sup>	1	1.80	1	1.86	58397.0	-1.415	.157
Blame <sup>a</sup>	1	1.19	1	1.29	59370.0	-1.511	.131
Segregation <sup>a</sup>	1	1.60	1	1.72	60005.0	-0.853	.394
Anger <sup>a</sup>	1	1.09	1	1.21	59715.0	-1.598	.110
Help <sup>a</sup>	1	1.99	1	2.50	56082.0	-2.375	.018*
Avoidance <sup>a</sup>	1	1.24	1	1.28	60432.5	-0.813	.416
Coercion <sup>a</sup>	2	2.30	2	2.85	52649.0	-3.268	.001**
<b>AAPPQ</b>							
Role security <sup>a</sup>	5.50	5.37	5.00	4.96	81657.0	5.43	<.001***
Therapeutic commitment <sup>a</sup>	5.80	5.77	5.47	5.43	81323.5	5.24	<.001***
Empathy <sup>a</sup>	4.25	4.30	4.25	4.27	66188.5	0.29	.769

Notes. \* p < .05. \*\* p < .01. \*\*\* p < .001.

<sup>a</sup> Distributions were similar, as assessed by visual inspection.

<sup>b</sup> Statistical significance calculated using an exact sampling distribution for U (Dineen & Blakesley, 1973).

### Personal experience

A Mann-Whitney U test was run to determine if there were differences in AQ-9 subscale and AAPPQ subscale scores based on personal experience of voices or voice hearers (Table 19).

Clinicians with personal experience of voices or voice hearers had lower ‘avoidance’, ‘coercion’ and higher ‘therapeutic commitment’ and ‘exploratory scores’. They did not significantly differ on other aspects of stigma including ‘pity’, ‘dangerousness’, ‘fear’, ‘blame’, ‘segregation’, ‘anger’, desire to ‘help’ and ‘empathy’.

**Table 19:** "Have you, or someone close to you (such as a relative or friend), heard voices?"

	Yes - Mdn	Yes- M	No - Mdn	No - M	U	z	Asymptotic sig. (p)
<b>AQ-9</b>							
Pity <sup>a</sup>	5	4.71	5	4.64	66084.5	0.34	.734
Dangerousness <sup>a</sup>	2	2.42	2	2.52	61293.5	-1.09	.277
Fear <sup>a</sup>	1	1.77	1	1.87	59609.0	-1.79	.073
Blame <sup>a</sup>	1	1.27	1	1.20	63480.5	-0.49	.622
Segregation <sup>a</sup>	1	1.61	1	1.72	60351.5	1.61	.107
Anger <sup>a</sup>	1	1.11	1	1.21	61658.0	-1.80	.072
Help <sup>a</sup>	1	2.29	1	2.40	62099.0	-0.86	.391
Avoidance <sup>a</sup>	1	1.18	1	1.30	60162.0	-2.19	.029*
Coercion <sup>a</sup>	2	2.44	2	2.81	57825.0	-2.13	.033*
<b>AAPPQ</b>							
Role security <sup>c</sup>	5.50	5.37	5.00	4.96	74565.0	1.78	.074
Therapeutic commitment <sup>c</sup>	5.80	5.76	5.47	5.44	77341.0	2.60	.009**
Empathy <sup>c</sup>	4.25	4.31	4.25	4.27	64354.5	-1.53	.127

Notes. \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ . Statistical significance calculated using an exact sampling distribution for U (Dineen & Blakesley, 1973).

<sup>a</sup> Distributions were similarly skewed, as assessed by visual inspection. <sup>b</sup> Ratings 1-9, with higher scores on the AQ-9 representing higher levels of stigma. <sup>c</sup> Ratings 1-7, with higher scores on the AAPPQ representing more positive attitudes to working with voice hearers.

<sup>d</sup> Ratings 1-4, with higher scores representing more exploratory interactions.

**Hypothesis 1b: Professions with more psychosocial training and experience will have less stigmatising attitudes.**

Psychiatrists, hospital-based HCSWs, nurses, community-based HCSWs and psychosocial professions were compared (for professional groupings, see Table 10). AQ-9 and AAPPQ scores violated assumptions of normality and outliers, so a Kruskal-Wallis test was performed.

Table 20 and 21 demonstrate significant differences. On the AQ-9, consistent with the hypothesis, psychiatrists and/or hospital-based support workers had higher levels of stigma relating to 'pity', 'dangerousness', 'fear', 'segregation' and 'coercion' than nurses, psychosocial professions and community-based support workers. Significant differences were not found for blame, anger, willingness to help or avoidance.

On the AAPPQ, results did not fit with the hypothesis, in that the highest levels of role security and therapeutic commitment were found for psychiatrists, and the lowest levels amongst hospital- and community-based support workers. No significant differences were found for empathy.

**Table 20:** Stigma differences between professional groups using Kruskal-Wallis test

	df	$\chi^2$ statistic <sup>b</sup>	Asymptotic sig. (2-sided test)
<b>AQ-9</b>			
Pity <sup>a</sup>	4	13.752	.008**
Dangerousness <sup>a</sup>	4	14.162	.007**
Fear <sup>a</sup>	4	18.664	.001**
Blame <sup>a</sup>	4	6.851	.144
Segregation <sup>a</sup>	4	18.470	.001**
Anger <sup>a</sup>	4	4.049	.399
Help <sup>a,c</sup>	4	9.822	.044*
Avoidance <sup>a</sup>	4	4.865	.301
Coercion <sup>a</sup>	4	38.534	<.001***
<b>AAPPQ</b>			
Role security <sup>a</sup>	4	108.896	<.001***
Therapeutic commitment <sup>a</sup>	4	69.797	<.001***
Empathy <sup>a,c</sup>	4	11.621	.02*

Notes. \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

<sup>a</sup> Boxplots were similar, as assessed by visual inspection. <sup>b</sup> The test statistic has been adjusted for ties. <sup>c</sup> Despite significance on the Kruskal-Wallis test, pairwise comparisons did not reveal significant group differences following adjustment by the Bonferroni correction for multiple tests.

Pairwise post hoc comparisons, performed using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons, revealed statistically significant differences (Table 21).

**Table 21:** Statistically significant differences between professional groups

AQ-9 <sup>a</sup>	Lower stigma staff group	Mdn	M	Higher stigma staff group	Mdn	M	Adj. sig. <sup>d</sup> ( $p$ )
Pity	Nurses	4.00	4.35	Psychiatrists	5.00	5.16	.037*
Dangerousness	Psychosocial professions	2.00	2.38	Hospital-based HCSWs	3.00	3.24	.011*
	Nurses	2.00	2.48	Hospital-based HCSWs	3.00	3.24	.020*
Fear	Nurses	1.00	1.69	Hospital-based HCSWs	2.00	2.26	.003**
	Psychosocial professions	1.00	1.83	Hospital-based HCSWs	2.00	2.26	.038*
Segregation	Community-based HCSWs	1.00	1.46	Hospital-based HCSWs	2.00	2.44	.038*
	Nurses	1.00	1.63	Hospital-based HCSWs	2.00	2.44	<.001***
	Psychosocial professions	1.00	1.64	Hospital-based HCSWs	2.00	2.44	.001**
Coercion	Psychiatrists	1.00	1.75	Hospital-based HCSWs	2.00	2.44	.009**
	Community-based HCSWs	1.50	1.85	Psychiatrists	3.00	3.43	.001**
	Community-based HCSWs	1.50	1.85	Hospital-based HCSWs	4.00	3.97	<.001***
	Psychosocial professions	2.00	2.44	Psychiatrists	3.00	3.43	<.001***
	Psychosocial professions	2.00	2.44	Hospital-based HCSWs	4.00	3.97	.002**
	Nurses	2.00	2.61	Psychiatrists	3.00	3.43	.002**
	Nurses	2.00	2.61	Hospital-based HCSWs	4.00	3.97	.015*



AAPPQ <sup>b</sup>		Mdn	M	Less positive attitudes	Mdn	M	Adj. sig. <sup>d</sup> ( <i>p</i> )
	More positive attitudes						
Role security	Psychosocial professions	5.20	5.10	Hospital-based HCSWs	4.25	4.22	<.001***
	Nurses	5.20	5.14	Hospital-based HCSWs	4.25	4.22	<.001***
	Psychiatrists	5.90	5.84	Hospital-based HCSWs	4.25	4.22	<.001***
	Psychosocial professions	5.20	5.10	Community-based HCSWs	4.40	4.44	.004**
	Nurses	5.20	5.14	Community-based HCSWs	4.40	4.44	.003**
	Psychiatrists	5.90	5.84	Community-based HCSWs	4.40	4.44	<.001***
Therapeutic commitment	Psychiatrists	5.90	5.84	Psychosocial professions	5.20	5.10	<.001***
	Psychiatrists	5.90	5.84	Nurses	5.20	5.14	<.001***
	Nurses	5.60	5.55	Community-based HCSWs	5.00	5.01	.041*
	Psychosocial professions	5.67	5.52	Community-based HCSWs	5.00	5.01	.033*
	Psychiatrists	6.00	6.04	Community-based HCSWs	5.00	5.01	<.001***
	Nurses	5.60	5.55	Hospital-based HCSWs	5.07	4.99	.001**
	Psychosocial professions	5.67	5.52	Hospital-based HCSWs	5.07	4.99	.001**
	Psychiatrists	6.00	6.04	Hospital-based HCSWs	5.07	4.99	<.001***
	Psychiatrists	6.00	6.04	Nurses	5.60	5.55	<.001***
	Psychiatrists	6.00	6.04	Psychosocial professions	5.67	5.52	<.001***

Notes. <sup>a</sup> Ratings 1-9, with higher scores on the AQ-9 representing higher levels of stigma. <sup>b</sup>

Ratings 1-7, with higher scores on the AAPPQ representing more positive attitudes to

working with voice hearers. <sup>c</sup> Ratings 1-4, with higher scores representing more

exploratory interactions. <sup>d</sup> Significance values have been adjusted by the Bonferroni

correction for multiple tests before reporting.

**Hypothesis 2a: Participants who have received Maastricht-informed training and/or personal experience will have interactions rated as more exploratory and psychosocial.**

A cumulative odds ordinal logistic regression was run to determine the effect of training and personal experience on the odds of exploratory and psychosocial interactions. Compared to those with no voices-specific training, the odds of those who had attended training was rated higher for psychosocial and exploratory encounters was 1.54 (95% CI, 1.138 to 2.092), a statistically significant effect,  $\chi^2(1) = 7.813$ ,  $p = .005$ . The odds ratio of being rated higher based on personal experience was 1.23 (95% CI, 0.916 to 1.664), a non-significant result,  $\chi^2(1) = 1.914$ ,  $p = .167$ .

**Table 22: Odds of interactions rated as more exploratory, compared with hospital-based HCSWs**

Clinician group	Odds	95% CI	df	Wald $\chi^2$	Sig. ( $p$ )
Maastricht trained	1.54	1.138 - 2.092	1	7.813	.005**
Personal experience	1.23	0.916 - 1.664	1	1.914	.167

Notes. \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

**Hypothesis 2b: Professions with more psychosocial training and experience will have interactions rated as more exploratory and psychosocial.**

A Kruskal-Wallis test revealed significant differences between staff groups on exploratory and psychosocial ratings of the encounter description.

**Table 23: Differences between professional groups using Kruskal-Wallis test**

	df	$\chi^2$ statistic <sup>b</sup>	Asymptotic sig. (2-sided test)
Exploratory and psychosocial rating <sup>a</sup>	4	85.692	<.001***

Notes. \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ . <sup>a</sup> Boxplots were similar, as assessed by visual inspection. <sup>b</sup> The test statistic has been adjusted for ties. <sup>c</sup> Despite significance on the

Kruskal-Wallis test, pairwise comparisons did not reveal significant group differences following adjustment by the Bonferroni correction for multiple tests.

Pairwise post hoc comparisons were performed using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons. Consistent with the hypothesis, psychosocial professions had significantly more exploratory and psychosocial interactions than hospital-based HCSWs, psychiatrists and nurses. Nurses had more exploratory and psychosocial interactions than psychiatrists. No statistical differences were found between any other group combination.

**Table 24:** *Statistically significant differences between professional groups*

Less exploratory/ psychosocial <sup>a</sup>	Mdn	M	More exploratory/ psychosocial <sup>a</sup>	Mdn	M	Adj. sig. <sup>b</sup> ( $p$ )
Hospital-based HCSWs	4.00	3.66	Psychosocial professions	6.00	7.06	<.001***
Psychiatrists	4.00	4.02	Psychosocial professions	6.00	7.06	<.001***
Psychiatrists	4.00	4.02	Nurses	4.00	5.17	.018*
Nurses	4.00	5.17	Psychosocial professions	6.00	7.06	<.001***

Notes. \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

<sup>a</sup> Ratings 1-12, with higher ratings suggesting more exploratory and psychosocial interactions. <sup>b</sup> Significance values have been adjusted by the Bonferroni correction for multiple tests before reporting.

***Hypothesis 3: Less stigmatising attitudes will be associated with more exploratory and psychosocial-rated encounter descriptions.***

A cumulative odds ordinal logistic regression was run to determine the effect of stigma on the odds of the encounter being rated as exploratory/psychosocial.

Please see Table 25 for the odds of having a higher exploratory and psychosocial rating for each 1-point increase on the Likert scale of the AQ-9 and the AAPPQ. Higher 'anger' and 'coercion' scores and lower 'empathy' scores were associated with a reduction in the odds of exploratory/ psychosocial rated encounters. No other significant results were found.

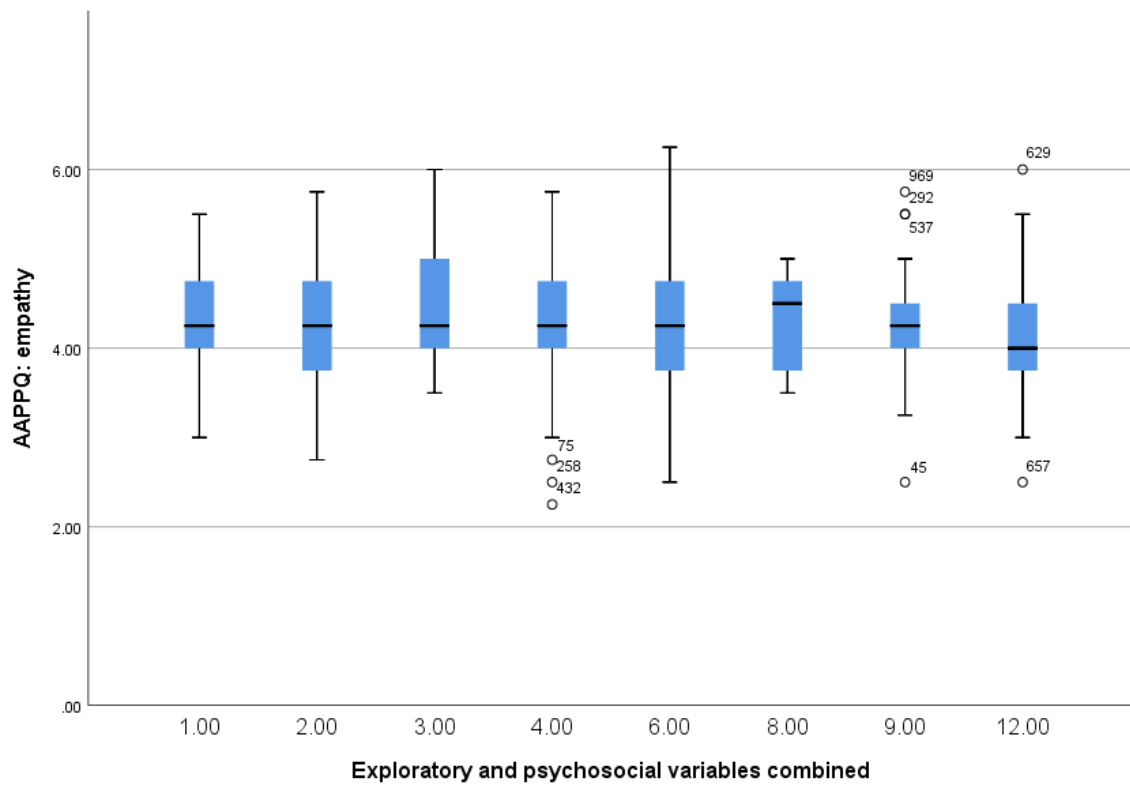
**Table 25:** Odds of having a higher exploratory/psychosocial rating

Subscale	Odds	95% CI	df	Wald $\chi^2$	Sig. (p)
AAPPQ: role security	1.03	0.83 - 1.27	1	0.05	0.825
AAPPQ: therapeutic commitment	1.06	0.81 - 1.39	1	0.20	0.655
AAPPQ: empathy	0.78	0.62 - 0.98	1	4.45	0.035*
AQ9, Q1 Pity	0.97	0.91 - 1.02	1	1.35	0.246
AQ9, Q2 Dangerousness	0.92	0.82 - 1.03	1	2.33	0.127
AQ9, Q3 Fear	1.07	0.93 - 1.22	1	0.87	0.351
AQ9, Q4 Blame	1.07	0.86- 1.34	1	0.40	0.528
AQ9, Q5 Segregation	1.01	0.88 - 1.15	1	0.01	0.929
AQ9, Q6 Anger	0.81	0.68 - 0.97	1	5.02	0.025*
AQ9, Q7 Help	1.00	0.94- 1.06	1	0.01	0.912
AQ9, Q8 Avoidance	1.02	0.85 - 1.22	1	0.05	0.830
AQ9, Q9 Coercion	0.87	0.80 - 0.95	1	10.38	0.001**

Note. \* p < .05. \*\* p < .01. \*\*\* p < .001.

Visual inspection of a graph revealed outliers and a non-linear relationship on the 'empathy' subscale, offering a possible explanation for this unexpected finding (Chart 1).

**Chart 1:** Graph showing non-linear relationship between 'empathy' subscale and exploratory/psychosocial variables.



### Qualitative research question

***What were clinicians' recorded intentions and actions in encounters with voice hearers? What themes are apparent in the descriptions, and do forms of stigma feature in the stories?***

Please see Table 26 for a list of themes and Table 27 for quotes, and Table 28 for a list of techniques described in the encounters.

**Table 26:** *Key and subthemes apparent in the encounter descriptions*

Key theme	Subthemes
Are voices real? Is this helpful to ask?	1a. Voices not real 1a i) positive outcomes 1a ii) Voices not real – negative outcomes 1b. Voices real 1b i) Client felt better 1b ii) Improved openness and engagement with the service 1c. Unproductive to discuss whether voices were real or not
Empathy and developing a trusting relationship	2a. The importance of trust 2b. Feeling and expressing empathy and compassion for the client's experience
Fearful and risk focused	3a. Fearful 3b. Used the encounter to assess risk 3c. Knowing the patient reduced fear
Confidence and training	4a. Lacking confidence or needing training 4b. Gaining confidence as a result of training or experience
Helpless to help	5a. Difficulties working within a system in which medication is often the only option. 5b. Lack of access to talking therapies or support groups 5c. Trying to help but patient declined
Patients' past negative experiences with other staff	

Most clinicians recognised that the patient experienced voices as real and recognised benefits to taking this approach. However, it appeared that some clinicians attempted to

reassure clients that their voices were not real, sometimes due to lack of knowledge about other approaches to take. This appeared to work for some patients, but not others.

Clinicians described many situations in which they felt compassion for patients' suffering. They described helping patients to overcome distressing and controlling voices by developing a trusting and warm therapeutic relationship.

Some clinicians described feeling fearful of patients' unpredictability. Many described assessing risk, and a few said knowing the patient better reduced their fear.

Clinicians also described not knowing what to do in response to voices, and that training could be - or had been - helpful. This tied in with an organisational lack of specialist resources which they could refer to. Some asked about voices but were disappointed when patients declined. Some clinicians described an awareness that patients had not received a satisfactory service previously, and that patients were surprised when they demonstrated an interest in their voices.

**Table 27:** *Quotes relating to themes identified in the encounter descriptions*

Number of participants	Example quotes
Theme 1: Are voices real? Is this helpful to ask?	
1a: Voices not real	
12	"I hoped to provide reassurance that the voices were not real - it is hard because this is not part of my role and I do not have training in how to deal with it." (other profession not specified)
i) Voices not real – positive outcomes	
5	"[the voices were] unreal. they are a result of mental disorder ... The outcome was positive. He ignored the command of those voices and complied with his prescribed medications" (nursing trainee). "they seemed to be pseudohallucinations in the context of a personality disorder / acute crisis. The patient was referred to the correct service to get psychotherapy" (psychiatrist)
ii) Voices not real – negative outcomes	
2	"Challenging client perception has been difficult and not accepted by the client - saw me as not believing her - increasing feelings of paranoia" (clinical psychologist).
1b: Voices real	

42 “No particular hope other than wanting the service user to feel listened to and validated that their voices were real and distressing to them.”  
(mental health nurse)

i) Client felt better

8 “For her to feel believed, understood and helped to feel less distressed”  
(mental health nurse)

ii) Improved openness, rapport and engagement with the service

19 “[I hoped] To help the patient feel heard, believed and more contained ... She had previously flitted from area to area and not engaged but has come to all subsequent team appointments” (psychiatrist).  
“[The voices] Appeared genuine ... The service user became more open with me over time... I felt I had made a difference to the service user”  
(senior mental health nurse)

1c: Unproductive to discuss whether voices were real or not

2 “I didn't keep telling her that the voices are not real as I believe that this approach cannot always be helpful as it can ruin your rapport and trust.”  
(mental health nurse)

Theme 2: Empathy and developing a trusting relationship

2a: The importance of trust

22 [I hoped] “That she would be able to trust me and go to the loo... She couldn't go but then we tried later and she did. She appreciated me staying with her.” (senior mental health nurse)  
[I hoped] “To help the patient feel heard, believed and more contained in her distress to forge a trusting and therapeutic relationship.”  
(psychiatrist)

2b: Feeling and expressing empathy and compassion for the client's experience

64 “It is painful to see someone so distressed” (mental health nurse).  
“they sounded really challenging to live with, it made me feel sad for the individual I was working with as they caused him a considerable amount of distress.” (assistant psychologist)

Theme 3: Fearful and risk-focused

3a: Fearful

12 “I felt nervous about whether the voices would make her unpredictable and if so, I would struggle to cope effectively with it” (support worker)  
[What was the outcome?] “violence toward myself” (support worker)

3b: Used the encounter to assess risk

62 “Its good to be aware that voices aren't always negative and don't necessarily indicate risk to self or others.” (occupational therapist)  
“to calm the situation avoid potential violence towards staff ongoing risk assessment.” (nursing trainee)

3c: Knowing the patient reduced fear

4 “he was using aggressive language which could sound scary Because he was loud, he would respond often but was a very gentle man and would never hurt anyone” (senior MHN)

Theme 4: Confidence and training

4a: Lacking confidence or needing training



- 22 “I lacked confidence to pursue the experience the service user was having. I am not clinically trained and have not had detailed training on how to ask someone about hearing voices that nobody else can hear.”  
(support worker)  
“left me wondering how best we can help those who experience hearing distressing voices and perhaps a more specific training would be of help”  
(psychiatrist)
- 4b: gaining confidence as a result of training or experience
- 5 “I feel as an organisation we should recived manditory training in hearing voices, most of my training is self taught from reading research and from supporting a hearing voices group, I am familar with the mastrixts model and developing constructs, I have also learned from colleages and from clients first hand experiences. I feel I have amassed a good deal of helpful knowledge but also feel I would benefit from offical training.” (support worker)

Theme 5: Feeling “helpless to help”

- 5a: Difficulties working within a system in which medication is often the only option
- 6 “I do not feel that i helped him on a fundamental level but superficially helped with the medication it did not help his recovery or understanding of his experience. it left me feeling "helpless to help".” (mental health nurse)
- 5b: lack of access to talking therapies or support groups
- 4 “I would like to have been able to signpost him to a peer support group but unfortunately I am unaware of any in the region” (occupational therapist)  
“There is a severe lack of access to talking therapies for hearing voices, which is very unfortuante as the patient could have benefited very much from this.” (psychiatrist)
- 5c: Trying to help but patient declined
- 13 “client declined engagement after 2 sessions... disappointing outcome and wondered if it would have been more successful if I had more experience in working in this field” (clinical psychologist)

Theme 6: Patients’ past negative experiences with other staff

- 17 “She seemed surprised as she is used to people telling her its all in her head.” (mental health nurse)  
“The person I worked with stated they had wished they had encountered a mental health professional that had been interested in their distressing experiences and that had worked with them on these experiences specifically, years before we met, as this might have saved them many years of distress.” (clinical psychologist)

**Table 28:** *Techniques clinicians described using during the encounter (N = 684)*

Technique	Frequency	% of responses
Reassure	99	14.47
Distraction	67	9.80
Express empathy or compassion	64	9.36
Validate	42	6.14
Discuss 'coping strategies'	39	5.70
Having/ instilling hope	25	3.65
Normalise	20	2.92
Psychoeducation	18	2.63
Challenge the voices	13	1.90

### ***Stakeholder consultation***

An expert-by-experience was concerned that support workers had higher stigma scores because “they’re front of house”. Her experiences with community-based HCSWs in a specialist service had been positive. She theorised that having stigmatising beliefs may prime patients to feel more scared or angry, which could perpetuate the negative beliefs. She was also surprised by the lack of training this group of staff receive, and suggested that this may exacerbate the problem.

When talking about the importance of the right approach, she said, “If you say the wrong thing, I’ll shut down. Anything that makes me feel like you’re scared or judging me, I’ll shut down”. In addition, it was important to her that clinicians were genuine, non-judgemental, had faith in her that she was not a risk, and treated her with respect.

She stated that being given a medical explanation would not have helped her, and that individual and group psychological therapy helped her make sense of her experiences. She did not think that reassurance was helpful, whereas believed that all other techniques described by clinicians could be helpful if used at the right time. For example, normalising

initially, distraction when she was most “sick”, but waiting to challenge voices until she was better.

A nurse trainer said that nurses are trained in a biopsychosocial model, but they tend to focus on the medical model when writing assignments. There is no training on working with voice hearers in the curriculum, and, “Nurses are trained to ask specifically about suicide, but not voices”.

He suggested that hospital-based HCSWs have the most face-to-face role with patients but see them at their most unwell. On top of lack of training they might receive less formal and informal supervision and support than other professions. Psychiatrists might feel more confident because, as they have a relatively narrow focus on the medical aspects, they can always offer an intervention which has some effect. If they refer to another professional, this limits their sphere of responsibility.

When discussing the qualitative findings, he said that the therapeutic relationship is crucial, especially when working with patients who have been through a lot of trauma. “I’ve worked with clients where their only ever positive male role model is me.”

## Discussion

This mixed-methods study investigated stigma and attitudes to working with voice hearers, and whether these differed dependent on training, profession and experience amongst a large sample of NHS mental health clinicians. Further, it explored what takes place in encounters between clinicians and voice hearers, including how exploratory and biomedical/psychosocial the interactions were and what approaches clinicians describe using.

The results provided partial support for Corrigan, Markowitz, & Watson's (2004) social cognitive model (Table 29). Individuals in more biomedical roles and those without specific training tended to have higher scores in certain areas of stigma, and to report less exploratory/psychosocial interactions. Clinicians with personal experience of voice hearing tended to have lower stigma, although this did not translate into differences in behaviour ratings.

**Table 29:** *Hypotheses and brief summary of findings*

Hypothesis/ research question	Findings
Hypothesis 1a: Participants who have received Maastricht-informed training and/or personal experience will have lower stigmatising attitudes.	Hypothesis upheld. Training was associated with significantly higher willingness to help, role security, therapeutic commitment and lower coercion attitudes. Personal experience was associated with significantly higher therapeutic commitment and lower avoidance and coercion attitudes.
Hypothesis 1b: Professions with more psychosocial training and experience will have less stigmatising attitudes.	Partially upheld. Psychiatrists and/or hospital-based support workers had higher stigma relating to dangerousness, pity, fear, coercion and

Hypothesis 2a: Participants who have received Maastricht-informed training and/or personal experience will have interactions rated as more exploratory and psychosocial.

Hypothesis 2b: Professions with more psychosocial training and experience will have interactions rated as more exploratory and psychosocial.

Hypothesis 3: Less stigmatising attitudes will be associated with more exploratory and psychosocial-rated encounter descriptions.

What were clinicians' recorded intentions and actions in encounters with voice hearers? What themes are apparent in the descriptions, and do forms of stigma feature in the stories?

segregation than nurses, psychosocial professions and community-based support workers.

Contrary to the hypothesis, psychiatrists had the highest role security and therapeutic commitment, and support workers of any type had lowest scores.

Upheld.

Those who had attended training were 1.54 times as likely to have a more exploratory/psychosocial-rated encounter. Those with personal experience were 1.23 times as likely (a non-significant result).

Upheld.

Psychosocial professions had significantly more exploratory and psychosocial interactions than hospital-based HCSWs, psychiatrists and nurses. Nurses had more exploratory and psychosocial interactions than psychiatrists.

Partially upheld.

Higher anger and coercion scores were significantly associated with more exploratory/psychosocial-rated encounters.

Empathy was significantly associated with less odds of having an exploratory/psychosocial-rated encounter.

Key themes were: 'are voices real? Is this helpful to ask?', 'empathy and developing a trusting relationship', 'fearful and risk-focused', 'confidence and training', 'helpless to help', and 'patients' negative experiences with other staff'.

Clinicians described using the following techniques: reassurance, distraction, expressing empathy, validation, discuss 'coping strategies', having/instilling hope, normalising, providing psychoeducation, challenging the voices.

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### ***Stigma***

Overall, stigma was low for all groups. The mean total AQ score (19.47) was much lower than a recent sample of mental health staff in Italy (40.44-43.90), which is partly attributable to the much lower coercion scores in the present study (mean score: 2.71 vs. 6.7; (Zaninotto et al., 2018), perhaps reflecting differing working patterns in these countries. The AAPPQ subscale averages were similar to those previously found by Berry and Greenwood (2016) and Mcleod and colleagues (2002), but with higher 'self-esteem' than the latter sample, suggesting that respondents to this study felt more pride about working with voice hearers. It is possible that this may reflect an improvement in some attitudes to mental illness over time (Henderson et al., 2020), although further research using this specific measure would need to bear this out.

Although questionnaire ratings of fear were low, this theme emerged in the qualitative data. A lack of training, experience, and taking a biomedical approach was linked to being more fearful. It is possible that this may be due to the violence which many NHS mental health staff face, as 14% of allied health professionals, 20% of medical staff, 43% of nurses and 64% of health care assistants have experienced at least one incident of violence in the past year, and episodes of violence are more likely in hospitals than the community (NHS, 2021).

### ***Training and personal experience***

Voice hearing training was associated with lower coercion and higher willingness to help, role security and therapeutic commitment. As this was a cross-sectional study, it was not possible to identify which variable led to another. Corrigan and colleagues' model would suggest a directional link from influences, to attitudes, to behaviours. Gorman & Cartwright

(1991) proposed that training preceded role security, which led to greater therapeutic commitment. However, it is possible that there is a bi-directional relationship; training may improve confidence (role security) which leads to greater willingness and perceived ability (therapeutic commitment); conversely, those who are more committed may seek out training. Further, in Corrigan and colleagues' model (2004) patients appear passive recipients of stigma, whereas they may educate clinicians or prompt them to seek further training.

Personal experience was associated with lower stigma, which corresponds with previous findings (Mittal et al., 2016). These findings may support the planned expansion of the peer worker role (NHS, 2019).

Pity, dangerousness, fear, blame, segregation, anger and empathy scores did not differ based on experience or training. This may be partly explained by very low scores and low variation. Given that education and contact have previously been found to reduce stigma (Corrigan et al., 2012), it may be that other elements of experience or training may have had more of an impact (e.g. inpatient or community work setting; Valery & Prouteau, 2020), or perhaps stereotypes received through the media or cultural groups may play more of a role (Thornicroft et al., 2008).

### ***Professions***

The difference between HCSWs working in a hospital and community setting in coercion and segregation is consistent with previous findings that staff working in inpatient settings appear to hold more negative attitudes toward mental illness (Hansson et al., 2013; de Jacq et al., 2020; Valery & Prouteau, 2020). Rates of training and personal experience of voices were much higher amongst community-based HCSWs, which may have influenced

these findings, and as the nurse trainer commented, hospital-based HCSWs will have encountered voice hearers at their most unwell.

The low role security scores among HCSWs, compared with other professions – notably psychiatrists – may be viewed in light of their low pay and status in the hierarchy of the NHS (Kessler et al., 2010) and their lack of training. Therefore, they may doubt their knowledge and skills, or that it is their right to ask about voices, as measured by the AAPPQ.

Hospital-based HCSWs reported the lowest levels of training, and indeed two reported that the only training they had received for working with voice hearers was breakaway or restraint training. Previous research has found that patients view communication skills as crucial to prevent aggression (Duxbury & Whittington, 2005; Lavalle & Grenyer, 2003), and that coercive or biomedical strategies to manage violence are counterproductive (Duxbury, 2002). It is possible that encounters escalate partly due to lack of training and a tendency to more coercive and segregating attitudes. It may be more helpful to move from a focus on risk or reducing symptoms to helping people to live well alongside their voices (Romme et al., 2009; Slade M., 2009)

Psychiatrists expressed higher coercion and pity and were less exploratory/ psychosocial. Perhaps this is to be expected: they have large caseloads, and medicine is their specialism. However, they are often the Responsible Clinician for the person's care (Mental Health Act, 2007). In light of evidence linking early adverse experiences with distressing voices (Romme & Escher, 2006; Scott et al., 2020) and the harmful side effects of medications (Whitaker, 2016), encouraging other coping strategies may allow lower doses of medication to be used, in line with guidelines (IRIS, 2012; NICE, 2014).



They also had higher therapeutic commitment and role security. This confidence may stem from medication being the most commonly used treatment for schizophrenia or psychosis (Gaebel et al., 2020; Mcleod et al., 2002), or providing a concrete intervention may be more satisfying, especially when providers of psychological interventions feel that their role is limited or precarious (Holtum et al., 2021). A bio-genetic perspective has been associated with lower burnout and higher professional satisfaction (Pavon & Vaes, 2017).

Many clinicians described lacking confidence working with voice hearers, echoing findings from previous qualitative research (McMullan et al., 2018). As well as lacking training, clinicians' powerlessness appeared to stem from a system in which psychosocial interventions were not available at an organisational level (Carter et al., 2017; Magliano et al., 2020; Schizophrenia Commission, 2012).

Despite voice hearing being an experience associated with many different diagnoses (APA, 2013; Kingdon et al., 2010; Moskowitz et al., 2017; Paulik et al., 2018), respondents overwhelmingly saw voice hearing as representing a psychosis diagnosis.

### ***Themes from encounter descriptions***

Although the majority recognised that voices were real to patients, a minority doubted this. Therapeutic approaches to working with voice hearers do not question the reality of the voices (Hayward, 2018). Some clinicians' may have intended to reduce voice hearers' sense of the omnipotence of the voices, thereby reducing distress (Birchwood & Chadwick, 1997). However, therapeutic approaches which challenge beliefs about voices acknowledge that this can feel "risky and uncomfortable", therefore sensitivity is required (Chadwick & Birchwood, 1994, p. 195). For patients who perceive their voices as real, telling them that they are not real risks being invalidating or shaming, may be seen as a

stigmatising response (Amsalem et al., 2018), may increase distress (Pyle & Morrison, 2014), worsen the voice-hearing experience (Carvalho et al., 2015), prevent subsequent disclosure and help-seeking (Vilhauer, 2017) and impede recovery (Alyahya et al., 2020).

Clinicians often described compassionate distress response to patients' experiences, and they used their empathic skills to support patients during some of their darkest times. The therapeutic alliance may help patients recover from trauma (Berry et al., 2020; Bucci et al., 2020), support personal recovery (Alyahya et al., 2020) engagement with treatments, improved functioning (Browne et al., 2019) and symptomatic recovery (Shattock et al., 2018). Kindness, acceptance, communication and understanding may also help mitigate some of the effects of stigma (Wood et al., 2015).

Clinicians commonly described providing reassurance, although it was unclear what this meant. It may be more effective in the form of psychoeducation (e.g. Sabucedo et al., 2020) than emotional reassurance (Pincus et al., 2013). CBT models would suggest that providing reassurance may maintain anxiety (Freeman, 2007; Gaynor et al., 2013; Kobori & Salkovskis, 2013). When we perceive high levels of uncertainty, potentially serious consequences and where we feel we have little control (as may be the case with malevolent and omnipotent voices), gaining mastery over the situation is likely to be more helpful (Kobori & Salkovskis, 2013; Hayward, 2018).

Clinicians also described using distraction, which is also commonly used by patients but has been found to be largely ineffective, and may worsen self-esteem in the long-term (Haddock et al., 1998). It is concerning that neither distraction nor reassurance (together representing around a quarter of encounter descriptions) are evidence-based.

Some evidence-based approaches from the Maastricht (Corstens et al., 2008), hearing voices (Romme & Escher, 2000) and CBT approaches (Hayward et al., 2018) were also described, including coping strategies, normalising, psychoeducation, having hope, and highly exploratory interactions. However, these were evident in only a minority of encounter descriptions. Voices were explored to some degree in approximately half of interactions described, although around one-sixth of interactions did not mention past experiences, social factors, relationship with the voices or a need for psychotherapeutic work. These types of encounters have previously been found to be valued less in voice hearer accounts (Hopkins et al., 2009; Rydon, 2005).

### **Limitations**

Responses to this study may have been affected by social desirability bias (Mortel, 2008; Michaels & Corrigan, 2013). This was minimised by having indirect, open questions in the qualitative section (Bergen & Labonte, 2019), having anonymity and by comparing between groups. Furthermore, the AQ-9 shows minimal social desirability bias (Michaels & Corrigan, 2013). Although training and experiences may lead to more awareness of what might be more socially desirable responses, this study's findings suggest that this knowledge also affects clinicians' behaviour. However, future research may be improved by incorporating an implicit measure of stigma, such as the Implicit Assumption Test (Greenwald et al., 1998).

Similarly, ratings of clinicians' descriptions of their interactions may have been affected by: a) the clinician knowing the term to use (i.e., 'normalise' or 'psychoeducation'); b) the clinician choosing to report it or knowing that this was relevant. Profession and

educational attainment may have influenced these factors. This data may inform development of a scale to explore these questions further.

The focus on distressing voice hearing in the present study may have primed participants not to acknowledge positive voice hearing experiences (Baumeister et al., 2017; de Leede-Smith & Barkus, 2013). In light of the link between training and stigma, it may have been helpful to provide links at the end of the survey to educational resources which may reduce stigma, as did Dabby and colleagues (2015); for example to the Maastricht approach (Corstens et al., 2008) or hearing voices network (Inter Voice, 2021).

There were several limitations to the measures. The AAPPQ has only been used in its present form in two published studies (Berry & Greenwood, 2016; Mcleod et al., 2002), and external validity has not been reported for the constructs. There have been variable results pertaining to construct validity on the AQ-9 (Rus et al., 2019), although this was minimised in the present study by presenting results of each answer, rather than an overall score. Other scales available for assessing clinician stigma (Rus et al., 2019) were either not suitable for amendment or were significantly longer so would add to response burden from clinicians, which may affect response rates (Glidewell et al., 2012).

The use of 'pity' in the AQ-9 (Corrigan et al., 2014) may be seen as a poor measure of stigma, as it can be defined as "sympathetic sorrow for one suffering, distressed or unhappy" (Merriam-Webster, 2020). Therefore clinicians having an empathic response may have scored higher on this item. Corrigan (2017) has discussed this in an editorial. Noting that whilst pity can motivate others to help an individual, "the more insidious message remains: People with illness are less than us, different from us. And difference is the base on which stigma rests" (p.82).

Finally, the present study could have been improved by exploring any differences which may have occurred based on the patient's ethnicity. 'Psychotic symptoms' are disproportionately found amongst ethnic groups (Vega & Fernandez, 2008), and there may be intersectionality between stigma relating to voice hearing, a mental health diagnosis and ethnicity (Rosenfield, 2012). The sample appears to be nationally representative for UK NHS staff (NHS Digital, 2021). Nonetheless, findings may not be applicable to the "Majority World" (Burkhard et al., 2021).

### **Conclusions and recommendations**

The present study found that stigma and behavioural outcomes were affected by training, personal experience and more biomedical professions. Hospital-based support workers and psychiatrists had low levels of voices-specific training, along with higher levels of certain stigmatising beliefs. Training these groups should be a priority, as hospital-based HCSWs have a significant amount of face-to-face contact with people who are most distressed, whereas psychiatrists are often responsible for service users' overall care. As well as providing an improved experience for patients, improved communication skills - developed as a result of additional training - may reduce aggressive incidents.

The results provided support for the destigmatising impact of personal experience, thereby providing support for the expansion of the peer worker role, as it is possible that working alongside voice-hearing colleagues with shared goals may have a destigmatising influence.

Many clinicians described using a validating response to voice hearers, being empathic, developing trusting, supportive relationships and encouraging use of coping strategies. However, some also described using unhelpful techniques, risk-focused

behaviour, lacking confidence, and frustration with lack of access to psychological or psychosocial resources. Services' support to expand hearing voices groups and greater provision of psychological therapies may help voice hearers to feel less alone and to make sense of their experiences.

## References

- Allport, G. (1954). *The nature of prejudice*. Cambridge/ Reading, MA: Addison-Wesley.
- Alyahya, N., Munro, I., & Moss, C. (2020). The experience of psychosis and recovery from consumers' perspectives: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing*, 00, 1-17. <https://doi.org/10.1111/jpm.12696>
- Amsalem, D., Hasson-Ohayon, I., Gothelf, D., & Roe, D. (2018). Subtle ways of stigmatisation among professionals: The subjective experience of consumers and their family members. *Psychiatric Rehabilitation Journal*, 41(3), 163-168.  
<https://doi.org/http://dx.doi.org/10.1037/prj0000310>
- Angermeyer, M., Holzinger, A., Carta, M., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: A systematic review of population studies. *The British Journal of Psychiatry*, 199, 367-372. <https://doi.org/10.1192/bjp.bp.110.085563>
- APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Washington, DC: American Psychiatric Association.
- Arbanas, G., Rožman, J., & Bagarić, Š. (2019). The attitudes of medical doctors, nurses and lay people towards schizophrenia, depression and PTSD. *Psychiatria Danubia*, 31, 84-91.
- Bauer, S., Schanda, H., Karakula, H., Olajossy-Hilkesberger, L., Rudaleviciene, P., Okribelashivili, N., . . . Stompe, T. (2011). Culture and the prevalence of hallucinations in schizophrenia. *Comprehensive Psychiatry*, 52, 319-325. <https://doi.org/10.1016/j.comppsy.2010.06.008>
- Beck, A., & Rector, N. (2003). A cognitive model of hallucinations. *Cognitive Therapy Research*, 27, 19-52. <https://doi.org/10.1023/A:1022534613005>
- Bergen, N., & Labonte, R. (2019). "Everything is perfect, and we have no problems": Detecting and limiting social desirability bias in qualitative research. *Qualitative Health Research*, 30(5), 783-792. <https://doi.org/https://doi.org/10.1177/1049732319889354>

- Berry, C., & Greenwood, K. (2016). The relevance of professionals' attachment style, expectations and job attitudes for therapeutic relationships with young people who experience psychosis. *European Psychiatry, 34*, 1-8.  
<https://doi.org/http://dx.doi.org/10.1016/j.eurpsy.2016.01.002>
- Berry, K., & Haddock, G. (2008). The implementation of the NICE guidelines for schizophrenia: Barriers to the implementation of psychological interventions and recommendations for the future. *Psychology and Psychotherapy: Theory, Research and Practice, 81*, 419-436.
- Berry, K., Read, J., Varese, F., & Bucci, S. (2020). How attachment theory can develop understandings of, and therapy for, distressing voices. In K. Berry, S. Bucci, & A. (. Danquah, *Attachment theory and psychosis: Current perspectives and future directions*. Abingdon, Oxon: Routledge.
- Birchwood, M., & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine, 27*(6), 1345–1353.  
<https://doi.org/10.1017/S0033291797005552>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. <https://doi.org/https://doi.org/10.1191/1478088706qp063oa>
- Browne, J., Nagendra, A., Kurtz, M., Berry, K., & Penn, D. (2019). The relationship between the therapeutic alliance and client variables in individual treatment for schizophrenia spectrum disorders and early psychosis: Narrative review. *Clinical Psychology Review, 71*, 51-62.  
<https://doi.org/https://doi.org/10.1016/j.cpr.2019.05.002>
- Bucci, S., Berry, K., Danquah, A., & Johnstone, L. (2020). How can attachment theory inform the design and delivery of mental health services? In K. Berry, S. Bucci, & A. Danquah, *Attachment theory and psychosis: Current perspectives and future directions* (pp. 237-519). Abindon-on-Thames, Oxfordshire: Routledge.



- Burkhard, C., Cicek, S., Barzilay, R., Radhakrishnan, R., & Guloksuz, S. (2021). Need for ethnic and population diversity in psychosis research. *Schizophrenia Bulletin*, *47*(4), 889-895.  
<https://doi.org/https://doi.org/10.1093/schbul/sbab048>
- Carter, L., Read, J., Pyle, M., Law, H., & Morrison, A. (2017). Mental health clinicians' beliefs about the causes of psychosis: Differences between professions and relationship to treatment preferences. *The International journal of social psychiatry*, *63*(5), 426-432.  
<https://doi.org/http://dx.doi.org/10.1177/0020764017709849>
- Carter, L., Read, J., Pyle, M., Law, H., Emsley, R., & Morrison, A. (2018). Causal beliefs in people experiencing psychosis: The relationship to treatment accessed and the perceived helpfulness of treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*(3), 332-344. <https://doi.org/http://dx.doi.org/10.1111/papt.12163>
- Carvalho, C., Motta, C., Pinto-Gouveia, J., & Peixoto, E. (2015). Hallucinatory activity in schizophrenia: The relationship with childhood memories, submissive behaviour, social comparison and depression. *World Academy of Science, Engineering and Technology*, *9*(5), 401-409. <https://doi.org/http://hdl.handle.net/10400.3/3991>
- Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: Cognitive approach to auditory hallucinations. *British Journal of Psychiatry*, *164*(2), 190-201.  
<https://doi.org/10.1192/bjp.164.2.190>
- Coffey, M., & Hewitt, J. (2008). 'You don't talk about the voices': Voice hearers and community mental health nurses talk about responding to voice hearing experiences. *Journal of Clinical Nursing*, *17*, 1591-1600. <https://doi.org/10.1111/j.1365-2702.2007.02185.x>
- Coffey, M., Higgon, J., & Kinnear, J. (2004). 'Therapy as well as the tablets': An exploratory study of service users' views of community mental health nurses' (CMHNs) responses to hearing voices. *Journal of Psychiatric and Mental Health Nursing*, 435-444.

- Cohen, A., Hamilton, A., Saks, E., Glover, D., Glynn, S., Brekke, J., & Marder, S. (2017). How occupationally high-achieving individuals with a diagnosis of schizophrenia manage their symptoms. *Psychiatric Services, 68*(4), 324-329. <https://doi.org/10.1176/appi.ps.201600031>
- Corrigan, P. (2002). Testing social cognitive models of mental illness stigma: The Prairie State stigma studies. *Psychiatric Rehabilitation Skills, 6*(2), 232-254.  
<https://doi.org/10.1080/10973430208408434>
- Corrigan, P. (2017). Beware the pity narrative. *Stigma and Health, 2*(2), 81-82.  
<https://doi.org/http://dx.doi.org/10.1037/sah0000050>
- Corrigan, P., & Shapiro, J. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30*, 907-922.  
<https://doi.org/10.1016/j.cpr.2010.06.004>
- Corrigan, P., Markowitz, F., & Watson, A. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*(3), 481-491.
- Corrigan, P., Powell, K., & Michaels, P. (2014). Brief battery for measurement of stigmatizing versus affirming attitudes about mental illness. *Psychiatry Research, 215*, 466-470.  
<https://doi.org/http://dx.doi.org/10.1016/j.psychres.2013.12.006>
- Corrigan, P., W., Morris, S., Michaels, P., Rafacz, J., & Rüsçh, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963-973.  
<https://doi.org/10.1176/appi.ps.005292011>
- Corstens, D., Escher, S., & Romme, M. (2008). Accepting and working with voices: The Maastricht approach. In A. Moskowitz, I. Schafer, & M. (. Dorahy, *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology* (pp. 319-332). Hoboken, New Jersey: Wiley-Blackwell.
- 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. no. 4), S285-S294.

<https://doi.org/http://dx.doi.org/10.1093/schbul/sbu007>

de Jacq, K., Norful, A., & Larson, E. (2020). Nurses' and mental health technicians' attitudes and social acceptance of people with mental illness. *Issues in Mental Health Nursing*.

<https://doi.org/http://dx.doi.org/10.1080/01612840.2020.1799272>

de Jager, A., Rhodes, P., Beavan, V., Holmes, D., McCabe, K., Thomas, N., . . . Hayward, M. (2016).

Investigating the lived experience of recovery in people who hear voices. *Qualitative Health Research*, 26(10), 1409-1423. <https://doi.org/10.1177/1049732315581602>

Dickens, G., & Picchioni, M. (2012). A systematic review of the terms used to refer to people who use mental health services: User perspectives. *International Journal of Social Psychiatry*, 58(2),

115-122. <https://doi.org/dx.doi.org/10.1177/0020764010392066>

Dietrich, S., Beck, M., Bujantugs, B., Kenzine, D., Matschinger, H., & Angermeyer, M. (2004). The relationship between public causal beliefs and social distance toward mentally ill people.

*Australian and New Zealand Journal of Psychiatry*, 38, 348-354.

Dineen, L., & Blakesey, B. (1973). Algorithm AS 62: A Generator for the Sampling Distribution of the

Mann-Whitney U Statistic. *Journal of the Royal Statistical Society. Series C (Applied Statistics)*, 22(2), 269-273. <https://doi.org/https://doi.org/10.2307/2346934>

Dunn, O. J. (1964). Multiple comparisons using rank sums. *Technometrics*, 6(3), 241-252.

Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design. *Journal of*

*Psychiatric and Mental Health Nursing*, 9(3), 325-337.

<https://doi.org/https://doi.org/10.1046/j.1365-2850.2002.00497.x>

Duxbury, J., & Whittington, R. (2005). Causes and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing*, 50(5), 469-478.

<https://doi.org/https://doi.org/10.1111/j.1365-2648.2005.03426.x>

- Evans-Lacko, S., Corker, E., Williams, P., Henderson, C., & Thornicroft, G. (2014). Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–13: An analysis of survey data. *The Lancet Psychiatry*, *1*(2), 121-128. [https://doi.org/https://doi.org/10.1016/S2215-0366\(14\)70243-3](https://doi.org/https://doi.org/10.1016/S2215-0366(14)70243-3)
- Faccio, E., Romaioli, D., Dagani, J., & Cipolletta, S. (2013). Auditory hallucinations as a personal experience: Analysis of non-psychiatric voice hearers' narration. *Journal of Psychiatric and Mental Health Nursing*, *20*, 761-767.
- Fominaya, A., Corrigan, P., & Rusch, N. (2016). The effects of pit on self- and other- perceptions of mental illness. *Psychiatry Research*, *241*, 159-164.  
<https://doi.org/https://doi.org/10.1016/j.psychres.2016.04.058>
- Free statistics calculators*. (2018). Retrieved May 23, 2018, from Calculator: A-priori sample size for student t-tests: <https://www.danielsoper.com/statcalc/calculator.aspx?id=47>
- Freeman, D. (2007). Suspicious minds: The psychology of persecutory delusions. *Clinical Psychology Review*, *27*, 425-457. <https://doi.org/https://doi.org/10.1016/j.cpr.2006.10.004>
- Gaebel, W., Stricker, J., & Riesbeck, M. (2020). The long-term antipsychotic treatment of schizophrenia: A selective review of clinical guidelines and clinical case examples. *Schizophrenia Research*, *225*, 4-14.  
<https://doi.org/https://doi.org/10.1016/j.schres.2019.10.049>
- Gaynor, K., Ward, T., Garety, P., & Peters, E. (2013). The role of safety-seeking behaviours in maintaining threat appraisals in psychosis. *Behaviour Research and Therapy*, *51*, 75-81.  
<https://doi.org/http://dx.doi.org/10.1016/j.brat.2012.10.008>
- Giandinoto, J., Stephenson, J., & Edward, K. (2018). General hospital health professionals' attitudes and perceived dangerousness towards patients with comorbid mental and physical health conditions: Systematic review and meta-analysis. *International Journal of Mental Health Nursing*, *27*(3), 942-955. <https://doi.org/http://dx.doi.org/10.1111/inm.12433>

- Gillard, S., & Holley, J. (2018). Peer workers in mental health services: Literature overview. *Advances in Psychiatric Treatment*, 20(4), 286-292. <https://doi.org/10.1192/apt.bp.113.011940>
- Glidewell, L., Thomas, R., MacLennan, G., Bonetti, D., Johnston, M., Eccles, M., . . . Grimshaw, J. (2012). Do incentives, reminders or reduced burden improve healthcare professional response rates in postal questionnaires? Two randomised controlled trials. *BMC Health Services Research*, 12(250). <https://doi.org/https://doi.org/10.1186/1472-6963-12-250>
- Gorman, D., & Cartwright, A. (1991). Implications of using the composite and short versions of the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ). *British Journal of Addiction*, 86, 327-334.
- Greenwald, A., McGhee, D., & Schwartz, J. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology*, 74, 1464-1480.
- Griffiths, R., Mansell, W., Edge, D., & Tai, T. (2018). Sources of distress in first-episode psychosis: A systematic review and qualitative metasynthesis. *Qualitative Health Research*, 1-17. <https://doi.org/10.1177/1049732318790544>
- Haddock, G., Slade, P., Bentall, R., Reid, D., & Faragher, E. (1998). A comparison of the long-term effectiveness of distraction and focusing in the treatment of auditory hallucinations. *British Journal of Medical Psychology*, 71(3), 339-349. <https://doi.org/https://doi.org/10.1111/j.2044-8341.1998.tb00996.x>
- Hansson, L., Jormfeldt, H., Svedberg, P., & Svensson, B. (2013). Mental health professionals' attitudes towards people with mental illness: Do they differ from attitudes held by people with mental illness? *International Journal of Social Psychiatry*, 59(1), 48-54. <https://doi.org/http://dx.doi.org/10.1177/0020764011423176>
- Harangozo, J., Reneses, B., Brohan, E., Sebes, J., Csukly, G., Lopez-Ibor, J., . . . Thornicroft, G. (2014). Stigma and discrimination against people with schizophrenia related to medical services.

*International Journal of Social Psychiatry*, 60(4), 359-366.

<https://doi.org/10.1177/0020764013490263>

Harris, I., Leskela, J., Lakhan, S., Usset, T., DeVries, M., Mittal, D., & Boyd, J. (2019). Developing organizational interventions to address stigma among mental health providers: A pilot study. *Community Mental Health Journal*, 55, 924-931.

<https://doi.org/https://doi.org/10.1007/s10597-019-00393-w>

Harris, J., Leskela, J., & Hoffmann-Kohn, L. (2016). Provider lived experience and stigma. *American Journal of Orthopsychiatry*, 86(6), 604-609.

<https://doi.org/http://dx.doi.org/10.1037/ort0000179>

Hayward, M. (2018). Evidence-based psychological approaches for auditory hallucinations: Commentary on... Auditory hallucinations in schizophrenia. *BJPsych Advances*, 24(3), 174-177. <https://doi.org/10.1192/bja.2017.11>

Hayward, M., Awenat, Y., McCarthy Jones, S., Paulik, G., & Berry, K. (2015). Beyond beliefs: A qualitative study of people's opinions about their changing relations with their voices. *Psychosis*, 7(2), 97-107. <https://doi.org/10.1080/17522439.2014.926388>

Hayward, M., Kingdon, D., & Strauss, C. (2018). *Overcoming distressing voices* (2nd ed.). London: Robinson.

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., . . . Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry*, 1, 467-482. [https://doi.org/https://doi.org/10.1016/S2215-0366\(14\)00023-6](https://doi.org/https://doi.org/10.1016/S2215-0366(14)00023-6)

Henderson, C., Robinson, E., Evans-Lacko, S., Corker, E., Rebollo-Mesa, I., Rose, D., & Thornicroft, G. (2016). Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatrica Scandinavica*, 134(Suppl. 446), 23-33. <https://doi.org/dx.doi.org/10.1111/acps.12607>

- Henderson, L., Potts, L., & Robinson, E. (2020). Mental illness stigma after a decade of Time to Change England: Inequalities as targets for further improvement. *European Journal of Public Health, 30*(3), 497-503. <https://doi.org/https://doi.org/10.1093/eurpub/ckaa013>
- Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing, 52*(5), 561-570. <https://doi.org/10.1111/j.1365-2648.2005.03623.x>
- Hewstone, M., & Swart, H. (2011). Fifty-odd years of inter-group contact: From hypothesis to integrated theory. *British Journal of Social Psychology, 50*(3), 374-386. <https://doi.org/https://doi.org/10.1111/j.2044-8309.2011.02047.x>
- Holttum, S., Wright, T., & Wood, C. (2021). Art therapy with people diagnosed with psychosis: Therapists' experiences of their work and the journey to their current practice. *International Journal of Art Therapy, 26*(4), 205-218. <https://doi.org/https://doi.org/10.1080/17454832.2021.1893370>
- Hopkins, J., Loeb, S., & Fick, D. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: A literature review. *Journal of Psychiatric and Mental Health Nursing, 16*, 927-937. <https://doi.org/10.1111/j.1365-2850.2009.01501.x>
- Inter Voice. (2021, July 1). *About voices*. Retrieved from Inter Voice: The international hearing voices network: <http://www.intervoiceonline.org/about-voices>
- IRIS. (2012). *IRIS guidelines update*. IRIS Initiative Ltd.
- Işık, I., & Ergün, G. (2019). Hope and belonging in patients with schizophrenia: A phenomenological study. *Perspectives in Psychiatric Care, 56*(2), 235-242. <https://doi.org/https://doi.org/10.1111/ppc.12418>
- Jenner, J., Rutten, S., Beuckens, J., Boonstra, N., & Sytema, S. (2008). Positive and useful auditory vocal hallucinations: Prevalence, characteristics, attributions, and implications for treatment. *Acta Psychiatrica Scandinavica, 118*, 238-245. <https://doi.org/10.1111/j.1600-0447.2008.01226.x>

- Jorm, A., Reavley, N., & Ross, A. (2012). Belief in the dangerousness of people with mental disorders: A review. *Australian & New Zealand Journal of Psychiatry, 46*(11), 1029-1045.  
<https://doi.org/10.1177/0004867412442406>
- Kessler, I., Heron, P., Dopson, S., Magee, H., Swain, D., & Askham, J. (2010). *The nature and consequences of support workers in a hospital setting*. NIHR Service Delivery and Organisation Programme.
- Kilbride, M., Byrne, R., Price, J., Wood, L., Barratt, S., Welford, M., & Morrison, T. (2013). Exploring service users' perceptions of cognitive behavioural therapy for psychosis: A user-led study. *Behavioural and Cognitive Psychotherapy, 41*, 89-102.  
<https://doi.org/10.1017/S1352465812000495>
- Kingdon, D., Ashcroft, K., & Bhandari, B. (2010). Schizophrenia and borderline personality disorder: Similarities and differences in the experience of auditory hallucinations, paranoia and childhood trauma. *Journal of Nervous and Mental Disease, 399*-403.
- Klapheck, K., Lincoln, T., & Bock, T. (2014). Meaning of psychoses as perceived by patients, their relatives and clinicians. *Psychiatry Research, 215*, 760-765.  
<https://doi.org/http://dx.doi.org/10.1016/j.psychres.2014.01.017>
- Kobori, O., & Salkovskis, P. (2013). Patterns of reassurance seeking and reassurance-related behaviours in OCD and anxiety disorders. *Behavioural and Cognitive Psychotherapy, 41*, 1-23. <https://doi.org/10.1017/S1352465812000665>
- Kvaale, E., Gottdiener, W., & Haslam, N. (2013). Biogenetic explanations and stigma: A meta-analytic review of associations among laypeople. *Social Science & Medicine, 96*, 95-103.
- Larkings, J., & Brown, P. (2018). Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *International Journal of Mental Health Nursing, 27*, 928-941. <https://doi.org/10.1111/inm.12390>



- Lavalle, O., & Grenyer, B. (2003). Differences between patient and staff perceptions of aggression in mental health units. *Psychiatric Services, 54*(3), 389-393.  
<https://doi.org/https://doi.org/10.1176/appi.ps.54.3.389>
- Longden, E., Madill, A., & Waterman, M. (2012). Dissociation, trauma and the role of lived experience: Toward a new conceptualisation of voice hearing. *Psychological Bulletin, 138*(1), 28-76.
- Lüllmann, E., Berendes, S., Rief, W., & Lincoln, T. (2011). Benefits and harms of providing biological causal models in the treatment of psychosis: An experimental study. *Journal of Behavior Therapy and Experimental Psychiatry, 42*(4), 447-453.  
<https://doi.org/http://dx.doi.org/10.1016/j.jbtep.2011.03.003>
- Magliano, L., Read, J., & Affuso, G. (2017). Predictors of staff attitudes toward schizophrenia treatments. *Psychiatric Services, 68*(12), 1321.  
<https://doi.org/http://dx.doi.org/10.1176/appi.ps.201700257>
- Maijer, K., Begemann, M., Palmen, S., Leucht, S., & Sommer, L. (2018). Auditory hallucinations across the lifespan: A systematic review and meta-analysis. *Psychological Medicine, 48*(6), 879-888.  
<https://doi.org/10.1017/S0033291717002367>
- Mannarini, S., Rossi, A., & Munari, C. (2020). How do education and experience with mental illness interact with causal beliefs, eligible treatments and stigmatising attitudes towards schizophrenia? A comparison between mental health professionals, psychology students, relatives and patients. *BMC Psychiatry, 20*(1), 167.  
<https://doi.org/http://dx.doi.org/10.1186/s12888-020-02580-6>
- Mawson, A., Cohen, K., & Berry, K. (2010). Reviewing evidence for the cognitive model of auditory hallucinations: The relationship between cognitive voice appraisals and distress during psychosis. *Clinical Psychology Review, 30*, 248-258.

- McCarthy-Jones, S. (2012). *Hearing Voices: The Histories, Causes and Meanings of Auditory Verbal Hallucinations*. Cambridge: Cambridge University Press.
- McCarthy-Jones, S., Romero, M., McCarthy-Jones, R., Dillon, J., Cooper-Rompato, C., Kieran, K., . . . Blackman, L. (2015). Hearing the unheard: An interdisciplinary, mixed methodology study of women's experiences of hearing voices (auditory verbal hallucinations). *Frontiers in Psychiatry, 6*, 181. <https://doi.org/https://doi.org/10.3389/fpsy.2015.00181>
- McCluskey, A., & deVries, J. (2020). Help, I can't help: A qualitative study of psychiatric nurse's perspectives on their care for people who hear voices. *Journal of psychiatric and mental health nursing*. <https://doi.org/http://dx.doi.org/10.1111/jpm.12642>
- McLeod, H., Deane, F., & Hogbin, B. (2002). Changing staff attitudes and empathy for working with people with psychosis. *Behavioural and Cognitive Psychotherapy, 30*(4), 459-470.
- McMullan, E., Gupta, A., & Collins, S. (2018). Experiences of mental health nursing staff working with voice hearers in an acute setting: An interpretive phenomenological approach. *Journal of Psychiatric and Mental Health Nursing, 25*, 157-166. <https://doi.org/10.1111/jpm.12448#>
- Mental Health Act. (2007). ch. 2. Retrieved from <https://www.legislation.gov.uk/ukpga/2007/12/contents>
- Merriam-Webster. (2020, December 22). *Pity*. Retrieved from Merriam-Webster: <https://www.merriam-webster.com/dictionary/pity>
- Mestdagh, A., & Hansen, B. (2014). Stigma in patients with schizophrenia receiving community mental health care: A review of qualitative studies. *Social Psychiatry and Psychiatric Epidemiology, 49*(1), 79-87. <https://doi.org/https://doi.org/10.1007/s00127-013-0729-4>
- Michaels, P., & Corrigan, P. (2013). Measuring mental illness stigma with diminished social desirability effects. *Journal of Mental Health, 22*(3), 218-226. <https://doi.org/https://doi.org/10.3109/09638237.2012.734652>

- Mittal, D., Ounpraseuth, S., Reaves, C., Chekuri, L., Han, X., Corrigan, P., & Sullivan, G. (2016). Providers' personal and professional contact with persons with mental illness: Relationship to clinical expectations. *Psychiatric Services, 67*(1), 55-61.  
<https://doi.org/http://dx.doi.org/10.1176/appi.ps.201400455>
- Morera, T., Pratt, D., & Bucci, S. (2017). Staff views about psychosocial aspects of recovery in psychosis: A systematic review. *Psychology and psychotherapy, 90*(1), 1-24.  
<https://doi.org/http://dx.doi.org/10.1111/papt.12092>
- Mortel, T. (2008). Faking it: Social desirability bias in self-report research. *Journal of Advanced Nursing, 25*(4), 40-48.
- Moskowitz, A., & Corstens, D. (2007). Auditory hallucinations: psychotic symptom or dissociative experience? *The Journal of Psychological Trauma, 6*(2/3), 35-63.  
[https://doi.org/https://doi.org/10.1300/J513v06n02\\_04](https://doi.org/https://doi.org/10.1300/J513v06n02_04)
- Moskowitz, A., Mosquera, D., & Longden, E. (2017). Auditory verbal hallucinations and the differential diagnosis of schizophrenia and dissociative disorders: Historical, empirical and clinical perspectives. *European Journal of Trauma & Dissociation, 1*(1), 37-46.  
<https://doi.org/https://doi.org/10.1016/j.ejtd.2017.01.003>
- NHS. (2019, July). *NHS mental health implementation plan 2019/20 - 2023/24*. Retrieved from <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>
- NHS. (2021, March). *National results*. Retrieved from NHS Staff Survey:  
<https://www.nhsstaffsurveys.com/results/national-results/>
- NHS Digital. (2021, January 26). *NHS Workforce*. Retrieved from Gov.UK: <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest>

- NHS Employers. (2019, May 12). *Age in the NHS*. Retrieved from NHS Employers:  
<https://www.nhsemployers.org/case-studies-and-resources/2019/05/age-in-the-nhs-infographic>
- NICE. (2011, December 14). *Service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services*. Retrieved from National Institute for Health and Care Excellence: <https://www.nice.org.uk/guidance/cg136>
- NICE. (2014). *Psychosis and schizophrenia in adults: Prevention and management*. London: National Institute for Health and Care Excellence.
- Ochoa, S., Usall, J., Cobo, J., Labad, X., & Kulkarni, J. (2012). Gender differences in schizophrenia and first-episode psychosis: A comprehensive literature review. *Schizophrenia Research and Treatment*. <https://doi.org/https://doi.org/10.1155/2012/916198>
- Palinkas, L., Aarons, G., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and policy in mental health*, 38(1), 44-53. <https://doi.org/https://doi.org/10.1007/s10488-010-0314-z>
- Paulik, G., Jones, A., & Hayward, M. (2018). Brief Coping Strategy Enhancement for distressing voices: Predictors of engagement and outcome in routine clinical practice. *Clinical Psychology & Psychotherapy*, 25(5), 634-640. <https://doi.org/10.1002/cpp.2299>
- Pavon, G., & Vaes, J. (2017). Bio-genetic vs. psycho-environmental conceptions of schizophrenia and their role in perceiving patients in human terms. *Psychosis*, 9(3), 245-253.  
<https://doi.org/http://dx.doi.org/10.1080/17522439.2017.1311359>
- Pincus, T., Holta, S., Vogel, M., Underwood, M., Savage, D., Walsh, D., & Taylor, S. (2013). Cognitive and affective reassurance and patient outcomes in primary care: A systematic review. *Pain*, 154(11), 2407-2416. <https://doi.org/https://doi.org/10.1016/j.pain.2013.07.019>
- Poyato, A., & Nogueira, O. (2021). The association between empathy and the nurse–patient therapeutic relationship in mental health units: a cross-sectional study. *Journal of Psychiatric*

*and Mental Health Nursing*, 28(3), 335-343.

<https://doi.org/https://doi.org/10.1111/jpm.12675>

Pyle, M., & Morrison, A. (2014). "It's just a very taboo and secretive kind of thing": Making sense of living with stigma and discrimination from accounts of people with psychosis. *Psychosis*, 6(3), 195-205. <https://doi.org/http://dx.doi.org/10.1080/17522439.2013.834458>

Reddyhough, C., Locke, V., Badcock, J., & Paulik, G. (2020). Changing attitudes towards voice hearers: A literature review. *Community Mental Health Journal*, 57, 1032-1044.

<https://doi.org/https://doi.org/10.1007/s10597-020-00727-z>

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

Romme, M., & Escher, S. (2006). Trauma and hearing voices. In W. Larkin, & T. Morrison, *Trauma and psychosis: New directions for theory and therapy*. Hove, East Sussex: Routledge.

Romme, M., Escher, S., & Dillon, J. (2009). *Living with voices: 50 stories of recovery*. Ross-on-Wye: PCCS Books Ltd.

Rosenfield, S. (2012). Triple jeopardy? Mental health at the intersection of gender, race, and class. *Social Science & Medicine*, 74(11), 1791-1801.

<https://doi.org/https://doi.org/10.1016/j.socscimed.2011.11.010>

Ross, C., & Goldner, E. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 16, 558-567.

Rus, M., Lorenzo, A., Lluch-Canut, M., Tomas-Sabado, J., & Zabaleta-Del-Olmo, E. (2019). Instruments to assess mental health-related stigma among health professionals and students in health sciences: A systematic psychometric review. *Journal of Advanced Nursing*, 75(9), 1838-1853. <https://doi.org/https://doi.org/10.1111/jan.13960>

- Rydon, S. (2005). The attitudes, knowledge and skills needed in mental health nurses: The perspective of users of mental health services. *International Journal of Mental Health Nursing, 14*(2), 78-87. <https://doi.org/https://doi.org/10.1111/j.1440-0979.2005.00363.x>
- Sandhu, H., Arora, A., Brasch, J., & Streiner, D. (2019). Mental health stigma: Explicit and implicit attitudes of Canadian undergraduate students, medical school students, and psychiatrists. *The Canadian Journal of Psychiatry, 64*(3), 209-217. <https://doi.org/dx.doi.org/10.1177/0706743718792193>
- Sansone, R., & Sansone, L. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience, 8*(5), 16-20. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115767/>
- Sapey, B. (2013). Compounding the trauma: The coercive treatment of voice hearers. *European Journal of Social Work, 16*(3), 375-390. <https://doi.org/https://doi.org/10.1080/13691457.2012.674490>
- Schizophrenia Commission. (2012). *The abandoned illness: A report from the Schizophrenia Commission*. London.
- Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P., Grabe, H., Carta, M., & Angermeyer, M. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 125*, 440-452. <https://doi.org/10.1111/j.1600-0447.2012.01826.x>
- Scott, M., Mossell, S., Meyer, D., Toh, W., & Thomas, N. (2020). Childhood trauma, attachment and negative schemas in relation to negative auditory verbal hallucination content. *Psychiatry Research, 290*. <https://doi.org/https://doi.org/10.1016/j.psychres.2020.112997>
- Shattock, L., Berry, K., Degnan, A., & Edge, D. (2018). Therapeutic alliance in psychological therapy for people with schizophrenia and related psychoses: A systematic review. *Clinical psychology & psychotherapy, 25*(1), e60. <https://doi.org/http://dx.doi.org/10.1002/cpp.2135>

- Simmons, P., Hawley, C., Gale, T., & Sivakumaran, T. (2018). Service user, patient, client, user or survivor: Describing recipients of mental health services. *The Psychiatrist*, *34*(1), 20-23.  
<https://doi.org/10.1192/pb.bp.109.025247>
- Singh, S., Wright, C., Joyce, E., Barnes, T., & Burns, T. (2003). Developing early intervention services in the NHS: A survey to guide workforce and training needs. *Psychiatric Bulletin*, *14*, 254-258.
- Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge: Cambridge University Press.
- Slade, P., & Haddock, G. (1996). A historical overview of psychological treatments for psychotic symptoms. In G. Haddock, & P. Slade (Eds.), *Cognitive-behavioural interventions with psychotic disorders* (pp. 28-42). London: Routledge.
- Smith, D. (2007). *Muses, madmen and prophet: Rethinking the history, science and meaning of auditory hallucination*. New York: Penguin Press.
- Smith, J., Mittal, D., Chekuri, L., Han, X., & Sullivan, G. (2017). A comparison of provider attitudes toward serious mental illness across different health care disciplines. *Stigma and Health*, *2*(4), 327-337. <https://doi.org/http://dx.doi.org/10.1037/sah0000064>
- Stuber, J., Rocha, A., Christian, A., & Link, B. (2014). Conceptions of mental illness: attitudes of mental health professionals and the general public. *Psychiatric Services*, *65*(4), 490-497.  
<https://doi.org/http://dx.doi.org/10.1176/appi.ps.201300136>
- Thatchuk, A. (2011). Stigma and the politics of biomedical models of mental illness. *International Journal of Feminist Approaches to Bioethics*, *4*(1), 140-163.  
<https://doi.org/https://doi.org/10.3138/ijfab.4.1.140>
- Thonon, B., & Larøi, F. (2017). What predicts stigmatisation about schizophrenia? Results from a general population survey examining its underlying cognitive, affective and behavioural factors. *Psychosis*, *9*(2), 99-109.  
<https://doi.org/https://doi.org/10.1080/17522439.2016.1229361>

- Thornicroft, G., Brohan, E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, 2(3), 1-7. <https://doi.org/10.1186/1752-4458-2-3>
- Thornicroft, G., Rose, D., & Mehta, N. (2018). Discrimination against people with mental illness: what can psychiatrists do? *Advances in Psychiatric Treatment*, 16(1), 53-59. <https://doi.org/https://doi.org/10.1192/apt.bp.107.004481>
- Valery, K., & Prouteau, A. (2020). Schizophrenia stigma in mental health professionals and associated factors: A systematic review. *Psychiatry research*, 113068. <https://doi.org/http://dx.doi.org/10.1016/j.psychres.2020.113068>
- Vega, W., & Fernandez, R. (2008). Ethnicity and variability of psychotic symptoms. *Current Psychiatry Reports*, 10(3), 223-228. <https://doi.org/10.1007/s11920-008-0037-y>
- Vilhauer, R. (2017). Stigma and need for care in individuals who hear voices. *International Journal of Social Psychiatry*, 63(1), 5-13. <https://doi.org/10.1177/0020764016675888>
- Vistorte, A., Wagner, S., Jaen, D., Jorge, M., Evans-Lacko, S., & Mari, J. (2018). Stigmatizing attitudes of primary care professionals towards people with mental disorders: A systematic review. *International Journal of Psychiatry in Medicine*, 53(4), 317-338. <https://doi.org/http://dx.doi.org/10.1177/0091217418778620>
- Whitaker, R. (2016, July). *The case against antipsychotics*. Retrieved from Mad in America: <https://www.madinamerica.com/2016/07/the-case-against-antipsychotics/>
- Wood, L., Burke, E., Byrne, R., Pyle, M., Chapman, N., & A., M. (2015). Stigma in psychosis: A thematic synthesis of current qualitative evidence. *Psychosis*, 7(2), 152-165. <https://doi.org/http://dx.doi.org/10.1080/17522439.2014.926561>
- Zaninotto, L., Rossi, G., Danieli, A., Frasson, A., Meneghetti, L., Zordan, M., . . . Solmi, M. (2018). Exploring the relationships among personality traits, burnout dimensions and stigma in a



sample of mental health professionals. *Psychiatry research*, 264, 327-333.

<https://doi.org/https://doi.org/10.1016/j.psychres.2018.03.076>

**Appendix A: Salomons Ethics Panel approval**

This has been removed from the electronic copy.

**Appendix B: NHS IRAS approval**

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## **Appendix C: Full survey**

### **Attitudes 2 Voices: Adult Services**

**Title of Project:** Attitudes to Voices: A survey exploring the factors associated with clinicians' perspectives on hearing voices

#### **PARTICIPANT INFORMATION SHEET – Adult version**

##### **Background**

Many people sometimes hear a voice or voices that other people do not hear. Some of these individuals might seek help from mental health services for voice-hearing or for other difficulties they might be facing. However, there has been little research on the views and experiences of clinical staff about voice-hearing.

##### **What is the purpose of the study?**

The A2V Project (Attitudes to Voices) seeks to understand more about: clinicians' thoughts, feelings and approaches to working with patients who hear voices. clinicians' views and attitudes towards voice-hearing and the assessment of this experience in patients.

The findings may be used to inform training on ways of working with this patient group in the future.

##### **Who can take part?**

**All clinicians** (e.g. mental health nurse, support worker, occupational therapist, clinical

psychologist, psychiatrist) working with adults in: Inpatient Mental Health Services  
Secondary care services such as Assessment and Treatment Teams, Community  
Mental Health Teams; Specialist services such as forensic or personality disorder  
services; All clinicians working in primary care mental health services, such as IAPT;  
both step 2 and 3 professionals (e.g. 'low intensity' and 'high intensity' workers).

*Version 3: 01/02/2019 IRAS: 257355*

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Page

Break

**adult\_PIS2 Do I have to take part?**

It is up to you to decide to take part in the study. If you wish to take part, you will be asked to read a consent page (next section) and give consent to take part by clicking on the '→' button at the bottom of the consent page.

You are free to stop doing the survey at any point, without giving a reason. However, if you do not complete the survey, you will be not be able to withdraw your data and any data you have contributed may still be analysed.

Deciding not to take part or withdrawing will not affect your employment. We do not expect this survey to cause distress, however if you find some of the questions trigger emotions which you find hard to manage, you may wish to seek additional support through supervision, occupational health or your GP.

**What do I have to do?**

If you decide to take part in this study after reading this information sheet and the consent page (next section), this study involves completing an **anonymous** online survey. This can be accessed after the consent page.

The survey should take no longer than 30 minutes. You can start the survey, save the link to your bookmarks and access it again at a later time, as long as it is within a 2-week window.

Questions are mostly multiple choice. Please read each of the statements carefully and

choose the answer that best matches your opinion. There will be a few optional open-ended questions.

The survey will ask you questions about:

your views and experiences of working with people who hear voices

demographic information Written responses to the optional open-ended questions

may be quoted in the study write up.

**Will my taking part be kept confidential?**

Yes. We **will not** collect any identifiable information within the survey. All your answers will be **anonymous**. You will not be asked to disclose the name of the service you work or any other information that may identify you.

*Version 3: 01/02/2019 IRAS: 257355*

**Adult\_PIS3 Where and how long will the data be stored?**

Data (information) will be stored in secure computer systems on NHS or university premises. Information on computers will be kept for 10 years after the study is finished, then all the information will be destroyed.

**What will happen to the results of the study?** The results will be reported within research articles that we hope to publish within a mental health research journal. The article will also be included within a student's thesis at Canterbury Christ Church University. Also, other researchers may request to access the anonymised data and use it for research reports. If you would like to receive a copy of any publications resulting from this research, please email Jenny Barnes directly. Your email address will be stored securely, cannot be linked to your responses to the survey and will not be shared or used for any other purposes. The University of Sussex is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. In case you email Jenny Barnes directly to ask for any publications resulting from this research, the University of Sussex will keep your email address for up to 12 months after the study is completed. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we use your information by contacting



researchsponsorship@sussex.ac.uk. University of Sussex, Canterbury Christ Church University and Sussex Partnership NHS Foundation Trust will collect information from you for this research study in accordance with our instructions. University of Sussex, Canterbury Christ Church University and Sussex Partnership NHS Foundation Trust will use your name and email address to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Individuals from the University of Sussex and regulatory organisations may look at your research records to check the accuracy of the research study. The participating NHS sites will pass these details to University of Sussex along with the information collected from you. The only people in the University of Sussex who will have access to information that identifies you will be people who need to contact you to send you any publication resulting from this research study if you have contacted the researcher by email or audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. University of Sussex, Canterbury Christ Church University and Sussex Partnership NHS Foundation Trust will keep your email address from this study for up to 12 months after the study has finished. *Version 3: 01/02/2019 IRAS ID: 257355*

**Q315 Who is organising this research?**

This research is being co-organised by the University of Sussex, Canterbury Christ Church University and Sussex Partnership NHS Foundation Trust, and is part funded by the Economic and Social Research Council.

**Who has checked and approved this study?** This study has been approved by an ethics committee at the University of Sussex, through the Sponsorship Sub-Committee (Reference number: 048 HAY). This committee can be contacted via email, using the following address: [researchsponsorship@sussex.ac.uk](mailto:researchsponsorship@sussex.ac.uk). The research has also been approved by the Health Research Authority.

The study has also been reviewed and given favourable opinion by the Salomons Ethics Panel, Salomons Centre for Applied Psychology, Canterbury Christ Church University.

**Who do I contact if I want to know more about the study?**

Please direct any questions to the researcher **Jenny Barnes** via email:

[j.barnes1288@canterbury.ac.uk](mailto:j.barnes1288@canterbury.ac.uk) If you are unhappy about any aspect of this study and wish to complain formally, then please contact Dr Antony Walsh, Research Governance Officer at **University of Sussex**, tel: 01273 872748 or email: [researchsponsorship@sussex.ac.uk](mailto:researchsponsorship@sussex.ac.uk)

***Thank you for taking the time to read this information sheet! Please ask any questions if there is anything that requires clarification***

*Version 3: 01/02/2019 IRAS ID: 257355*

**Title of Project:** Attitudes to Voices: A survey exploring the factors associated with clinicians' perspectives on hearing voices

The information on this page concerns your consent to participating within this study. If you have any questions about the consent form, please contact the research team prior to completing the survey. By selecting the boxes below you are agreeing with the content of each box and consenting to take part in the study.

**You must agree with and click on each of the boxes below to proceed with the study.**

1. I confirm that I have read and understood the Participant Information Sheet (previous section, dated 1st February 2019, version 3) and have had the opportunity to have my questions answered. (1)

2. I understand that participating in this study will involve completing an **anonymous** survey (starting on the next page), which will take approximately 30 minutes. (2)

3. I understand that my participation is voluntary. I can choose not to participate, or I can withdraw from the study without being penalised or disadvantaged in any way. I understand that I can withdraw from the study by simply closing the

internet browser, and that if I do this, my data will be recorded and the data I have contributed may still be analysed. (3)

4. I understand that any information I provide is confidential, and that no information that I disclose will lead to the identification of any individual in the reports on the project, either by the researcher or by any other party. (9)

5. I understand that data will be stored securely, and that information will be handled in accordance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018. (10)

6. I consent for the Sussex Partnership NHS Foundation Trust, Kent Surrey and Sussex Clinical Research Network to audit/monitor the research data collected in this study. (11)

7. I understand that data may be shared with collaborators of the research team, for the purpose of answering additional research questions. (12)

8. I agree to take part in the above study. (13)

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*If you have any further questions about this consent form, please contact the main researcher: Jenny Barnes ([j.barnes1288@canterbury.ac.uk](mailto:j.barnes1288@canterbury.ac.uk))*

*or the project supervisors:*

Dr. Mark Hayward ([M.I.Hayward@sussex.ac.uk](mailto:M.I.Hayward@sussex.ac.uk))

Dr Sue Holttum ([sue.holttum@canterbury.ac.uk](mailto:sue.holttum@canterbury.ac.uk))

The full survey has been removed from the electronic copy due to copyright reasons.

**Appendix D: More than one profession stated: Profession chosen for analysis.**

As the analysis had more power with fewer groups, it was necessary to select one profession for analysis. Therefore, the highest paid, most senior or most patient-facing profession was selected. Where professions were presumed to be equal in these factors, the first profession listed was selected. This did not make a difference to the analysis, as in each of these cases professions were within the same staff group (e.g. psychosocial professions).

<b>First profession identified</b>	<b>Second profession identified</b>	<b>Third profession identified</b>	<b>Main profession selected</b>
Occupational therapist	CBT therapist		CBT therapist
Senior mental health nurse	CBT therapist		CBT therapist
Healthcare assistant	Other		Healthcare assistant
Counselling psychologist	CBT therapist		CBT therapist
CBT therapist	Art therapist	Psychotherapist	CBT therapist
Support worker	Trainee nurse		Trainee nurse
Psychological wellbeing practitioner	Counsellor		Counsellor
AP	Counsellor		Counsellor
Senior mental health nurse	CBT therapist		CBT therapist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Senior mental health nurse	Other	Senior mental health nurse
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Senior mental health nurse		Mental health nurse
Support worker	Healthcare assistant		Support worker
CBT therapist	Psychotherapist		CBT therapist
Mental health nurse	Senior mental health nurse	Other	Senior mental health nurse

Healthcare assistant	Trainee nurse		Trainee nurse
Psychiatrist	Other		Psychiatrist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Student		Mental health nurse
Trainee nurse	Student		Trainee nurse
Assistant psychologist	Other		Assistant psychologist
Support worker	Healthcare assistant		Support worker
Assistant Psychologist	Support worker		Assistant psychologist
Support worker	Other		Support worker
Support worker	Student		Support worker
Social worker	Support worker		Social worker
Occupational therapist	Student		Occupational therapist
Psychotherapist	Clinical psychologist		Clinical psychologist
Support worker	Healthcare assistant		Support worker
Psychological wellbeing practitioner	Support worker	Other	Psychological wellbeing practitioner
Psychiatrist	Other		Psychiatrist
Support worker	Other		Support worker
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Art therapist	Other		Art therapist
Psychiatrist	Psychotherapist		Psychiatrist
Mental health nurse	Senior mental health nurse	Other	Senior mental health nurse
Mental health nurse	Student		Mental health nurse
Trainee nurse	Student		Trainee nurse
Psychological wellbeing practitioner	Other		Psychological wellbeing practitioner
Mental health nurse	Student		Mental health nurse

Mental health nurse	Psychotherapist		Psychotherapist
Support worker	CBT therapist		CBT therapist
Healthcare assistant	Trainee nurse		Trainee nurse
Support worker	Trainee nurse		Trainee nurse
Art therapist	Other		Art therapist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	CBT therapist		CBT therapist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Psychiatrist	Psychotherapist		Psychotherapist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
CBT therapist	Counsellor		CBT therapist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Healthcare assistant	Trainee nurse	Student	Trainee nurse
Counselling psychologist	Other		Counselling psychologist
Occupational therapist	Other		Occupational therapist
Social worker	Other		Social worker
CBT therapist	Other		CBT therapist
Healthcare assistant	Trainee nurse		Trainee nurse
Support worker	Trainee nurse		Trainee nurse
Support worker	Other		Support worker
Mental health nurse	Senior mental health nurse	Other	Senior mental health nurse
Mental health nurse	Other		Mental health nurse
Trainee nurse	Student		Trainee nurse
Social Worker	Support worker	Counsellor	Social worker
Trainee nurse	Student		Trainee nurse
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Assistant psychologist	Student		Assistant psychologist



Mental health nurse	Counselling psychologist	Counsellor	Counselling psychologist
CBT therapist	Clinical psychologist		Clinical psychologist
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Support worker	Trainee nurse		Support worker
Mental health nurse	Senior mental health nurse		Senior mental health nurse
Mental health nurse	Other		Mental health nurse
Mental health nurse	Student		Mental health nurse
Trainee nurse	Healthcare assistant	Student	Trainee nurse
Mental health nurse	Trainee nurse		Mental health nurse
CBT therapist	Counsellor		CBT therapist
Support worker	Other		Support worker
Mental health nurse	Senior mental health nurse	CBT therapist	CBT therapist
Art therapist	Other		Art therapist
Social worker	Other		Social worker
Counselling Psychologist	Clinical psychologist		Counselling psychologist
Mental health nurse	Senior mental health nurse	CBT therapist	CBT therapist
Psychiatrist	Other		Psychiatrist
Student	Other		Student
Senior mental health nurse	CBT therapist		CBT therapist
Healthcare assistant	Student		Healthcare assistant

### **Appendix E: Rationale for division of staff groups**

Following discussion with the PI (SH), the following divisions between professions were decided upon. This corresponded with the hypothesis wording “psychosocial or biomedical training or experiences” and was in accord with previous research on biomedical or biogenetic versus psychosocial perspectives on voice hearing and mental illness (Angermeyer, Holzinger, Carta, & Schomerus, 2011). Professions which were not mental health clinicians or which could not be classified as to psychosocial or biomedical were removed from analysis. This included research staff, students, admin staff, those who selected ‘other’, missing data, and HCSW from specialist services or ‘other’ teams.

Psychological, psychotherapeutic and professions with a social model of mental health difficulties (social workers, occupational therapists) were grouped together as they work predominantly in a psychosocial framework (Heller & Gitterman, 2011). Peer workers were also included in this category due to their life experience.

Psychiatrists and nurses were given separate group categories as their training and experiences lead to different degrees of medical interventions and experiences.

Mental health nurse training consists of two thirds core nursing skills, with additional training around mental health. Whilst administering medication, nurses also work through by building therapeutic relationships and psychosocial interventions.

<https://www.healthcareers.nhs.uk/explore-roles/nursing/roles-nursing/mental-health-nurse>

Psychiatry training consists of five years of core medical training, with subsequent training whilst working as a psychiatrist. Treatments used largely consist of medical

treatments. <https://www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry/how-to-become-a-psychiatrist>

Healthcare support workers were divided into inpatient and community roles, as they have differences in experience in these two settings (inpatient settings being more focused on medical interventions) and they may have been influenced more by experience and less by training than other professions. These two groups also have differing training experiences, with a higher percentage of community-based HCSWs describing themselves as having received training, and also identifying as having attended one of the training courses listed in the questionnaire.

#### Differences between community-based and hospital-based HCSWs

		I have received training with regard to hearing voices	I have no training with regard to hearing voices, but considerable experience through clinical work	I have received no training with regard to hearing voices and very limited experience through clinical work	Total
HCSWs community setting	Count	14	18	5	37
	% within professional category	37.8%	48.6%	13.5%	100%
HCSWs hospital setting	Count	11	33	5	49
	% within professional category	22.4%	67.3%	10.2%	100%
		Has attended specific training on hearing	Has not attended specific voice hearing training as listed in the survey		total

		voices listed in the survey		
HCSWs community setting	Count	9	29	38
	% within professional category	23.7%	76.3%	100.0%
HCSWs hospital setting	Count	5	47	52
	% within professional category	9.6%	90.4%	100.0%

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**Appendix F: Notes from consultation meetings with an expert-by-experience and a nursing lecturer**

**Notes from stakeholder consultation with an expert-by-experience**

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**Notes from stakeholder consultation with a Nurse Trainer (Senior Lecturer)**

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## Appendix G: Coding schedules for qualitative data

### Exploratory ratings:

#### 1. Definitely did not ask about voices

Lack of exploratory approach clear from story.

Asked about something else

E.g. "I explained the disease process and what might be contributing it. I also worked towards admission to hospital."

"I asked what clinical support they were receiving and if it has been helpful."

"I reassured him and told him to ignore the voices and keep taking his prescribed medication"

Intention to distract rather than explore

e.g. "to get the patient's attention and take them away from the current situation of hearing voices"

Specifically mention not asking further

e.g. "I did not further assess as had already spoken to psychiatrist and psychologist. Did not want service user to have to keep repeating themselves talking about their voices"

"Did not want to cause embarrassment to the service user in front of her peers by drawing attention to her symptoms"

#### 2. Appeared to ask about voices but unclear to what extent.

"interested in the persons responses" (without any further detail)

“we talked about how it felt, what had helped in the past” (not directly mentioning voice hearing experience).

“explored what the person was experiencing and how it was impacting upon them.”

### 3. Asked but not in depth

Asked 1 or 2 questions- e.g. “Asked about nature and content of the voices”

Mention curiosity

asked questions about experience

asked about the voices, content

Number, content and nature of voices

### 4. Definitely exploratory

- describe asking 3 or more questions about the voices
  - e.g. “I assessed the number of voices heard (one or more), asked if the patient could identify those voices as people he knew, asked what the voices said, asked if the voices gave him commands and whether he acted according to the voices, asked if the voices were aggressive in nature or asked him to harm himself or other people.”
- Asked open questions rather than “internal/external”,
- Showing from answers that they already knew a lot about the voices
  - e.g. “asked if they could tell me a bit more about the voices. What they were saying.... she was able to tell me that they were telling her to leave the building. We were able to discuss whether this was something she wanted, or the voices wanted which led to a discussion over her perceived control over the voices.”
- “We discussed them at length”, “I asked a lot of questions about them”, “I was interested in what the voices (and visual hallucinations) were, so spent the whole session discussing his experiences”

### 5. Declined to talk

“The service user disclosed the fact she was hearing voices but she did not want to elaborate further about them.”



“I asked once about what she was hearing, but she clearly did not want to talk about it or even admit she was hearing anything I couldn't, so I let the subject drop.”

### **Biomedical vs. psychosocial**

If exploratory, consider the reason for the exploration.

Story is predominantly:

1) Biogenetic/biomedical response

Causal attributions: biological abnormalities/ chemical imbalances/ physical causes e.g. response to drugs, maternal illness during gestation.

Current experiences: labelling current experiences using medical terminology, relating the experiences to physical disease, denying reality of voices.

Exploring experiences with clear biomedical-related purpose (e.g. risk assessment, medication prescription, for the purpose of diagnosing).

Treatment: focus on medical treatment/physiological interventions, such as medication, also referral on to a medical professional (psychiatrist). Focus on removing symptoms as key to reducing distress.

2) Neutral or ambiguous response, either not mentioning anything clearly either biomedical/biogenetic nor psychosocial, or mentioning equal aspects of both.

3) Psychosocial response

Rich, in depth understanding of:

Casual attributions: impact of past experiences, trauma, social factors, relationships with others, psychosocial stressors

Current experiences: impact on social functioning, exploring psychological impact of voices (e.g. Relationship with voices, response to voices, meaning of what they say), psychosocial impacts

Treatment: psychological treatment recommended. Social factors considered. Focus on wellbeing, quality of life and managing despite symptoms. Not clearly wanting to get rid of voices, e.g. "living with voices".

### Appendix H: Full results

***Hypothesis 1a: Participants who have received Maastricht-informed training and/or personal experience will have lower stigmatising attitudes.***

*Training in supporting voice hearers and stigma – Kruskal-Wallis test*

Null Hypothesis	Test	Sig.
The distribution of AAPPQ: role security is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.000
The distribution of AAPPQ: therapeutic commitment is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.000
The distribution of AAPPQ: empathy is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.742
The distribution of AQ9, Q1 Pity is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.173
The distribution of AQ9, Q2 Dangerousness is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.062
The distribution of AQ9, Q3 Fear is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.157
The distribution of AQ9, Q4 Blame is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.131

	The distribution of AQ9, Q5 Segregation is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.394
	The distribution of AQ9, Q6 Anger is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.110
0	The distribution of AQ9, Q7 Help is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.018
1	The distribution of AQ9, Q8 Avoidance is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.416
2	The distribution of AQ9, Q9 Coercion is the same across categories of Any of the above training courses.	Independent-Samples Mann-Whitney U Test	.001

*“Have you, or someone close to you (such as a relative or friend), heard voices?” and stigma*

	Null Hypothesis	Test	Sig.
	The distribution of AAPPQ: role security is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.059
	The distribution of AAPPQ: therapeutic commitment is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.010

	The distribution of AAPPQ: empathy is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.103
	The distribution of AQ9, Q1 Pity is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.734
	The distribution of AQ9, Q2 Dangerousness is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.277
	The distribution of AQ9, Q3 Fear is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.073
	The distribution of AQ9, Q4 Blame is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.622
	The distribution of AQ9, Q5 Segregation is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.107
	The distribution of AQ9, Q6 Anger is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.072
0	The distribution of AQ9, Q7 Help is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.391

1	The distribution of AQ9, Q8 Avoidance is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.029
2	The distribution of AQ9, Q9 Coercion is the same across categories of Personal experience of voices.	Independent-Samples Mann-Whitney U Test	.033

***Hypothesis 1b: Professions with more psychosocial training and experience will have less stigmatising attitudes.***

*Stigma differences between professional groups using Kruskal-Wallis test*

	Null Hypothesis	Test	Sig.
	The distribution of AAPPQ: role security is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.000
	The distribution of AAPPQ: therapeutic commitment is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.000
	The distribution of AAPPQ: empathy is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.177
	The distribution of AQ9, Q1 Pity is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.008

	The distribution of AQ9, Q2 Dangerousness is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.007
	The distribution of AQ9, Q3 Fear is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.001
	The distribution of AQ9, Q4 Blame is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.144
	The distribution of AQ9, Q5 Segregation is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.001
	The distribution of AQ9, Q6 Anger is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.399
0	The distribution of AQ9, Q7 Help is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.044
1	The distribution of AQ9, Q8 Avoidance is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.301
2	The distribution of AQ9, Q9 Coercion is the same across categories of prof cat. bio/psychosoc. inc. HCSWs.	Independent-Samples Kruskal-Wallis Test	.000

*Role security between professional groups***Independent-Samples Kruskal-Wallis Test Summary**

Total N	717
Test Statistic	109.085 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.000

a. The test statistic is adjusted for ties.

**Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs**

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
HCSWs hospital setting- HCSWs community setting	50.3 17	5 2.321	.962	. 336	1. 000
HCSWs hospital setting- Psychosocial profession	194. 611	3 7.607	5.175	. 000	.0 00
HCSWs hospital setting- Nurses	197. 485	3 7.614	5.250	. 000	.0 00
HCSWs hospital setting- Psychiatrists	364. 099	4 1.145	8.849	. 000	.0 00
HCSWs community setting- Psychosocial profession	144. 294	4 0.392	3.572	. 000	.0 04
HCSWs community setting- Nurses	147. 167	4 0.399	3.643	. 000	.0 03
HCSWs community setting- Psychiatrists	313. 782	4 3.706	7.179	. 000	.0 00



Psychosocial profession-Nurses	- 2.874	1 7.572	-.164	. 870	1. 000
Psychosocial profession- Psychiatrists	- 169.488	2 4.226	- 6.996	. 000	.0 00
Nurses- Psychiatrists	- 166.614	2 4.237	- 6.874	. 000	.0 00

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

#### *Therapeutic commitment between professional groups*

#### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	719
Test Statistic	69.844 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.000

a. The test statistic is adjusted for ties.

#### **Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs**

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
HCSWs hospital setting- HCSWs community setting	27.0 95	5 2.135	.520	. 603	1. 000
HCSWs hospital setting- Nurses	143. 096	3 7.246	3.842	. 000	.0 01

HCSWs hospital setting- Psychosocial profession	146. 040	3 7.231	3.923	.	.0 000	.0 01
HCSWs hospital setting- Psychiatrists	283. 725	4 0.829	6.949	.	.0 000	.0 00
HCSWs community setting- Nurses	116. 001	4 0.522	2.863	.	.0 004	.0 42
HCSWs community setting- Psychosocial profession	118. 945	4 0.509	2.936	.	.0 003	.0 33
HCSWs community setting- Psychiatrists	256. 630	4 3.839	5.854	.	.0 000	.0 00
Nurses- Psychosocial profession	2.94 3	1 7.610	.167	.	.0 867	1. 000
Nurses- Psychiatrists	- 140.629	2 4.311	- 5.784	.	.0 000	.0 00
Psychosocial profession- Psychiatrists	- 137.685	2 4.288	- 5.669	.	.0 000	.0 00

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

#### *Empathy between professional groups*

#### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	717
Test Statistic	6.310 <sup>a,b</sup>
Degree Of Freedom	4

Asymptotic Sig.(2-sided test)	.177
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a. The test statistic is adjusted for ties.

b. Multiple comparisons are not performed because the overall test does not show significant differences across samples.

*Pity between professional groups*

### Independent-Samples Kruskal-Wallis Test Summary

Total N	701
Test Statistic	13.752 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.008

a. The test statistic is adjusted for ties.

### Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
Nurses- Psychosocial profession	10.6 42	1 7.242	.617	. 537	1. 000
Nurses- HCSWs community setting	- 18.085	4 1.262	-.438	. 661	1. 000
Nurses- Psychiatrists	- 68.769	2 3.713	- 2.900	. 004	.0 37
Nurses- HCSWs hospital setting	- 94.962	3 6.570	- 2.597	. 009	.0 94

Psychosocial profession-HCSWs community setting	- 7.443	4 1.215	-.181	. 857	1. 000
Psychosocial profession- Psychiatrists	- 58.128	2 3.632	- 2.460	. 014	.1 39
Psychosocial profession-HCSWs hospital setting	- 84.321	3 6.518	- 2.309	. 021	.2 09
HCSWs community setting- Psychiatrists	50.6 85	4 4.314	1.144	. 253	1. 000
HCSWs community setting- HCSWs hospital setting	- 76.878	5 2.333	- 1.469	. 142	1. 000
Psychiatrists- HCSWs hospital setting	- 26.193	3 9.982	-.655	. 512	1. 000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

#### *Dangerousness between professional groups*

#### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	698
Test Statistic	14.162 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.007

a. The test statistic is adjusted for ties.

**Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs**

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
Psychosocial profession-Nurses	- 6.096	1 6.735	-.364	. 716	1. 000
Psychosocial profession- Psychiatrists	- 28.529	2 2.993	- 1.241	. 215	1. 000
Psychosocial profession-HCSWs community setting	- 74.762	3 9.936	- 1.872	. 061	.6 12
Psychosocial profession-HCSWs hospital setting	- 115.440	3 5.386	- 3.262	. 001	.0 11
Nurses- Psychiatrists	- 22.433	2 3.072	-.972	. 331	1. 000
Nurses- HCSWs community setting	- 68.666	3 9.981	- 1.717	. 086	.8 59
Nurses- HCSWs hospital setting	- 109.344	3 5.437	- 3.086	. 002	.0 20
Psychiatrists- HCSWs community setting	- 46.233	4 2.978	- 1.076	. 282	1. 000
Psychiatrists- HCSWs hospital setting	- 86.911	3 8.786	- 2.241	. 025	.2 50
HCSWs community setting- HCSWs hospital setting	- 40.678	5 0.701	-.802	. 422	1. 000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

*Fear between professional groups***Independent-Samples Kruskal-Wallis Test Summary**

Total N	698
Test Statistic	18.664 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.001

a. The test statistic is adjusted for ties.

**Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs**

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
Nurses- Psychiatrists	- 22.437	2 1.564	- 1.040	. 298	1. 000
Nurses- Psychosocial profession	25.5 78	1 5.642	1.635	. 102	1. 000
Nurses- HCSWs community setting	- 97.985	3 7.369	- 2.622	. 009	.0 87
Nurses- HCSWs hospital setting	- 121.259	3 3.121	- 3.661	. 000	.0 03
Psychiatrists- Psychosocial profession	3.14 1	2 1.490	.146	. 884	1. 000
Psychiatrists- HCSWs community setting	- 75.548	4 0.170	- 1.881	. 060	.6 00
Psychiatrists- HCSWs hospital setting	- 98.822	3 6.252	- 2.726	. 006	.0 64

Psychosocial profession-HCSWs community setting	- 72.406	3 7.327	- 1.940	. 052	.5 24
Psychosocial profession-HCSWs hospital setting	- 95.681	3 3.073	- 2.893	. 004	.0 38
HCSWs community setting- HCSWs hospital setting	- 23.275	4 7.388	-.491	. 623	1. 000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

#### ***Blame between professional groups***

##### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	698
Test Statistic	6.851 <sup>a,b</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.144

a. The test statistic is adjusted for ties.

b. Multiple comparisons are not performed because the overall test does not show significant differences across samples.

#### ***Segregation between professional groups***

##### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	698
Test Statistic	18.470 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.001

a. The test statistic is adjusted for ties.

**Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs**

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
Nurses- HCSWs community setting	- 4.039	3 5.153	-.115	. 909	1. 000
Nurses- Psychosocial profession	11.4 57	1 4.714	.779	. 436	1. 000
Nurses- Psychiatrists	- 20.028	2 0.285	-.987	. 323	1. 000
Nurses- HCSWs hospital setting	- 132.890	3 1.158	- 4.265	. 000	.0 00
HCSWs community setting- Psychosocial profession	7.41 8	3 5.114	.211	. 833	1. 000
HCSWs community setting- Psychiatrists	15.9 89	3 7.788	.423	. 672	1. 000
HCSWs community setting- HCSWs hospital setting	- 128.851	4 4.579	- 2.890	. 004	.0 38
Psychosocial profession- Psychiatrists	- 8.571	2 0.216	-.424	. 672	1. 000
Psychosocial profession-HCSWs hospital setting	- 121.432	3 1.113	- 3.903	. 000	.0 01



Psychiatrists- HCSWs hospital setting	- 112.862	3 4.103	- 3.309	. 001	.0 09
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Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

### ***Anger between professional groups***

#### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	697
Test Statistic	4.049 <sup>a,b</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.399

a. The test statistic is adjusted for ties.

b. Multiple comparisons are not performed because the overall test does not show significant differences across samples.

### ***Help between professional groups***

#### **Independent-Samples Kruskal-Wallis Test Summary**

Total N	697
Test Statistic	9.822 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.044

a. The test statistic is adjusted for ties.

Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs						
Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>	
HCSWs community setting- Psychiatrists	11.5 91	3 8.090	.304	. 761	1. 000	
HCSWs community setting- Nurses	14.2 52	3 5.440	.402	. 688	1. 000	
HCSWs community setting- Psychosocial profession	52.1 33	3 5.394	1.473	. 141	1. 000	
HCSWs community setting- HCSWs hospital setting	- 62.523	4 4.934	- 1.391	. 164	1. 000	
Psychiatrists- Nurses	2.66 1	2 0.458	.130	. 897	1. 000	
Psychiatrists- Psychosocial profession	40.5 42	2 0.378	1.990	. 047	.4 66	
Psychiatrists- HCSWs hospital setting	- 50.932	3 4.375	- 1.482	. 138	1. 000	
Nurses- Psychosocial profession	37.8 80	1 4.846	2.552	. 011	.1 07	
Nurses- HCSWs hospital setting	- 48.270	3 1.413	- 1.537	. 124	1. 000	
Psychosocial profession-HCSWs hospital setting	- 10.390	3 1.361	-.331	. 740	1. 000	

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

***Avoidance between professional groups***

**Independent-Samples Kruskal-Wallis Test Summary**

Total N	696
Test Statistic	4.865 <sup>a,b</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.301

a. The test statistic is adjusted for ties.

b. Multiple comparisons are not performed because the overall test does not show significant differences across samples.

***Coercion between professional groups***

**Independent-Samples Kruskal-Wallis Test Summary**

Total N	695
Test Statistic	38.534 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.000

a. The test statistic is adjusted for ties.

Pairwise Comparisons of prof cat. bio/psychosoc. inc. HCSWs					
Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	S ig.	A dj. Sig. <sup>a</sup>
HCSWs community setting- Psychosocial profession	70.5 23	4 0.026	1.762	. 078	.7 81
HCSWs community setting- Nurses	90.9 52	4 0.066	2.270	. 023	.2 32
HCSWs community setting- Psychiatrists	177. 893	4 3.062	4.131	. 000	.0 00
HCSWs community setting- HCSWs hospital setting	- 203.457	5 0.800	- 4.005	. 000	.0 01
Psychosocial profession-Nurses	- 20.429	1 6.814	- 1.215	. 224	1. 000
Psychosocial profession- Psychiatrists	- 107.370	2 3.060	- 4.656	. 000	.0 00
Psychosocial profession-HCSWs hospital setting	- 132.934	3 5.469	- 3.748	. 000	.0 02
Nurses- Psychiatrists	- 86.942	2 3.128	- 3.759	. 000	.0 02
Nurses- HCSWs hospital setting	- 112.505	3 5.513	- 3.168	. 002	.0 15
Psychiatrists- HCSWs hospital setting	- 25.564	3 8.862	-.658	. 511	1. 000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

**Hypothesis 2a: Participants who have received Maastricht-informed training and/or personal experience will have interactions rated as more exploratory and psychosocial.**

**Odds of interactions rated as more exploratory, compared with hospital-based HCSWs**

		Standard Error	Wald	df	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Threshold	[Explor_Psyc hosoc = 1.00]	.230	196.792	1	.000	3.678	2.776
	[Explor_Psyc hosoc = 2.00]	.187	9.757	8	.000	2.135	1.403
	[Explor_Psyc hosoc = 3.00]	.183	5.826	6	.000	1.841	1.124
	[Explor_Psyc hosoc = 4.00]	.175	9.947	9	.002	.894	.209
	[Explor_Psyc hosoc = 6.00]	.175	6.785	6	.009	.113	.797
	[Explor_Psyc hosoc = 8.00]	.176	4.220	1	.000	.319	1.009
	[Explor_Psyc hosoc = 9.00]	.193	0.984	7	.000	1.245	2.001
Location	[Train_YN=0]	.155	7.813	7	.005	.738	.130
	[Train_YN=1]	.	.	.	.	.	.
	[Person_exp voices=0]	.152	1.914	1	.167	.509	.088
	[Person_exp voices=1]	.	.	.	.	.	.

**Hypothesis 2b: Professions with more psychosocial training and experience will have interactions rated as more exploratory and psychosocial**

**Differences between professional groups on exploratory/psychosocial rating using  
Kruskal-Wallis test**

**Independent-Samples Kruskal-  
Wallis Test Summary**

Total N	593
Test Statistic	85.692 <sup>a</sup>
Degree Of Freedom	4
Asymptotic Sig.(2-sided test)	.000

a. The test statistic is adjusted for ties.

**Pairwise Comparisons of Profession category**

Sample 1- Sample 2	Test Statistic	S td. Error	Std. Test Statistic	Sig.	A dj. Sig. <sup>a</sup>
HCSWs hospital setting- Psychiatrists	10.4 21	3 6.410	.286	.775	.100
HCSWs hospital setting- Nurses	78.4 62	3 3.345	2.353	.019	.186
HCSWs hospital setting- HCSWs community setting	109. 372	4 9.060	2.229	.026	.258
HCSWs hospital setting- Psychosocial profession	176. 276	3 3.176	5.313	.000	.000
Psychiatrists- Nurses	68.0 42	2 1.743	3.129	.002	.018
Psychiatrists- HCSWs community setting	- 98.951	4 2.045	- 2.353	.019	.186
Psychiatrists- Psychosocial profession	165. 856	2 1.482	7.721	.000	.000

Nurses- HCSWs community setting	- 30.909	3 9.421	-.784	. 433	1. 000
Nurses- Psychosocial profession	97.8 14	1 5.739	6.215	. 000	.0 00
HCSWs community setting- Psychosocial profession	66.9 05	3 9.277	1.703	. 088	.8 85

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

**Hypothesis 3: Less stigmatising attitudes will be associated with more exploratory and psychosocial-rated encounter descriptions.**

## Parameter Estimates

Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test			Exp(B)	95% Wald Confidence Interval for Exp(B)	
			Lower	Upper	Wald Chi-Square	df	Sig.		Lower	Upper
AAPPQ: role security	.024	.1099	-.191	.240	.049	1	.825	1.025	.826	1.271
AAPPQ: therapeutic commitment	.061	.1377	-.209	.331	.199	1	.655	1.063	.812	1.393
AAPPQ: empathy	-.245	.1162	-.473	-.017	4.446	1	.035	.783	.623	.983
AQ9, Q1 Pity	-.034	.0294	-.092	.024	1.346	1	.246	.966	.912	1.024
AQ9, Q2 Dangerousness	-.088	.0574	-.200	.025	2.325	1	.127	.916	.819	1.025
AQ9, Q3 Fear	.064	.0684	-.070	.198	.870	1	.351	1.066	.932	1.219
AQ9, Q4 Blame	.071	.1119	-.149	.290	.399	1	.528	1.073	.862	1.336
AQ9, Q5 Segregation	.006	.0685	-.128	.140	.008	1	.929	1.006	.880	1.151
AQ9, Q6 Anger	-.208	.0927	-.390	-.026	5.020	1	.025	.812	.677	.974
AQ9, Q7 Help	-.003	.0295	-.061	.055	.012	1	.912	.997	.941	1.056
AQ9, Q8 Avoidance	.020	.0919	-.160	.200	.046	1	.830	1.020	.852	1.221
AQ9, Q9 Coercion	-.138	.0427	-.221	-.054	10.384	1	.001	.871	.802	.948
(Scale)	1 <sup>a</sup>									

Dependent Variable: Exploratory and psychosocial variables combined

Model: (Threshold), AAPPQ: role security, AAPPQ: therapeutic commitment, AAPPQ: empathy, AQ9, Q1 Pity, AQ9, Q2 Dangerousness, AQ9, Q3 Fear, AQ9, Q4 Blame, AQ9, Q5 Segregation, AQ9, Q6 Anger, AQ9, Q7 Help, AQ9, Q8 Avoidance, AQ9, Q9 Coercion

a. Fixed at the displayed value.



## Appendix I: End of study report

**Background:** Traditional approaches to working with voice hearers aimed to shut down or remove the voices ('auditory hallucinations'). However, research into voice hearers' perspectives has found that the experience of hearing voices is meaningful (Klapheck et al., 2014) and that accepting and exploring the voice hearing experience may be helpful for recovery (Corstens et al., 2014; Romme & Escher, 2000). Further, voice hearers frequently report wishing to discuss their experiences with clinicians (Coffey & Hewitt, 2008; Griffiths et al., 2018).

Stigma may pose one barrier to clinicians exploring voice hearing experiences (Vilhauer, 2017). Individuals with a diagnosis of schizophrenia (which is frequently associated with voice hearing; (APA, 2013) suffer from negative preconceptions amongst both the general public (Thonon & Larøi, 2017) and mental health staff (de Jacq et al., 2020).

The present study used the social cognitive model of stigma (Corrigan et al., 2004) to examine the interaction between the source of stereotypes (e.g. orientation of training, experience), stigmatising beliefs and self-reported behaviours in an interaction with a voice hearer.

**Method:** Mixed methodology was used to analyse the responses of 1018 staff working in mental health trusts who responded to an online survey. Inductive and deductive thematic analysis was used to explore responses to an open-ended question, and descriptive statistics and responses to questionnaires on attitudes and stigma were analysed. A bracketing interview was conducted to minimise researcher bias. An experts-by-experience steering group was consulted at an early stage, and consultation on results was sought from an expert-by-experience and a nursing lecturer.

**Results:** Overall, stigma was low for all groups, although there was some conflict between questionnaire and qualitative data; for example, fear emerged as a theme in the open-ended question. Clinicians working in more psychosocial professions, those with specific training to work with voices/ voice hearers and with personal experience tended to have lower stigma, and to describe more exploratory and psychosocial interactions with voice hearers. Support workers based in hospitals and psychiatrists tended to have lower levels of training and higher stigma than other professions. In the interactions, clinicians predominantly described providing reassurance and encouraging distraction; both approaches which may be unhelpful. Approaches which may be more helpful such as psychoeducation, hopefulness, normalising and exploring voices were less commonly described.

**Clinical and research implications:** Clinicians most often described attempting to help in ways which have been reported to be unhelpful or to increase distress in previous literature. Consistent with previous research, a lack of training and biomedical training orientation was linked with both worse attitudes and less helpful responses to voice hearers. It is possible that a bi-directional relationship exists based on service users' angry responses to unhelpful approaches used by staff, and subsequent worsening clinician attitudes. Personal experience of voices or voice hearers was linked with better attitudes.

Clinicians described frustration with their lack of training. It is recommended that voice hearing training with a psychosocial orientation should be provided for all clinicians as part of their induction. As it is likely that skilling up clinicians to provide a more therapeutic response will reduce negative reactions from patients, training should especially be targeted

at those most at risk of violence. Further, skills gained from this training (e.g. validation) are likely to be helpful working with all patient groups.

Clinicians also described frustration with the lack of availability of psychological or psychosocial resources to refer patients to. Greater provision of psychological or psychotherapeutic therapies, in accordance with NICE guidelines is recommended. Hearing voices groups are a peer-led (therefore lower-stigma) source of validation and support, yet are not currently available in all areas. Increased liaison and additional provision of financial and logistic support to the Hearing Voices Network is recommended.

One further implication of the findings is that approaches which increase personal experience, such as working alongside voice hearers is likely to improve attitudes. This supports the proposed increase of the peer worker role in the NHS. Additionally, there is a need for increased support for clinicians who occupy 'dual roles' to be open about their experiences (e.g. training and consultation from the organisation in2gr8mentalhealth, 2021).

## **Appendix J: Author guidelines for publication in Psychosis journal**

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the [Uniform Requirements for Manuscripts Submitted to Biomedical Journals](#), prepared by the International Committee of Medical Journal Editors (ICMJE).

### Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

### Word Limits

Please include a word count for your paper.

The maximum word length for an Article in this journal is 6000 words (this limit includes tables, references and figure captions).

The maximum word length for a First Person Account is 3500 words.

The maximum word length for a Brief Report is 1500 words.

The maximum word length for an Opinion Piece is 1500 words.

The maximum word length for Letters to Editor is 400 words.

The maximum word length for a Book Review is 1000 words.

### Style Guidelines

#### Font

Use Times New Roman font in size 12 with double-line spacing.

#### Margins

Margins should be at least 2.5cm (1 inch).

#### Title

Use bold for your article title, with an initial capital letter for any proper nouns.

#### Abstract

Indicate the abstract paragraph with a heading or by reducing the font size. The instructions for authors for each journal will give specific guidelines on what's required here, including whether it should be a structured abstract or graphical abstract, and any word limits. Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation".

Please note that long quotations should be indented without quotation marks.

#### Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text.

To assist you in preparing your paper, we provide formatting template(s).

[Word templates](#) are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us [here](#).

#### References

Please use APA referencing